

A PRIMER FOR JOURNALISTS ON MEDICARE REFORM PROPOSALS

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From time to time, President Bush has offered observations on the imperative of reforming the Medicare program. He did so in his *State of the Union Address* and in the follow-up address in Michigan. He did so again on March 3, 2003 in his address to the American Medical Association entitled “*21st Century Medicare: More Choice—Better Benefits.*”

In this endeavor, the President builds on ideas initially advanced in the journal *Health Affairs* by Brookings economists Henry Aaron and Robert Reischauer, who in the mid-1990s, offered the outlines of a premium-support model for Medicare based on managed competition among private health plans¹. These ideas subsequently informed the work of the *Bi-Partisan Commission on the Future of Medicare*, which, however, did not have a majority vote to support the proposal before it. The *Commission's* proposal was subsequently introduced as a bill in the Senate by two members of the *Commission*, Senators John Breaux (D-LA) and Bill Frist (R-TN). It is known in the literature as *Breaux-Frist I*. A subsequent bill authored by the two Senators, called *Breaux-Frist II*, focused not on an overall Medicare reform, but mainly on adding prescription drug coverage, which the authors of the bill would have included in both the traditional Medicare program and the *Medicare+Choice* program established with the *Balance Budget Act of 1997*.

Because the President's proposal remains at the level of highly abstract sketches of a mere framework for Medicare reform, it would be premature to comment on it in detail, other than its main thrust, which appears to be a set of tax-financed financial incentives for Medicare beneficiaries deliberately tilted in favor of private health plans. Therein lies the plan's most controversial feature.

In the following primer on Medicare reform, I focus initially on the shortcomings of the traditional Medicare program and their origin. Thereafter I comment on the nature of choice and the style of competition that might be offered by Medicare reform and on the diverse goals the authors of Medicare reform proposals may have in mind. The objective is not to proffer one or the other proposal, but merely to provide for journalists a framework that might help them formulate targeted questions on this issue.

¹ Henry J. Aaron and Robert D. Reischauer, “The Medicare Reform Debate: What is the next Step?” *Health Affairs* (Winter, 1995): pp. 8-30.

A. THE SHORTCOMINGS OF THE TRADITIONAL MEDICARE PROGRAM

The traditional Medicare program, which was passed into legislation in 1965, still covers over 80 percent of the 40 million or so Medicare beneficiaries. The program remains highly popular among Medicare beneficiaries and their children. In surveys on consumer satisfaction with how well various insurance products or carriers satisfy consumers, the Medicare program invariably receives among the highest and often the highest satisfaction scores.² It appears to be so, because Medicare is administratively simple from the beneficiary's perspective and offers them a sense of *permanent security*—health insurance that one cannot lose. Furthermore, most Medicare beneficiaries have supplementary insurance to cover the gaps in the traditional Medicare benefit package.

What is proposed to be reformed, then, is a government-run program that remains highly popular among the citizenry, even if not among all policy analysts and policy makers. To understand better the current imperative of reform, it is well to explore why this inherently popular program has the shortcomings attributed to it and precisely who should be blamed for these shortcomings. My short answer is that the main culprit is not the much maligned bureaucracy administering Medicare, but its Board of Directors: the Congress of the United States.

The Critics of Medicare: The critics of Medicare--chiefly market-oriented policy analysts and policy makers--call the program hopelessly "outdated." To quote from the President's recent press release entitled "21st Century Medicare: More Choices—Better Benefits" (March 3, 2003):

As successful as Medicare has been, it has not kept pace with decades of dramatic improvements in health care delivery. As a result, Medicare today does not provide the benefits and choices that are available to many other Americans. The program lacks an outpatient prescription drug benefit, full coverage of many preventive benefits, and protection from high out-of-pocket costs.

This assertion is certainly valid. The question raised earlier, however, remains: Why is that so? Why were such large gaps in coverage left when the program was passed in 1965? And why has the program not been modernized in step with medical developments?

Gaps in Coverage at Medicare's Inception: When Medicare began its life in 1965, it was expressly designed to be a *passive* adaptation to these standards set by private health insurance. Consequently, Medicare did not cover prescription drugs at its inception in 1965 because, at that time, private health insurers typically did not cover prescription drugs either. In fact, private insurers

² See, for example, Davis et al., "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs Web Exclusive*, October 9, 2002. In surveys by the Kaiser Family Foundation Medicare also received very high marks by both Medicare beneficiaries and younger respondents. See Henry J. Kaiser Family Foundation and Harvard School of Public Health, *National Medicare Policy Options Survey* (Menlo Park and Boston: Kaiser/Harvard, 1998), available on the website www.kff.org.

began coverage of prescription drugs only in the early 1990s. Until then, drugs did not play nearly the important role in clinical therapy that they do today.

Similarly, private plans typically did not cover preventive care. Finally, private insurers in those days were mere bill payers. They would not have dreamt of interfering in the ongoing doctor-patient relationship (i.e., to “manage” care), and they paid each doctor and hospital their “usual, customary, reasonable” (UCR) fees, without any explicit bargaining over price discounts. With very few exceptions, most private insurers simply paid whatever bill was submitted to them. Cost control was not needed, because no one (especially employers) asked for it.

Initially, Medicare, too, paid providers each their “usual, customary and reasonable fees,” or retrospectively covered each provider’s full cost. Furthermore, Medicare was specifically forbidden to interfere with the doctor-patient relationship in the way that is common under modern managed care. The very idea of “disease management” was anathema to physicians at the time, even for patients under private health insurance.

As noted, only in the 1990s did most private insurers begin to cover prescription drugs and to “manage” care through direct interventions in ongoing therapies. It was made possible by selective contracting by insurers with a limited number of doctors, hospitals and other providers, which gave insurers economic leverage over the selected providers. The ability not to do business with certain providers allowed insurers to bargain with providers over price discounts, and it also made providers put up with controls on utilization, through primary-care gate keepers for specialist care, pre-authorizations of costly procedures, practice guidelines or refusals to pay for services rendered. Congress has never allowed Medicare to engage in selective contracting of this sort.

The Failure to Modernize Medicare: For starters, the common accusation that Medicare has not been innovative is only partly true. In some areas, it has been a world leader in innovation.

