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# Consumer Choice in Medicare

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### Introduction

Efforts to provide Medicare beneficiaries with a choice of health plans have proven difficult over the years. Programs have been tried and have faltered. Many employers who once helped to fund retiree benefits have stopped doing so or have scaled back their support. Future choices for beneficiaries will almost certainly mean having to use their own resources to help cover the cost.

The reality is that Medicare never has been “free” for beneficiaries. There have always been substantial premiums for Part B coverage (25% of program costs) and significant costs associated with deductibles, coinsurance, and uncovered services. The Centers for Medicare and Medicaid Services (CMS) estimates that Medicare currently is paying just over half of an elder’s health care costs.<sup>1</sup>

These costs are certain to increase as health care becomes more expensive and as a greater proportion of the American population is eligible for Medicare as the Baby Boomer generation ages into the program.

In addition to core Medicare costs, most beneficiaries find it desirable to also purchase or to have provided a Medicare supplemental policy to fill-in the many gaps left by Medicare. This extra coverage may be provided by a former employer, purchased on an individual basis, or funded through a public program like Medicaid. Current proposals to add a prescription drug benefit may help offset some of these costs for some people, but most estimates are that even a ten-year \$400 billion drug benefit will cover at most one-fifth of Medicare beneficiaries’ drug costs. And even that would be an optimistic estimate since part of the \$400

billion will go toward services other than medications.

In addition, scheduled cuts in Medicare payments are certain to result in fewer physicians, and possibly hospitals, accepting Medicare patients. Continuing prohibitions on balance billing and private contracting within the Medicare program will only aggravate the problems.

Higher costs and limited choice of providers is likely to result in greater demand for options. This will be especially true if employment-based health coverage continues in the direction of consumer driven health care, enabling individuals to choose their own physician, save money for future needs, construct their own benefit packages, and choose from a variety of health plan offerings. Aging workers that become accustomed to this level of consumer choice may rebel when they turn 65 and are forced onto a restricted Medicare program.

The federal government needs to pay attention to changes in the under-65 market to anticipate the expectations of a new flood of empowered workers who will demand similar empowerment when they become 65.

### **Employer Retiree Benefits Shrink**

**E**mployers have cut back dramatically on funding for retiree health benefits over the past 15 years. In 1988, 66 percent of firms with more than 200 workers provided benefits. That has dropped to 38 percent in 2003.<sup>2</sup> Smaller firms are even less likely to provide such coverage.

Employer cutbacks of retiree health benefits do not signal indifference toward retirees by employers, but a change in the regulatory environment. While employers are dropping retiree health plans, they are not dropping pension programs. In 1988, 38 percent of all workers participated in an employer-sponsored retirement plan, rising to 43% by 2001. Employers are, however, changing the type of pension program they offer. The assets held in defined benefit programs has dropped from 33

percent of the total in 1985 to 17 percent in 2001, while the percent in IRAs and defined contribution plans is growing, from 10% and 18% respectively in 1985 to 22% and 20% in 2001.<sup>3</sup>

One of the primary reasons retiree health coverage has fallen while pension programs have grown is a ruling (FAS-106) of the Financial Accounting Standards Board issued in December, 1990, which required employers to record future retiree health liabilities in their accounting statements. According to Paul Fronstin of the Employee Benefits Research Institute (EBRI), "The recognition of these liabilities in financial statements dramatically impacts a company's calculation of its profits and losses and thereby creates a strong incentive for financial managers to limit expenses."<sup>4</sup>

The EBRI study cites a number of surveys that show fewer employers offering coverage to either early retirees or those eligible for Medicare.<sup>5</sup> One is a William Mercer study of employers with more than 500 workers, which shows the number of employers offering coverage to early retirees dropping from 46% in 1993 to 31% in 2000, and those covering Medicare retirees dropping from 40% to 24% in the same time period.

