Final Report of Study Panel
on Medicare and Markets

The Role of Private Health Plans in Medicare:

Lessons From the Past, Looking to the Future

November 2003

EXECUTIVE SUMMARY

National Academy of Social Insurance

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Executive Summary

The National Academy of Social Insurance (NASI) convened a study panel in 2001 to consider the role of market-oriented reforms and private health plans in Medicare, as part of its broader project on the future of the Medicare program. The panel interpreted its charge broadly and set as its goal strengthening Medicare overall, including both the fee-for-service (FFS) system and private health plans. Members of the study panel were selected for their recognized expertise and knowledge of Medicare; they were also selected to represent different disciplines and diverse views on the role of private health plans in Medicare. The study panel met four times, convened several conference calls, and commissioned original research in pursuit of its mission. In its work, the panel strove to reach consensus on a wide range of challenging and complex issues. In most cases, the panel reached a common understanding and viewpoint, however, on some issues, there was a divergence of views among panel members, which is noted in the text. This is the panel's final report.

Proponents of increasing the role of market forces and private health plans in Medicare argue that original Medicare's fee-for-service payment system is antiquated and inherently incapable of meeting the challenges of modern health care delivery, serving poorly both beneficiaries and taxpayers.[1] They maintain that it creates incentives for unnecessary (sometimes harmful) and uncoordinated medical care, leaves beneficiaries exposed to substantial financial risk, inefficiently allocates resources, thwarts innovation through outdated benefits and rigid payment systems, lacks accountability, and invites excessive Congressional involvement in the program's management and operations. They further suggest that Medicare ought to provide beneficiaries with the same array of private health plans through which many working-age Americans get health insurance.

Opponents of market-based reform in Medicare, while agreeing that benefit coverage and financial protections for beneficiaries must be greatly improved, argue that market forces will undermine a very popular social insurance program that has effectively improved the health care and financial status of elderly and disabled Americans. In their view, competition among private health plans, variations in their individual practices, and plan movement in and out of the Medicare market inevitably undermine beneficiaries' financial security, create inequity in benefits, promote unevenness in coverage, and disrupt relationships with physicians. In their view, shifting benefits and administrative requirements can overwhelm those with cognitive or sensory impairments. They maintain that competition among private health plans creates incentives for plans to avoid the sick and market to the healthy, increasing the vulnerability of frail Medicare beneficiaries. They assert that cost control through competition is more myth than reality.

In the study panel's view, debate over the appropriate role of market forces in Medicare

1 In this report, the terms "original Medicare," "FFS Medicare," and "FFS" are used interchangeably.

often has been characterized by misunderstanding and polarized by ideology, with claims that do not comport with experience. They do not expect that a better understanding of Medicare's history and analysis of its performance alone will result in a consensus view on Medicare reform. Values play an important part — and rightly so — in shaping views about public policy. But they hope that a dispassionate analysis of both original Medicare and Medicare+Choice (M+C)[2] will help clarify the issues and dispel some misconceptions.

As the complexity of Medicare has grown, misunderstanding has increased. As new goals have emerged for the program, policies intended to advance some goals have inadvertently undermined others. As Medicare's administration has grown more complex, it has become harder to make sense of what each part of the program is intended to achieve. For example, while some view the M+C program as the "market" part of Medicare, its payments to plans are established in law, rather than by market forces, and while it has offered some choice for the majority of beneficiaries, effective competition among private health plans has occurred only in certain portions of the country.

Participants in the debate often rely on idealized conceptions of their favored part of the program. Some proponents of increased involvement by private health plans have based their predictions on conceptions of how markets could work if they were used for a large percentage of Medicare beneficiaries, not on their actual experience in Medicare or how well these plans have performed for working age Americans. Some opponents have evoked an old-fashioned version of fee-for-service medicine, one in which beneficiaries choose freely among doctors and hospitals of equal quality, all willing to treat them, and appropriate care is unconstrained by imperfect rules or bureaucratic red tape.

Neither of these views speaks to the current and future reality of the Medicare program: a vital asset for beneficiaries as individuals and as a group, but one that suffers from serious shortcomings, inefficiencies, and inequities. Neither offers a realistic assessment of the capacity for market-oriented reforms to improve Medicare's performance, compared to a system with only original Medicare.

Given this range of views, the study panel decided that the best way to begin its work was through an objective analysis of Medicare's current performance, both in FFS and M+C, along a number of crucial dimensions. The panel evaluated Medicare's performance in providing financial security, choice of plans and providers, access to health care, quality of care, cost containment, and reducing the prevalence of racial, ethnic, socioeconomic, and gender disparities in the provision of health care. By using multiple criteria, the study panel sought an in-depth understanding of the program's performance. Providing a clearer picture of Medicare's successes and limitations also focuses policymakers' attention on larger challenges facing Medicare, regardless of the way services are delivered.