During the 1970s, for example, Medicare initiated break-through research on the payment of hospitals and physicians, which led to major practical innovations in the 1980s and early 1990s. As early as 1983, Medicare introduced the case method of payment for hospital care (based on *Diagnostically Related Groupings* of medical cases, or DRGs), a system that has in the meantime been copied in many other countries—notably in France, in Australia and now Germany. In the early 1990s, Medicare developed and introduced the *Resource Based Relative Value Scale (RBRVS)*, which underlies the current Medicare fee schedule for the payment of physicians and has been widely adopted by private insurers in the United States as a basis for negotiating fees for physicians. Further payment reforms have been instituted recently in outpatient hospital care and in home- and skilled nursing care. These innovations required major breakthroughs at the intellectual level and in policy implementation.

It is true, however, that the traditional Medicare program did not adopt any of the managed care techniques introduced by private insurers in the 1990s, nor did it modernize the program’s benefit package to include drug therapy and catastrophic care. It is, therefore, eminently fair to call

the traditional Medicare program “old-fashioned,” “outdated” and “out of tune with modern clinical practice.” Once again, however, it is also fair to ask why this is so.

Who Bears the Blame for Medicare’s Shortcomings? When politicians or other critics of Medicare call Medicare outdated and not sufficiently innovative, they tend to imply that these shortcomings mirror the shortcomings of the “unwieldy, incompetent government bureaucracy” that administers Medicare. That explanation has resonance among the citizenry and among pundits, but it is a bum rap.

The fault in this regard lies not with the Medicare bureaucracy. Fair observers will trace these shortcomings almost wholly to Medicare’s Board of Directors, notably the *House Ways and Means Committee* and the *Senate Finance Committee* of the Congress of the United States. Together, these two committees form the bulk of the Board that governs the vast insurance company called Medicare. As Boards of Directors of an insurance company go, Congress performance in this role has not been impressive.

That Board (Congress), for example, allows Medicare an administrative budget of less than 2% of total expenses. It can be doubted that any private insurance company could administer so vast a program properly at such a low overhead expense ratio.

Similarly, the Board (Congress) allows Medicare to spend only \$15 million (yes, *million*) on operations research, which is to cover both the Medicare program and the Medicaid program for the poor. As a percentage of the total \$400 billion or so spent on these two programs, the Board’s (Congress’) allocation for operations research amounts to 0.0038% of total spending. Can one imagine the Board of any business firm constraining the firm’s operations research budget in this truly scandalous way?

In short, is it any wonder that Medicare has had trouble managing the program, even if it were allowed by Congress to be innovative? It can be argued that, if this Board were in the private sector, its mode of governance would be subject to serious review and severe sanctions by the authorities. In a nutshell, the following can fairly be asserted:

If the traditional Medicare program does not cover prescription drugs, it is so because the Congress of the United States has willed it so.

If the traditional Medicare program does not work as a prudent purchaser with selective centers of excellence or with other preferred providers known to give cost-effective care, it is so because Congress has expressly forbidden that kind of contracting and prudent purchasing.

If the traditional Medicare program does not engage in “disease management” or “managed care” of any type, it is so because Congress has willed it so.

If the traditional Medicare program has hardly ever had the benefit of being able to solicit competitive bids for the products and services it purchased on behalf of seniors, it is so because the Congress has willed it so.

Think of a major shortcoming of the traditional Medicare program, and it will typically turn out that the shortcoming exists because the Congress has consciously and deliberately willed its existence. Journalists would be well advised to inquire of members of Congress why this should be so.

B. WHAT “CHOICE” AND WHAT STYLE “COMPETITION”?

Americans take it for granted, and economists agree, that, where feasible, government-run programs should be subjected to competition from private-sector entities offering at least the same benefits. For these two reasons, one should welcome any reform that sets up a *fair* and *intellectually manageable* competition between the traditional Medicare program and equivalent private-sector health insurance products.

There also seems to be widespread acceptance of the premise that “more choices” is always to be preferred to “fewer choices” in the design of social programs. Modern behavioral economists, however, would warn us that there can be such a thing as too much choice. It happens when choices set before individuals are not accompanied by adequate information on these choices. It also happens when the sheer complexity of the choice menu overwhelms the individual’s capacity to make rational choices.

If the Administration and the Congress wish to confront Medicare beneficiaries—especially the frail elderly—with ever more complex choices in health insurance, it is incumbent upon government to accompany these choices with clear information about them and to structure them so as to make rational choice manageable by ordinary human beings.

In this regard, one is not at all assured by the recent headline that “Medicare Officials Order End to Instructive Services” (The New York Times, January 25, 2003, p. A12). The article opens with the statement:

“Running short of money, Medicare officials have ordered immediate cuts in a wide range of services that provide information, advice and assistance to Medicare beneficiaries.”

If this is an augury to come for Medicare reform, then “more choice” may well end up as “more confusion” and “more regret” *ex post*. As noted earlier, the blame for this policy rests solely on the Administration and the Congress, which jointly set Medicare’s administrative budget. **Consequently, it is proper for reporters to query representatives of these branches of government sharply on this facet of Medicare reform.**

Choice of what? In thinking further about “more choice” for Medicare beneficiaries, a distinction should be made among (a) choice among alternative insurance products, (b) choice among doctors, hospitals and other providers of health care, and (c) choice among alternative therapeutic strategies (including drug therapies).

Since about the mid 1980s, Medicare has afforded its beneficiaries at least some choice among insurance products—most expressly so since passage of the *Balance Budget Act of 1997* (BBA '97), which established the *Medicare+Choice* program. That choice, however, is now said to have been hampered by the payment structure Congress had imposed on it in the BBA '97.

Medicare beneficiaries have always had the freest conceivable choice among providers of health care in the United States. It is hard to imagine how that choice could be enhanced by any reform.

Finally, Medicare recipients and their physicians have always had completely unfettered Choice among therapies, although not all components have been covered by Medicare, which indirectly limits choice. In principle, the problem could be solved simply by legislating their inclusion in the traditional Medicare benefit package. The problem is not an immutable state of nature. It is of Congress' own making.

The Fairness of Competition: The next question is what form the competition should take. Two distinct visions of this competition are now put before the American people.