Those who still offer coverage are modifying their benefits to make future costs more predictable. It is virtually impossible for an employer to anticipate health care costs for employees who may be 20 years away from retirement, and yet FAS-106 requires them to do precisely that. Many employers have responded by promising a capped contribution. For instance, an employer may offer to pay future retirees a fixed annual amount of money, say \$50 per year of service upon retirement, to help offset health benefits costs. The balance, if any, is to be paid by the retiree. Employers with more than 1,000 employees are increasingly likely to place a dollar cap on the amount they contribute to retiree health costs. In 1993, 72% of such employers had no cap on their contribution and only 15% had a cap. By 2000, only 55% of employers had no cap and 29% had a cap.<sup>6</sup>

Already some employers have discovered that the purchasing value of the promised payment has eroded because of excessive medical inflation, especially for the aged. Medicare retiree costs went up 24% in the year 2000, compared to 10% for non-Medicare retirees. FAS-106 makes it extremely difficult for employers to readjust their contribution to compensate for such spikes in costs.<sup>7</sup>

### **But Consumer Empowerment Is Growing**

The recent IRS guidance on Health Reimbursement Arrangements (HRA)<sup>8</sup> has given employers another tool in dealing with retiree health benefits. HRAs, along with Medical Savings Accounts<sup>9</sup> and Flexible Spending Accounts,<sup>10</sup> all give workers a source of cash funds with which to pay directly for health care services. Each program is currently limited, but the prospects are strong for expansion. All three approaches are teaching active workers how to manage their own health care needs, and HRAs and MSAs make it possible for an employee to save unspent funds for future health care needs – including filling in the gaps of Medicare.

By some estimates, HRAs may capture 25 percent of the benefits market by 2010.<sup>11</sup> That may be optimistic. It is impossible to predict with any certainty how the market will respond, either in terms of enrollment or future benefits structure.

What is certain is that the market is moving in the direction of consumer choice and empowerment. In five to ten years, a large number of new Medicare beneficiaries will be coming into the program with experience in selecting and paying directly for health care services, and they will have a store of money accumulated for their health care needs.

These new beneficiaries are unlikely to be pleased with the current Medicare program, with its shrinking selection of providers, inadequate payment by

Medicare for needed services, and inability of beneficiaries to supplement Medicare payments with their own funds. They will have the money, the knowledge, and a tradition of independence. They will expect a choice of plan designs, and they will be willing to pay extra for extraordinary services.

### **Earlier Attempts At Consumer Choice in Medicare**

The track record for consumer choice in Medicare is mixed. It is probably fair to say that Medicare risk contracting from 1985 through 1997 was fairly successful, but the Medicare+Choice program enacted as part of the Balance Budget Act of 1997, has been less successful.

One thing that is clear is that beneficiaries are interested in choice. The numbers enrolled in managed care programs grew throughout the 1990s, from just over one million in 1990 to a peak of more than six million in 1999.<sup>12</sup> After the change to Medicare+Choice, enrollment shrank, not because beneficiaries weren't still interested, but because the plans were forced to withdraw from the market due to inadequate payment. According to Mathematica's Marsha Gold, "In 1999, ninety-seven plans withdrew or reduced their service areas, directly affecting 407,000 enrollees." In 2000, 99 plans with 327,000 enrollees withdrew, and in 2001 withdrawals affected 934,000 enrollees. Gold attributes the problem in Medicare +Choice to Congress paying "insufficient attention to market dynamics." Many of these affected beneficiaries were able to sign up for other managed care plans, but the number of choices was reduced, and they were more likely to have to pay supplemental premiums after the withdrawals.

It is also the case that the M+C program did not attract the competing forms of health care plans (PPO, POS, FFS, and MSA) that Congress envisioned. There were regulatory reasons for this failure to attract competing forms. Gold, for instance, points out that, "PPOs do not have the same control over care systems (that HMOs have),

and often do not regard themselves as managing care.” Yet they were subject to the same “quality assurance” regulations as HMOs were.

### **Why Didn't Companies Offer Medicare MSAs?**

I did a survey of prospective Medical Savings Account providers in 1998<sup>13</sup> to determine what they viewed as the advantages and obstacles to providing an MSA through Medicare. The results were illuminating.

