McDonalds v. Burger King, A "Nothing Burger" Debate on Medicare Reform
Prepared Statement of Jeff Lemieux, Senior Economist, Progressive Policy Institute
Special Committee on Aging, U.S. Senate
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Thank you Senator Craig, Senator Breaux, and committee members for inviting me. My name is Jeff Lemieux, and I am the senior economist for the Progressive Policy Institute (PPI). My statement focuses on (1) comparisons of spending trends between government-run Medicare and private health insurance coverage, and (2) Medicare competitive choice systems, within the context of a reformed and modernized Medicare system. Here are the main points:

- For policymaking, comparisons of long-term spending trends between Medicare and private health insurance cannot possibly settle a debate over which sector is a better value. That is because trends in Medicare and private health insurance spending are interrelated. When Medicare finds ways to save money and add value, private insurers face pressure from employers to mimic those efficiencies or find alternative savings. When private health insurers find ways to save money or add benefits and value, Congress faces pressure from the public to enact similar cost savings or benefit enhancements in Medicare. Spending trends reflect those pressures -- they tell us nothing about anything intrinsic to either government-run or private health insurance.

- In my opinion, policymakers should assume that the advocates of government-run health insurance and private health insurance are both correct: Each type of insurance is more efficient than the other. Then, the logical conclusion for Medicare policy would be for the federal government to create a level playing field for both types of coverage, possibly patterned after the Federal Employees Health Benefits (FEHB) program. Let both government-run and private health plans compete for seniors' business, and let the competition directly and quickly pressure both types of coverage to find efficiencies, new and helpful benefits, and other value improvements for both seniors and taxpayers. Direct competition and choice would be a more efficient way for each sector to match the other's improvements. It would be faster, less cumbersome, and less error-prone than waiting for the political process to improve Medicare when it falls behind, or waiting for employers to force improvements in private health insurance when private plans lag.

- For direct competition and choice to work for the benefit of both seniors and taxpayers, the government-run plan needs added flexibility to shape its benefits and payment systems. Likewise, private health plans in Medicare need a stable, predictable, and fair platform from which to make business plans. Congress and the public need a thorough understanding of how competitive choice systems in Medicare would work and play out over time before policy decisions can be made. These conditions are not present in Medicare.

- The main efficiency improvements in both Medicare and private health insurance over the last two decades have been reductions in overpayments to health care providers. Although there may still be overcompensated providers in some parts of the health care system, that method of efficiency gain has largely run its course.

- Future gains in efficiency will probably result from improvements in the quality of health care, especially for patients with chronic illnesses. These improvements will range from basic error reduction measures to rudimentary educational or disease management programs for seniors with a particular chronic illness, such as diabetes, to sophisticated case management, home-based monitoring, and community support services for patients with multiple chronic conditions.

PPI believes that the next great challenge for Medicare will be shifting the program's emphasis toward chronic care. Medicare has always been a reliable bill payer when beneficiaries suffered an acute health care crisis requiring hospitalization or extensive medical procedures. Now, Medicare must learn how to better help the increasing number of seniors with chronic illnesses stay out of the hospital and maintain the best possible health and quality of life. This, we believe, is key to improved health outcomes, higher quality health care, and greater value for every health dollar spent.

PPI's Medicare reform proposal, the "ABC" proposal, is focused on chronic care and healthy aging.[i] Its three main elements are:

- ***Accountability:*** a radical decentralization of Medicare's administration, so that local Medicare administrators and medical directors are directly empowered to create disease management and health improvement programs targeted to the needs of beneficiaries in their area;

- ***Benefits:*** a drug benefit structure that helps link, not fragment, Medicare benefits and provides information to target disease management programs; and

- ***Choices:*** a much expanded menu of private insurance plans in Medicare, along with locally-run comprehensive disease and care management programs for fee-for-service beneficiaries with specific or multiple chronic conditions.

