Medicare Influence on Private Insurance: Good or Ill?

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INTRODUCTION

Medicare has profoundly affected private insurance market oportunites, the technology and infrastructure used by private insurance, the culture and expectations of providers with whom private insurers must deal, and the culture and expectations of the employers and individuals who purchase private insurance.

The Medicare program might be characterized as the pre-eminent fee-for-service (FFS) indemnity health insurance program in the United States. It protects or indemnifies its beneficiaries against the costs of covered health services by any licensed physician or health care provider they choose and pays bills for their services. Medicare's pre-eminence has been earned by taking what was state-of-the-art private practice at the time of the program's passage and greatly refining it through research and demonstration over its 30-year lifetime. In this refinement process, Medicare has profoundly influenced private insurance practices and markets, both for good and ill—from the perspective of private insurers.

Private insurance practice today, ironically, is rapidly moving away from the FFS indemnity model. Medicare is in danger of being left behind, and the direction of influence between Medicare and private insurance being shifted.

To better understand Medicare's past influence and potential future, it is useful to look at four areas: private insurance market opportunities; insurance technology and infrastructure; provider culture and expectations of insurance; and insurance buyer culture and expectations of insurance. This article looks at Medicare's past and future influence in the framework of shifting paradigms. The shifts are explained in the rest of this article and summarized in Table 1. It is worth noting that many of the influences for good and ill described here apply to all FFS insurers, not just to Medicare.

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INSURANCE MARKET OPPORTUNITIES

Prior to 1965, private insurance found a relatively weak market in the population over 65 years of age. The Medicare program opened two new markets to private insurers.

Administrative Services

The paradigm shift is from the use of intermediaries to handle administrative services to the bearing of this burden by plans that are under at-risk contracts. Past Medicare legislation called for the use of private insurers to handle the administrative processing for the program. The use of intermediaries, as they are called under Part A, and carriers, as they are called under Part B, allowed the program to be set up rapidly, using private processing capabilities already in place. It also allowed private insurers, particularly Blue Cross and Blue Shield plans, to profit greatly from the enactment of the program. Medicare's vast processing load required—and Medicare financed—upgrades of private insurers'

Table 1

Shifting Paradigms in the Medicare Framework

Area	Past	Future
Insurance Market Opportunities	Administrative Services Medicare Supplementary Policies	At Risk Health Plans
Insurance Technology/ Infrastructure	Fee-for-Service, Cost Reimbursement Provider Credentialing	Premiums Outcomes and Satisfaction
Provider Culture and Expectations of Insurance	Cut Unreimbursed Costs Pay Costs Procedure Code Culture Too Many Services Advocate of Patient	Shift Costs Competitive Bids Provider at Risk Too Few Services Partner of Plan
Buyer Culture and Expectations of Insurance	Choice of Providers Standard Benefits and Premiums Beneficiaries Entitled to Coverage	Choice of Plans Varying Benefits and Premiums Subsidized Buyers Choice

SOURCE: Jones, S.B., George Washington University, Washington, DC, 1996.

administrative services capabilities across the country. These capabilities proved very important to insurers in subsequent years as private employers increasingly moved to self-insure their employees and purchase administrative services from insurers.

Today, this insurance administrative services market, however, is undergoing an important shift. It is being eroded by the increasing enrollment of health maintenance organizations (HMOs) and other managed care plans, with whom employers generally contract on an at-risk basis, and by formerly self-insured employers who are electing to return to at-risk contracts with health plans for all of their employees. To some extent, Medicare is moving in the same direction as private employers, as more beneficiaries move from employers' traditional self-insured FFS plans into at-risk HMOs. Indeed, the nearest parallel to Medicare is the large private or public self-insured employer.

Medigap Policies

The paradigm shift is from the purchase of medigap policies to enrollment in prepaid health plans. In the past, Medicare's high cost-sharing requirements and relatively weak protection (indemnification) against catastrophic health care costs also opened to private insurers a vast new supplemental insurance market. This "medigap" market, as it came to be known, has proven to be a windfall for private insurance. The vast majority of the elderly, who prior to Medicare would not have been able to afford any private insurance, have purchased medigap policies. And private insurers, few of whom chose to market to the elderly before Medicare, have found it possible and profitable to underwrite the much-reduced risk of medigap policies (Medicare carries most of the risk of the elderly). Some might argue this contribution to the welfare of the insurance industry was not necessarily a contribution to the welfare of the country in general or the elderly in particular. For example, medigap administrative costs are very high (this type of policy could be provided by Medicare for far lower costs than those involved in marketing private insurance to individual beneficiaries). In addition, medigap coverage increases the costs of Medicare by eliminating the financial disincentives (deductibles and coinsurance) to the use of Medicare-covered services.