Fifty-nine insurers were chosen based on their track record with either MSAs or in the senior market with Medigap policies. Only 28 companies returned the survey, but 46 companies were contacted and interviewed over the phone. Of the companies returning the survey forms, 13 were Blue plans and 15 were commercial carriers, 23 were selling HIPAA-qualified MSAs, 19 were selling Medigap products, and six were Medicare intermediaries.

Having experience in the elderly market was seen as a virtual prerequisite for marketing Medicare MSAs. Twenty-two companies said it was “very important” and six said it was “somewhat important.” At the time virtually all of the companies were cautiously watching the regulatory process before committing one way or another on Medicare MSAs. When asked what factors would enter into their decision to develop and market an MSA product for the Medicare population, there were distinct differences between Blue Cross Blue Shield plans and commercial carriers. The Blue plans thought the presence of competitors would be an important factor, while commercial companies were more concerned about the regulatory environment and the quality of their sales force. Strong majorities of all the companies said they would be more likely to participate if they could individually underwrite applicants and less likely if they had to use community rating. Possibly more interesting were some of the comments made during the telephone interviews. Companies were reluctant to commit

the R&D resources for a new product for a number of reasons, many of which would apply not only to an MSA product, but any private alternative to Medicare FFS:

- There was widespread uncertainty of the future stability of Medicare generally and the Medicare+Choice program specifically. The Breaux-Thomas Commission had recently been authorized and the prospect of major Medicare reform was looming.
- Several executives expressed skepticism that they would ever be allowed to make a profit on the product, or even recover their development costs. They believed the program was too politically charged and that if they began to make money on it, they would be accused of “profiteering” on the elderly.
- At the time the survey was conducted, the regulations governing the program had not yet been finalized by the Health Care Financing Administration (HCFA, now CMS). Companies had little faith that the regulations would be reasonable, consistent, or stable over time.
- Companies that were not already Medicare risk contractors or intermediaries felt daunted by federal procurement rules and accounting procedures that are unique to the federal government. Medigap carriers were confident in their ability to market to and contract with beneficiaries themselves, but thought creating the entirely separate set of procedures to become a federal contractor was too great a hurdle.
- Even companies that were interested in participating were reluctant to be the first. They thought the burden of educating the entire elderly population about what a MSA is and how it worked was overwhelming, especially the prospect of setting up call-in centers to answer the questions of potentially 39 million people.

- Finally, the companies had to prioritize their R&D resources. With all of these hurdles, it made more sense to them to focus on other projects that had better potential.

In essence, the companies expected HCFA to treat them as if they were surrogate government agencies, with a single mission, unlimited R&D resources, no need to innovate, no expectation of profitability, and a mandate from Congress. “Market dynamics” were indeed absent, and not a single carrier developed an MSA product for Medicare.

## Lessons For Medicare Reformers

People approaching Medicare eligibility today are different than the stereotype of yesterday. They are better educated, healthier, and increasingly equipped with the experience and resources needed to make their own decisions in health care.

At the same time, they will be less likely to have third-party support for their medical needs as employers continue to cut back on retiree benefits or take a “defined contribution” approach to funding those benefits.

Many of them will have cash to spend on health care, either in the form of a dollar contribution from their former employer or from accumulated balances in HRAs or MSAs. Some number of future beneficiaries will be accustomed to supplementing core employer-sponsored benefits with their own funds, not only to “buy-up” to a better benefits package, but to pay extra to see the provider of their choosing or receive services outside of the regular plan coverage.

These characteristics will clearly not apply to all beneficiaries. Medicare-eligibles are no more homogeneous than the rest of the American population. A reformed Medicare program should be able to accommodate the diversity of the population it serves.

Such diversity implies offering private sector alternatives to a core Medicare program. But a private sector alternative is much more than just having a privately-owned company standing in the shoes of CMS. As Marsha Gold said, Congress must understand “market dynamics.”