One arrangement would be to style the choice and competition among health insurance products as one between (a) a *modernized*, government-run Medicare program that includes prescription drugs, preventive care and catastrophic coverage, and that is allowed by Congress to use techniques of modern “managed care” and (b) equivalent private-sector insurance products managed by private health plans. The arrangement would attempt to create a level playing field between a government-administered Medicare and private-sector competitors.

An alternative arrangement—one deliberately designed to erode the popularity of the traditional Medicare program—is to style the choice and competition in Medicare as one between (a) the traditional, unreformed, government-run Medicare program, whose development has been and will continue to be deliberately stunted by the Congress and (b) more modern private-sector insurance products offered by private health plans. It appears to be the style of competition preferred by the President, who would endow the traditional Medicare program with only a skimpy drug benefit³ and subsidize drug benefits through private plans more heavily, and who would otherwise not alter Medicare's benefit package.

No one, not even its proponents, would call this proposal fair competition. It is the analogue of a parent offering a high school graduate, as a graduation gift, a choice between (A) a Ford Taurus and (B) a similar Chevrolet, on the condition that the parents will pay for a CD player in the Ford Taurus and pick up the annual maintenance costs on it, but that they will not cover these items for the

³ Medicare beneficiary choosing to stay in the traditional Medicare program would receive free of charge a drug-discount card—presumably administered by a pharmaceutical benefit management company or a private insurance carrier—to benefit from bulk purchasing. They would also have catastrophic coverage for drug spending exceeding an annual threshold, which is left unspecified. Low income beneficiaries would, in addition, receive a \$600 annual subsidy toward their drug purchases.

Chevrolet. It can be doubted that either GM or the kid would call this a fair choice. In this analogue, the President would be seen simply to favor the Ford Taurus, period.

The question thus arises what rationale one might offer for styling the competition between Medicare and substitute private health plans in this unfair way. It is a question reporters would be well advised to probe.

First, it might be argued that, under our system of political governance and campaign financing, it will always be impossible to modernize Medicare in step with changes in modern medicine. The argument would be that Congress and successive Administrations have managed Medicare sloppily because, by its very nature, American government manages everything it does sloppily. It is a troublesome thought, especially at a time when the nation embarks upon a government-run war and upon government-run nation building abroad. Yet that thought appears to have much currency in this country at this time.

Second, it may be argued that government-run health insurance programs are inherently cumbersome, because they must strive to be *horizontally fair* to all parties, while market mechanisms usually are not subject to that constraint, unless government imposes on them. To illustrate, Medicare must observe scrupulously horizontal equity in its dealings with hospitals and physicians. (Horizontal equity means two physicians or hospitals would always be treated the same way). There are public hearings on proposed changes, notices in the Federal Register, comment periods, and such. By contrast, private health plans need not be so fair. They can treat different physicians differently, if they can cut different deals with them, and they can change rules or contracts with providers and patients overnight, without much notice, and subject only to the tort system and contract law. Therein lies greater flexibility.

A **third** argument for the proposed, unfair competition might be that, by their respective natures, private health insurance plans will always be more *efficient* than government-run insurance plans in anything they do. In principle, that hypothesis is amenable to empirical verification, after one has defined carefully what is meant by “efficient.” If there is a body of empirical research that convincingly supports this hypothesis (which there might be) I am not aware of it. **In any event, it is proper and, indeed, important to challenge proponents of this style of competition to adduce a convincing body of empirical evidence (not just one study) to support this hypothesis, if that is what drives the preference for this unfair form of competition.**

Fourth, one may prefer styling the competition in this unfair way simply with appeal to ideological aesthetics—that is, because one likes the private sector better than the public sector, whatever their relative efficiencies may be.

The Forthcoming Debate: The forthcoming debate over Medicare reform will be largely over these two alternative forms of choice and competition for Medicare.

If, in their wisdom, the Administration and the Congress decide not to allow the government-run Medicare program to modernize its *modus operandi* in any way—e.g., not to include a

comprehensive prescription drugs in its benefit package—then that decision amounts to a slow-death sentence for the traditional Medicare program—especially as more and more business firms cut away at their retiree-health benefit packages, which now typically include drug coverage.

It is a choice a nation can rationally make, of course. But if that were the goal of any proposed Medicare reform, it should be openly acknowledged and debated in a properly functioning democracy.

C. EVALUATING MEDICARE REFORM PROPOSALS AGAINST THEIR GOALS

Whether a health reform proposal will “work” depends crucially on what goal one seeks to achieve with it. Remarkably, the debate on Medicare reform is intolerably vague on the matter of goals. Often they are merely implicit in the debate, if not carefully camouflaged.

Reporters following this debate should be persistent in extracting from the various camps the specific goal or goals they would posit for Medicare reform. Prominent among these goals might be

- Reduction in total health spending per Medicare beneficiary, from all sources, however it may be split between taxpayers and Medicare beneficiaries.
- Reduction only in the taxpayer’s exposure to Medicare spending, even if it increased total health spending per Medicare beneficiary.
- Obtaining better value for the health care dollar, whatever the source, and whatever Medicare reform does to total health spending per Medicare beneficiary, from whatever source.
- Rescuing the private health insurance from a slow death march caused by the ever-finer risk segmentation that occurs under mass customization of private health insurance.

One can think of yet other objectives—for example, the fourth rationale spelled out toward the end of the previous section. In what follows, I elaborate on these four goals.

GOAL 1: REDUCTION IN TOTAL HEALTH SPENDING PER ELDERLY

Many people seem sincerely to believe that a Medicare reform will help the nation substantially to lower the total economic burden that future health spending on the growing number of elderly will impose on the economy. I have serious doubts that this goal can be achieved. In all likelihood, the reform would merely redistribute that growing burden from taxpayers to Medicare beneficiaries.

Think about it. The nation’s total health spending on its elderly population in future years is tautologically the product of (a) the total number of elderly in the various age-gender categories times (b) the age-specific health spending per capita for the respective age-gender categories.

Reforming Medicare cannot change future demographic trends perceptibly⁴. It follows that Medicare reform could affect total national health spending on the elderly only by changing average age-gender specific health spending per capita. Specifically, people who argue that a Medicare reform, along the lines proposed in *Breaux-Frist I* or the President's March 3rd sketch, will lower the overall economic burden that health care for the elderly will place on our economy would have to demonstrate convincingly that under a privatized Medicare program the average per-capita health spending for, say, 75-year old females in 2020 would be lower than it would be under continuance of the traditional Medicare program.