2 The Medicare+Choice program refers to the range of private health plans authorized by Congress in the Balanced Budget Act of 1997.

The panel found a number of shortcomings in Medicare, with some more pronounced in original Medicare and others in M+C. Neither original Medicare nor M+C is ideally structured, or has performed optimally, to remedy the following weaknesses in the program:

- Medicare was enacted with the promise to provide financial security and access to medical care comparable to that of insured working-age Americans. It no longer does so. While Medicare provides very good access to care for elderly beneficiaries, those with moderate incomes or chronic illnesses are at risk for health care expenses that far exceed their ability to pay for it.[3] For disabled beneficiaries, Medicare provides access to care equivalent to employer-sponsored insurance.[4] But the financial burden of paying for care falls harder on disabled beneficiaries, 39 percent of whom reported that they were unable to pay their medical bills. Another 33 percent said they had to alter their lifestyles to pay for health care (Davis et al. 2002).
- Original Medicare has not kept pace with the benefit packages of the vast majority of employer-sponsored health insurance plans, which typically cover prescription drugs (although with growing restrictions), preventive services, and an annual cap on out-of-pocket liability (Kaiser Family Foundation and Health Research and Educational Trust 2002).[5]
- The fee-for-service reimbursement systems in original Medicare do not promote effective chronic care because they pay providers only for discrete services rendered, not to manage the care of people with complex health care needs. This approach fragments care, instead of encouraging a team approach or coordination among providers (Eichner and Blumenthal 2003).
- Medicare will face increasing fiscal constraints in the years ahead, as the baby boom generation becomes eligible for benefits. Medicare currently accounts for 2.6 percent of the Gross Domestic Product (GDP), and is projected to increase to 4.75 percent by 2030. By then, the aging of the baby boom generation will cause the number of Medicare beneficiaries to almost double to 79 million. (Board of Trustees 2003).[6]
- Medicare has locked in historical and dramatic geographic differences in the resources used for the care of beneficiaries, with per capita expenditures in some parts of the country two to three times higher than spending in other

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3 For example, beneficiaries with annual incomes less than $10,000 spent almost 30 percent of their income on health care. Twenty percent of elderly beneficiaries have incomes in this range (CMS 2002b).

4 Disabled beneficiaries experience more access barriers than elderly beneficiaries.

5 Original Medicare covers none of these benefits, while Medicare beneficiaries enrolled in some M+C plans, most notably in high payment areas, have received some of these additional benefits.

6 Although the study panel is mindful of these issues, its mission did not include examining Medicare financing for the future. A companion NASI report, *Financing Medicare's Future* (September 2000), focuses on that issue.

regions.[7] The M+C program has institutionalized these inequities, which encourages participation and richer benefits in plans located in high-payment areas.

- Quality of care for Medicare beneficiaries appears to fall short of that for working-age adults with health insurance, in large part because its beneficiaries are in frailer health and are more likely to have multiple chronic conditions. As a result, Medicare beneficiaries seem more likely to suffer from medical errors with serious adverse outcomes. They also tend to be more likely to experience greater difficulties in coordination of health care services.
- Although Medicare provides all beneficiaries with the same health insurance coverage, there are still dramatic disparities in the use of health care services related to race and ethnicity as well as socio-economic status.[8]

To rejuvenate Medicare's commitment to beneficiaries and the American public, its performance should be improved. To fulfill its charge, the Panel sought to identify the ways in which market-oriented reforms might either facilitate or impede these improvements. This assessment required that we (a) disentangle multiple concepts that are often commingled under the rubric of "market reforms," (b) determine how the distinctive needs and circumstances of Medicare beneficiaries should alter the design and scope of market-oriented reforms, (c) identify those shortcomings in Medicare's current performance that are not easily cured by market reforms, and (d) propose arrangements that could increase accountability in both original Medicare and the private health plans that contract with the program. Not all of the program's shortcomings are solvable by any feasible policy, but many could be more effectively addressed than they are today, or in any currently proposed reforms.

SORTING OUT THE CHANGES INVOLVED IN MARKET ORIENTED REFORMS

Advocates of market reforms in Medicare promise benefits linked to two distinct changes in Medicare. The first involves giving beneficiaries choices of private health plans as an alternative to original Medicare. The second seeks to create competition among health insurance options based on both price and quality. Although both are often grouped together as "market reforms," our findings suggest that (a) they have very different implications for Medicare beneficiaries, (b) some of these changes are more readily implemented than others, (c) we know more about the implications of some of these changes than others, and (d) confusion about types of market-oriented policies has clouded the debate over Medicare reform.

Since its inception, Medicare has contracted with private health plans to provide services to beneficiaries who choose them. Beginning in 1997, private health plan options have been called the "Medicare+Choice"

7 Most of these differences persist after costs are adjusted to account for differences in the costs of the input measures (Wennberg, Fisher, and Skinner 2002).