Medicare reform is an attempt to create better health for seniors and better value for both seniors and taxpayers. By my definition, reform is an attempt to create a "win-win" situation. By contrast, current proposals for Medicare drug benefits generally create a "win-lose" scenario: beneficiaries win by getting new benefits (maybe) and taxpayers lose by incurring new obligations with little or no hope for offsetting savings. Setting aside the important question of which group of citizens is more deserving, citizens as Medicare beneficiaries or citizens as taxpayers, we have switched the Medicare debate from reform to redistribution.

I believe that two fundamental reforms should be considered: (1) the development of an FEHB-style competitive choice system, and (2) the development of an infrastructure for improvements in chronic care, both in private plans and the government-run system. Both of these reforms have potential to create "win-win" outcomes.

The primary impediment to an FEHB-style system is analytic: Medicare is too important to launch into reforms without careful planning and analysis of the likely impact of change. We must be very sure that a "win-win" situation would result. In the absence of the needed analysis, Medicare reform has been stymied, to the detriment of the Medicare debate.

Medicare and Private Health Insurance Spending: McDonalds vs. Burger King

Both Marilyn Moon of the Urban Institute and Joe Antos of the American Enterprise Institute calculate that per-enrollee Medicare and private health insurance spending for some comparable services grew at nearly identical rates until the mid-1980s.[ii] After that point, Medicare spending grew slightly more slowly for several years. But starting in about 1993, growth in spending in each sector returned to a roughly equivalent rate. Because Medicare grew more slowly between 1986 and 1993, its per-enrollee spending has risen by a little less over a thirty-year period, so by that measure, Medicare's cost performance seems slightly better.

However, Dr. Antos is correct that the actuarial value of private health insurance benefits grew more rapidly than the value of Medicare benefits during this period. Therefore, when growth in benefit generosity is taken into account, the private health insurance "cost-benefit" performance seems better.

By analogy, Dr. Moon argues that McDonalds is better than Burger King because its burger prices have increased by a few pennies less over time. Dr. Antos counters that Burger King isn't less efficient than McDonalds if you consider that Burger King's food has improved at a faster rate; in fact, by his calculations Burger King is a better value.

Policy wonks on both sides of the political aisle will use these calculations as ideological ammunition in the meta-struggle for or against government-run or private health insurance. Backers of the government-run Medicare fee-for-service program argue that Medicare should be like McDonalds. Backers of private insurance options in Medicare argue that policymakers should choose Burger King.

Of course, health insurance is more important than convenience food, and I don't mean to demean the importance of these calculations.

But the larger point is: Policymakers should not have to choose whether Medicare beneficiaries get their insurance from government-run or private health plans. Instead, *beneficiaries* should be able to choose from among the health insurance equivalent of

McDonalds *and* Burger King, as well as Wendy's, Popeye's, Taco Bell, the organic market, the gourmet shop, or even a home-cooked snack.

Our great foundations and policy institutes and scholars could do the most accurate and subtle calculations, but they could never definitively determine whether McDonalds was better than Burger King, or if the Beatles were better than the Rolling Stones, or, for that matter, whether fat guys really drink Lite beer because it "tastes great" or is "less filling."

One other point is clear: Competition and rivalry between different types of fast food joints or health insurance plans helps spur innovation and progress. Certainly, the spending and benefit trends in Medicare and private health insurance bear this out.

Medicare and Private Cost Containment Efforts and Benefit Enhancements are Related

Prior to the mid-1980s, both Medicare and private health insurance were the same type of product: fee-for-service insurance with a relatively narrow scope of benefits and few limits.

Medicare made the first move toward cost savings in 1983, with the enactment of the Prospective Payment System (PPS) for inpatient hospital payments. This was the first innovative, large-scale payment control method anywhere in the U.S. health sector, and it was effective. The number of hospital inpatient beds, which had grown steadily for decades, suddenly started contracting as the PPS system was implemented. Medicare's costs dipped from double digit to previously unheard of single digit growth rates in the mid-1980s.

Gradually, private insurers became aware that Medicare was paying considerably less for hospital care. A series of studies in the early 1990s by what was then called the Prospective Payment Assessment Commission (ProPAC) asserted that Medicare typically paid about 90 percent of the hospitals' costs of treating Medicare patients, while private insurers paid about 130 percent of costs. (Those studies were somewhat off-base, because they seemed to assume that hospital costs were independent of Medicare and private insurers' willingness to pay. But nevertheless, it was clear to employers that the private insurers were paying much more than Medicare for inpatient hospital care.)

