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BUILDING A BETTER MEDICARE PROGRAM: Lessons from the Private Sector

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EXECUTIVE SUMMARY

For years, it has been conventional wisdom in health-policy circles that government-run, Fee-for-Service Medicare is more efficient than private insurance. It is said that Medicare, America's single-payer health-insurance system for the elderly, has lower administrative costs than private insurers do. Single-payer advocates argue, therefore, that the United States would have a more cost-effective and affordable health-care system if Medicare were expanded to encompass all Americans.

However, recent studies have shown that private insurers are more efficient, with lower administrative costs, than Medicare is. As a result, private insurance–based reforms of the Medicare program, such as those proposed by Senator Ron Wyden and Representative Paul Ryan, have gained renewed interest among policymakers. While the Wyden-Ryan proposal and similar ones contemplate giving future retirees the choice between private insurance and the traditional Medicare "public option," there are also opportunities to make government-run, Fee-for-Service Medicare more efficient.

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Among large corporations that self-insure their workers—directly paying health-related claims without using external insurance—a model that has gained favor is that of administrative services organizations, or ASOs. ASOs, which are often run by traditional insurers, allow large companies to continue to directly pay for workers' health claims, while outsourcing to an ASO the management of those claims, such as negotiating reimbursement rates to hospitals, doctors, and pharmacies.

In this paper, we explore how the use of ASOs in the traditional Medicare program might make that program more cost-efficient, so that traditional Medicare becomes a more fiscally sustainable option for seniors who prefer it to private insurance.

MEDICARE WRESTLES WITH SIGNIFICANT WASTE, FRAUD, AND ABUSE

The claim that Medicare is more efficient than private insurance rests on flawed premises: it fails to account for rampant waste, fraud, and abuse in the Medicare program; it fails to account for the degree to which Medicare's administrative costs are borne by other government agencies; and it involves an arithmetically incorrect calculation of Medicare's administrative costs.

By assuming that low administrative costs are always better than higher ones, policy analysts ignore the value that health-insurance administration provides. Specifically, private insurers invest substantial sums in ensuring that their premium revenues are spent on legitimate health expenses rather than on fraudulent or wasteful ones.

In 2010, the Centers for Medicare & Medicaid Services estimated that the traditional, government-run, Fee-for-Service Medicare program spent $34.3 billion on improper payments—an error rate of 11 percent.[1]

Malcolm Sparrow, a Harvard expert on Medicare and Medicaid fraud, stated in a 2009 Senate testimony that in the Medicare and Medicaid programs, "[l]oss rates due to fraud and abuse could be 10 percent, 20 percent, or even 30 percent in some segments."[2] This fraud could be prevented, Sparrow said, "[b]ut to do that, one would have to spend 1 percent or maybe 2 percent (as opposed to the prevailing 0.1 percent), in order to check that the other 98 percent or 99 percent of the funds were well spent."

Private insurers have to hire employees and expend resources to collect premiums. Economist Benjamin Zycher has estimated that a full accounting for these administrative expenses would double Medicare's administrative cost ratio to 6 percent.[3]

There are other, even more opaque, costs to the Medicare program. Medicare is funded substantially by tax revenues from the working-age population. The cost of collecting these taxes, called "deadweight loss" by economists, could amount to as much as 20 percent of the revenue they generate and is not included in Medicare's administrative costs.

THE FAULTY MATH BEHIND MEDICARE'S "LOW ADMINISTRATIVE COSTS"

In the private sector, administrative costs are calculated using the medical loss ratio (MLR). Financial analysts use medical loss ratios to calculate an insurer's gross margin. A private insurer's medical loss ratio consists of the ratio of how much the insurer has paid to health-care providers in claims divided by how much the insurer has collected in premiums.

If an insurer has paid less in claims than it has collected in revenues, the remaining funds can be used to pay for its administrative costs, such as employee wages, business expenses, and a minimal profit margin. From 1960 to 2010, the average administrative cost ratio for private insurers was 12 percent. The administrative costs of Medicare's government-run hospital insurance program, by contrast, is said to be only 3 percent.

