

iLUminate Blog Transcript: Chad Meyerhoefer on What You Need to Know About Medicare

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- ANNOUNCER: 00:03 [music] This podcast is brought to you by iLUminate, the Lehigh Business blog. To learn more, please visit us at business.lehigh.edu/news.
- JACK CROFT: 00:15 Welcome. I'm Jack Croft, host of the iLUminate podcast for Lehigh University's College of Business. Today is October 4th, 2023, and we're talking with [Chad Meyerhoefer](#) about what you should know about the upcoming [Medicare Open Enrollment Period](#), which starts on October 15th and runs through December 7th. Dr. Meyerhoefer holds the Arthur F. Searing Professorship in economics and is the chair of the department of economics in Lehigh's College of Business. His research focuses broadly on the economics of health and nutrition and involves the use of micro-econometric methods to evaluate and inform public policy. Chad, thanks for joining us again on the iLUminate podcast.
- CHAD MEYERHOEFER: 00:58 Hi, Jack. It's good to be here.
- CROFT: 01:00 All right. Let's start at the beginning. What was the original intent when the Medicare program was created in 1965, and what was covered or not covered in Medicare's original scope?
- MEYERHOEFER: 01:14 So the original intent of the Medicare program was to provide a social safety net in terms of publicly available health insurance for the elderly population. Now, the way that public and private insurance in the United States evolved is somewhat unusual. During World War II, the government-imposed wage controls to keep inflation from running out of control because of the limited supply of workers just because so many people were fighting over in Europe and in Asia. As a result, private companies had to compete for workers by offering additional benefits. And health insurance was one of the benefits that they started to offer. As a result of that process, health insurance became part of the employment wage package that was offered to people of working age. If you contrast it to Europe, where World War II really devastated the economy and created a, in some cases, unsanitary living conditions and things like that, there was a much greater need to make sure everybody had health insurance, so public health insurance evolved for everybody. But that wasn't the case in the United States because of this evolution of the employer-provided health insurance system. However, it became clear that eventually that wasn't sufficient. Because when people retired, some companies didn't offer health insurance as a retirement benefit. So a lot of older people were uninsured after they stopped working. And the Medicare program was intended to make sure that those individuals had access to health care through a public health insurance system. And it covered the most basic health care needs. So hospitalization coverage, coverage for doctor visits. The two major areas that were left out were prescription drug coverage because prescription drug use back in 1965 wasn't as high as it is today and prescription drugs were relatively less expensive. And it also didn't cover dental or vision care.
- CROFT: 03:28 OK. Now, what have been the biggest changes to Medicare in the years since then?

MEYERHOEFER: 03:33

So Medicare has changed significantly, but for many years, it didn't really change that much. The first large change was in 1972, where Medicare was expanded to cover people less than the age of 65 with certain health conditions. In particular, if they had end-stage renal disease or if they were on SSDI, which is Supplemental Security Disability Income, for at least two years, they would qualify for Medicare. So there's this under-65 disabled population that receives Medicare coverage. Then there was a small expansion in 2001 to cover people with ALS that were under the age of 65. That's Lou Gehrig's disease. But the largest expansion of Medicare occurred in 2006 when prescription drug coverage was implemented under the Medicare Part D program. And that was actually at the time the largest expansion of public health insurance coverage since the start of Medicare in 1965.

CROFT: 04:39

That was the point, then, there where private insurance came into the Medicare world.

MEYERHOEFER: 04:46

Right. Well, private insurance had already been an element of Medicare through what's called Medicare Part C, which are HMO, or managed care plans. But introducing Medicare Part D was significant in that it was exclusively provided through private insurance plans. So there is no government option. There's no public option per se for Medicare Part D. All the plans there are administered through private companies. Now, they're regulated. They have to meet certain coverage rules. But they're all basically managed by private insurance companies. And in many cases, individuals have multiple options, a large number of options to choose from with different characteristics.