Of course, private insurers could not collectively implement a massive payment control system of their own. They could not collude to gain sufficient market power, and they could not independently impose payment restraints because of market conditions.

However, by the early 1990s, private insurers found a way to get payment reductions of their own: managed care. By steering patients to certain hospitals or doctors, health plans gained leverage to negotiate better deals.

As a result, the growth private health insurance spending for employer-based coverage tumbled in the mid-1990s. (In the statistics used by Drs. Moon and Antos, continued rapid growth in private Medigap and retiree insurance spending on behalf of Medicare beneficiaries offset some of the decline in employer-based premiums.)

With managed care savings, private plans were able to slow cost growth and offer enhanced benefits, usually with low copayments for each service. The growth of private insurance plan enrollment in Medicare skyrocketed.

Managed care's sudden cost-saving success led to political actions that dramatically reduced Medicare's spending. First, anti-fraud and abuse controls were tightened in 1996. In 1997, the Balanced Budget Act sharply reduced payments to health providers. As a result, the growth Medicare spending tumbled in the late-1990s.

Medicare's benefits also became a political topic. The absence of retail prescription drug benefit in the government-run plan suddenly became a political issue in late 1998 and early 1999, and it has remained a hot issue to this day.

At the same time, some of the early managed care savings proved fleeting, as health care providers consolidated and rebelled against tight payment controls from private insurers. However, one private sector approach has proved durable: helping provide coordinated care for patients with chronic illnesses.

Although Medicare started the cost-cutting trend in the 1980s, it is private-sector innovations with disease and case management for patients with chronic illnesses that offer the best hope for quality improvements and savings looking forward.

Chronic Care, Healthy Aging, and PPI's Medicare Proposal

To foster improved chronic care and disease management in Medicare, PPI encourages Congress to consider two simple tests for any legislative proposal:

- **No new silos.** Separated, unlinked, or uncoordinated benefits can thwart disease management efforts. Congress should scrap the idea of a premium-based stand-alone drug benefit. In general, health benefits should be integrated under one administrative structure, so that the insurer has the ability and the incentive to evaluate tradeoffs -- for example, adding drug benefits known to reduce the incidence or cost of hospitalizations. Even if benefits cannot be fully integrated under one insurance carrier, at the very least they should be linked, so that information can be shared between primary and supplemental insurers. Adding another separate, add-on benefit to Medicare's current, outdated structure would work against disease management and comprehensive, coordinated care for people with chronic illnesses.

- **No new benefits without accountability.** It doesn't make sense to add benefits without making fundamental changes to Medicare's processes, so that we can learn whether or not the benefits improved seniors' health. Even preventive and screening benefits should be accompanied by permanent evaluation systems designed to identify and help people who are at risk for particular problems or are coping with multiple ailments. All new benefits must help reorient the Medicare program toward more optimal care of chronic illness and be accompanied by new processes to spur systematic improvements in health care quality and outcomes.

CMS needs the flexibility to create disease and care management programs for Medicare beneficiaries. However, Congress is not going to give the CMS bureaucracy vast new powers without greatly enhanced accountability and oversight systems. Moreover, disease management is inherently a local system, requiring cooperation between local health providers, community institutions, consumer and seniors' groups, and, in some cases, local government agencies. CMS cannot run effective localized disease management and health improvement programs from its headquarters in Baltimore.

PPI's proposal is explained in greater detail in the report *An 'ABC' Proposal to Modernize Medicare*, and it contains several similarities with a prescription drug bill introduced by Representative Cal Dooley (D-CA) in the House last month (H.R. 1568). Here are the basic elements of the PPI proposal:

Accountability. Medicare officials should be held accountable for measuring and improving the health of older Americans. They should be given the freedom to make improvements at the local level, in accordance with local needs, with clear public disclosure of results and Congressional oversight. The model for the PPI's proposal is the "CompStat" system developed in New York City to help fight crime. In that system, crime trends were tracked in real-time, and local police commanders were given flexibility to deploy resources as needed in their precincts in exchange for real accountability for their crime-fighting plans and success. Unsuccessful commanders who did not have a credible plan for performance improvement were replaced.