8 Medicare is not unique in this respect; disparities are pervasive throughout the U. S. health care system.

program.[9] Following enactment of the Balanced Budget Act and changes in the managed care industry, the types and numbers of plans and the stability of their participation in Medicare markedly changed.

Insufficient information about the role of private health plans in Medicare makes it difficult to have a comprehensive understanding of their effects. A fair amount of evidence about the relative performance of some types of M+C plans, particularly risk-based HMOs exists, but less information is available about the performance of Preferred Provider Organizations (PPOs), Provider-Sponsored Organizations (PSOs), and private FFS (PFFS) plans. There is evidence that the impact of private health plans tends to be more beneficial, the more competitive is the local market.[10] But we know very little about the potential for competition based on price and quality. Medicare's payments to private health plans are based on prices set by law, rather than those generated by market forces. Efforts to create competition based on quality are still in their infancy. For insights into the potential costs and benefits of these types of plans and full price competition, we must look to the experience of employer-based insurance.

Drawing upon these sources of evidence and experience, the study panel finds that the involvement of private health plans in Medicare is promising, in that:

- Medicare beneficiaries and the general public both favor providing greater choice of health plans, as long as this does not undermine the affordability of original Medicare.
- Giving beneficiaries a choice of plans, with differing benefits, helps policymakers and plans identify which plan features or benefits are important to beneficiaries. In general, Medicare beneficiaries value choice of plans, though only a subset (typically younger or disabled beneficiaries) makes a serious effort to consider choice. But choice under M+C has been seriously restricted because plans are not equally available throughout the country and because practices by Medigap insurers limit beneficiaries' ability to switch freely between M+C plans and original Medicare.
- Access to coordinated care plans has allowed some beneficiaries to reduce significantly the burden of paperwork and improve their financial security. In addition, coordinated care plans have improved diagnosis of illness and reduced disparities related to race and income for preventive services. Although PFFS plans have been operating for too short a time to have an established track record, early indications suggest that they are not producing the same gains as coordinated care

9 The Balanced Budget Act of 1997 defined several types of private health plans that could contract with Medicare. Coordinated care plans include risk-based HMOs, Provider-Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs). Private Fee for Service (PFFS) plans are not included in the definition of coordinated care plans. When the term "coordinated care plan" is used in this report, the BBA definition is used.

10 (Pizer and Frakt 2002), for example, found that M+C plans offered more generous coverage when they operated in more competitive markets.

plans with respect to enhanced financial security.

- Enrollment in coordinated care plans has the potential to produce a one-time reduction in Medicare spending on the order of 5 to 7 percent.[11] However, to date, Medicare has not realized savings because M+C plans have enrolled disproportionate numbers of relatively healthy enrollees who would have cost less in original Medicare. Savings are not achieved because payments to plans are not adequately risk-adjusted to account for enrollees' better health status. Instead, these savings have gone largely to beneficiaries in the form of additional benefits that are not part of the Medicare benefit package. Although there are ongoing efforts to improve risk adjustment, it is unclear whether these alone will be sufficient to achieve Medicare cost savings for the foreseeable future.
- Price-based competition has the potential to further reduce program spending and (depending on the format of the competition) reduce geographic disparities in Medicare spending. Because Medicare has no experience in this arena, potential benefits are uncertain. The Centers for Medicare and Medicaid Services (CMS) actuaries have estimated savings at 2 to 3 percent of program spending over 30 years; others have estimated larger savings, achieved by shifting costs to beneficiaries.

THE DISTINCTIVE CHALLENGES OF MARKET-ORIENTED REFORM FOR MEDICARE

Defining an appropriate role of private health plans for the elderly and disabled does not, in the panel's assessment, require that the Medicare program be remade in the image of the private market for employer-based health insurance. Indeed, emulation of all aspects of employer-based insurance would be counterproductive, because Medicare beneficiaries have needs, circumstances, and capacities that differ in important ways from those of working-age adults.

To serve beneficiaries well, Medicare must reflect these differences. In the assessment of this panel, two differences standout as essential guideposts for policy-making:

First, nearly 13 percent of Medicare beneficiaries have both cognitive and physical impairments. These impairments rise with age, with more than 25 percent of beneficiaries over age 80 having both cognitive and physical impairments (Moon and Storeygard 2001). About two-thirds of beneficiaries have multiple chronic conditions. Twenty percent of aged beneficiaries and 14 percent of disabled beneficiaries have five or more chronic conditions (Eichner and Blumenthal 2003). A third of all beneficiaries have vision that is no better than fair, another 17 percent have limited literacy (Gold et al. 2001). For these groups, the opportunities for choice that are appealing (or at least manageable) to younger beneficiaries might seem threatening, or

11 These estimates reflect the net savings associated with lower spending on medical care in M+C plans, combined with their higher costs for marketing, administration, and profits.

simply be beyond their capabilities. The same dynamic qualities of markets that make them so appealing to policy-makers because of flexibility and innovation can be problematic for beneficiaries who need stability and reliability, especially in their relationships with health care providers. These are not simply preferences; they become a necessary part of life for those trying to cope with multiple health problems, or whose mental capacity may be diminished.

