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Chapter 7

Managed Competition and the Elderly: An Analysis of Potential Benefits and Pitfalls

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With the enactment of Medicare nearly 30 years ago, health policymakers sought to reduce the financial burden of health insurance for the elderly and provide universal access to everyone over 65 years old. Today, issues of cost and access are propelling the rest of the nation into a health care reform as sweeping as the one that reshaped health care for the elderly in 1965. Ironically, the rest of the nation may end up leading Medicare to a resolution of issues that have plagued the program since its inception—the continued high cost of health care for the elderly and, consequently, continued barriers to full health coverage.

More than any other single health care program, Medicare has fueled the continued rise in American health care costs. Since 1970, government expenditures on health care, of which Medicare consumes the major share, have risen faster than inflation, faster than private expenditures, and faster than state and local health care expenditures (OECD 1992). Of the average annual 5.5 percent increase in health care costs over the past 20 years, about 3 percent can be attributed to an increase in the volume of health care services consumed disproportionately by the Medicare population. The remaining 1.5 percent rise in health care costs can be attributed to increased costs over and above inflation.

One factor that has contributed to the overall increase in health care costs and, specifically, to the increase in Medicare spending is the steady rise in the proportion of the population 65 years old and over. This group represented 8 percent of the population in 1960 but now represents 12 percent. By some estimates, these people require four times as much health care as the rest of the population, which, when coupled with their growing numbers, have been estimated to increase health spending almost

three quarters of a percent per year since 1967 (Washawsky 1991). Perhaps most discouraging, however, is that for such a large federal investment in fulfilling Medicare's commitment to provide universal health care to the elderly, the program still pays for less than half of the medical expenses of its beneficiaries (OECD 1992).

President Clinton and the members of his task force on health care reform have identified cost and access as two of the principal problems that reform should address. The President also has indicated that the reform most likely will implement a system of health care insurance purchasing called *managed competition*, and the public expenditure for health care will most likely be limited by a global budget.

Any health care system reform will have to address the increasing share of health care costs generated by the growing elderly population in this country, and managed competition, under a global budget in particular, could well address some of the shortcomings of Medicare. At the same time, it could open new gaps in the health care coverage for the elderly, for example, by limiting expenditures at the extremes of life. It has the potential to pose a threat to a segment of the population that lives on a fixed income and consumes an increasing share of health care services.

It would be in the best interests of the elderly to consider the impact of managed competition and then to help shape health care reform to redress the shortcomings of Medicare while avoiding the potential pitfalls of a new system. The sections of this chapter that follow examine important themes relevant to reform:

- *Shortcomings of Medicare.* High copayments, inadequate coverage of preventive health care, lack of long-term care coverage, and no prescription drug reimbursement have long been seen as unresolved problems.
- *Managed Competition under a Global Budget.* Key architects of the president's task force on health care reform have described this system of insurance purchasing, its philosophical grounding in managed care, its structure, and its cost-containment potential under a national budget. Where does Medicare fit in?
- *Redressing Medicare's Shortfall.* Certain inherent elements of managed competition may resolve issues that have plagued Medicare since its inception, many of them lifted directly from managed care, others from the benefit of a national health insurance system.
- *Potential Pitfalls.* A system reliant on cost-effective, outcomes-based medicine may be less willing to fund high-cost medicine near the end of life than to fund preventive programs. Reimbursement adjustment may be inadequate (or simply inaccurate), leading providers to attempt to discourage elderly subscribers.

Although allusions are made here to contributions from an extensive geriatric literature, social science literature, and examinations of Medicare's social health maintenance organization (HMO) and Medicare competition demonstration projects, this chapter is not intended to be a comprehensive review of these areas (see Newcomer, Harrington, and Friedlob 1990). And although it would seem that the long-term care controversy has critical bearing on any discussion of health care reform, space is not adequate here to discuss this issue in depth. Instead, this chapter addresses how the acute and chronic (nonlong-term) care needs of the elderly will fare under managed competition and what specific aspects of the reform proposal bear on Americans aged 65 and over.

Shortcomings of Medicare

At Medicare's enactment, 38 percent of the elderly who were no longer working had private health insurance, and spending for medical care consumed a major portion of the elderly's income. Medicare is credited with addressing most of those needs through its Part A coverage (for short-term hospital care, postacute skilled nursing facilities, and home health services) and Part B coverage (a voluntary supplementary program that covers physician charges and ambulatory care).

Despite multiple revisions and amendments to Medicare since 1965, substantial gaps still exist in the program. Specifically, it lacks provisions to cover the cost of prescription drugs, physician charges in excess of the amount Medicare defines as reasonable, hospital stays over 150 days, and most long-term care services (Rowland 1991).

In attempts to address initial shortcomings, the federal government expanded hospital coverage in 1967, established coverage for intermediate care facilities and skilled nursing facilities in 1972, and established rural health clinics in 1977. (Table 7.1 lists major revisions since 1965.)

Financial Burden

Since Medicare's creation those persons over age 65 who could, bought supplemental health insurance called "Medigap." It is estimated that 72 percent of the elderly Medicare beneficiaries own such policies. In 1989 the mean annual premium was \$718 and the market for such policies was estimated to be approaching \$20 billion (Rice and Thomas 1992). Another 8 percent of Medicare recipients who cannot afford to buy their own Medigap policies receive Medicaid assistance to pay premiums, deductibles, and other portions of costsharing.

An examination of the costs of health care shared by the elderly demonstrates the need for such Medigap policies, as well as the continued

TABLE 7.1 Health Legislation and the Elderly: 1965-1989^a

<i>Year</i>	<i>Legislation</i>	<i>Provisions</i>
1965	Social Security Amendments of 1965	Established Medicare and Medicaid.
1967	Social Security Amendments of 1967	Expanded hospital coverage and durable medical equipment.
1970	Public Health Service Amendment of 1970	Authorized grants and contracts for research on provision of home health services.
1972	Social Security Amendments of 1972	Added disabled and ESRD for Medicare; increased premiums and deductibles; established Medicaid ICFs; Medicare ECF converted to SNFs.
1977	Rural Health Clinics Act	Medicare coverage of rural health clinics.
1980	Social Security Disability Amendment of 1980	Voluntary certification of Medicare; supplementary health insurance policies.
1982	Tax Equity and Fiscal Responsibility Act 1982	Medicare hospice benefit.
1986	Omnibus Budget Reconciliation Act of 1986	Medicaid option to poverty level for full coverage or buy-in 1987.
1987	Omnibus Budget Reconciliation Act of 1987	Nursing home reform.
1988	Medicare Catastrophic Coverage Act of 1988	Expanded Medicare benefits; Medicaid buy-in, spousal impoverishment.
1989	Omnibus Budget Reconciliation Act of 1989	Medicare mental health benefits; pap smears.
1989	Medicare Catastrophic Coverage Repeal	Repeals all except Medicaid provisions.

^aSource: Rowland D. Financing Health Care for Elderly Americans. In: Ginzberg E, ed. *Health Services Research: Key to Health Policy*. Cambridge: Harvard University Press, 1991.

financial burden of health care. In 1993 patients are required to pay

- \$676 as an initial deductible for hospital stays;
- Daily copayments of \$169 for hospital stays in excess of 60 days, but not in excess of 90 days, and \$338 for 60 “lifetime reserve” days for stays in excess of 90 days;
- A \$100 annual deductible on physician and related “recognized” charges;
- 20 percent coinsurance on additional physician and related charges deemed “reasonable” by Medicare.