Is this scenario plausible? Surely it is fair to ask to ask this question at a time when even large employers—including CalPERS, that allegedly most savvy purchaser of health insurance--face premium increases for private group health insurance policies in the mid to high double digits? These numbers do not inspire confidence on the matter of cost control.

Let us probe this matter further. A reduction in the total health spending per Medicare beneficiary, from whatever source, implies that either (a) the volume of services rendered these beneficiaries, or (b) the prices paid for them, or (c) both, must decrease relative to the volume and the prices that would obtain for the same beneficiaries under the traditional, government-run Medicare program. How realistic is that expectation?

Lower Prices? Is it reasonable to suppose that private health plans will be able to procure health care from doctors, hospitals and other providers at lower fees than those the traditional, government-run Medicare has been able to achieve? I would rate that chance slim to nil.

In all likelihood, the plans would have to pay higher prices. Indeed, Medicare reform proposals often are pitched to doctors and hospitals on the promise that private insurers will pay them better than does traditional Medicare. (A test of that prospect might be how the providers react to the President's proposal. If they favor it, we can bet that they expect to receive higher fees from the plans).

The fact that the premiums charged by private insurance plans to employers now rise at double-digit annual rates is added reason to doubt that the private plans would have more market clout in bargaining over fees than does Medicare.

Lower Utilization? If the health plans will not be able to buy health care for the elderly at lower fees and yet total health spending on the elderly is to fall, then all of that reduction in spending must come from reductions in utilization of real health care services.

Such reductions may well be possible and clinically defensible. Unfortunately, to achieve those reductions in utilization, the health plans would have to put into effect precisely the

⁴ Purists may argue that better management of Medicare might alter mortality rates, and so forth; but that would trigger at best an imperceptible change in future demographics.

managed-care techniques that were so vehemently opposed by doctors and patients (and the Congress) and that brought on the managed-care backlash among employed Americans.

In fact, one can only imagine what sort of backlash physicians might be able to trigger—in the face of traditionally unaccustomed utilization controls for Medicare patients—if they can use the elderly as the megaphones for their opposition.

Journalists might question proponents of privatizing Medicare on this point. Do the health plans have in mind techniques of lowering the use of health services by means other than the managed care techniques of yore? If so, what would they be, and what would them more acceptable to doctors and patients. Furthermore, are they now operative anywhere in the U.S. on sufficiently large scale to inspire confidence?

Lower Overhead? As noted above, Medicare itself now spends less than 2% of its total outlays on administrative expense. There are no marketing expenses to speak of and, of course, no profits for shareholders to cover out of premium income. To this Medicare expense ratio, however, must be added the additional administrative and marketing expenses, and profits, currently included in the premiums for the *Medigap* policies carried by most Medicare beneficiaries. Presumably, a privatized Medicare benefit package would cover what traditional Medicare plus *Medigap* policies now cover combined.

Unfortunately, there is no evidence that a privatized Medicare would reduce the total overhead for administration, marketing and profits per beneficiary relative to the cost of these items under traditional Medicare plus *Medigap*. They may easily cost more. **It is a question reporters might probe with proponents of Medicare reform: do these proponents have convincing empirical evidence that privatizing Medicare will reduce the fraction of total health spending per elderly devoted to marketing, administration and profits?** (In insurance jargon, we would talk about the *Medical Loss Ratio (MLR)*. It is the fraction of the total premium for health insurance paid out for medical benefits. The question then is whether privatizing Medicare would increase the *MLR*, i.e., reduce the fraction devoted to marketing, administration and profits).

Boot up website www.kff.org and search for the chart book *Trends and Indicators in the Changing Health Care Marketplace*, 2002 (May 2002). As is shown in Exhibit 3.8 of that handy chart book, the annual growth rates in per-capita health spending under private health insurance and under Medicare seesaw over the long haul. During 1980-84, for example, the Medicare growth rate exceeded the private-sector growth rate. From 1985-1992, private-sector growth exceeded substantially the growth in per-capita Medicare spending. During 1993-97, the trends had flip-flopped once again. Since 1998, private sector growth has, once again, exceeded the growth in per-capita Medicare spending by quite some margin.

Prognosis on Cost Containment: In short, I am not persuaded by the historical empirical evidence that private health plans actually can control the annual growth in per-capita health spending consistently better than has the traditional Medicare program. Whatever the virtues of privatizing Medicare may be, history provides reason to doubt that lowering the total burden of health spending for the elderly (from all sources) in the decades ahead is unlikely to be one of these virtues.

Unless medicine itself comes up with major labor-saving breakthroughs in clinical therapy (e.g., through novel drug therapy, including pharmacogenomics and gene therapy, or novel devices), we seem to be more or less stuck with the future economic burden imposed on us by demography. We can at best reshuffle its incidence among the American people which, I believe, is what Medicare reform is all about.

Journalists should demand of anyone who would argue otherwise a body of scientific, peer-reviewed empirical evidence (not just one or a few studies commissioned by special interest groups from compliant consulting firms) that consistently and persuasively supports the contrary view.

GOAL 2: REDUCTION MERELY OF THE TAXPAYER'S EXPOSURE

An alternative goal for Medicare reform might to construct a legislative platform that would enable future Congresses to limit the taxpayer's exposure to increases in total health spending per beneficiary, whatever the trend in total spending might be, and to let the elderly bear the risk of future health-care cost inflation. **I have the impression that tacitly many proponents of privatizing Medicare really have this goal in mind, even though it may not be politically correct actually to say so.**

The argument here would be that, with only 2.2 workers per elderly in 2020 (versus 3.8 now), the elderly must be forced to pay a higher fraction of their own health care costs out of their own pockets. Under the current, *defined-benefit* structure of Medicare, such a cost shift would have to be made explicitly and therefore might trigger a political reaction from the elderly. Privatizing Medicare would implicitly convert Medicare into a defined-contribution model, which would enable Congress to achieve that cost shift much more gradually, over time, in subtle ways designed to avoid a sharp political reaction from the elderly.