CROFT: 05:38

Right. And so that was the advent of what's called the Medicare Advantage plans as well as pharmaceutical drugs that also cover, as you just mentioned, I think a wide array of other options, including a couple of the things that were left out of the original Medicare coverage of dental and vision coverage among others. So what is the government's role in overseeing those Medicare Advantage plans, as well as the pharmaceutical drug plans that are offered by private insurance companies?

MEYERHOEFER: 06:17

Medicare Advantage was developed in order to introduce some choice and competition into the Medicare program. So the general idea is that those plans are, they're essentially given a payment for Medicare to cover people under their mechanisms. And they were intended to reduce costs by introducing managed care characteristics. Meaning that individuals were restricted to a network of providers, and in order to seek care from specialists, they have to go through what's called a gatekeeper. Meaning, they have to go to their primary care physician to receive a referral. But in exchange for those restrictions, they receive additional benefits. And so those include potentially a dental insurance component, a vision component. And after Part D was introduced, individuals had the option of either buying a stand-alone prescription drug plan under the Part D market or buying a Medicare Advantage plan, a Medicare HMO or managed care plan that had prescription drug coverage included in it. And that's actually how many people get their drug coverage now. So those plans, they have to follow Medicare's rules with regard to the quality of coverage. And there's also limitations on the premiums that can be charged. So the premiums have to be charged within a certain band, coverage has to meet certain restrictions. But outside of those general rules, plans are allowed to develop their own health care networks in the way they see fit. And they're allowed to adjust the cost-sharing

amounts, essentially the co-payments, that they charge people in order to compete with other privately administered plans in that market.

CROFT: 08:19

OK. That brings us up to where we are now, which is near the beginning of the annual open enrollment period. So just kind of the basics first, but why do we need an annual open enrollment period within Medicare? And what are some of the things that people should look at each year when this rolls around?

MEYERHOEFER: 08:45

Most types of insurance have an open enrollment period. So that it's no different than when you sign up for health insurance through your employer. And the reason why insurance has open enrollment is because we don't want individuals to initially decide not to purchase health insurance when they're healthy and then only purchase health insurance when they become ill. That would lead to a lot of what's called adverse selection. So there would be no way to pool risk because only people who are sick would be enrolled insurance because they'd wait until that happened to sign up for insurance. So open enrollment ensures that we get a pool of people signed up for health insurance who are both healthy and sick, and then we can better pool that risk across that population. It allows insurance companies to essentially raise enough premium to cover out people's bills when they do get sick. So that's conceptually why we have open enrollment.

MEYERHOEFER: 09:54

The important thing to consider when you're navigating the Medicare open enrollment are just all the options and think about the things that you really want in a health insurance plan. Because there are actually quite a few options that most people have when they enter open enrollment. So there's a contrast between traditional Medicare, which is parts A and B that you can sign up for. And the advantage of that is that you can go to pretty much any provider you want because almost all providers accept Medicare insurance. So if you really place a large emphasis on flexibility and being able to seek care at any facility you would prefer, then that could be a good option for you. However, it has fairly high cost-sharing associated with it. So the co-insurance rate is 20%. And 20% can be a lot when you're undergoing medical procedures associated with more expensive treatments.

MEYERHOEFER: 11:07

Now, of course, the hospitalization coverage is fairly comprehensive and similar to what you'd get in a managed care plan. But it's really those outpatient costs that can be significant under traditional Medicare. And that's kind of why Medicare Advantage plans, they fill in some of those costs by offering you lower co-payments. However, that's not the only way to go. Another possibility is that you can sign up for traditional Medicare and you can buy what's called a Medigap plan, which is a supplemental private insurance plan that will cover some of those additional costs for an additional premium. So that's a good plan for somebody who wants lots of choice. But for many people, actually, Medicare Advantage plans have a lot of advantages because they're significantly less expensive, both in terms of the-- mainly in terms of the cost-sharing, but sometimes also in terms of the premium. And they tend to provide more supplemental benefits. Dental care can be particularly important for older Americans, and that is usually covered. It's not necessarily covered as well as if you had a supplemental dental plan, but there's some basic dental coverage and vision coverage and most people do access those services. So the one thing, though, you have to pay attention to is whether the providers you want to go to are in that managed care network because usually there's limited or even no coverage for going outside the network.