Catastrophic Coverage

In 1988 the Medicare Catastrophic Coverage Act was passed, representing the most significant expansion in Medicare’s scope and the first major restructuring of benefits since the enactment. It placed a ceiling on out-of-pocket spending for costsharing, eliminated the restriction on days covered under hospice care, and added coverage for outpatient prescription drugs, respite care, and mammography screening. Although it was repealed in 1989, in part because of resentment among the elderly over its financing, which would have been shouldered entirely by Medicare beneficiaries, the Catastrophic Coverage Act filled longstanding gaps in Medicare coverage.

Prescription Drugs

Analyses of out-of-pocket expenses among the elderly before and after the enactment of Medicare showed decreasing protection from out-of-pocket liability. A major share of these costs were prescription drugs, which account for 10 percent of health care spending (7 percent outpatient and 3 percent inpatient use) (Rosenblum 1985). The Medicare population uses a disproportionate percentage of the prescription drugs sold in the United States. The lack of a comprehensive prescription drug benefit, therefore, is a significant hardship for this population.

Preventive Health Services

The repealed Catastrophic Coverage Act included coverage for mammography screening, which had been shown to be cost effective. Mammography screening was reinstated as part of 1990 legislation and remains a reimbursable expense. However, Medicare still specifically excludes coverage for preventive health services such as routine physical examinations (although many recipients receive such examinations when visiting

physicians with more specific complaints), most immunizations (special exception was made for pneumonia vaccines in 1980), screening examinations, and health education and counseling.

Long-Term Care

The Medicaid program is the major public source of funding for long-term care, although, of the estimated \$62 billion spent on nursing home care for elderly in 1992, nearly 60 percent was paid by elderly patients and their families (Cohen et al. 1992; Waldo et al. 1989).

Adverse Selection

The Medigap market offers insurers an opportunity to "cherry pick," that is, to tailor policies to discourage particularly risky groups of potential subscribers (Enthoven 1993). Of course, whether this or any other shortcomings in the Medicare program will be addressed by health care reform in the form of managed competition will depend on Congress's reaction to the Clinton administration's proposal. Recall that the Catastrophic Coverage Act was an attempt to redress at least some of the shortcomings; but, no renewed effort has been made to pass a new version of the act in the four years since its repeal.

Managed Competition Under a Global Budget

To understand how some of the current proposals in health care reform can redress some of Medicare's shortcomings, and, in contrast, how they potentially may create new gaps in health care for the elderly, this section reviews managed competition as it has been described by the principal architects of President Clinton's health care reform effort.

The concept of managed competition grew out of the experience of managed care, and, specifically, the experience of early prepaid group practice health care plans, although it differs significantly from such plans now (Enthoven 1993). These health care plans contracted with employers to provide comprehensive health care services in exchange for a pre-arranged per capita charge, thereby shifting the financial risk from the employer to the health care plan. The plans had an economic incentive to deliver cost-conscious medicine and, in this way, departed from the cost-unconscious, fee-for-service plans. In fee-for-service, consumers are insulated from costs because insurers agree to pay all reasonable charges and physicians have cost-increasing incentives to deliver more care, not less. Prepaid plans, in contrast to fee-for-service plans, competed with one another based on their ability to deliver care of adequate quality at

lower costs. Although managed competition focuses on managed care, the two are not synonymous.

Managed Care

Managed care describes a health care delivery system such as a health maintenance organization (HMO) in which a third party influences the doctor-patient interaction to a greater or lesser degree. An HMO's administration, for example, may specify what physicians a patient can use, what specialists may be consulted, or whether an admission is covered or not. The old style, traditional fee-for-service payment system, in which an insurance company pays all or a portion of services billed after treatment, is not managed care. However, managed care organizations comprise a broad range of health care delivery systems. They include indemnity style entities in which the physicians are paid by fee-for-service but are subject to some level of managerial oversight. For example, they may be required to use a restricted panel of specialists or certain hospitals. In fact, HMOs also may pay their physicians fee for service, rather than a capitated rate.

Managed Competition

Managed competition is a health care purchasing system in which groups of patients purchase health care services from accountable health care plans, and these may include managed care organizations as well as traditional fee-for-service insurance companies. The "competition" takes place between these plans, and they vie to attract individuals from these pools of patients. The patient groups have administrative representatives, formerly called health insurance purchasing cooperatives (HIPCs) and now called health care alliances (HCAs), that determine which providers may compete for the patients in the pool. These administrative representatives probably will be required to accept a range of providers, including an old style, fee-for-service insurance company, although they will be encouraged to emphasize managed care organizations. Large employers and current Medicare intermediaries also may act as administrative representatives.

Health Alliances

The role of the health alliances has not been publicly defined, and, within working groups in Washington, the definition is the subject of controversy. If the flow of money spent on health care is followed closely, then the role of the health alliance becomes clearer.

Money will be pooled from several sources. These sources may in-

clude employers and employees who contribute a portion of the payroll, HCFA for current Medicare and Medicaid recipients, and additional surtaxes such as the so-called "sin taxes" on cigarettes and alcohol, an energy tax, and a new tax on employer-paid health benefits that exceed a certain basic level (currently, all employer health benefits are tax sheltered.) That pool of money will then be used by health alliances to purchase health care services from a selected panel of accountable health care plans for everyone in the population. Some employers may be allowed to bypass the pool of funds, however, and purchase health care services directly from their own panel of health care plans for their own employees, in effect serving as their employees' health care alliance. Medicare, similarly, may also serve as an independent health alliance for the current enrollees, purchasing services from a panel of health care plans for the elderly. Allowing small employees, individuals, and the uninsured to be represented by health alliances will give these groups increased purchasing power and, as a result, market forces may provide them with lower cost health care. Large employers and current Medicare intermediaries may also be administrative representatives.

The health alliances may be regional entities. States may oversee these regional buying groups, although they also may be allowed exemptions from the national system if they develop their own system for providing their populations with universal access. A National Health Board probably will be established to set criteria for a minimum health benefit package that each state in turn will be required to meet. The National Health Board may serve other important functions in the larger organizational structure as well, such as collecting and interpreting data on health outcomes or monitoring the distribution of comparative information among subscribers.

The accountable health care plans will be paid a capitated annual fee, that is, an age- and sex-adjusted fixed amount of money to provide a comprehensive benefit package to each patient. Their revenue would rise or fall based on the number of subscribers they attract and the efficiency with which they deliver health care. Competition for subscribers would be managed by the health alliance with a system of rules and incentives to protect subscribers from free market failures such as *risk selection*, which is the practice used by health insurance companies to refuse insurance to patients who are likely to incur high costs (often patients with pre-existing conditions, chronic illnesses, or the elderly). Similarly, *experience rating* (charging higher premiums to people with pre-existing conditions) would be replaced by *community rating*. The health alliances would manage the enrollment process in which all subscribers have an annual opportunity to change plans. The alliance may be directly responsible for providing the information necessary for subscribers to choose between

plans based on their cost, what benefits they may offer above the basic package (for these added benefits, subscribers would pay a premium), and their quality. The plans themselves may choose to charge copayments or deductibles to influence patients to do their part in reducing costs.