We propose that Congress create approximately 150 local Medicare administrative regions and staff each local area with a Medicare medical director and Medicare local administrator. We believe those officials should be given flexibility to create new programs to improve health in their areas, with budget authority to create local programs that are budget-neutral within a 10-year period. Local officials would be ranked annually on their ability to foster improvements in health quality and outcomes in their regions, and Congress would establish a new congressional agency, patterned after the Joint Committee on Taxation, to oversee the local officials' actions, proposals, programs, and ratings. Local administrators with poorer performance results would be replaced. Medicare's central bureaucracy would be reduced as the local officials were put in place.

Benefits. PPI believes the most realistic and workable Medicare drug benefit would be a universal, zero-premium catastrophic benefit, provided mostly through the supplemental

insurers that already serve Medicare beneficiaries, including employment-based plans, Medigap plans, and state programs. (Seniors without any supplemental benefits would choose a discount card that also provided the catastrophic drug benefit.) The catastrophic benefit would be based on total drug spending; PPI proposes that the catastrophic benefit explicitly allow seniors to have additional coverage under the catastrophic "deductible" without forfeiting their catastrophic benefits. By contrast, Congressional proposals that base a catastrophic drug benefit only on "out-of-pocket" drug spending would be unfair to beneficiaries who have and want additional drug coverage, and could disrupt the employment-based retiree coverage many seniors receive. PPI's preferred approach is more expensive for the government, but it is more practical and workable. Under PPI's proposal, low-income seniors would be eligible for additional drug benefits, including "up-front" benefits that started at much lower levels of drug spending.

We believe that universal catastrophic drug coverage would create tremendous side benefits by building an information-based infrastructure for disease and care management programs. CMS would obtain real-time data from the supplemental insurers and other plans and discount cards administering the benefit, so that Medicare would know when a patient hit the catastrophic deductible, and Medicare's liability was triggered. Therefore, Medicare would have a nearly real-time database of all beneficiary drug expenditures, which would help local Medicare administrators target quality improvement and disease management programs to particular demographic groups or regions. The new data could also dramatically improve risk adjustment methods, which would help private comprehensive plans stay in Medicare.

Choices. PPI proposes to revitalize Medicare's HMO program and expand the PPO demonstration program nationwide. We would establish a new type of Medigap coverage that included some up-front drug benefits; however, to keep the cost down, the "New Medigap" plan would not have absolute first-dollar coverage of beneficiaries' coinsurance for Medicare's other benefits. Beneficiaries could enroll annually in private plans, New Medigap options, and new comprehensive disease management programs, and have premiums deducted from their Social Security checks.

Ultimately, Medicare should switch toward the FEHB model. Of course, the government-run plan would remain the dominant offering (it currently enrolls almost 90 percent of Medicare beneficiaries). But switching Medicare to a direct menu-based purchasing system, with all health plans -- including the government-run plans -- treated as equals, would be more efficient and would allow a more rapid evolution of Medicare benefits toward those needed for proper chronic care.

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[i] See Jeff Lemieux, David B. Kendall, Kerry Tremain, and S. Robert Levine MD, "An 'ABC' Proposal to Modernize Medicare" Progressive Policy Institute (February 14, 2003 || www.ppionline.org), and David B. Kendall, Kerry Tremain, Jeff Lemieux, and S.Robert Levine MD, "Health Aging v. Chronic Illness: Preparing Medicare for the Next Health Care Challenge" (Progressive Policy Institute (February 14, 2003 || www.ppionline.org).

[ii] See Cristina Boccuti and Marilyn Moon "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades" *Health Affairs* (March/April 2003 || www.healthaffairs.org), and Joseph R. Antos, with Alfredo Goyburu "Comparing Medicare and Private Health Insurance Spending" The Heritage Foundation, Webmemo #250 (www.heritage.org).