CROFT: 12:50

Now, you had mentioned that the Medicare Advantage plans and a larger role for private insurance companies came into being with the idea that they would offer more competition and choice. So starting with those private insurance plans, what are some of the main potential benefits that these plans have? In other words, are we getting competition? Are we getting a real choice and lower costs and all those other things? And then what are some of the pitfalls of going with a private insurance plan?

MEYERHOEFER: 13:33

Right. So if we think about the benefits to the individual versus the benefits to the public at large or the government, then they vary. I think we've talked about some of the benefits to the individual in terms of lower cost-sharing, more supplemental coverages. As far as the benefits to the government are concerned, as I said, they originally intended to reduce Medicare costs, but that hasn't really happened to the extent that the government thought it would. So these plans were originally subsidized by the government in order to encourage private insurance companies to offer them. And that's also true of prescription drug plans through Medicare Part D. Those were subsidized temporarily, and they were reinsured by the government. And so that's why when Medicare Part D was unrolled in 2016 or 2006, there were so many plans to choose from because it was really difficult to actually lose money on those plans at that time. So some of those subsidies have been adjusted.

MEYERHOEFER: 14:45

But the subsidies for a Medicare Advantage plan were in place for a long period of time, and if you looked at how much money those plans saved in terms of lower hospitalization costs or reductions in total medical care costs for their members relative to traditional Medicare, those savings didn't really justify the subsidies those plans were receiving. So one of the factors or one of the pieces of individual legislation that was part of the Affordable Care Act was to remove those subsidies. And so the Affordable Care Act, otherwise known as Obamacare, that was passed in 2010. So the government reduced the subsidy to those Medicare Part C plans, those Medicare Advantage plans, by \$135 billion. So it's a pretty significant reduction. So in terms of the benefits, then, there is this notion that there could be some competition from those plans that would save the government money, but it's just more limited than policymakers expected.

CROFT: 16:00

Now, in recent years, there's been increasing consolidation within health care, both in terms of networks and providers. So what impact has that had on health care costs? And how has Medicare responded to help shield patients from those changes?

MEYERHOEFER: 16:18

It's actually kind of interesting how this consolidation evolved. Economists talk about what's known as economies of scale as a natural reason for consolidation. And that's just the idea that if you have a larger network, then you can provide the service more efficiently. And so an example would be cell phone networks. It's more attractive to have a cell phone that works all over the country through a large network than it is just to have one that works within the state or within your local community. So health care networks have some of those properties in the sense that often if you look at the size of a health care network maybe 20, 30 years ago that those networks could be more efficient, provide lower costs, and more options to patients if they were larger. And that fuels some of the consolidation we're seeing.

MEYERHOEFER: 17:16

Now, the worry is that consolidation leads to market power. And so the idea that hospitals or health care networks have less competition, they can increase prices and Medicare would have to push back on that. But one thing that's interesting is that

Medicare indirectly helped fuel a lot of that consolidation. And that's because Medicare payments, so the amount that Medicare pays to hospitals and other providers, have gone down in real terms over time. Medical systems used to rely quite heavily on these payments, and they were always above-- they always provided positive margins. Meaning that when you saw a Medicare patient, you were assured to make money on those visits or providing that care. And that was the case for a long period of time. And then gradually, those payments for Medicare went down. And then around 2003, 2004, they became slightly negative.