A second distinctive feature of the program involves the health needs of beneficiaries: many live with chronic illnesses. Sixty-six percent of aged beneficiaries and 62 percent of disabled beneficiaries had more than one chronic condition (Eichner and Blumenthal 2003). The experience of working-aged people with chronic illnesses suggests that they do not benefit much from plan choice. Because they are reluctant to disrupt continuity of care with their health care providers, they often remain in plans that are performing poorly, even when given a number of alternative plans from which to select. Past experience with some M+C plans and employer-based plans also suggests that for people with chronic health problems, the benefits of coordinated care plans might be offset by the perceived problems in access to specialists and disruptions in continuity of care. These shortcomings are exacerbated when plans leave the program.

To this end, the panel believes that Medicare beneficiaries should have an option to remain in FFS Medicare. Most panel members believe that original Medicare should remain a vital program and serve as a safety net, in the event that private health plans fail or withdraw from Medicare, or for beneficiaries who want greater stability than M+C plans have provided. The panel recognizes the shortcomings of FFS in meeting the complex needs of beneficiaries who are disabled or have multiple chronic conditions. In their view, maintaining and improving original Medicare is critical precisely because it serves a disproportionate number of vulnerable beneficiaries, including the oldest beneficiaries and those who are disabled.[12]

While the study panel agreed that beneficiaries should have an option to remain in original Medicare, they differ don how original Medicare should be treated in a more market-based system. The treatment of original Medicare in a competitive environment was the most difficult issue the panel considered. This is not surprising because it is also one of the most contentious issues in the 2003 Congressional debate on prescription drugs and Medicare reform.

The panel agreed that assured access to health insurance has been an important accomplishment of the Medicare program, and one that should be preserved in some way. However, members of the panel differed over how that would be best accomplished.

Most panel members believe that FFS Medicare is essential to an assurance of universal access to coverage, so much so that FFS Medicare should not to be placed in direct price competition with private health plans because that could jeopardize the viability of FFS Medicare in the market. Experience in the Federal Employees Health

12 See a companion NASI report, *Medicare in the 21st Century: Building a Better Chronic Care System* (Eichner and Blumenthal 2003) for recommendations to improvements in the care of beneficiaries with chronic illnesses.

Benefit Program (FEHBP) has shown that competition can lead to a "death spiral" as relatively healthier enrollees flee high cost plans for lower cost plans, ultimately increasing costs in the high cost plans. They fear that if FFS Medicare were placed in direct price competition with private health plans; FFS premiums might increase to the point that FFS could become unaffordable for lower income beneficiaries.

A few panel members disagreed with this view. They believe that original Medicare can and should compete directly with private health plans, with one modification. Because Medicare payments include not just health care provided to Medicare beneficiaries, but also costs associated with larger social goals, such as graduate medical education and payments for hospitals serving disproportionate numbers of low income people, payments for these functions should be paid separately — "carved out" — from payments made for providing services to Medicare beneficiaries. This would assure continuing funding for these services.

These panel members believe that protection of FFS Medicare from price competition with private health plans is logically and practically inconsistent with the desire to make choices available to beneficiaries, and to use comparisons among options to monitor performance and improve the accountability of FFS Medicare. They recognize, however, that direct price competition could be disruptive to vulnerable beneficiaries, particularly those with cognitive impairments or serious illnesses. They propose to create insurance that would protect vulnerable beneficiaries from increases in premiums above a pre-determined amount. But most panelists viewed such insurance as inadequate, offering no safeguard for vulnerable beneficiaries against the unexpected cuts in coverage, discontinuities of care, disrupted relationships with doctors, and rising out-of-pocket costs that have resulted from unstable participation by private plans in the M+C program.

The study panel also considered the adequacy of Medicare benefits. The program's lack of prescription drug coverage and an annual cap on out-of-pocket health care spending has put the program out of step with prevailing practices in large employer-based insurance and exposed beneficiaries to unacceptable financial risk. Therefore, the panel recommends that these benefits be added to both original Medicare and M+C. The panel is mindful that these reforms will increase the cost of the program.[13] Coupled with the concern about keeping FFS premiums affordable, these proposals made some panelists fear that original Medicare would simply become too expensive to be politically sustained over the long term. But the majority of the panel concluded that political and managerial accountability for cost containment is strong, noting that the costs of original Medicare had grown more slowly than the costs of employer-based insurance over the past two decades.[14]

Finally, the Study Panel concluded that the continued vitality of Medicare depends on reforms in the market for supplemental insurance (Medigap) policies. These policies pro-

13 Caps on out-of-pocket spending can be budget-neutral if there are offsetting increases in the deductibles or premiums paid by Medicare beneficiaries (Maxwell, Storeygard, and Moon 2002).