Like the administrative services market, however, the medigap market is undergoing an important shift. More and more private health plans are seeking to market both basic Medicare benefits and supplemental coverage to beneficiaries as alternative health plans. Although this market seems to have started slowly (it still has not reached 10 percent of Medicare beneficiaries), it has reached 50 percent in some counties where HMOs have been around for a long time. Both Medicare demonstrations and legislative proposals would promote this shift. And insurers are gearing up with excitement to sell in this market in which they do not have to take customers from competing private plans, but only from a government plan bound into noncompetitive behavior by legislation and regulation. Such health plans are offering relatively comprehensive coverage to Medicare beneficiaries that can be $1,000 per year cheaper than the combined Part B and medigap premiums, sometimes including prescription drugs.

INSURANCE TECHNOLOGY/ INFRASTRUCTURE

Other areas in which Medicare has had a profound influence on private insurance are payment technology and credentialing infrastructures. Medicare's vast enrollment and the high proportion of physician, hospital, and other revenues represented by its population, have made its payment systems and licensure requirements into de facto standards for private industry.

FFS and Cost Reimbursement

The paradigm shift is from cost reimbursement to the use of premiums. Medicare's original "usual, customary, and reasonable" rules for paying physicians marked an advance over the relatively arbitrary fee schedules used by private insurers at the time. It was also a politic route through the sticky wicket of how much to pay various physicians by letting doctors establish their own fees based on what they had charged in the past and what their peers were charging in their area.

Cost reimbursement of hospitals and other institutional providers built on state-of-the-art practices by some private insurers, notably Blue Cross plans, and greatly refined this technology. It also seemed politic, in that Medicare would only pay costs, not full charges. Medicare and its administrative agents became the experts on hospital financing. There was a time when Medicare intermediaries knew every hospital financial officer by name and their budget by heart. This helped put Blue Cross plans in a position to negotiate payment arrangements with hospitals for new insurance offerings (such as HMOs).

As costs of Medicare climbed over the years because of the system's inability to control the volume of hospital services (as opposed to the cost or price paid for them), Medicare led the industry into the world of diagnosis-related groups (DRGs). Payment to hospitals by DRGs marked a major shift in the relation of Medicare and its intermediaries to the hospital industry and a great step forward in payment technology. The technology has been picked up by many private payers. Many others have picked up the philosophy of transferring some financial risk to providers in order to give them incentives to reduce intensity of services and shorten length of stay.

Similarly, Medicare developed its system for paying physicians according to a resource-based relative value scale (RBRVS) to correct skewed financial incentives among various procedures and medical specialties. The RBRVS is the most sophisticated

physician payment technology in the industry (albeit a more sophisticated and politic way of letting doctors set their own fees!).

Against this history, health insurance payment technology is moving through a paradigm shift. Private insurers are paying more and more physicians and other providers through capitation or global fees under which providers assume ever-larger shares of the insurers' financial risk. And self-insured employers who previously pursued direct purchase from doctors and hospitals are moving toward paying premiums to health plans to organize and reimburse providers according to this new paradigm. The shift is evident in Medicare itself. When a Medicare beneficiary chooses an HMO, the Medicare program pays a set premium, and leaves it to the HMO to determine, within very broad limits, how it will pay doctors and hospitals for their services. And health plans are moving away from FFS (even DRGs and RBRVS) toward capitation and other new payment arrangements. Medicare's experiment with global rates to centers of excellence and its venture to set a capitation amount for end stage renal disease (ESRD) patients represent the same shift.

Provider Credentialing

The paradigm shift is from provider credentialing to the measurement of outcomes and satisfaction. Another area in which Medicare influenced private insurers was in standards for participating providers of care and for what services can be performed by what providers. Medicare's procedures set the standard in the industry and had profound effects on institutional providers. A little-known chapter in racial integration in the United States was written because of Medicare's hospital requirements.