MEYERHOEFER: 18:21

So where we are now is that when you see a Medicare patient, you're basically getting paid the cost of the service. You're not earning extra money on those patients in any sense. And what that's done is that's shifted a lot of the burden for raising revenue onto prices negotiated between hospitals, health care systems, and private insurance companies. So in order to make up for those lower margins that hospital systems get through Medicare, they negotiate harder with private insurance. And one of the ways they can increase their market power in those negotiations is by consolidating so that they can't be excluded from those private insurance networks. And so we've had somewhat of an arms race between consolidation in the medical provider market and consolidation in the private insurance market. And what the data suggests is that hospitals and health care systems, they've been successful through this consolidation in increasing or keeping their private insurance margins above cost, so they continue to earn positive margins on those payments.

MEYERHOEFER: 19:36

And so there is always this worry, though, over the long term that those health care networks could start to push back against Medicare. But Medicare, of course, is so large that it still will always have greater pricing power than those health care networks. So Medicare just has to make sure that it doesn't cut payments so far that it could actually pose a serious threat to the operation of those facilities. And that was a concern after Obamacare was passed because Obamacare does include some significant cuts in Medicare payments. We talked about the payment cut, the \$130-so billion that was cut to Medicare Part C. Well, there's also some Medicare part A cuts in the multiple billions of dollars range there that hospital systems were worried about. Now, so far, we haven't seen a lot of closures of hospitals because of those payment cuts, but it's always a concern. So Medicare does have to use its pricing power appropriately and make sure that it doesn't want to overpay providers, but doesn't want to underpay them either.

CROFT: 20:52

So on a related note, one of the most significant changes in recent years is allowing Medicare, through legislation, for the first time in history to directly negotiate drug prices. And the first list of 10 drugs selected for the first round of negotiation has been announced, and it includes the most expensive and some of the most used drugs on the market. And ones that anybody who watches TV certainly would know if only from the commercials. Like Eliquis, which Kareem Abdul-Jabbar is talking about now. And Jardiance, and Xarelto, Januvia, Farxiga, Entresto, Enbrel, Imbruvica, Stelara, and Fiasp and the delivery systems for the insulin. According to the U.S. Department of Health and Human Services, those 10 drugs alone accounted for 20%, or \$50.5 billion, of the total Part D gross covered prescription drug costs between June 1 of '22 and May 31st of '23, which is the time period that was designated to determine which drugs were eligible for negotiation. So how successful do you think the federal government will be in negotiating lower prices? And in terms of what you were just talking about, is there that same kind of balance you were talking about with the

health systems where if they impose prices that are too low, there'll be a chain reaction in other ways in the system?

MEYERHOEFER: 22:45

Yeah.

CROFT: 22:45

For Medicare recipients, the last thing will just be, and when would they expect to actually see lower costs, whatever they are?

MEYERHOEFER: 22:53

Sure. So it's a really interesting initiative and something that a lot of advocates have been pushing for for quite some time. And the reason for that is that we pay relatively high prices for prescription drugs in the United States. Particularly branded drugs. So we don't actually pay more for generic drugs. We actually pay less than many other countries for generic drugs. But for branded drugs like the ones you mentioned, we do pay significantly more. And that's because of what economists call price discrimination. Prescription drug companies take advantage of the fact that we don't bargain for these drugs as a country. Each individual insurance company, through a pharmacy benefit manager [PBM], will bargain for lower prices for these drugs. But of course, those individual companies have a lot less power than they would if they were negotiating for the entire country.

MEYERHOEFER: 23:52

Also, Americans tend to have high willingness to pay for these treatments. And so drug companies take advantage of those two characteristics by charging us higher prices than individuals in other countries. So this is a way to leverage our collective market power through the Medicare program to bargain for lower prices. And for drugs that are used predominantly by older Americans, we're talking about almost the entire market. So it would be similar to the country of Canada negotiating on behalf of its citizens for lower prices, which it does. In the case of drugs that are used by the entire population, of course, Medicare will have a little less bargaining power because it's only representing a portion of that market, although usually a pretty large portion. So if we look at the experience of other countries, we can expect that these negotiations will be successful in lowering the prices that Americans pay for these drugs through the Medicare program.