14 This difference remains even when one takes into account changes in coverage in both private insurance and Medicare over this period of time.

vide an important source of additional coverage for those who desire greater financial security. But current pricing practices make these policies unaffordable to most of those who qualify for Medicare coverage due to disability. And they can trap elderly beneficiaries in M+C plans that provide inadequate care, because their Medigap premiums would be higher because of impaired health status if they switched back to original Medicare.[15] The panel therefore endorsed federal reforms to require community-rated Medigap coverage with open enrollment. Some panelists expressed concern that these reforms could lead to the sickest enrollees concentrating in some Medigap plans, driving premiums up in those plans to a point that they were no longer affordable. To limit adverse selection, consideration should be given to restricting the number of times beneficiaries are allowed to switch between FFS Medicare and M+C plans, and to limiting the number of Medigap options offered with community-rating.

THE LIMITATIONS OF MARKET REFORMS: PROBLEMS THAT REQUIRE PROGRAM-WIDE STRATEGIES

The potential benefits of greater choice of private health plans and greater competition among plans are significant. For some beneficiaries, particularly the relatively young and healthy, these benefits may be highly valued. Market-oriented arrangements should be refined to make these benefits more widely available to Medicare beneficiaries. We offer some specific recommendations to this end. But it is equally important to be clear about what market-oriented reforms, even in their most refined form, will not bring to Medicare.

- There is little evidence that market-based reforms have slowed the rate of growth in private health spending in the long term, compared to the historical trend.
- Involvement of private health plans in Medicare has limited potential for enhancing financial security for beneficiaries who are most likely to incur high out-of-pocket costs. The advantages of the average coordinated care plan in M+C in reducing out-of-pocket costs for beneficiaries who are disabled or who have chronic illnesses have eroded as co-payments and coverage limitations have become more common, although some plans have had more positive experiences.
- It is essential to recognize that markets are, by their nature, dynamic. This results in substantial changes over time in benefits covered by M+C plans, turnover among physicians affiliated with each plan, as well as continuing entry and exit of plans from the Medicare program. Minority and disabled beneficiaries and those in frail health are disproportionately affected by this instability.[16] Although constrained

15 Some options currently exist. A half-dozen states require that Medigap premiums be community-rated (set at the average actuarial cost for both healthy and unhealthy enrollees); AARP offers a community-rated policy to its members. But the majority of the panel felt that a reliance on state intervention or a private group like AARP offered neither reliability nor equity in the treatment of Medicare beneficiaries. (See Chapter three for more details.)

16 The most recent assessment of the impact of M+C plans leaving the Medicare program was provided by Booske, Lynch, and Riley (2002).

M+C payment rates have exacerbated the instability, much of the instability appears to be due to industry-wide practices outside the control of the Medicare program.

- Without adequate risk adjustment, private health plans have weak incentives to improve quality for beneficiaries with expensive chronic conditions (though some do offer disease management programs), which are more prevalent among older people and those who are disabled. Under current Medicare financing mechanisms, private health plans have few incentives to reduce either racial or socio-economic disparities in medical care and they may, under some circumstances, exacerbate those disparities.[17] Private health plans have reduced disparities in terms of preventive care, although substantial disparities related to race and income remain. And disparities are not reduced for treatment choices and the quality of follow-up care.

Problems related to financial insecurity, growing costs, quality shortfalls, and unequal treatment will thus persist in Medicare, whether benefits are administered through original Medicare or private health plans. Therefore, changes must be made to address these concerns, applied with equal vigor to both parts of the program.

We identify below some of the most pressing of these program-wide reforms, though we defer to other reports many of the detailed recommendations for their structure or implementation. But we believe that these sorts of specific reforms will be effective only if more fundamental changes are made to ensure that the Medicare program is administered in an effective and accountable manner.

ENHANCING MEDICARE'S ACCOUNTABILITY

To address these concerns, the study panel believes that both original Medicare and Medicare's private health plans need to be more accountable, which will require a transformation of Medicare's governing culture. For too long, Medicare replicated the practices of a 1960s version of private insurance, focusing on paying claims and promoting access, to the detriment of other goals. CMS has focused on broader administrative goals in recent years, although the participation of different types of private health plans since 1997 adds to the challenges of effective accountability. But the superficial differences between the two parts of the program should not obscure the fact that both have historically relied on the same three mechanisms to encourage accountability:

- **Consumer Accountability:** emphasizes individual beneficiaries assessing their own experiences and responding when they think that better outcomes can be found with other providers or in other settings.

17 It should be noted that private health plans have historically enrolled a disproportionate number of low-income beneficiaries, although the most recent data on minority enrollment shows little difference between FFS and M+C plans. (Thorpe and Atherly 2002).