“Market dynamics” include a lot of specific qualities. It would take an encyclopedia to discuss them all. But some of the core ideas were mentioned in my interviews with insurers:

**A stable regulatory environment that allows for experimentation, innovation, and refinement of products.** Neither Congress nor CMS can predict ahead of time, for example, what level of deductible will be most appealing in a voluntary market. For that matter, neither can insurance companies. The market dynamic is that a company takes an educated guess, sees how the market responds, and then refines the product accordingly. This process is fundamentally different from the development of a government program that operates on a “take-it-or-leave-it” basis – or more accurately, a “take-it-whether-you-want-it-or-not” basis.

**A realization that new ideas are embraced first by “innovators” and “early adopters.”** Cell phones, fax machines, desk-top computers, all are purchased first by people who are willing to take a chance on something new. They tend to be risk-takers and are usually younger, wealthier, and better educated than the rest of the population. This may look at first like “adverse selection” to policy-makers. In fact, this process is essential to new product development. Ideas are tested on these risk takers, and refined before being accepted by the larger population. It is a fair exchange. The innovators accept a higher risk for the advantage of a newer and better product. The rest of the population also makes a trade off. They opt for stability at the cost of not being able to use a newer and better product for a few years. But, soon enough, the good ideas become tested and mature – and more affordable for everybody.

**Product development is not cost-free.** A company that develops a new product or that enters a new market incurs considerable costs. It is not solely the direct cost of research, development, and distribution. It is also the “opportunity cost” of not doing something else with those resources. A private company will invest its resources where it thinks the returns are most promising. It is not enough to argue that money can be made by doing X. The argument has to be that doing X will be more lucrative than doing Y or Z.

**Profitability of a product is not the only consideration.** Most companies think strategically. That is why almost all of my survey respondents said having experience in the elderly market was a prerequisite to offering a Medicare MSA. Marketing to and servicing an elderly market requires fundamentally different skills than marketing other kinds of insurance programs. A company has to think about how this new product line fits into its overall plan for growth.

With these market dynamics in mind, it may be easier to see how Medicare reform might best be structured:

1. The population coming into the program with cash resources will need a place to put the funds dedicated to their health care needs which allows them to continue to benefit from whatever tax advantage the funds received.
2. Private carriers need to be able to phase-in a new program. They cannot risk being deluged with 40 million beneficiaries. No private carrier in America could manage that burden.
3. Newly eligible beneficiaries are likely to be far more interested in new forms of coverage than are older beneficiaries. Someone just turning 65 has had a very different life experience than someone who is 85 and in Medicare for 20 years. It would make

sense to ease into Medicare reform by making it available only to new beneficiaries.

4. It is guaranteed that the initial program design will not be the optimal design. Constructive failure is built into the private market but not into government programs. If it is to use private sector resources, Medicare must be willing and able to undergo continuous transformation. In other words, Medicare reform cannot be a one-time thing.
5. The federal government is reasonably good at collecting and distributing money, but not so good at running an insurance company. It needs to create a new agency that is focused on facilitating private sector resources and dynamics. This agency should qualify participating carriers, but not contract with them. Beneficiaries could then contract directly with the carrier of their choice, using funds provided through the Medicare program. This would be analogous to the federal Food Stamp program versus surplus food giveaways.
6. We should worry less about selection and more about choice. It is given that a new program will have favorable selection in the first few years, but that will fade as the program matures. The best way to manage selection is to give each beneficiary a risk-adjusted voucher, so that plans enrolling older and higher-risk beneficiaries are rewarded for doing so.
7. People should be encouraged to supplement their Medicare funds with their own money when possible. This should apply not only to plan selection but also to direct payment for services as well. The prohibitions on balance billing and private contracting should be eliminated, allowing individuals to reward higher-quality providers by paying them more.

8. The new agency should concentrate resources on customer support services, including on-line or telephonic advice, disease-specific support groups, publication of available price and quality information, information on treatment alternatives, etc.

9. The agency could also help prepare consumers for Medicare, much as the Social Security Administration is preparing people for retirement by sending out information on what beneficiaries can expect when they turn 65. Such information could encourage people to save for their future health care needs by warning them of the gaps in Medicare coverage.