Global Budget

What differentiates managed competition as discussed by key members of President Clinton's task force on health care reform from earlier notions of "managed competition" is an additional cost-containment strategy called global budgeting. Many other nations, for instance the United Kingdom, Germany, Canada, and the Netherlands, use different forms of *global budgeting* or expenditure targets to check increases in health care costs. In all likelihood, President Clinton will propose such a global budget to contain health care costs, although some advocates of managed competition believe that this will not be necessary once market forces exert their effect on a more mature system.

Top-down budgeting holds particularly important implications for the elderly. Such a budget limit may require that the marginal benefit of a given medical expenditure be weighed against its cost. Less value, therefore, may be placed on therapies that benefit patients with shorter life expectancies, which raises the specter of a system in which a potentially lifesaving therapy such as dialysis for end-stage renal disease will be denied to patients based on age. This is an informal, although accepted, practice in other countries with limits on health care expenditures. Such rationing of health care could be brought about either by the imposition of a budget limit, such as a global budget, or by the kind of market competition inherent in managed competition. For example, market competition may lead certain health care plans to decrease costs by reducing the availability of an expensive medical therapy, like coronary artery bypass grafting to patients over a specified age. Thus, although these plans may not be directly subject to a national global budget, they have their own budget limits imposed on them by the need to remain financially solvent.

Medicare Reform

To date, little specific information has been released about the role of Medicare and the treatment of health care coverage for the elderly. Some of President Clinton's health care advisors feel that, initially, Medicare beneficiaries could elect to maintain their same health care coverage under a Medicare program that acts as a kind of national health alliance, but that, as more Medicaid enrollees elect to join other plans within their

regional health alliances, traditional Medicare eventually will wither away (Starr and Zelman 1993).

Other members of the task force argue that Medicare should be maintained in its present form. Such a solution is politically expedient, and surveys of Medicare recipients show that most participants prefer to have their own health care plan and are concerned that their interests would be discounted if health care is folded into a larger national pool. Proposing to shift the 31 million elderly Americans from Medicare into a disparate group of health alliances could be disruptive to the health care system, and it might impede the acceptance and passage of the entire program (Kronick 1993). Whether Medicare is significantly restructured or not, the impact of any reform on the rest of the health care system still will affect Medicare beneficiaries.

Redressing Medicare's Shortfall

The most significant impact of managed competition on the elderly may come with a pervasive shift in the philosophy of medical care delivery in America. This anticipated shift goes from a system of medicine that believes that more is better to one of managed care that rewards more efficient care. Drugs, devices, and procedures, although usually beneficial or at least not harmful, nevertheless carry with them statistically significant risks of adverse outcomes that may outweigh a marginal benefit. Surgical treatment of prostate cancer, for example, may lead to impotence and incontinence. Prostate cancer is usually slow growing, however, and a man over 65 years old is more likely to die of other causes than the prostate cancer itself. In this case, the risks of impotence and incontinence, although relatively small, probably outweigh the benefit.

The traditional system of medical care in this country is embodied in the fee-for-service system. Each additional procedure performed by the physician increases the physician's income. The patient is largely insulated from cost—except for deductibles and copayments—by an insurance policy. Such a system has been called cost-increasing, cost-unconscious medicine and may lead to overtreatment. Such overtreatment not only fuels the rise in health care costs but also may actually lead to a poorer quality of health care in certain situations.

The movement toward more cost-conscious, cost-effective medicine is embodied in managed care systems such as the HMO, the preferred provider organization (PPO), the independent practitioner association (IPA), and the point of service (POS) plan. In an HMO, for example, the physician (or group to which the physician belongs) is often paid a fixed fee to provide comprehensive care for an individual for a fixed period. A portion of this fixed fee is allocated to pay for hospital care, diagnostic proce-

dures, and treatments, in addition to routine health care. The incentive, therefore, is to deliver less rather than more care.

More recent innovations in managed care systems have made the financial arrangements between physicians and the managed care organizations more complex. In the IPA model, for example, physicians practice in their own offices with their own management style and see patients outside the HMO. They have a less direct relationship with the HMO than more traditional HMO arrangements in which physicians practice together and see only HMO members. The financial outcome and the allegiance of the physician to the IPA is less direct than to a traditional staff-model HMO. Some IPAs have sought to achieve a better "buy in" by physicians in the culture of the HMO by creating two- and three-tier HMOs (Hillman, Welch, and Pauly 1992). Two-tier HMOs contract directly with physicians, paying them outright and offering financial incentives through bonuses. They also withhold accounts and other mechanisms to contain costs through reducing hospital, specialist, or other service use. Three-tier HMOs differ in that they contract with an intermediary organization—a middle tier—that in turn contracts with physicians. Examples of such intermediaries are hospital medical staffs, physician groups, and physicians in geographic areas that receive capitation payment from the contracting HMO but then are free to negotiate different contractual arrangements and incentives with individual physicians.

Traditional two-tier systems, in which HMOs contract directly with physicians and often pay them by capitation, put the financial risk of treatment more directly on the individual physician, whereas the managerial control of the patient (for example, the extent of utilization management and other nonfinancial constraints) often remains with the HMO. Such arrangements may produce physician resentment, however, because the control (but not the financial risk) remains remote and adversarial. In a three-tier system, the financial risk of under- or overtreatment can be retained by the middle tier and removed from the individual physician. For example, a middle-tier contracting organization may choose to replace financial incentives with other influences on individual physicians, such as utilization management, intense information feedback, or some other change in the culture in which the physician practices. In this way physicians have more flexibility to manage their own behavior, independent of financial concerns. Decisionmaking is removed from remote third parties.

Such a three-tier arrangement simulates the proximity and peer group influences that occur in non-IPA HMOs and, although not yet fully evaluated in scientific studies, holds promise for improving competition's ability to change constructively the medical practice styles of physicians in different types of managed care organizations so that more participants

in a system of managed competition practice more cost-conscious, more cost-efficient medicine. Managed competition is a system of financing, but its potential for cost savings lies in its ability to change the style of medical practice and structures of management, to promote cost-conscious, high quality medical decisionmaking (Starr and Zelman 1993).

Although regional health alliances may be required to offer a fee-for-service option and Medicare recipients may be allowed to continue the relationship with their current physicians, substantial inducements also may be offered to attract them into managed care plans, because these often offer more comprehensive benefits at a lower price.

Case Management

Medicare patients are sicker and their care is more complicated than average patients. They often are prescribed a wide array of drugs for multiple medical problems, and these medications must be monitored and adjusted frequently as the patient's condition changes. These factors argue strongly for case management, a technique often used by managed care organizations to provide uniform, coordinated care by assigning patients to one responsible case manager or primary care physician. Managed care organizations also use such case managers as gatekeepers, to reduce the number of patient self-referrals to specialists, another contributor to the high cost of medical care. The primary care physician evaluates the patient's need for a specialist before making a referral. Then the primary care physician takes responsibility for orchestrating the patient's health care. Primary care physicians refer patients to specialists when needed, confer with specialists, and prevent redundant or counterproductive therapies and medications. Such coordination would be especially useful for the elderly, because they often see multiple specialists: for example, a rheumatologist for arthritis, a dermatologist for skin cancer, a cardiologist for congestive heart failure, and a pulmonologist for chronic obstructive pulmonary disease.