- **Political Accountability:** involves the oversight provided by Congressional committees charged with the supervision of the program.
- **Managerial Accountability:** is exercised by CMS, the federal agency that administers the program; insurers and other organizations under contract to CMS; the Secretary of the U.S. Department of Health and Human Services (HHS); and various other government agencies, such as the General Accounting Office (GAO) and the Office of the Inspector General in HHS.

Although original Medicare is often seen as accountable primarily to the political process, both consumer choice and CMS monitoring of performance have played important roles in improving the program's performance. And although market-based reforms are often justified in terms of consumer accountability, both Congress and CMS have had an active role (for better and worse) in governing the M+C program.

Each of these approaches to accountability has demonstrated distinct strengths and weaknesses, which are reflected in the track record comparing Medicare FFS and M+C over the past 15 years (Figure 1). Consumer accountability has the strength of relying on individual choices, which reflect the diverse needs and preferences of Medicare beneficiaries. But consumers, even if well informed, cannot readily judge some aspects of quality or have much sense of disparities in treatment. CMS has assumed leadership in encouraging quality improvement, but is constrained by both political considerations and resource limitations in its ability to interact creatively with providers, beneficiaries, or health plans. Political oversight has a crucial role to play in striking the right balance among Medicare's various goals and determining the appropriate level of expenditures for the program.

It is precisely because the different parts of the Medicare program embody different arrangements for accountability that each part of the program can serve as an important standard of comparison for assessing and improving the performance of the other part. And because these different combinations of accountability arrangements produce a distinctive pattern of strengths and weakness, it is the *combination* of both public and private forms of Medicare that offers the greatest accountability. The differences between original Medicare and M+C ought to be viewed as assets for the program, not problems that ought to be eliminated by future reforms.

The study panel thus considers it essential that both original Medicare and its private health plan contractors be encouraged to learn from each other's experience. In this way, new innovations or important lessons from one part of the program will encourage improvements in the other. The perceived stability that makes FFS Medicare attractive to more frail beneficiaries could become undesirable stasis, if not stimulated by innovative practices in private health plans. Conversely, the experimentation of private health plans could degenerate into disorder, without having original Medicare as a standard for comparison and a focus for political support. Original Medicare and M+C can and should be seen as useful complements to one another.

To ensure that each part of the program learns from the other, mechanisms for accountability need to be strengthened to

Figure 1

Summary Comparisons of Performance of Original Medicare and M+C

	Fee-For-Service	M+C
Financial Security	Inadequate, particularly for poor beneficiaries and beneficiaries who are older and in frailer health.	Better than FFS, but eroding in past five years. More responsive to changing technologies, as illustrated by coverage of prescription drugs. But more risky for beneficiaries whose plans leave the program or who disenroll voluntarily.
Choice	Maximum choice of health care providers. Restricted choice among Mediap plans for the disabled and elderly beneficiaries who wish to change plans several years after retirement.	Plans concentrated in densely populated areas and not available in many parts of the country. Few areas have multiple choices. Less choice of providers than in FFS.
Access	Better than employer-based insurance, but emerging access problems in some geographic areas. Access for disabled not as good as for elderly.	For those enrolled, access to providers does not appear to be a problem. Access disrupted for beneficiaries when plans leave program. Access for disabled not as good as for elderly.
Quality	Achievements: Industry leader in access to cutting edge medical technologies; quality improvement initiatives on par with most progressive in employer-based insurance. Shortfalls: Treatment at "wrong" sites; excessive use of therapies; inadequate primary and preventive care and follow-up; medical errors; failures of coordination.	Similar quality problems as FFS, except: a higher percentage of beneficiaries have an established relationship with a primary care provider; higher immunization ratio; some cancers identified earlier. But continuity of care and communication tend to be worse than in FFS settings. Care seems to be less effective for older enrollees with more severe and chronic health conditions.
Cost Containment	From 1970-1998, Medicare performed slightly better than the private sector.	Introduction of coordinated care plans could produce one-time savings of 5-7 percent, but only if risk adjustment improved and implemented. Annual growth rates thereafter are similar to original Medicare.
Racial, Ethnic and Income-related Disparities	Systematic and sustained difference between whites and blacks, and between low and high-income beneficiaries, including; primary and preventive care, use of surgical and follow up. Limited evidence on disparities in care for Latinos and Asians. Gender disparities limited; largely related to age and income.	Only one study that compare disparities between FFS & M+C shows higher black immunization rates. Other studies suggest a reduction in disparities for primary and preventive care, but with no comparable reductions in disparities for follow-up care. Similar to FFS for disparities between low and high income. No evidence on other racial, ethnic, or gender disparities.

reinforce connections between original Medicare and M+C. To promote consumer accountability, beneficiaries should be effectively informed about the comparative performances of original Medicare and M+C plans. They should understand that the two forms of insurance are indeed one program, a recognition that may be threatened by current M+C practices (See chapter five). To promote managerial accountability, CMS should act as a managerial "bridge" between the two parts of the program, facilitating the transfer of lessons and incorporating incentives for improved performance. CMS will need new resources to pursue a more active role in assuring access and quality of care, following the trend of many of America's large employers in recent years. And it argues against dividing program administration into separate parts for original Medicare and M+C, as proposed in some Medicare reform plans. To promote more effective political accountability, Congress needs to become more involved in setting goals and priorities for both original Medicare and M+C and in ensuring that that both parts of the program pursue these goals with equal vigor, without micromanaging program operations.