There are substantial problems with this comparison. Medicare covers nearly all Americans older than 65; private insurers cover Americans younger than 65. Because retirees tend to consume far more health care than non-retirees, the amount that Medicare pays out in health claims is significantly higher than that of private insurers on a per-beneficiary basis.

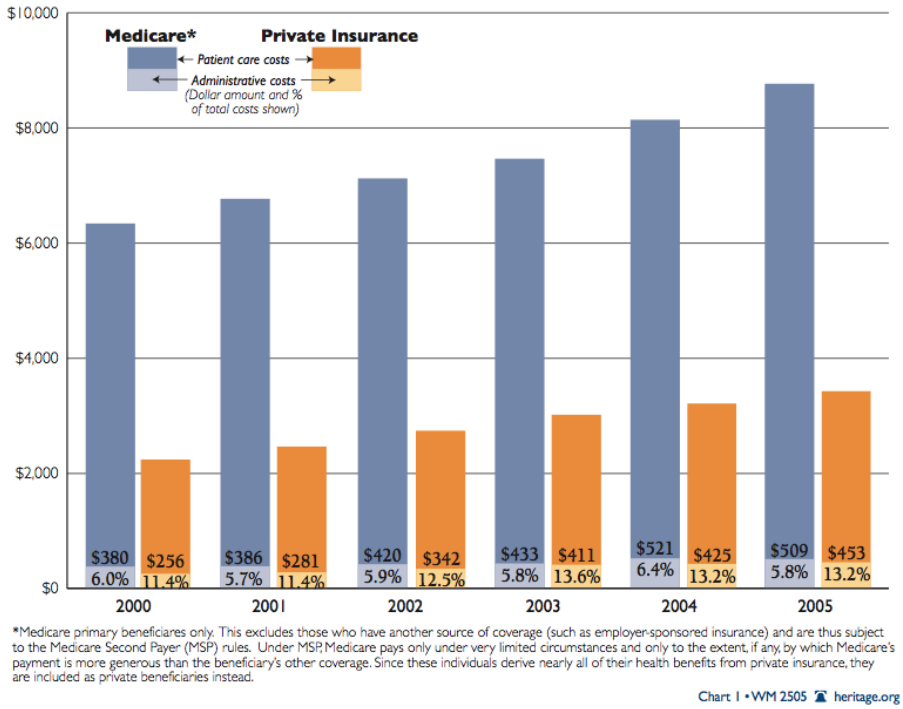
Say that two patients cost $3,000 each to manage: the first requires $10,000 of health expenditures; and the second, much sicker, patient requires $100,000. The first patient's insurance will have an administrative cost ratio of 30 percent, and the second's will have a ratio of only 3 percent. This hardly means that the second patient's insurance is more efficient; administratively, the patients are identical. Instead, the more favorable figure is produced by the second patient's more severe illness.

The proper way to compare administrative costs between Medicare and private insurers is to look at administrative cost ratios not on an overall basis but on a per-beneficiary basis. In the example above, the two insurers spent an identical $3,000 on a per-beneficiary basis; the sicker patient had a lower administrative cost ratio not because of any greater efficiency but because he was sicker.