Medicare's Managed Care Competition

Most elderly Americans prefer the old style, fee-for-service system. Acceptance of managed care among all ages varies by region, with greatest enrollment in the West and limited enrollment in the Northeast. Medicare formally encouraged enrollment of Medicare recipients in managed care plans in 1982 with the passage of the Tax Equity and Fiscal Responsibility Act. And in 1983, HCFA initiated the National Medicare Competition demonstration in which managed care plans were recruited to provide comprehensive care to Medicare recipients. By 1992, the demonstration

project had recruited 100 HMOs and had enrolled one million Medicare recipients (Retchin et al. 1992). Few Medicare recipients joined for several reasons. Many did not want to lose the opportunity to choose their own physician, and they wanted to hold on to longstanding relationships with physicians whom they trusted and who knew their complicated medical histories. Medicare recipients also feared that they might not get the care they wanted because the managed care organization might deny benefits it deemed unnecessary. In addition, HMOs did not join the demonstration projects as rapidly as expected because most of their experience was with a healthier population, and they either had difficulty or believed they would have difficulty in delivering comprehensive care to a sicker population for a fixed fee.

Several studies addressed the concerns of the elderly as well as those of the HMOs. For example, comparison of Medicare recipients treated in HMOs with Medicare recipients treated in traditional plans showed no significant differences in functional status and no significant differences in medical visits, suggesting comparable quality and access to care (Retchin et al. 1992). Another comparison of participants in the HMO demonstration project with others in traditional forms of care showed no significant differences in utilization with two exceptions: the HMO patients made more frequent visits to community health clinics and had longer stays in hospitals for medical procedures, suggesting that they may have received a higher level of care (Wan 1989).

Most studies on managed care plans have involved the non-elderly. Some have postulated that retired enrollees of HMOs will demonstrate different usage patterns because of greater need and more free time (Thomas and Kelman 1990). An examination of this issue showed no statistically significant effect of retirement on the use of health services, suggesting that the cost savings of managed care plans applied equally well to the elderly as to the non-elderly (Soghikian et al. 1991).

Financial Burden

The level of financial burden that would be borne by Medicare recipients depends on the level of benefits guaranteed by the standard basic benefit package. President Clinton is considering multiple levels of benefits, with the most generous being increased coverage for those persons 65 and older, whereas the least generous would reduce the benefit now available through Medicare. Details of the various funding mechanisms, which will determine whether the new health plan will cost Medicare recipients more or less than currently, are still unclear. Greater reliance on payroll taxes, for example, would benefit the elderly because they no longer pay such taxes. Greater reliance on energy taxes or on a sin tax would affect the

elderly to the same extent that they would affect other segments of the population.

The choice of funding mechanisms and the composition of the basic benefit package will determine whether the elderly will find themselves paying higher or lower copayments and deductibles than currently. For those who chose to join managed care organizations, however, their out-of-pocket contribution might be less because these organizations typically offer more comprehensive benefits at a fixed price (Bates and Brown 1988). Fee-for-service plans generally use higher copayments and deductibles as mechanisms to reduce patient use of services. A fee-for-service plan offered under managed competition could potentially continue to use such negative financial incentives. Managed care plans, however, use different financial incentives to reduce costs, and such plans could be offered to Medicare recipients more widely.

Prescription Drugs

The costs of prescription drugs have risen faster than inflation and the volume of prescription drug use by the Medicare population (the major user of pharmaceuticals) has also risen, both contributing to the increasing proportion of health care expenditures for prescription drugs. These rising costs have led to recent calls for governmentally imposed price controls. Such controls, however, pose a challenge for managed competition, which will likely be asked to balance the need to rein in drug prices with the need to allow pharmaceutical companies sufficient profits to sustain adequate research and development programs. American pharmaceutical companies are world leaders in new drug development. Aggressive price regulation risks the slowing or even stalling of such innovation. Although the elderly could benefit from lower priced drugs, this should be weighed against the potential harmful effect of such cost savings from price controls on the potential future benefit of drug development. Appropriate profits that allow adequate spending on research and development without reducing access to drugs are necessary.

The potential of managed competition to address the lack of comprehensive Medicare prescription drug plans lies with the focus on managed care. If the Medicare population joins more comprehensive health plans, such as HMOs, they would be more likely to receive prescription plans as part of the standard coverage. In one survey of HMOs that accept Medicare recipients, the majority offered unlimited coverage with a copayment of from \$2 to \$5 on each monthly supply of a drug (Bates and Brown 1988). Like many specific issues in managed competition, the composition of the standard basic benefit package will determine whether prescription drugs will be a standard benefit or one offered at a higher price by some plans (Berthgold 1993).

Preventive and Routine Health Care

Some gerontologists believe that managed care systems, with their reliance on primary care physicians as gatekeepers to the system and as case managers, will offer the elderly more coordinated care (Parker and Secord, 1988). Such plans routinely cover regular physical examinations, screening examinations, health education and counseling, and immunizations. It is in the financial interest of these systems to offer primary care, for example, by catching an illness early, when it is simpler (and cheaper) to treat.

Medicare currently does not pay for vision and hearing deficits, but the majority of HMOs do cover vision and hearing examinations: two thirds place no limit or copayment on auditory evaluations, and one third do not restrict vision benefits. Coverage for glasses or hearing aids has occurred less frequently. Almost half the HMOs surveyed covered some dental benefits, and a few paid for dentures (Bates and Brown 1988).

Long-Term Care

Although it is unclear whether the basic benefit package will cover long-term care for the elderly, economic analyses, health policymakers, and advocates for the elderly have supported the establishment of a formal program. Although managed care programs are more likely to pay for skilled nursing facilities, they apply the same limits on length of stay that traditional Medicare providers use. The basic benefit package will address the level of long-term care offered.

Although many of the shortcomings in today's Medicare system have yet to be addressed specifically by President Clinton's health care reform proposal, a shift in the philosophy of medical care delivery toward cost-conscious, comprehensive care plans seems likely to redress the financial burden and economic barriers to care found in Medicare. The experience of the elderly in such managed care systems, although theoretically beneficial, has yet to be tested adequately. Moreover, it is unclear whether the elderly will be willing to give up a system that they know well for plans that traditionally have appealed most to younger people.

Potential Pitfalls

Health care reform may conflict with the interests of the elderly simply because of the increasing share of national health care expenditures devoted to this segment of the population. Any effort to reduce expenditures, therefore, could potentially limit health care services for those aged 65 and over, or increase the elderly's financial burden.

Global Budget and Market Competition

Two distinct cost-containment strategies have been promoted by the current health care reform proposal, and each has the potential to reduce Medicare benefits or increase the financial contribution expected from Medicare recipients. One strategy relies on market competition. That is, the accountable health plans must compete with one another for patients and the fixed annual fees these patients bring. Faced with a fixed fee for each patient, these plans will seek to deliver care as efficiently as possible. Even after adjusting the capitation paid to the AHP for age, gender, and possibly, comorbidities, there still may be an incentive to seek out low-cost patients, (for example, employed young adults), and to avoid high-cost patients (those with chronic disease and the elderly). Similarly, the plans will seek to reduce costs by delivering less care per patient, which carries the risk of undertreatment. Both cost-reducing strategies may put the elderly at risk.

The second cost-containment strategy, the global budget, was added to the reform plan to ensure that overall expenditures on health care would stop rising immediately. Some health care economists believe it will take from five to ten years before the competitive marketplace exerts its cost-reducing effects. It is unclear now who will be responsible for setting, imposing, monitoring, and enforcing a global budget. Such an expenditure limit could be enforced at the national health board level, at the state or regional levels, at the health alliance level, at the accountable health plan level, at the bedside by the physician.