If accountability in Medicare is enhanced in this manner, we believe that original Medicare and M+C can operate in effective synergy. This would allow more effective responses to the findings that we report below, and more effective implementation of the specific reforms that follow from the findings.

FINDINGS AND RECOMMENDATIONS OF THE STUDY PANEL

The History of Private health plans in Medicare (Chapter Two)

Finding: Early decisions about how to structure the participation of private health plans in Medicare have had lasting and problematic ramifications; repeated Congressional efforts to ameliorate unforeseen effects have sometimes done more harm than good, and have damaged the government's reputation as a reliable business partner.

Finding: Over time, Congress has increased policy objectives for private health plans to the extent that not all objectives can be met because some objectives are contradictory.

Finding: Effective competition among M+C plans is strongest in urban areas. Having multiple plans, each with distinctive provider panels, is unlikely to be feasible in rural areas because of the difficulty of building and sustaining viable networks in sparsely populated areas.

Finding: Private fee-for-service (PFFS) plans are currently providing beneficiaries with some additional benefits not covered by Medicare, but fewer than those provided by coordinated care plans. However, because PFFS plans operate primarily in low cost areas that receive "floor" payments, Medicare payments to PFFS plans are well in excess of the costs that original Medicare would incur for Medicare-covered services.

Finding: Even with unstable participation, caused in part by constrained Medicare payment rates, the participation of private health

plans in Medicare has brought certain benefits to the program as a whole.

Finding: The way M+C plans are currently paid does not rely on market forces. The payment structure Congress established in law is an administered pricing system, not a market-based system.

Finding: The entrance and exit of private health plans in Medicare, whatever the cause, results inevitably in disruptions in access to care and continuity of care, as well as changes in coverage of extra benefits.

The Financial Security of Medicare Beneficiaries (Chapter Three)

Finding: Original Medicare does not provide adequate financial security to beneficiaries, particularly those with limited incomes and chronic health problems. Many low-income beneficiaries eligible for additional federal assistance are not enrolled in the means-tested programs intended to help them pay for health care because they are not informed about these programs, or are reluctant to apply for them.

Finding: Private health plans have provided greater financial security to some beneficiaries than original Medicare. However, greater financial security is associated only with enrollment in some coordinated care plans, not PFFS plans. For beneficiaries in frail health, ongoing reductions in coverage in coordinated care plans are exposing them to substantially greater financial risk than in previous years.

Recommendation: The Medicare program should incorporate an annual limit on out-of-pocket spending for Medicare covered services.

Recommendation: The Medicare program should provide Medicare beneficiaries with access to outpatient prescription drug coverage to protect them against large out-of-pocket expenses.

Choices Available to Beneficiaries (Chapter Three)

Finding: Some Medicare beneficiaries are willing and able to choose and switch among competing health plans. However, it is not realistic to expect all beneficiaries to do so, especially those with multiple chronic conditions or cognitive impairments. For those beneficiaries, policies that require annual reconsideration of their insurance options, or switching health plans can be very disruptive to continuity of care or a source of confusion.

Finding: Failures in the market for Medicare supplemental policies are preventing some Medicare beneficiaries from trying M+C plans, and locking other beneficiaries involuntarily into M+C plans. Medigap premiums that are adjusted for health status or denied entirely to beneficiaries who are disabled trap less healthy beneficiaries, who are unable to disenroll without having to either forego supplemental coverage or pay much higher premiums. Beneficiaries with moderate incomes are most likely to become trapped in this manner.

Recommendation: Beneficiaries must be assured that original Medicare is available in all areas and will remain so over time. Most panel members believe that keeping original Medicare premiums affordable should be a priority, but that view was not unanimous.

Recommendation: Medicare supplemental policies should be community-rated, with greater freedom to switch among plans. To prevent adverse selection, consideration should be given to restrictions on the number of times beneficiaries can switch between FFS Medicare and M+C plans, or on the number of plans that are available on a community-rated basis.

Access to Care (Chapter Three)

Finding: Both original Medicare and M+C have provided good access to care so far, with original Medicare performing better than employer-based insurance for aged beneficiaries. However, access to care is better for aged beneficiaries than disabled beneficiaries, regardless of whether they are enrolled in original Medicare or M+C.