The paradigm shift in which we are involved also moves us toward allowing health plans greater flexibility in these areas. HMOs and other health plans focus on assuring the satisfaction of their retail customer, the beneficiary, and on providing quality and favorable outcomes to their wholesale customers, such as Medicare and large employers. And they desire more freedom to use providers as they think best to these ends.

This same trend is reflected in Medicare's work to develop a Medicare quality-reporting and measurement program along the lines of the private Health Employers' Data Information System (HEDIS).

PROVIDER CULTURE AND EXPECTATIONS OF INSURANCE

Because of the amount of their revenue stream represented by Medicare and perhaps because of the political visibility of battles over Medicare payment, physician and institutional providers' culture and expectations of health insurance have been profoundly shaped by Medicare.

Cut Unreimbursed Costs

The paradigm shift is from cutting unreimbursed costs to shifting costs. In the beginning, Medicare greatly reduced the unreimbursed costs of hospitals and physicians by paying "costs" for services to elderly beneficiaries who were formerly uninsured. In the early days, Medicare justified not paying for a share of hospital bad debt because most of its payment relieved what were formerly bad debts! This Medicare payment vastly decreased the pressure on hospitals to increase prices to private insurers to make up for these bad debts. One might call it Medicare cost-absorption. One can only speculate that this enabled a further expansion of private insurance by keeping premiums down.

Medicare's creation also relieved providers and physicians of much of their charity care and teaching cost burden and perhaps helped undermine the charity orientation of both by making it government policy that health care providers should be paid for all.

However, as cost pressures on Medicare grew and Congress looked for ways to reduce costs by retarding DRG and fee increases, physicians and providers again resorted to increasing fees to the private insurers to make up for what they perceived as shortfalls in Medicare payment. At least, the private insurance industry became convinced this was going on. In fact, private actuaries quantify the impact on private premiums of cuts in Medicare payments over the years.

Of course, one can argue that Medicare's low fees simply represent the program using its leverage in the market to purchase at good prices on behalf of its beneficiaries, and that private insurers should do the same. But, insurers argue, Medicare is a 700-pound gorilla. When it rolls over, providers who share the bed have no choice but to go along. And insurers simply don't carry the same weight.

But even this paradigm is shifting. Because of the oversupply of physician and hospital resources, managed care plans are finding it possible to strike deals with selected providers that even a 700-pound gorilla would envy. Medicare's centers of excellence program attempts some of this same strategy.

Pay Costs

The paradigm shift is from paying costs to seeking competitive bids. By paying "costs" of teaching, capital, and a wide definition of "appropriate care" by today's standards, Medicare has helped fund a large tertiary care and teaching establishment, an expansion of hospital beds, an increase in the number of physicians (especially specialists) and health professionals, the growth of the for-profit sector, and a burgeoning home health and independent laboratory industry. The development of DRGs and RBRVS has reversed some of these trends, but not all. Doubtless this expansion has improved access to services for millions of beneficiaries and privately insured alike. But it has also bequeathed all insurers, public and private, a problem of containing costs of an industry that seems to be able to produce its own demand for services.

Ironically, this increase in supply of services may have produced its own downfall. In the paradigm shift underway today, private health plans, including those marketing to Medicare beneficiaries, selectively contract with providers and physicians to obtain favorable prices, pay in ways that discourage excess resources, and require providers to comply with treatment protocols that define "appropriate care" more narrowly. They also favor primary care providers and are making practice less remunerative for specialties in oversupply.

Procedure Code Culture

The paradigm shift is from the reliance upon procedure codes to the placement of providers at risk for services performed. Medicare's procedure and diagnosis-based fee structure for physicians and institutional providers greatly refined the state of the art. However, there is little doubt this has contributed heavily to a physician and provider culture where the codes that are recorded and perhaps sometimes the services that are provided are influenced by what Medicare will pay for. It may be one of the low points of our FFS experience in the United States that many providers have such disrespect for insurers and Medicare that they say in confidence that they have little choice but to put down whatever the

insurer wants to see; and insurers say in confidence that they think providers will do or say anything necessary to get paid the maximum. Medical technology is even developed and marketed to fit in with procedure coding structures—or capitalize on the delay expected before procedure codes and prices can be changed to reflect new and simpler technology. Medicare has contributed heavily to this gaming or cops-and-robbers culture.