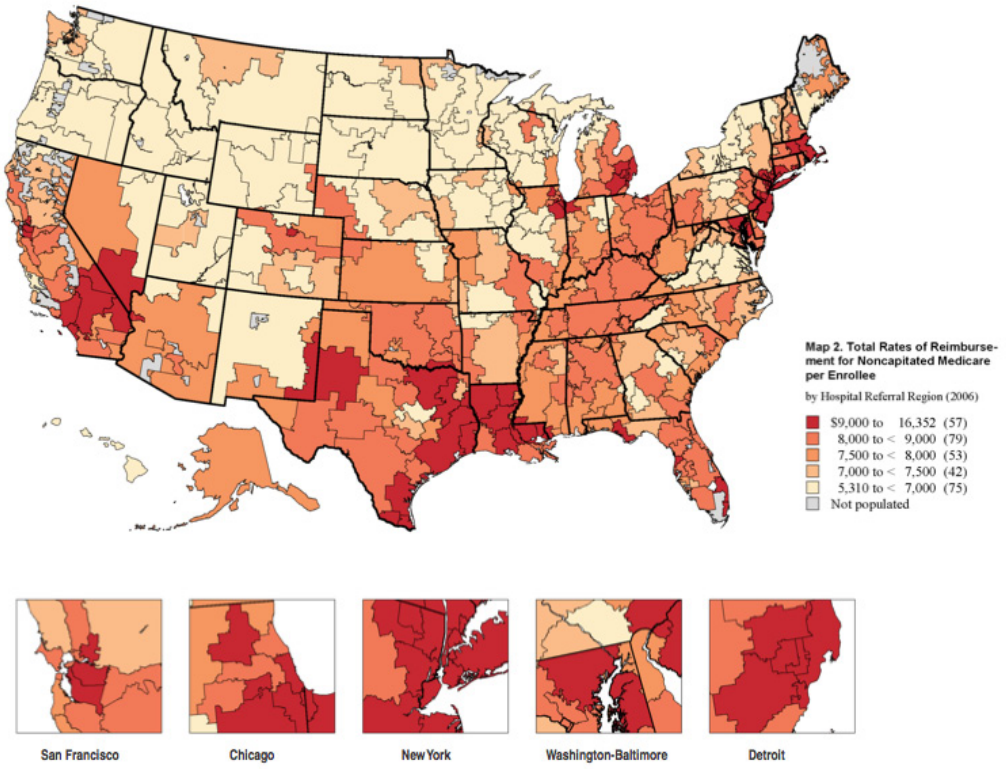
Robert Book has shown that in each year from 2000 to 2005, Medicare's per-beneficiary administrative costs were higher than those paid by private insurers.[4] In 2005, for example, private insurers spent $453 per beneficiary on administrative costs, compared with $509 for Medicare—a 12 percent higher rate.

PRIVATE INSURERS ARE MORE COST-EFFICIENT THAN MEDICARE

In theory, traditional Medicare can keep prices low because of Medicare's size and market power; very few doctors and hospitals can afford to say no when Medicare demands lower rates. But Medicare does not use this monopsony power to the degree that it could, which leads to a great deal of waste and inefficiency. Under current law, Medicare must pay for health care



Source: http://www.heritage.org/research/reports/2009/06/medicare-administrative-costs-are-higher-not-lower-than-for-private-insurance



Source: http://www.dartmouthatlas.org/downloads/reports/Policy_Implications_Brief_022709.pdf

delivered by any hospital or doctor willing to do so at Medicare rates—Medicare's "any willing provider" provision. The any-willing-provider provision limits the government's power to distort the market. But if every provider can participate in Medicare, the program has limited leverage to steer seniors to the most cost-efficient providers.

As researchers at Dartmouth College have shown, the considerable geographic variations in Medicare spending cannot adequately be explained by demographic and health-related factors.[5] In addition, variations within geographic areas do not necessarily relate to cost and quality of care.

Medicare Advantage, known as Medicare Part C, is a market-oriented alternative to traditional, single-payer, government-run Medicare. A major benefit of Medicare Advantage is that the private insurers that participate in the program can negotiate among providers for favorable prices, and they can do more to manage complex cases. As a result, Medicare Advantage can offer a superior benefit package compared with traditional Medicare.

Table. Lowest Plan Bids vs Traditional Medicare Costs, 2006-2009[a]

		Average Plan Bid, % of Traditional Medicare Costs				
Year	Average Traditional Medicare Costs, $/mo	Lowest	Second-Lowest[b]	Third-Lowest	Fourth-Lowest	Fifth-Lowest
2009	717	87	91	94	95	96
2008	721	82	87	89	91	91
2007	705	84	89	92	94	95
2006	699	82	88	90	93	94

[a] Based on Medicare Advantage plan payment data and actual fee-for-service Medicare spending data.[4] All costs are adjusted to 2009 US dollars.
[b] Under the Ryan-Wyden plan, the second-lowest bidding private health plan in a county (or the county's traditional Medicare costs, whichever is lower) serves as the benchmark. All plans bidding above the benchmark must charge beneficiaries a premium equal to the difference between the plan's bid and the benchmark. The lowest-bidding private plan, in counties in which traditional Medicare is not the lowest bidder, would offer a rebate to plan beneficiaries.