The reason that these cost-containment strategies—the global budget and market competition—have potential pitfalls for the elderly is that older Americans incur a disproportionate share of health care budget expenditures. The biggest utilizers in the system are at highest risk.

A small proportion of medical care users account for disproportionate costs (Freeborn et al. 1990). In 1990, for example, HCFA reported that 18.8 percent of those eligible for Medicare incurred 80 percent of Medicare's total payments, and that 45 percent accounted for only 2.2 percent of total Medicare payments (Iglehart 1972). A high proportion of medical care expenditures takes place at the extremes of life. Despite broader discussion of putting limits on such treatments, a recent study showed that, since 1976 among Medicare recipients, no significant change has occurred in the proportion of Medicare expenditures accounted for by persons in their last year of life. The share has remained about 27 to 30 percent of such expenditures (Lubitz and Riley 1993). Could this high concentration of expenditures be distributed more evenly throughout the population or, for that matter, throughout life?

The exigencies of meeting a fixed budget may force health policymakers

to answer yes to this question and begin to require that clinicians make judgments about directions in treatment based on more than clinical evidence. To some degree, these considerations already have surfaced in the clinical literature. In evaluating aortic valve replacement in an 87-year-old patient, the author of a recent case study in the *New England Journal of Medicine* asked at what age a patient was "too old" to be treated. The answer would have to await a national consensus, the author suggested (Thibault 1993).

Such a discussion marks a departure from the practice of medicine in the past but may indicate what would happen under a fixed health care budget, as well as under the influence of the competitive market place. One example of rationing made explicit is the Oregon program for Medicaid health care rationing. In Oregon, policymakers created a list of health care services, which they ranked by perceived benefit and relative merit, and then funded as many as the state's Medicaid budget would allow. The proposal planned to leave unfunded those services whose cost/benefit ratio placed them lower on the list. Depending on how significant a factor the ranking system considers patient age and potential life-years gained from treatment, the elderly could find that services now routinely funded could be reduced. Less explicit rationing takes place in Great Britain, as well as in other countries that have national health services, and age restrictions are accepted for procedures like dialysis and open heart surgery.

Living Wills

A similar discussion arises when advanced directives or living wills are considered. In a cost-conscious health care system, those patients who elect to have all medical treatment, even when the cost exceeds the marginal benefit, could reasonably be asked to pay more for these higher cost services. If a patient is willing to pay for such treatment, then it may be allowed, as long as the cost is not subsidized by the public system. The ethical challenge to society arises when those who are unable to pay for more aggressive treatment are denied it.

Case-Mix Adjustors

Managed competition carries an inherent risk of discrimination against enrollees who incur high health care costs (Hillman et al. 1993). In managed competition, accountable health plans will be paid per enrollee, not per service rendered. Therefore, as discussed previously, managed health plans have the incentive to seek those enrollees who cost the least and to avoid high-risk groups such as the aged, the chronically ill, and people with acquired immunodeficiency syndrome (AIDS).

In managed competition, several mechanisms have been proposed to prevent such risk selection and to ensure equity. These include universal coverage in which all plans will be required to accept any enrollee who chooses them; subsidized access to a basic plan; a standard comprehensive basic benefits package; continuous coverage; and community rating.

Community rating, however, is problematic. Plans naturally would seek to avoid more costly patients, because they alone could jeopardize the economic viability of a plan. The RAND Health Insurance Experience showed that the most expensive 1 percent of patients accounted for 28 percent of the plan's costs (Manning et al. 1984). Some people have proposed that community rating be modified to allow for "age rating" if it is felt that pure community rating would require excessive subsidies of the old by the young (Enthoven 1933).

The problem with such rating systems is that they depend on case-mix adjusters, formulas used to predict the medical costs of different groups. Experience with such equations, however, is disconcerting. None has been shown to predict costs accurately, even when comparing seemingly equivalent conditions. Two patients with HIV, for example, can have widely different clinical courses and costs. No case-mix adjusters have been shown to predict these differences accurately.

Administrative Complexities

Managed competition poses complex administrative problems that fail to lend themselves to ready solutions. The current Medicare system, with overlapping Medicare coverage and supplemental coverage, requires patients, physicians, and hospital billing departments to fill out multiple forms to receive reimbursement. In 1991, 75 percent of Medicare recipients had supplemental private insurance. About 37 percent purchased the supplementary insurance on their own, employer-sponsored coverage accounted for 33 percent, and five percent had both forms of supplementary coverage (Chulis et al. 1993). It is unclear whether health care reform will reduce or exacerbate such complexity. Employers still may find themselves paying for some supplementary benefit, and Medicare recipients may find themselves faced with a more complex decision of what such supplementary coverage should be used for—certain surgical procedures not deemed cost effective, for example, or the choice of long-term care facilities. The composition of the basic benefit package may clarify some of these issues.

Quality of Care

A potential pitfall in a cost-effective health care delivery system is lower quality care. Americans and American physicians have long embraced

the notion that another laboratory test, the addition of a second or third drug, or yet one more imaging procedure represented better medical care. It is a notion that managed care organizations have sought to dispel. Studies in regional variations in medical treatment have shown wide disparities with no apparent differences in outcomes. But the belief seems to remain that *more care* represents *better care*. A risk of a competitive health care plan is a reduction in the intensity of care, perhaps even undertreatment. Studies of managed care organizations that are faced with the kind of financial incentives likely to affect health care alliances have shown that they practice a different style of medicine, one in which patients are admitted to hospitals and referred to specialists less often (Luft 1978). Although no adverse outcomes have been found in evaluations of such care, no clear benefit has been found either; but reductions in the quality of care, although not yet detected, may occur. Incentives to undertreat may be greater under managed competition, creating greater risks for undertreatment. High-cost patients, including the elderly, would logically be at higher risk of undertreatment. Members of President Clinton's task force have sought to create a system of rules and incentives to safeguard quality in managed competition (Hillman et al. 1993). Yet, it is important to repeat that the traditional "more is better care" can be potentially harmful to patients as well. No matter what the final outcome of health care reform may be, it seems clear that the elderly, with their high costs and fixed incomes, are at risk of receiving less than optimal health care or are in line to pay an increased share of the costs for that care.

Conclusion

The flaws in the current Medicare system, inadequate coverage and a prohibitive financial burden of copayments, may well be corrected under a new health care plan. Managed competition under a global budget offers to change the philosophy of medical decisionmaking, creating a cost-conscious system with a comprehensive benefit package, coordinated care, and reduced financial burden. However, inherent in this particular program is a philosophy dedicated to a balanced health care budget with benefit.

The elderly population is at risk because those persons over aged 65 are responsible for the largest and most rapidly growing portion of the public health care budget. After all aspects of President Clinton's health care reform are revealed to the public, it is highly likely that the elderly will again try to tailor the standard benefit package to meet their needs. The elderly will need to demonstrate, however, that the benefits of such expenditures are worth the costs.