As noted, at the moment it is not yet politically correct to articulate this goal openly. It is therefore discussed in code words—such as vague references to the “fiscal sustainability of Medicare.” In the President's sketch of his Medicare reform proposal, for example, is the observation that

While Medicare must be modernized and improved to meet the needs of its current participants, the program must also be made sustainable for future generations. Given the financial challenges Medicare faces in the future, changes to the

Medicare program we make today must not exceed our nation's means to deliver them tomorrow.

Given currently projected demographic trends, it is eminently reasonable for a nation to engage in an open discourse on how the fiscal burden of caring for the nation's elderly should be shared between the elderly and the working population. But one would hope, in a proper democracy, that the idea would be forthrightly put to the electorate, if that were the goal of the proposed reform. **Journalists have a unique opportunity here to set Goal 2 bluntly before politicians and to flush them out of the closet on it: do they endorse it or not?**

Although the President's March 3rd sketch on Medicare reform is vague on the precise structure and magnitude of the financial contribution Medicare would make toward the purchase private health insurance, one gains the impression that, initially, the reform does not envisage a rigid (risk adjusted) defined contribution that would be set by Congress will appeal to its own budgetary pressures. Instead Medicare's contribution would be set as a fraction of some national average of the premiums competitively bid by the private health plans for the prescribed benefit package. (As will be argued below, however, it is not at all clear the private health plans would ever agree to competitive bidding for Medicare.)

This approach would provide future Congresses with a highly flexible platform for future changes in either direction. Congress could use that platform to freeze the fraction of the total premium charged to the elderly, and continue to leave payroll-tax and income-tax paying workers exposed to considerable risk for future cost escalation. Alternatively, the fraction of total costs charged to the elderly could be increased in subtle ways over time, either by raising the fraction explicitly, or implicitly by manipulating the base--"average premium bid"--of which the Medicare beneficiaries' share would be that fraction. A decade or so hence, the fraction could even be means formally tested, as it partially would be from the outset through larger subsidies to "low income" households.

GOAL 3: BETTER VALUE FOR THE DOLLAR

The proponents of Medicare reform might (and often do) argue that the specific intent of the reform is neither to reduce overall health spending on the elderly (Goal 1) nor even to limit the taxpayer's exposure to that spending (Goals 2), but merely to procure through superior managed-care techniques (including disease management) in the private sector an increase in the value received per dollar of total health spending on the elderly. Economists would call it an increase in *efficiency*.

This appears to be the message sent to the media by the health insurance industry. In a recent press release, for example, it was stated that:

"The unique strengths of the health plan community continue to be demonstrated in the public-private partnership of Medicare+Choice. A new Kaiser Family Foundation report shows that Medicare+Choice - despite being under funded - provides a better value to beneficiaries and lowers their out-of-pocket costs.

If greater value for the dollar were the goal of privatizing health care, then its proponents can fairly be challenged to demonstrate empirically that this efficiency would actually come about. This, then, should be the focus of the public debate on the proposal, and also the focus of media inquiries.

One yearns for this empirical demonstration because, quite frankly, the President's proposal deliberately to tilt a competition between traditional Medicare and private health plans in favor of the latter—as described earlier—gives one pause about the proposition that private health plans actually could deliver better value for the dollar in a fair competition. In the President's proposal of March 3rd, it is stated that

The President's framework will ensure that the benefits offered under Enhanced Medicare [to be offered by private health insurers] are sufficiently attractive to seniors, relative to traditional Medicare, to guarantee that Enhanced Medicare is a viable system.

Why is this necessary? To an economist, there is something both puzzling and troubling about the idea that a privatized Medicare will be “viable” only if it is bolstered by a huge, tax-financed subsidy for prescription drug coverage that would be largely denied elderly Americans who prefer to stay in the traditional Medicare program. As a long-time defender of the industry in the face of the managed-care backlash of the 1990s, I find myself on the defensive on this one. Asking government for that special favor clearly is not one of the industry's higher moments.

Journalists might probe why, if private health plans really do offer the elderly demonstrably better value for the dollar—e.g., better disease management—these plans could not attract enough elderly in a competitive world without having the competitive deck stacked artificially through a tax-financed come-on.

GOAL 4: RESCUING PRIVATE INSURERS FROM A SELF-IMPOSED DEATH MARCH

In an article on *Health Affairs's Web Exclusive*,⁵ entitled “From the Field: How and Why the Health Insurance System will Collapse,” Humphrey Taylor, an astute longtime student of American health care, predicts that the risk segmentation inherent in the novel consumer-choice models in private health insurance will lead to a “death spiral of adverse [risk] selection.” The thesis is that the industry's march toward ever finer risk segmentation in private insurance, under the banner of “defined contributions” and “mass customization,” tends to flush out for public coverage chronically ill people who cannot afford the actuarially fair premiums that their costly medical conditions warrant and, ultimately, end up on the good mercy of government.

At this time, for example, private insurance covers only about one third of total national health spending, although it still covers about two thirds of the American population. It is so, because government programs typically cover the relatively more expensive Americans: the elderly, people on

⁵ http://www.healthaffairs.org/1130_abstract_c.php?ID=http://www.healthaffairs.org/Library/v21n6/s28.pdf

renal dialysis, the blind and otherwise disabled, pauperized Medicare beneficiaries in nursing homes, and the poor. If Americans who will be priced out of the private health insurance system through further risk segmentation were absorbed into *bona fide* government-run programs (Medicare, Medicaid and S-Chip), then a decade hence private insurers might control only about a quarter of total national health spending. This is the death spiral of which Taylor speaks.

It may well be that the private insurance industry can be rescued from that self-inflicted death spiral only if government comes to its rescue. The rescue would take the form of tax-financed subsidies for the purchase of private health insurance by Americans who could otherwise not be served by the private health insurance industry. Evidently, privatizing Medicare would be an instrument *par excellence* for achieving that goal.

Although I would not propose this goal as the sole or even the chief motive for Medicare reform, this country economist from rural New Jersey is not naïve enough to exclude it altogether from the multiple objectives pursued with privatizing Medicare. Like cash hungry-universities, who forever pass the hat to finance their sundry missions, members of Congress must forever pass the hat to fund their own reelection. In that sense, Congress can be thought of as a chronically cash hungry business enterprise and, from the perspective of that enterprise, the private health insurance industry has been and will be a much better business partner than would be the constituents arrayed around the traditional Medicare program. That circumstance may help fuel calls for Medicare reform. Certainly this hypothesis should appeal to Senator John McCain and like-minded members of Congress who see in our campaign-finance laws intolerable conflicts of interest for policy making in the Congress.