Source: http://www.intellectualtakeout.org/library/chart-graph/lowest-plan-bids-vs-traditional-medicare-costs-2006-2009

An August 2012 study by three Harvard economists found that, using comparable benefit packages, the second-cheapest Medicare Advantage plan in 2009 was 9 percent more cost-efficient than traditional Medicare, while the cheapest plan was 13 percent more cost-efficient.[6]

A separate study, published by the Kaiser Family Foundation in October 2012, found that Medicare plans sponsored by private insurers, in a Wyden-Ryan-like competitive bidding system, would be less costly than traditional Medicare in 40 out of 50 states.[7]

INTRODUCTION TO ADMINISTRATIVE SERVICES ORGANIZATIONS

Could traditional Medicare learn from private insurers how to become more cost-efficient? One model that Medicare could adopt from private-sector practices would be administrative services organizations, or ASOs.

Under Section 514 of the Employee Retirement Income Security Act of 1974, or ERISA, companies that directly fund their workers' health benefits (instead of purchasing health insurance on their behalf) are not bound by state insurance regulations.[8] Because state insurance regulations often drive up the cost of health insurance, many companies—especially large ones with a broad risk pool—are better off if they self-insure their workers.

Imagine two large companies, each with 50,000 employees, whose workers consume an average of $5,000 each in health care per year. The first company pays for these costs directly (self-insurance), for a total annual expense of $250 million. The second company pays for an outside insurer to cover its 50,000 workers. Because the administrative costs of the external insurance plan are 12 percent, the second company spends $284 million on health care instead of $250 million. The first company, by self-insuring, has saved $34 million relative to its competitor.

Typically, self-insured companies will outsource the administrative function of their health-care expenses to ASOs. In contrast to conventional insurance, where the insurer collects premiums and pays for health expenses—taking on the financial risk thereof—in the ASO model, the employer takes on the financial risk for paying health expenses.

The ASO administrator creates the co-pay system, the network of doctors and hospitals, the reimbursement rates, and other features that would resemble a typical insurance plan. The theory is that insurers have broader expertise to manage health claims more efficiently than do individual companies, whose expertise is in their core business functions.

The ASO charges a fee for this service: about 2 percent of expenditures, instead of 12 percent—a much better deal for the employer, especially if that 2 percent fee results in savings of greater than 2 percent. From the standpoint of the ASO administrator, lower administrative costs are balanced by the very large population enrolled in such a program.

AREAS OF ASO EXPERTISE IN THE PRIVATE SECTOR

ASOs improve the efficiency of self-insured companies by applying their experience in case management to improve clinical outcomes and reduce costs.

- *Prevention and wellness*. ASOs can use proprietary algorithms to analyze beneficiary data from such factors as claims, laboratory tests, and pharmacy usage to ensure that patients and physicians are aware of potential gaps in care.

- *Management of patient transitions*. One of the most significant problems in the U.S. health-care system is the mismanagement of patient transition from one facility to another, such as the discharge of hospital patients into an outpatient setting. ASOs can reduce the length of hospital stays and

dramatically reduce readmission rates through better management of these situations.

- *Emergency-room overutilization*. ASOs can ensure that patients seeking access to the emergency room are provided with appropriate care and that those with nonemergency issues are routed to less costly facilities

- *Chronic disease management.* ASOs, by monitoring patient compliance and providing dedicated nurses, are able to reduce hospital admissions for chronic diseases such as asthma, diabetes, and heart failure by 6 to 9 percent.

- *Evidence-based medicine*. ASOs help guide the implementation of evidence-based medicine by physicians and patients.