This paradigm is also shifting. Global fees and capitation payments are giving providers both more clinical flexibility and more responsibility to manage the costs of care. Risk-sharing arrangements are replacing the insurer's need to police what providers do, or say they do, at the procedure level. We should be concerned that the huge investment Medicare has made in procedure-based data systems might drive it to require health plans and capitated providers to produce similar procedure-based data for policing use (even though it is filled with inaccuracies) instead of developing more global ways to hold plans accountable and allowing health plans to develop their own more effective data systems for their internal clinical and financial management.

Too Many Services

The paradigm shift is from the potential for too many services being delivered to the potential for too few. Medicare's FFS heritage nurtured a culture among providers of "more services means better care"—or at least better revenues. Medicare has had to police against too many services. The DRG system helped address this problem at one level for the hospitals, but the culture remains strong. Indeed, "good care" seems increasingly associated with FFS, because it will pay for whatever the provider does.

The new forms of paying for services by private insurers and Medicare managed care plans create powerful financial incentives for physicians and providers to provide too few services. These forms create a profound challenge to providers and physicians alike to sequence services or reduce tests and services based on considerations of cost. They also challenge clinical professionalism by requiring a professional cost-management role. Medicare and private insurers alike will be profoundly challenged to develop reporting and monitoring systems that measure underservice without squelching the potential for physician and provider management of costs.

Advocate of Patient

The paradigm shift is from the provider as advocate of the patient to the provider as a partner in the health plan. Under Medicare's traditional design, the physician's or provider's interest often coincides with the patient's in such a way as to make them allies against Medicare or the insurer. The physician or provider has no stake in the cost of the Medicare program—and no financially enforceable responsibility for containing the costs of the program. Providers can advocate to the program on behalf of patients for services that they both feel are needed and appropriate.

This alliance of patient and provider has been challenged somewhat by the DRG system, which may prompt hospitals to release patients earlier than may be appropriate, at least from the patient's perspective. The financial incentive for hospitals to look at the DRG as defining the target (or de facto limit) for the number of days a particular patient should be hospitalized, rather than the average for the group of patients, is powerful. And it starts a paradigm

shift in Medicare and private plans to even stronger financial incentives.

In the new paradigm, physicians and providers are essentially often given a financial stake in the health plan's costs, or given a per capita share of the plan's revenues and allowed to keep what they don't spend on patients. This at best muddies the patient advocacy role of providers and at worst makes them financial partners of the plan against the patient. In the new provider-sponsored plans, the physician or provider might actually be or own the health plan. The provider in these situations is providing health insurance, not just clinical care.

BUYER CULTURE AND EXPECTATIONS OF INSURANCE

Medicare has also shaped the expectations of employers and individuals who purchase private insurance and, of course, of the elderly in particular.

Choice of Providers

The paradigm shift is from consumer choice of provider to choice of health plan. Medicare continues to give the beneficiary the widest possible choice of physicians, hospitals, and other providers. Almost any willing and licensed provider can give covered care to Medicare beneficiaries. Hospitals, moreover, must accept the patient and also accept Medicare's payment as payment in full. Physicians can choose whether to accept Medicare's rate as payment in full or charge the additional percentage allowed by law.

In the new paradigm, the employee or beneficiary has a choice of health plans offered by the employer or Medicare but is likely to be limited by health plans to panels of providers much narrower than Medicare's. The trend for private employers is away from offering FFS plans with unlimited choice. Where employers still offer FFS, the trend among employees is into managed care plans. Medicare-choice trends to date seem to mirror this. Employees and beneficiaries seem to be trading off wide choice of physician and provider for lower premiums or better benefits.

Standard Benefits and Premiums

The paradigm shift is from standardized to varying benefits and premiums. Over the years, Medicare established a practice of offering the same standard benefits to all enrollees and charging the same (Part B) premium to all enrollees, regardless of where they live or any other factor. This simpler administrative practice may well have reinforced the desire of many national employers and insurers to offer a similar standard package at a standard national premium.

This practice is shifting radically. With the advent of HMOs and managed care plans that are regional in nature, national employers find themselves offering and national insurers find themselves competing with local health plans. These plans offer differing premiums to the employer and employee based on their own risk pool, their local health care costs, and on discounts or efficiencies in managing care. Managed care plans often convert lower costs into differing additional benefits.