D. THE DEGREE OF EGALITARIANISM IN MEDICARE

Medicare was enacted largely by a generation that had suffered together through the Great Depression and World War II. It had come to appreciate in these experiences that good fortune in life is substantially the product of good luck, and that the spoils of good luck should be shared with less fortunate members of society. It is, therefore, not surprising that the structure of the traditional Medicare program was highly egalitarian in its intent, albeit not in practice.

Within the benefit package covered by Medicare, the program is, indeed, highly egalitarian. Every beneficiary is entitled to the same covered benefits, regardless of socio-economic status. Every beneficiary has the same free choice of provider within the relevant market area. Every provider in the relevant market area is paid the same fee for a particular service, regardless of the recipient's socio-economic circumstance, and providers may not bill significant fees on top of the Medicare fee (if any at all). By contrast, society's valuation of physician's work for, say, children, varies considerably with the child's. If a state legislator is willing to budget only \$10 per pediatric visit for a child covered by Medicaid, but \$60 for his or her own child covered by his or her private insurance, then that legislator inevitably signals the physician a clear message on the relative valuation of work devoted to the Medicaid child and to the legislator's own child.

Within the confines of the covered benefit package, Medicare thus is as exquisitely egalitarian as those of the Canadian provincial health plans or of Germany's sickness funds. The problem all along has been that the limited benefit package of traditional Medicare precludes a completely egalitarian sharing of the total health care experience among the elderly. A well to do beneficiary, or one with generous employer-paid *Medigap* coverage, for example, will have a quite different health care experience in the face of a given illness than does a low-income beneficiary without drug coverage, and similarly for other uncovered services.

Without much greater specificity on the actual design parameters of Medicare reform, it is impossible to assess how it might alter the overall degree of egalitarianism in the provision of health care to America's elderly (and other Medicare beneficiaries). By itself, the broadened benefit package promised by the reform would be scored as an increase in egalitarianism. On the other hand, the *defined-contribution* feature incorporated into the reform and the choice among many, customized private insurance products would be scored as a likely decrease in the overall egalitarianism of the health care experience of elderly Americans (and other beneficiaries).

On the issue of egalitarianism score, then, the jury is still out. Journalists, however, might keep the issue in sight, probe deeply into their findings to the public, when the time comes to be more specific. It would be entirely appropriate, for example, to grill a proponent of a particular reform to make explicit his or her assessment of the impact of the proposed reform on this aspect of a health care arrangement for Medicare beneficiaries.

E. SOME MAJOR OBSTACLES FACING MEDICARE REFORMERS

The proposed reform would face a number of technical and political problems in addition to those raised above, some of which already had surfaced under the Clinton Plan.

Competitive Bidding: A central idea underlying many Medicare reform proposals—including the President's current proposal of March 3, 2003—is that private health plans would bid their premiums competitively for a specified benefit package for Medicare beneficiaries. If history is any guide, this is much easier said than achieved.

During the past decade the then Health Care Financing Administration (HCFA)—and now Centers for Medicare and Medicaid Services (CMS)—had tried on numerous occasions to experiment in a few markets with competitive bidding by private managed-care plans for Medicare beneficiaries. Each and every time the experiment was abolished, at the behest of the private health plans, and through the good offices of Medicare's Board of Directors, the Congress.⁶

⁶ In this connection see the entire section entitled "Medicare Reform" in *Health Affairs* (September/ October, 2000), pp.8-59, especially the paper by Bryan Dowd *et. al.* "A Tale of Four Cities: Medicare Reform and Competitive Bidding."

Reporters are entitled to wonder why things would be different in the future and they should probe that issue vigorously. What evidence is there that the private insurance industry will ever accede to competitive bidding for so large a clientele as Medicare?

My prediction is that private health plans would instead plead for administered prices. From the perspective of the industry, administered prices have two advantages. First, they can be more easily influenced through the political process. Second, they can be used as a scapegoat whenever something goes wrong with Medicare beneficiaries.

The Wennberg Variations: The President's proposal might also flush into better view the enormous regional variations in Medicare spending per statistically equivalent elderly.⁷ Although the President's reform proposal might be viewed as an attempt to eliminate that variation through competitive market forces, for a while (perhaps a decade) these variations would be likely to remain. Greater transparency on them might cause political problems.

Reporters should probe in what way a proposed Medicare reform plan—including the Presidents—will cope with the enormous regional and sub-regional variations in the average Medicare spending per statistically age-sex adjusted Medicare beneficiary.

Risk Adjustments: Like the Clinton health reform plan, the President's Medicare reform of March 3rd, 2003 requires the existence of a workable risk-adjustment mechanism that can protect individual health plans from being stuck with an unusually large number of medical risks. The adjusters are needed, because the President proposes that, once they have made their premium bids, the private health plans "will have to accept any Medicare participant wishing to enroll regardless of whether the beneficiary lives in a rural or remote area."

The risk adjusters currently used for the *Medicare+Choice* program are fairly crude and have been vehemently opposed by the private health plans. Unfortunately, the plans themselves have never proposed a superior, workable, budget-neutral alternative.

Reporters should probe precisely how any risk adjustment under competitive bidding and community-rated premiums is to work.

Insurer of Last Resort: In some Medicare reform proposals, the traditional Medicare program would be forced to compete with private health plans just like any other health plan. There is the question who will act as insurer of last resort for the elderly under such a scheme. Presumably, any private health plan serving Medicare beneficiaries at one point in time could terminate those contracts and pull out of entire regions, as the private health plans have done in the past few years under the *Medicare+Choice* program. That privilege surely would carry over to the President's plan as well.

⁷ John E. Wennberg and Megan McAndrew Cooper, *The Dartmouth Atlas of Health Care in the United States* (1999). See also their website www.dartmouth.edu/~atlas/, which exhibits these data by county.