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Commentary: John Rother

In Chapter Seven of this book, William Greer and Alan Hillman caution that “the elderly population is at risk because those people over age 65 are responsible for the largest and most rapidly growing portion of the public health care budget.” Although their analysis is presented in the context of “managed competition,” it could be inferred from this reasoning that the nation’s aged population should be wary of any approach to health care reform. The elderly do use more medical services than those under age 65 and, because the nation has chosen to provide health insurance to its aged citizens through a federal program, federal health expenditures for this group are greater than for any other. That said, however, it is important to keep in mind that the single largest contributor to the deficit has come from increases in *system-wide* health care costs that persist despite significant reductions in Medicare. Between 1984 and 1990, an estimated \$82 billion was saved from Medicare Part A. The Omnibus Budget Reconciliation Act 1990 (OBRA) cut Medicare by an additional \$43 billion from fiscal year FY 1991 to FY 1995. Because providers were able to shift costs, these reductions have not altered total health care spending trends dramatically. Medicare accounts for about 16 percent of total health care expenditures in the United States (CBO 1993).

Medicare Shortfalls

Greer and Hillman correctly note that the current Medicare program has numerous shortcomings. Although Medicare is highly valued by the nation’s older population—the program enrolls virtually all (95 percent) of the aged population—it is significant that Medicare still covers only about half of beneficiaries’ health bills. As a consequence, more than three fourths of beneficiaries are covered by insurance that supplements Medicare. It is estimated that, in 1991, elders spent more than twice as much (after adjusting for inflation) on out-of-pocket health care costs as they did *before* the establishment of the Medicare program (Lewin/ICF for Families USA 1992). The nation’s elders spend more out-of-pocket than any other age group for premiums, deductibles, and coinsurance,

as well as for liabilities for noncovered services, such as outpatient prescription drugs. In marked contrast to employer-sponsored insurance, where most plans have out-of-pocket caps of \$1000 to \$2000 for individual coverage (Sullivan et al. 1992), Medicare has no upper ceiling on beneficiary out-of-pocket liabilities.

Medicare's lack of coverage for most long-term care services represents a major shortcoming, particularly because of the high costs for such care and the absence of adequate and affordable alternatives to public coverage. Although Medicaid covers long-term services—it covers about 46 percent of all nursing home care costs (or about 12.5 percent of total Medicaid expenditures)—elders must impoverish themselves by “spending down” to the federal poverty level to qualify for this aid. Furthermore, Medicaid has an institutional bias that favors nursing home care at the expense of home and community-based care, which most older people prefer.

Long-Term Care and Reform

The inclusion of long-term care coverage in a reformed system is critically important to public support and is especially important to older Americans. A recent poll conducted for the American Association of Retired Persons (AARP) indicated that the inclusion of long-term care raised the overall level of support for health care reform among respondents from 46 percent to 83 percent (ICR Survey Research Group 1993). The array of complex financing and delivery issues makes the task of crafting an acceptable long-term care benefit uniquely challenging. Certain elements, however, are essential: a long-term care system should be based on a social insurance model, and it should provide care for all who need it. Ultimately, the program should become a part of Medicare to promote and facilitate better care management. It should be financed broadly and include meaningful cost-containment provisions. Although most policymakers recognize that a full-blown benefit will have to be phased-in over time, older Americans will be looking for a meaningful downpayment toward comprehensive long-term care coverage. In the long run, a federal long-term care program will provide an ideal opportunity to develop mechanisms that provide a genuine continuum of care by integrating acute and long-term care.

Although the specifics are still uncertain, President Clinton's health reform proposal appears to incorporate several features from earlier managed competition proposals. The plan should provide a reasonably comprehensive benefit package and probably will encourage enrollment in managed care organizations through various incentives to employers and consumers alike; most likely, multiple health insurance options will

be available through large purchasing coalitions or corporations known as health alliances. Medicare beneficiaries also will be given options and incentives to enroll in the new managed care plans. The intent of health care reform is to reorder priorities and restructure financing *and* health delivery. If successful, beneficiaries and all others will be affected by a shift in philosophy, from "more is better" to "less can be good too."

Because of its current shortcomings, Medicare needs to be part of comprehensive health care reform. At the same time, the effects of integrating Medicare into a managed competition strategy must be understood fully. Indeed, the emphasis on managed care delivery systems could be beneficial to Medicare beneficiaries. Traditional managed care organizations, such as health maintenance organizations (HMOs), typically provide a more comprehensive range of benefits than Medicare, including outpatient prescription drugs and preventive services; however, current Medicare experience with managed care organizations, particularly non-traditional models, is very limited. As of May 1993, only 1,644,411 Medicare beneficiaries, or about 5 percent of the total Medicare population, were enrolled under 96 Medicare Tax Equity and Fiscal Responsibility Act (TEFRA) risk contracts in the health care financial administration's (HCFA's) coordinated care program. Medicare's experience with preferred provider organizations (PPOs) has just begun under the Medicare Select program in which 15 states are participating in a demonstration of this model. An evaluation of Medicare Select will be conducted to determine patient satisfaction, quality, program savings, and so forth. Neither beneficiaries nor HCFA has experience with other models that exist in the private sector.

Greer and Hillman have enumerated the reasons why the Medicare HMO risk program has failed to thrive. Added to their list are the deficiencies of the reimbursement methodology. It is noteworthy that only 17.5 percent of HMOs participate as risk contractors in the Medicare program. HMO reimbursement is based on the average adjusted per capita cost (AAPCC) and thus is pegged to the fee-for-service system. County-based, the AAPCC methodology results in wide variation across the country. Correction of the AAPCC methodology is necessary to encourage reasonable HMO participation levels in the Medicare program and to ensure that Medicare payments are set at appropriate levels.¹

Clearly, managed care is not for everyone. Even if Medicare beneficiaries were more familiar with it, the emphasis on this delivery system could be problematic for those beneficiaries who prefer not to join one of these plans, particularly if benefits favored by beneficiaries, such as outpatient prescription drugs or long-term care, are used as enrollment incentives. President Clinton's plan retains a fee-for-service option, as must the Medicare program. In addition to the underlying importance of choice, Greer

and Hillman note some of the pitfalls that Medicare beneficiaries could encounter under a managed competition-like strategy; these point to how important effective quality assurance and consumer representation will be on the health alliance governing bodies that arise out of the reformed system. The authors warn that under a global budget, plans may have incentives to avoid enrolling older, higher cost patients. In addition, plans may attempt to reduce costs by undertreating enrollees. Until risk adjusters become more sophisticated and more accurate, these very real possibilities might pose problems for Medicare beneficiaries. With stringent requirements and timely appeal procedures to ensure appropriate responses to consumer grievances, with vigilant external review of the quality of care provided, and with rigorous enforcement, any adverse potential of underserving should be avoidable.

Greer and Hillman also suggest that the elderly may suffer under managed competition because plans will interpret cost-containment strategies as license to ration, reasoning that, in a budgeted system, "the elderly could find services reduced that now are routinely funded." Here again, managed competition, or any other reform strategy, need not limit expenditures inappropriately at the end of life. The need to safeguard against this possibility certainly exists. Widely accepted misconceptions abound that rapidly rising health care costs can be attributed to the cost of treatment during the last year of life and that heroic measures account for a substantial share of Medicare expenditures. On the contrary, the share of Medicare payments for care provided at the end of life has been stable since 1976 (Lubitz and Riley 1993). In addition, the intensity of treatment actually declines with age and functional ability. In 1987, had all medical care been withheld from every Medicare beneficiary in the last year of life, then total savings would have been about \$22.7 billion out of approximately one half trillion dollars spent on health care in that year (Jahnigen and Bienstock 1991). Talk of fiscally necessary rationing is therefore premature. With effective cost containment, the United States has the resources to ensure access to acute and long-term care services for all individuals, without compromising the quality of care.