Medicare beneficiaries face this same variation in premiums and benefits in alternative health plans. Although the Part B premium remains standard, Medicare HMOs convert their lower costs under Parts A and B into additional attractive benefits that must otherwise be purchased with medigap and charge varying premiums for the total package. In some cases

this premium is zero, netting a savings of as much as $1,000 in medigap premiums for the beneficiary.

A concern with this trend to varying benefits and premiums is that the variations will reflect unfair or coincidental plan advantages (such as lower area costs or favorable risk selection) rather than plan efficiencies. Medicare's average adjusted per capita cost (AAPCC) method of payment to health plans attempts to eliminate health plan savings from factors other than discounts and efficiency. It is the most sophisticated system in use in the country for adjusting payments to health plans, but even it is inadequate.

Beneficiaries

The paradigm shift is from the consumer as beneficiary to the consumer as subsidized buyer. As a public program, Medicare from its beginning regarded persons eligible for Medicare as beneficiaries to be protected and taken care of by the program. This attitude was not very different from the more paternalistic attitude of large employers toward their employees and their benefit packages. Medicare and the large employer and its FFS insurer provided the one coverage and went the extra mile to relieve the individual of concerns about health plan choice. This doubtless fostered an attitude among beneficiaries and employees that they were being watched out for.

Multiple choices and managed care have brought about an important shift in this paradigm. As already noted, managed care often changes the incentives of the provider so that provider interests are not as well aligned with those of the employee or beneficiary. Moreover, multiple choice of health plans leaves the employee or beneficiary with the burden of choosing among health plans with various provider arrangements, differing panels of providers, and varying benefits and premiums. Although Medicare and employers screen health plans and hold them accountable as best they can, based on their performance, much more of the risk and responsibility for finding a satisfactory arrangement for their particular needs falls on the individual. The one thing the individual can count on is Medicare or the employer's contribution to their premium—with the individuals making up the difference. Beneficiaries become buyers in need of a great deal more knowledge and sophistication than in the past.

Medicare and employer attempts to develop better health plan credentialing requirements in collaboration with the National Committee on Quality Assurance and the HEDIS data set are important efforts to assure that the plans offered beneficiaries and employees meet basic standards of quality. The need for such efforts confirms the direction of the paradigm shift.

Entitled to Coverage

The paradigm shift is entitling beneficiaries to choice rather than coverage. From its inception, Medicare has been regarded as an entitlement program that required government to do whatever was necessary to ensure that the coverages specified in the law were provided to beneficiaries. As already noted, Medicare's interpretation of what services are covered and are necessary and appropriate seems generous by current managed care standards. The same might be said of large private FFS insurers. Both have created an expectation on the part of beneficiaries and employees that most of what their doctor suggests (or they suggest to their doctor) will be covered.

The paradigm shift today is in the direction of entitling beneficiaries and employees to choice, in addition to coverage, and even in lieu of assured coverage. Beneficiaries will find varying definitions of "necessary and appropriate" among the health plans from which they can choose. Beneficiaries will also find various provider payment arrangements that give incentives to doctors (and other providers) to suggest different things than they might have suggested under traditional Medicare (or to respond to patients' suggestions differently!).

Medicare's requirement that all plans offer basic Part A and B coverages and that physician payment incentives be balanced are aimed at preventing this shift from going too far, but they leave a lot of room for plans to vary what otherwise would have been regarded as standard coverage to which beneficiaries are entitled. Entitling beneficiaries to choice of plans shifts the paradigm, as it has for employees across the country.

CONCLUSION

Given the pre-eminence it has achieved as an FFS payer and its past influence on the private insurance market, where does Medicare's future lie? The paradigms in insurance and health care are shifting. How can Medicare maintain its leadership?

The challenge would seem to be to emulate the past efforts of the Medicare program to adopt private insurance practices and adapt them for use by a public program. To regain its position of leadership, Medicare might adopt the new state-of-the-art private insurance technologies, refine them based on research, and adapt them so as to take account of the opportunities and constraints of a public/government program.

Much about managed care technology makes it difficult for public payers to adopt. But adaptation is possible. The developing centers of excellence and alternative health plan demonstrations are good starts. Medicare still has the leverage, research capability, and management philosophy needed to profoundly influence the private insurance industry in these new areas.

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