Cost Containment and Market Forces (Chapter Three)

Finding: Private health plans have the as-yet unrealized potential to achieve modest one-time cost savings for the Medicare program, on the order of 5 to 7 percent for coordinated care plans and 2 to 3 percent for premium support programs. However, under current price-setting practices, these savings depend, respectively, on more effective risk-adjustment and national premium-setting that have, to date, proven technically difficult and politically infeasible. The savings associated with coordinated care plans may not apply to private fee-for-service plans because of the higher payment rates they receive in "floor counties."

Finding: There is little evidence that private insurance, which relies on market forces, has reduced the rate of growth in private health spending over the long term, compared to either the historical trend or the rate of increase in Medicare spending.

Recommendation: Medicare should conduct competitive pricing demonstrations to pay private health plans. Most panel members think that original Medicare should be excluded from the demonstration to protect it against adverse risk selection, although a few panel members think it should be included. These demonstrations should test both competitive bidding and the Federal Employees Health Benefits Program (FEHBP) models.

Quality of Care (Chapter Four)

Finding: Despite aggressive new policies by CMS to improve quality, low quality remains an important problem for Medicare. Most strikingly, none of the current mechanisms for monitoring quality under either original Medicare or M+C can measure certain crucial dimensions of practice, such as errors in treatment, selection of appropriate venues for treatment, or adequate coordination of care for beneficiaries with multiple chronic conditions.

Recommendation: The performance monitoring systems (CAHPS, HEDIS) used by CMS to measure access to care under original Medicare and M+C should include new measures related to chronic illness, as well as increased sample sizes of disabled enrollees.

Recommendation: CMS should modify the Medicare conditions of participation for hospitals to require mandatory reporting of

adverse events that result in death or serious harm. CMS should also develop the capacity to identify beneficiaries admitted to low-volume hospitals for procedures where outcomes are sensitive to the volume of procedures performed. CMS should be encouraged to consider a system that could prospectively screen such admissions.

Recommendation: CMS should develop and implement a payment system for health plans that incorporates explicit incentives for improving quality of care. Parallel incentives should be established for FFS providers. In the short-run, these may be limited to physicians in group practice in FFS Medicare, but eventually should be extended to all physicians.

Recommendation: Congress should give CMS the necessary resources and authority to stimulate changes to improve quality of care for beneficiaries, such as expanded requirements for geriatric training for clinicians treating Medicare beneficiaries, and capacity to promote regionalization of care for procedures shown to have a relationship between volume and quality.

Finding on Disparities in Care Based on Race, Ethnicity, Socio-economic Status, and Gender (Chapter Four)

Finding: Racial, ethnic, and income-related disparities exist in preventive care, primary care, and essential medical and surgical treatments. These are of a magnitude that merits immediate redress.

Finding: Racial, ethnic, and income-related disparities in preventive care are reduced by beneficiaries' enrollment in coordinated care plans. Evidence is mixed in terms of the quality of primary care, and there is no evidence that coordinated care plans reduce racial or income-related disparities in essential medical and surgical treatments.

Recommendation: CMS should measure and assess disparities in preventive care, primary care, essential medical and surgical procedures, and follow-up treatment on a regular basis. Disparities based on race, ethnicity, socio-economic status, and gender should be studied in both original Medicare and M+C. Aggregate measures should be reported on an annual basis. Plan-specific measures should be used whenever possible to encourage improvement at the local level.

Findings on Collateral Missions of Medicare (Chapter Five)

Finding: Support for the current Medicare program is lower in communities where there is substantial Medicare enrollment in private health plans. In areas where private enrollment exceeds 30 percent of all Medicare beneficiaries, support for taxes to finance Medicare's future is at half the level found in other communities. Lower levels of support for government involvement are most pronounced in promoting quality and equity of treatment among beneficiaries.

Recommendation: CMS should help beneficiaries better understand that they are enrolled in Medicare regardless of whether they receive care through original Medicare or an M+C plan, and the conditions under which they can disenroll from M+C and return to original Medicare. This educational effort must be carefully designed to clarify the structure of the program, while not confusing beneficiaries about the terms under which they have enrolled in particular M+C plans.

Findings on Accountability (Chapter Six)

Finding: Medicare lacks sufficient consumer, political, and managerial accountability in both original Medicare and M+C to assure optimal performance.

Recommendation: Mechanisms should be developed to ensure greater consumer, political, and managerial accountability that more effectively stimulates learning between original Medicare and M+C. This would require (a) providing all beneficiaries with comparative information on performance of the two parts of the programs, regardless of whether they are actively considering a switch between the two, (b) providing CMS with additional resources, and allowing it to retain managerial responsibility for both parts of the program, and (c) encouraging Congress to more effectively and consistently monitor the performance of both FFS Medicare and M+C plans with respect to broad program goals and priorities, without micromanaging the program's operations.

Recommendation: Congress should create a more stable environment for the M+C program by refraining from legislating frequent changes in the program's structure and payment rates.

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