10. Finally, the agency would have an important oversight responsibility. We have argued it should qualify private plans, not contract with them. The qualification process is critical. It should include solvency assurance, anti-fraud measures, "truth in marketing" requirements, and assurance of adequate customer services. Only after a plan has met these criteria may it market directly to beneficiaries.

## Conclusion

We must move away from the idea that there are two disconnected health care systems – one for the elderly and another for everybody else. People are not much different the day after their 65th birthday than they were the day before. As the under-65 market moves toward consumer driven financing, Medicare should adapt so that new enrollees are able to continue the beneficial habits they have developed.

The federal government has played a critical role in assuring health coverage for the elderly through Medicare. But part of that role in the future must include the recognition that people who turn 65 have 65 years worth of experience in a private health care system that in most cases has worked quite well for them. There is no particular reason to

force them into a radically different financing system on their 65th birthday.

At the same time, Medicare must also be sensitive to the needs of current beneficiaries who may be fearful of change. There is no contradiction here. It should be entirely possible to assure continuity of coverage for existing enrollees while allowing new beneficiaries a variety of choices that are similar to what they enjoyed prior to becoming eligible.

This phase-in of reform has the added advantage of recognizing the development requirements of private carriers. It allows them to try new products and revise and refine them based on real-life experience. It also allows companies to ease into the Medicare program without fear of being swamped by tens of millions of enrollments before their systems can handle it.

Reform of the Medicare program should not be seen as a one-time event but as a never-ending process of refinement and improvement. Attempting to reform the entire program all at once leads to political gridlock, as members of Congress want to protect 40 million constituents from change that may or may not be positive, and which is impossible to prove either way in advance. It is wiser, they believe, to do nothing than to risk the well being of 40 million elderly.

They are not wrong in this concern. Medicare works reasonably well for existing beneficiaries. Granted that providers are unhappy and that policymakers know the current system is unsustainable, but the beneficiaries themselves are content and not much interested in change.

Reformers need to respect that perspective. They should focus reform efforts on the newly eligible. Over time, that will reform the entire program without ever risking the wrath of people who are accustomed to the existing program. Had we done that ten years ago, 47% of the Medicare population would be in a reformed system today, and 78% in another ten years.

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## ENDNOTES

<sup>1</sup> Centers for Medicare and Medicaid Services, “Program Information on Medicare, Medicaid, SCHIP, and other programs of the CMS,” June 2002.

<sup>2</sup> “Employer Health Benefits, 2003 Annual Survey,” Kaiser Family Foundation and Health Research & Educational Trust, September, 2003.

<sup>3</sup> “EBRI Research Highlights: Retirement Benefits,” EBRI Special Report SR-42, June, 2003.

<sup>4</sup> Paul Fronstin, “Retiree Health Benefits: Trends and Outlook,” EBRI Issue Brief #236, August 2001, page 3.

<sup>5</sup> Ibid, page 9. The study points out that the survey results do not necessarily mean existing employers are “dropping” coverage since new employers who never offered coverage are included as well.

<sup>6</sup> Ibid, citing Hewitt Associates studies of salaried employee benefits in 1993 and 2000, page 11.

<sup>7</sup> “Cost Control Issues Arise for Retiree Medical Plans,” Towers Perrin Monitor, March 2001

<sup>8</sup> Notice 2002-45 and Revenue Ruling 2002-41, both released on June 26, 2002.

<sup>9</sup> P.L. 104-91, Title III (A)(220).

<sup>10</sup> Internal Revenue Code, Section 125.

<sup>11</sup> Forrester Research, Inc, cited in press release by Destiny Health dated September 4, 2003. Contact Eileen Rochford at eileenr@theharbingergroup.com.

<sup>12</sup> Marsha Gold, “Medicare+Choice: An Interim Report Card,” Health Affairs, July/August, 2001.

<sup>13</sup> Greg Scandlen, “Carrier Survey of Medicare MSA Interest,” commissioned by the Robert Wood Johnson Foundation and presented at a briefing on Medicare Medical Savings Accounts: Implementation and Policy Issues, Annapolis, MD March 11-12, 1998.

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