Conclusion

Ultimately, the scope and content of health care reform is a reflection of national priorities. Although it is expected that the needs of older persons will be recognized, there is more theology than hard evidence regarding the advantages of managed competition for this population. Although the potential to combine a better designed program with broader health reforms is great, the integration of Medicare and managed competition should only proceed with extreme care as unavoidable

trial and error help make the health care system more responsive to consumer needs and make it more fiscally sustainable.

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Notes

1. In contrast to Medicare's limited exposure to managed care, 41.4 million people nationwide are enrolled in HMOs, and an additional 85 million are eligible to participate in PPOs (GHAA 1993; Marion Merrell Dow 1992). Over half of all workers covered by employer-sponsored coverage are enrolled in managed care plans. Conventional indemnity insurance accounts for only about eight percent of employer-sponsored plans (Sullivan et al. 1992). The trend, even in nonmanaged care plans, is to apply utilization management techniques such as preadmission certification or concurrent review; 92 percent of employees covered under employer-sponsored programs are in plans that have some form of utilization management (Sullivan et al. 1992).

Commentary: Peggy M. Connerton and J. Peter Nixon

William Greer and Alan Hillman examine many deficiencies in the Medicare program, such as high copayments, inadequate coverage of preventive health care, and the lack of coverage for long-term care and prescription drugs. They argue that one way to extend coverage and still reduce costs for Medicare recipients is to encourage care through health maintenance organizations (HMOs) and other managed care institutions. Not only would this lower costs for recipients, but it also would save the federal government money, especially if the system could be constructed so that managed care providers would compete with one another for Medicare clients under a regulatory framework known as *managed competition*.

In drafting the recently released Health Security Act, the Clinton administration was heavily influenced by advocates of managed competition. Medicare is retained as a separate program, although states would have the option of integrating Medicare beneficiaries into the Health Alliances that will serve the majority of the under-65 population. They would only be allowed to do this if they could guarantee that the federal government's costs would not increase and that Medicare beneficiaries would have access to the same or better coverage as standard Medicare benefits. The Clinton plan would also provide Medicare beneficiaries with a new prescription drug benefit.

Although eventual incorporation of the Medicare program into the reformed system should remain the goal, the Clinton administration's caution is well warranted. By contrast, Greer and Hillman appear too confident that managed competition can contain Medicare's growing costs without affecting significantly the quality of care received by program beneficiaries.

Boiled down to its essentials, the argument from Greer and Hillman is based on four propositions. The first is that moving Medicare recipients into prepaid health plans (such as HMOs) will reduce the program's costs through more aggressive case management and lower utilization. The second is that competition between plans will help reduce costs still fur-

ther. The third is that a switch to prepaid plans would not affect adversely the quality of care that Medicare beneficiaries receive. The final assumption is there are no significant barriers to incorporating the Medicare population into a new national system.

The argument set forth in this commentary is that none of these propositions is entirely true. In the next few pages, each issue will be addressed in greater depth.

Can Managed Care Cut Medicare Costs?

In theory, prepaid health plans like HMOs are expected to have lower costs than traditional fee-for-service plans, because the provider faces financial incentives to provide less care rather than more. The opposite is true for fee-for-service medicine, where the more services that the providers deliver, the more they benefit.

In practice, however, managed care has been somewhat disappointing. Although the average cost per employee in 1991 for HMOs was almost 15 percent less than the average cost per employee for indemnity plans, HMO premiums increased almost as fast as the premiums for indemnity plans (9.8 percent versus 11 percent) (Iglehart 1992). HMOs have benefitted from their ability to reduce hospital admissions and shorten lengths of stay, but they have been unable to alter the long-term rate of increase in health care costs.

More specific data on the potential impact of managed care on Medicare costs are available from the Health Care Financing Administration's (HCFA's) National Medicare Competition Demonstration, which recruited HMOs to provide care to Medicare recipients. Numerous evaluations of the demonstration were prepared by Mathematica Policy Research, Inc., showing mixed results that suggest that the use of prepaid plans may not reduce program costs as much as was previously believed.

HMOs seem to be able to reduce the number of services used by Medicare clients. For example, HMO patients in hospitals had lengths of stay that were 17 percent lower than patients in the traditional fee-for-service plan, although HMOs did not affect the rate of admission to hospitals (Hill et al. 1992). Substantial reductions in utilization of mostly discretionary tests and procedures were found among HMO patients, compared to those in fee-for-service settings. Reductions also occurred in the amount of rehabilitative care provided by HMOs, both in and out of the hospital.

Despite reduced utilization, HMOs did not reduce Medicare's program costs. HCFA paid 5.7 percent *more* for enrollees in HMOs than would have been spent on them under a fee-for-service plan. The principal reason was favorable selection, with HMOs recruiting, on average, healthier Medicare recipients than traditional plans. Because these ben-

eficiaries used fewer services, it would have been cheaper for the federal government to reimburse providers on a fee-for-service basis (Hill et al. 1992).

Will Competition Reduce Costs?

Many advocates of managed competition are not deterred by the lack of success that prepaid health plans have had in bringing costs under control. They argue that because prepaid plans compete with less efficient fee-for-service plans, they are able to "shadow price" (i.e., price their plans just under the level of the fee-for-service plans). Because many employers offer only one or two prepaid plans in addition to their fee-for-service plan, competition between plans is severely attenuated.

By contrast, under a pure managed competition approach, all plans are prepaid, and the traditional tax exemption granted employees for employer contributions to health insurance is limited to the cost of the lowest priced plan available. If subscribers opted for more expensive plans, then they would have to pay taxes on the difference in cost between their plan and the lowest cost plan. Advocates of managed competition argue that this system would increase the competitive pressures on all plans, leading to cost reductions. Greer and Hillman argue that such a system could be used to reduce the costs of the Medicare program.

Although this seems attractive in theory, there are a number of reasons why it would probably not function as effectively as Greer and Hillman believe. Medicare recipients are even less likely than the non-elderly population to behave like the consumers of classical economic theory, carefully comparing price and quality information across many different plans. The majority of Medicare recipients are known to value long-term relationships with one or more physicians and are probably unwilling to switch plans except under exceptional circumstances.

The other principal problem is medical technology, which is one of the single most important factors in explaining the rapid rise in medical costs. Although the move toward managed care can ameliorate some of the pressures to use new technologies, primarily by removing the physician's financial incentive to "do more," it cannot eliminate them. In fact, the highly competitive market envisioned under managed competition could exacerbate the problem if each health plan acquires these technologies to recruit plan participants or new physicians. This has happened with hospitals in large metropolitan areas. For example, the hospitals in the Minneapolis-St. Paul area have five bone marrow programs, 13 open-heart surgery centers, and 23 magnetic resonance imaging centers (one more than exists in all of Canada) (Kent 1992).

One of the best working models of managed competition is the California Public Employees Retirement System (CalPERS), which administers a health program with 25 plans that compete for the business of nearly one million state and local government workers, family members, and retirees. CalPERS announced at the beginning of 1993 that the premiums for its basic health plans would rise an average of 1.5 percent, compared to 10 to 12 percent nationally. Stanford Professor Alain Enthoven, father of the managed competition concept, argues that "this is powerful evidence that managed competition works."