The question arises whether, if private health plans would find serving Medicare patients in, say, certain counties in Connecticut or Iowa unprofitable and pulled out of those regions, the traditional Medicare program could also decide to pull out, or whether it would have to stay as insurer of last resort. If so, one can ask in what sense such a competition between the government-run Medicare as insurer of last resort and private health plans could be labeled “fair.”

G. CONCLUSION

The purpose of this memo has not been to naysay the President’s proposal, which deserves a full and fair debate, nor have I intended to sell one particular approach. I am not wedded at all to a preferred approach.

My plea merely is that in the forthcoming debate on Medicare reform we depart from empirically vacuous clichés—e.g., that the private sector is always more efficient than the public sector or, conversely, that private health plans always put “profits over people”—and that the pros and cons of the proposal be debated *forthrightly*, with appeal to the best scientific empirical evidence available on the issue.

In this regard, it is particularly important to understand why the traditional, government-run Medicare program has been left by Congress as outdated as it is. A part of the debate on Medicare reform should be why Congress has behaved in this way and why it seems determined to continue to behave in this way.

Finally, in my view, Medicare reform is unlikely to be the magic bullet that will lessen significantly, if at all, the total burden on the economy of providing health care to the nation’s growing number of elderly. Medicare reform can at best limit the taxpayer’s exposure to that growing burden, leaving the elderly themselves to pick up a larger fraction of the total cost of their care. It is a matter eminently worth debating at this time, but that debate should not be conducted in code words or clichés. It should be conducted forthrightly in our democracy.

APPENDIX A

AN ECONOMIC PRIMER ON MEDICARE

To think about Medicare reform, it may be helpful to distinguish between two facets of the economics of Medicare, as is done in the sketch overleaf:

1. the real resource flow of goods and services from the providers of health care to Medicare beneficiaries (the lightly shaded arrow) and

2. (the financial flows A, B and C, which transfer claims to the nation's GDP (money) from Medicare beneficiaries and taxpayers to private health-insurance carriers and thence to the providers of health care. To keep the schematic simple, Medicare itself is not shown on it, mainly because it administers the Medicare program through private health insurers who act as Medicare intermediaries.

To be explored is how Medicare reform proposals would affect the real resource flow (that is, the actual medical care going to the elderly) and the financial flow (that is, the total money reward going to the providers of health care, and the apportioning of this burden to the taxpayer and to the elderly). To think about these questions, some more commentary on these real and financial flows may be warranted.

Prices: The fees paid providers for health care rendered the elderly form the linkage between the real-resource flow in Medicare (the lightly shaded pipe) and the money pipes (A,B,C and D).

If there were only one health care service in the world – e.g., standard physician visits – then the price per visit would be simply the money flow in pipe D divided by the number of physician visits in the real resource pipe. In the real world, of course, things are much more messy, but the basic linkage remains.

It is important to keep this linkage in mind as we think about Medicare reform. If privatizing Medicare is to reduce health spending –as some proponents claim it would -- then the question is how much, if any, of that reduction in spending will come from (a) reductions in fees paid providers, (b) reductions in the use of real health services by the elderly (the shaded pipe), or (c) both.

I have found it very difficult to get answers to this fundamental question from the proponents of privatizing Medicare, or from health insurance executives. Attached hereto as Appendix B, for example, is a questionnaire I once submitted to a group of health-insurance executives. With the exception of one, none of them were willing to respond to that

questionnaire. Yet an answer to this question seems fundamental, in a democracy, in the public debate on this issue.

The Medical Loss Ratio (MLR): According to the Trustees of the Medicare trust funds, Medicare currently spends less than 2% of its total outlays on administration, mainly for the work of private insurance carriers who function as Medicare intermediaries in claims processing. This means that more than 98 cents of every dollar collected by Medicare goes to the providers of health care.

It is inconceivable that a private insurer could operate at a MLR of only 98% (an administrative expense ratio of only 2%). My own estimate is that private health plans would need at least 10 cents of every premium dollar collected for Medicare beneficiaries for administration, marketing and profits.⁸ Here it must be recalled that Medicare does not have to market its products, nor pay profits to shareholders. By contrast, under the President's proposal private health plans would have to market to the elderly individually and, of course, they would have to retain some funds for their shareholders.

In fairness, it must be added that Medicare visits considerably administrative work on doctors, hospitals and other providers of health care. It is not clear, however, whether those costs borne by providers are larger for Medicare (as a percent of the providers' revenues) than are the costs they bear for processing the claims against private insurers. There is also the fact that the supplementary coverage Medicare beneficiaries purchase as a complement to the traditional Medicare coverage carries with it administrative and marketing costs that would be obviated by more comprehensive private coverage in health plans.

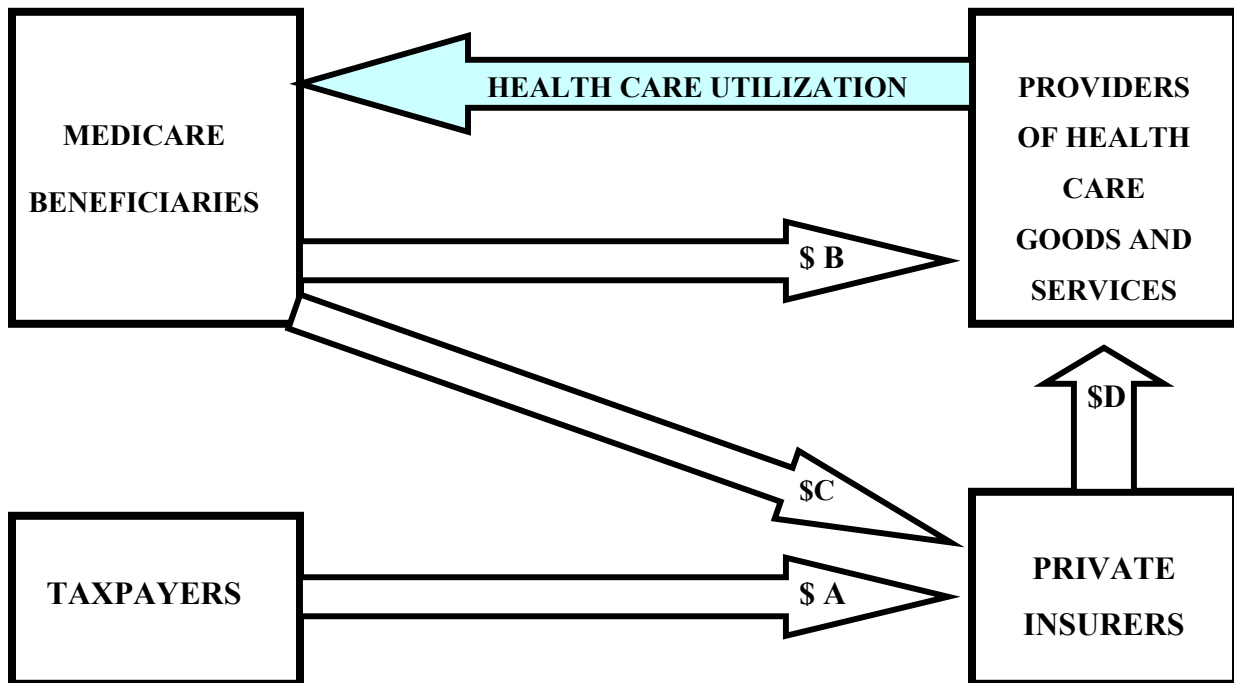
The Taxpayer's Dollar Exposure: Pipe A in the schematic represents the taxpayer's exposure for the Medicare program. It consists of the sum of (1) what we call "Medicare spending" (now roughly half of the total health spending A+B+C on the elderly, (2) Medicaid spending on the elderly and (3) other government spending on elderly American. For this purpose, we view the elderly themselves as taxpayers when they pay taxes of all sorts.