- *Provider networks*. ASOs can steer patients to health-care providers based on quality and cost metrics, leading to lower complication and readmission rates and fewer wasteful procedures. For example, specialized transplant centers can reduce re-transplant rates, and kidney specialists can reduce dialysis costs.

ASOS COULD BE A BETTER MODEL FOR MEDICARE THAN ACOS

A Medicare ASO program could serve as a bridge between traditional Medicare and Medicare Advantage. The ASO would apply the administrative services model to traditional Medicare, in which private insurers would process Medicare's health claims, in the way that insurers do for companies that self-insure their workers.

ASOs could use Medicare's conventional reimbursement rates, or use their own—higher or lower—rates by negotiating directly with providers. An ASO program could include financial benchmarks, so that administrators would be rewarded for saving Medicare money or by increasing the quality of care. ASOs could give patients more incentive to use high-quality, cost-efficient providers, by reducing co-pays or coinsurance rates in those instances. ASOs could compete against one another by offering benchmarks for quality and cost.

In these ways, ASOs could function in a similar way to the Accountable Care Organizations, or ACOs, that are created by the Affordable Care Act of 2010. ACOs, like ASOs, aim to provide integrated, better-managed care, but ACOs require consolidation of health-care providers. A major driver of rising health costs in the United States is hospital consolidation. Mounting evidence suggests that hospital consolidation is associated with a substantial increase in health-care prices, as provider monopolies and oligopolies use their market power to demand that payers accept higher reimbursement rates.[9]

In November 2011, Federal Trade Commissioner J. Thomas Rosch stated that higher prices are likely to be an "unintended consequence" of ACO-driven provider consolidation and that "[t]he net result may therefore be higher costs and lower quality health care."[10]

ASOs, by contrast, require no provider consolidation and, in fact, will drive greater cost efficiencies in environments where there is *less* consolidation and therefore greater provider competition.

MEDICARE ASOS ARE COMPATIBLE WITH A WIDE RANGE OF REFORM OPTIONS

Leaving Medicare unchanged is not a plausible policy option. Growth in Medicare spending is the largest driver of America's fiscal crisis. Members of both parties and analysts of all ideological stripes agree that improving the program's efficiency and its quality is arguably the nation's most pressing domestic challenge.

Medicare cannot become more efficient as long as providers of health care have no incentive to compete on quality and cost and as long as patients

have little information with which to choose among these providers. ASOs could do much to improve this state of affairs.

An advantage of introducing ASOs into Medicare is that ASOs are compatible with a broad range of policy approaches to Medicare reform. ASOs could help Medicare's Fee-for-Service public option compete with private plans in the premium support and competitive bidding model advocated by center-right analysts. ASOs could also be grafted onto the Affordable Care Act with no additional structural changes to Medicare.

A pilot program in which Medicare assigns half of a given state's Medicare Fee-for-Service beneficiaries to an ASO, stratified by prior health status and other relevant factors, could examine the degree to which ASOs could reduce costs and improve health outcomes. Success on these measures could lead to broad adoption of ASOs in the traditional Medicare program.

The long-term trajectory of Medicare spending is unsustainable and requires significant reform of Medicare's structure. ASOs alone could never solve Medicare's problems. However, under a wide range of scenarios, they could be part of the solution.

ENDNOTES

[1] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/Medicare_FFS_2010_CERT_Report.pdf

[2] http://www.hks.harvard.edu/news-events/news/testimonies/sparrow-senate-testimony

[3] http://www.manhattan-institute.org/html/mpr_05.htm

[4] http://www.heritage.org/research/reports/2009/06/medicare-administrative-costs-are-higher-not-lower-than-for-private-insurance

[5] http://www.dartmouthatlas.org/downloads/reports/Policy_Implications_Brief_022709.pdf

[6] http://jama.jamanetwork.com/article.aspx?articleid=1273025

[7] http://www.kff.org/medicare/upload/8373.pdf

[8] http://en.wikipedia.org/wiki/Employee_Retirement_Income_Security_Act

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[10] http://www.ftc.gov/speeches/rosch/111117fallforumspeech.pdf