The truth is somewhat more prosaic. Throughout the 1980s, CalPERS experienced higher premium increases than employers nationally. Only in the last two rounds of premium negotiations, for plan years 1992-93 and 1993-94, were costs held well below national trends. The reason is that, in response to California's fiscal crisis, the state froze contributions to the program and used its clout as a multiemployer purchasing cooperative to negotiate aggressively any premium increases charged by CalPERS plans (SEIU 1993).

Can Prepaid Plans Maintain High Quality Care for Medicare Patients?

A major risk inherent in moving Medicare beneficiaries into prepaid plans is that the very incentives designed to eliminate the provision of unnecessary care may result in the denial of needed care. The debate over whether prepaid plans provide lower quality care has raged for years without being settled definitively. The weight of the evidence suggests that HMOs have been successful in reducing utilization without having a negative impact on patient outcomes.

Although Greer and Hillman argue that a switch to prepaid plans would not result in lower quality care for Medicare recipients, the evidence from HCFA's HMO demonstrations is more equivocal. It is true, for example, that comparisons of the inpatient care received by HMO and fee-for-service clients for two conditions, stroke and colon cancer surgery, showed no differences, on the one hand, in death or readmissions (Retchin et al. 1992). On the other hand, one third of Medicare recipients enrolled in HMOs disenrolled within the first two years. More than two thirds of those who disenrolled returned to the fee-for-service sector, suggesting dissatisfaction with some aspects of the care they received (Langwell et al. 1992).

Does the Medicare Population Face Special Barriers?

Although incorporation of the Medicare population into prepaid plans as part of a unified national health care system is attractive for many rea-

sons, it is important to appreciate the difficulties involved. If done improperly, the incorporation of Medicare beneficiaries could destabilize the new system or lead to a political backlash that would make the furor over catastrophic health insurance look mild by comparison.

The root of the problem is that Medicare beneficiaries have significantly different needs than younger, healthier individuals, who historically have gravitated to prepaid plans. As one ages, health becomes more valuable relative to other goods, because the probability of a severe illness increases. The development of an established relationship with a physician who is aware of a person's medical history becomes much more important, as does access to specialized services. HMOs try to limit the use of specialist care, and, in some cases, they may not even have an ongoing relationship with certain types of specialist providers. For these reasons, the elderly tend to favor plans that give them greater choice of providers, and they resist changing health care plans, even as the plans become more expensive.

The experience of retirees in the CalPERS system illustrates this phenomenon. PERS-CARE, the principal fee-for-service plan in the CalPERS system,¹ serves a disproportionate number of retirees, rural employees, and the less healthy. As of January 1993, the average age difference between CalPERS HMO and PERS-CARE enrollees had climbed to eight years (51 for a PERS-CARE member and 43 for an HMO member), which represents one-and-one-half times the age difference just 10 years ago (SEIU 1993).

The tendency of retirees to cluster in plans that give them greater choice of provider drives up the price of those plans, causing younger and healthier individuals to leave, which drives up the price even higher.² The gap between the family premium for PERS-CARE and the average HMO now exceeds \$100 a month for a one-person plan, \$160 a month for a two-person plan, and \$210 a month for a family plan (SEIU 1993).

The potential of Medicare recipients to destabilize a prepaid health plan could well lead to discrimination against them, either in enrollment or in treatment. Although it is likely that any Medicare reform legislation will require plans to enroll anyone who applies, the history of antidiscrimination legislation suggests some discriminatory practices can escape the definition of the law. A more significant problem is likely to be discrimination in treatment, where the elderly are denied access to clearly beneficial care that is extremely costly. A 1991 study of California HMOs by the Medicare Advocacy Project concluded that "Medicare beneficiaries are extremely vulnerable to misleading marketing by HMOs," and that those who enroll in HMOs "have few meaningful appeal rights" if they disagree with a physician about seeing a specialist (Perry 1993).

The incentive to discriminate can be reduced by risk-adjusting the capi-

tation rates that the federal government would pay to prepaid plans. As Greer and Hillman point out, however, risk adjustment is not an exact science, and many insurance carriers believe it cannot be done. It will probably also be necessary to develop enforcement mechanisms for the antidiscrimination provisions if there is a future attempt to incorporate the Medicare population into a reformed system.

Prepaid plans are likely to complain bitterly, however, if antidiscrimination provisions are used to prevent them from denying costly forms of care that appear to yield little benefit to Medicare patients. This raises the extremely complicated issue of how to "ration" health care. Greer and Hillman are correct to point out that whether costs are controlled through a global budget or by competitive pressure, any finite limit on expenditures implies that at some point care must be denied. The advantage of the current Medicare system is that it is subject to some degree of democratic accountability. Moving Medicare beneficiaries into prepaid health plans attenuates that accountability. Given that the United States lacks a national system of practice guidelines and quality standards for health care, the risk is that the idiosyncratic choices of the insurance industry about when and how to deny care will affect the elderly disproportionately because, as Willie Sutton replied when asked why he robbed banks, "that is where the money is."

Conclusion

The problems with the Medicare program that Greer and Hillman outline are real ones, and they have performed a valuable service by reviewing them. Undoubtedly, reform of the Medicare system should be linked to reform of the whole health care system. For years, the private sector has been allowed to insure the young, the healthy, and the financially secure, whereas the public sector has been left with the job of insuring the elderly, the sick, and the poor. Although costs have risen for the private and public sectors alike, the burden of public sector programs has been especially heavy of late, and threatens to bankrupt federal, state, and local governments. Folding all private and public insurees into one purchasing system would allow risk and cost to be spread more widely over a larger pool, easing the burden on taxpayers.

Unfortunately, having outlined the problems with Medicare, Greer and Hillman do not advance the debate significantly as to what the solutions should be. They are unable to move beyond the vague, if appealing phraseology of "managed competition under a global budget." Implementing such a proposal for the Medicare population faces a number of obstacles that advocates of managed competition have not thought through seriously. These advocates, who range from Professor Alain Enthoven to the

New York Times editorial page, continue to believe, despite mounting evidence to the contrary, that market forces alone are capable of controlling rapidly rising health care costs.

This is not to say that Medicare recipients should not take advantage of new kinds of delivery systems, or that market forces should not be used to improve certain aspects of plan management. Caution must be exercised to ensure that organized delivery systems include institutional mechanisms to guarantee that Medicare beneficiaries and the entire health care system are not affected adversely. Some proposals along these lines include the requirement that prepaid plans for Medicare beneficiaries have "point-of-service" options so that the elderly can receive care from providers outside the system without incurring severe financial losses. Another idea would be to establish "centers of excellence" for certain capital-intensive surgical procedures so that competitive pressures do not lead plans or hospitals to intensify the technological "arms race." It is extremely important for public authorities to collect and disseminate to consumers information about the quality of the health plans from which they may choose. Quality should be defined broadly to encompass not only medical outcomes but also customer satisfaction.

Finally, and in this Greer and Hillman are correct, Medicare and the entire health care system must be brought under the discipline of a global budget. Only a global budget can protect families, employers, and governments from the staggering burden of health care costs.

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Notes

1. PERS-CARE is a Preferred Provider Organization (PPO), a modified fee-for-service plan that offers reduced costsharing if plan members use certain designated providers.

2. This trend explains the difficulty that PERS-CARE has had in controlling premium increases, which have averaged 13.9 percent a year over the last five years (SEIU 1993).