The Dollar Exposure of Medicare Beneficiaries: The sum of pipes B+C represents the exposure of the elderly for their own health care. To keep the schematic simple, pipe C is thought to include the Part B premiums paid by the elderly for Medicare coverage.

With these preliminaries, we can now turn to the question raised earlier: what benefits does the President expect from the privatization of Medicare?

⁸ See Uwe E. Reinhardt, "Perspective: Does U.S. Tax Financed Health Care Really Incur Waste?" *Health Affairs* (July/August, 2002): pp. 99-100.

THE FLOW OF REAL AND OF FINANCIAL RESOURCES IN MEDICARE



SOME FUNDAMENTAL DEFINITIONS

$\$ B$ = out-of-pocket payments by Medicare beneficiaries to providers

$\$ C$ = premiums paid by Medicare beneficiaries to private insurers (and for Part B).

$\$ A + \$ B + \$ C$ = total health spending per year on the elderly, from all sources

$\$ A + \$ C - \$ D$ = funds retained by private insurers for administration, marketing
And profits

$\$ D / (\$ A + \$ C)$ = the insurers' "Medical Loss Ratio" (MLR)

$\$ B + \$ D$ = revenues received by the providers of health care

APPENDIX B

QUESTIONNAIRE FOR INSURANCE EXECUTIVES ON MEDICARE REFORM

Your name: _____ Your company: _____
 (Please print) (Please print)

SOME QUESTION ON PRIVATIZING MEDICARE A LA BREAUX-FRIST I

1. According to the Trustees of the Medicare trust funds, slightly less than 2% of total spending by Medicare is currently absorbed by the program's administrative expense.⁹ My question is whether, under a privatized Medicare on the Breaux-Frist I model, private health plans can manage with a similarly small load factor for administrative expenses and profits or, if not, who should pay for any extra above Medicare's 2%. To enlighten me on this point, may I ask you to respond to the following questions? Please mail your responses to Uwe Reinhardt, 351 Wallace Hall, Princeton University, Princeton, N.J. 08544. Many thanks.

a. On average, what fraction of the total premium received by your company for a Medicare enrollee (from whatever source) would your company need for

- General Administration	_____ %
- Marketing	_____ %
- Profits for shareholders	_____ %
<hr/>	
-TOTAL	_____ %
<hr/>	

b. If your estimated TOTAL expense ratio exceeds 2%, who, in your view, should pay for the additional cost of SG&A and profits experienced by private health plans?

_____/ providers, through greater efficiency in the procurement of health care (i.e., lower revenue to them);

_____/ the elderly, through commensurately higher contributions they would make toward premiums;

_____/ the taxpayer, through higher defined contributions from Medicare paid the elderly for their health insurance

⁹ Medicare does visit considerable additional administrative costs on the providers of health care, although these costs probably are not larger, as a percentage of total revenue received, than they are for revenues received from private health insurers. While Medicare billing is predominantly electronic, many private insurers still bill on paper. Furthermore, Medicare tends to pay promptly. "Days of accounts receivable outstanding" from private insurers tend to be three to four times as high as the comparable Medicare figure.

_____ / *the providers of Medigap insurance, who would lose that business because the private health plans would provide broader coverage*

_____ / *all of the above, to some extent.*

2. In your view, relative to the prices at which Medicare will be able to procure health care on behalf of Medicare beneficiaries, the prices at which private health plans will be able to procure the same health care from the same providers will be

_____ / lower

_____ / about the same

_____ / higher

3. Please assume now that the traditional Medicare program were enhanced by coverage for prescription drugs. Relative to the ***total health care cost per Medicare beneficiary*** experienced under that enhanced Medicare program (paid by whatever source, and including administrative expenses), do you believe that the comparable cost figure *for the same benefit package and for similar beneficiaries* experienced under coverage by private health plans would be

_____ / lower

_____ / about the same

_____ / higher

4. Please assume again that the traditional Medicare program were enhanced by coverage for prescription drugs. Relative to the health care costs per Medicare beneficiary *then to be borne by the elderly* themselves under this enhanced Medicare program (i.e., their out of pocket payments at point of service plus their own contributions to premiums), do you believe that the comparable out-of-pocket spending to be borne by the aged, *for the same benefit package and for similar beneficiaries* experienced under coverage by private health plans, would be

_____ / lower

_____ / about the same

_____ / higher

5. Open-ended question: In your view, what would be the strongest selling point to persuade *Medicare beneficiaries* that receiving their health care through private health plans would be better for them than receiving it through the traditional Medicare program (but enhanced by drug coverage).

6. Open-ended question: In your view, what would be the strongest selling point to persuade *the tax-paying public* that privatizing Medicare on the *Breaux-Frist I* model would be a good idea