MEYERHOEFER: 24:55

It'll be interesting to see how these prices, this price setting through Medicare or these negotiations through Medicare, affect how much private insurance companies pay. Because one possibility is that these drug companies negotiate a harder bargain with PBMs and private insurance companies for people under 65 in order to shift, essentially, revenue generation from the Medicare market to the private insurance market, like we've seen with health insurance. Or it could go the opposite way because if Medicare is such a large portion of the market for these drugs, that could just become the new market price. At a minimum, though, I would expect this to significantly lower the cost of these drugs from Medicare recipients. Now, unfortunately, there's been a lot of talk about this initiative recently because it's being implemented, but unfortunately, people won't actually see those savings for several years. So there's two rounds of negotiations that occur before the final negotiated prices are determined. And that's going to happen over the next two-year period. So these prices, these lower prices, won't actually take effect until January of 2026.

CROFT: 26:17

And finally, is there anything that we haven't talked about that you think our listeners should know as they consider their options during the open enrollment period?

MEYERHOEFER: 26:28

I would just recommend that they do take some time to go through all their options during open enrollment and learn a little bit about the plans that are available to them. So we have a tendency to want to minimize mundane or administrative tasks. So a lot of people will have private insurance through a company when they were working. And let's say it's Blue Cross Blue Shield, or it's Aetna. And so they will have had that type of insurance for many, many years. And then when they transition onto Medicare, oftentimes those companies will try to convert them from their employer-provided insurance to a Medicare plan or a Medicare Advantage plan. And that's perfectly fine, but there are a lot of options available to people.

MEYERHOEFER: 27:29

So I think it is worth it to spend some time looking at all the plans. They can go to Medicare's website and see what plans are available in their area. And this is particularly the case if they're currently in a plan that doesn't have supplemental coverages for dental care or vision attached to it. Because there are now a lot of plans that offer those supplemental benefits. And they don't necessarily cost more than plans that don't offer the benefits. Sometimes they even cost less. If you haven't evaluated your plan for a while, I think it's a good idea to do that. You could end up saving yourself some money and allowing things to run more smoothly when you do need care. The only thing to caution is just to make sure that the providers you want to continue to see remain in the health care network of the plan you choose if that's a Medicare Part C or Medicare Advantage plan.

MEYERHOEFER: 28:30

So there's two ways to do that. You can go on to the plan's website, and you can enter your provider's name, and they should have a way of verifying that that provider is eligible to receive payments from that plan or you can just call your physician's office directly and ask them if they participate in that plan. And so many of these plans like Blue Cross and Blue Shield or UnitedHealthcare, Aetna, they're large companies. They do have pretty large networks. So usually, it's more of an issue that you're geographically restricted. So if you live outside a major metropolitan area, but you're maybe an hour or two away from that area and you choose the Medicare Advantage plan, it's possible that you may not be able to see providers in that city because they're in a different managed care region.

MEYERHOEFER: 29:26

So the example I would give in Pennsylvania where we're located is for Blue Cross, for example, there's the Capital region, which includes the Lehigh Valley in Harrisburg, and then there's the Independence region, which includes Philadelphia. So if you're in a managed care plan and you live in the Lehigh Valley, you can typically go to providers here. You can go to providers near Hershey, Pennsylvania. But you wouldn't be able to go to providers down in Philadelphia. That would be out of network. Now, some of these Medicare Advantage plans do offer out-of-network coverage. It's just that your cost-sharing is going to be higher. So that's not a bad way of preserving some independence just in case there's really somebody you want to go to that's outside your network, but still getting lower costs for people in your local area.

CROFT: 30:16

Well, I'd like to once again thank our guest, Chad Meyerhoefer, for giving us some things to think about with the open enrollment period. Chad's research has appeared in top field journals in economics and information systems, such as the American Journal of Agricultural Economics, Information and Management, the Journal of the American Medical Informatics Association, and the Journal of Health Economics, as well as leading journals in health policy, medicine, and dentistry. Chad's research also has been supported by the National Institutes of Health and the Agency for

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