RESTRUCTURING MEDICARE FOR THE LONG TERM PROJECT

Report of the Medicare
Steering Committee

Restructuring Medicare Next Steps

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NATIONAL
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Foreword

Over the past four years, the *Restructuring Medicare for the Long Term* project of the National Academy of Social Insurance has examined the economic, political, social and philosophical issues involved in restructuring the Medicare program. A diverse Steering Committee directed this work, which was carried out by study panels of experts from fields including economics, finance, law and public policy, medicine, gerontology, public health, and sociology. The project has produced objective and timely analyses of some of the most important questions facing those who will be charged with restructuring Medicare.

The intent of this project has been to raise questions and to introduce issues that can inform discussions among policymakers, such as members of Congress, their staff, and executive branch officials, and researchers, policy analysts, and others interested in the future of Medicare. Each of the four study panels has addressed an interrelated set of technical and policy questions including issues related to capitation, fee-for-service Medicare, the program's larger social role, and Medicare's financing. The panels have produced their own reports, drawing policy-relevant conclusions based on analysis of available evidence. This report of the Steering Committee provides an overview of the panels' work. The findings and recommendations of the panels, when viewed as a whole, suggest that structural reform will be necessary in order to preserve Medicare as an adequate national social insurance program. The reports also raise specific questions that need to be addressed regarding the implementation of reforms affecting the organization and management of either the traditional Medicare fee-for-service system or a new system that would rely on structured competition among health care plans.

The Steering Committee will continue to explore these issues, and do what it can to contribute to the policy process and public understanding of Medicare.

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Robert D. Reischauer
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Executive Summary

The Medicare Steering Committee chaired by Robert D. Reischauer, Senior Fellow, The Brookings Institution, convened four study panels for the Academy's *Restructuring Medicare for the Long Term* project in 1995 to conduct an objective and systematic review of options for basic structural reform in the Medicare program. The four study panels were:

- the Study Panel on Medicare Capitation and Choice, chaired by Joseph P. Newhouse, John D. MacArthur Professor of Health Policy and Management, Harvard University.
- the Study Panel on Modernizing Fee-for-Service Medicare, chaired initially by Janet L. Shikles, former Director of the Health and Human Services Division, U.S. General Accounting Office, and current Vice President for Health Care Research and Consulting, Abt Associates, Inc., and chaired since early 1997 by Paul Ginsburg, President, Center for Studying Health System Change.
- the Study Panel on Medicare's Larger Social Role, chaired by Rosemary A. Stevens, Stanley I. Sheerr Endowed Term Professor in Arts and Sciences, University of Pennsylvania.
- the Study Panel on Medicare Financing, chaired by Marilyn Moon, Senior Fellow, Urban Institute.

The mandate of the four panels was to address the long-term challenges that the Medicare program faces, in view of pressures to restrain health care spending, the projected insolvency of the Hospital Insurance (HI) Trust Fund, and the retirement of the Baby Boom generation. In its Interim Report, *Securing Medicare's Future* (released March 1997), the Steering Committee indicated that the major challenges are Medicare's long-term financing, protection of Medicare beneficiaries against excessive out-of-pocket health care expenses, and support by the Medicare program of other social goods.

Each Academy study panel drew up its own agenda and scope of work, which included studies conducted by panel members and well as background papers, research syntheses, and special studies commissioned from outside experts. The study panels also issued separate reports, all but one of which have been published. The remaining report — from the Study Panel on Medicare Financing — is scheduled for release in the winter of 2000.

Neither the panels nor the Medicare Steering Committee endorsed a specific proposal for reforming or restructuring the entire Medicare program. The panels addressed the difficult technical, administrative, and political issues involved in crafting a workable Medicare reform plan from a variety of perspectives, and developed recommendations designed to pave the way for long-term reforms. Drawing on the panels' work, and the important contributions of the Bipartisan Commission, as well as other proposals and problems that came to light during and after the Commission's deliberations, this report provides a structure in which discussions about the future of Medicare can move ahead.

The work of the four study panels taken together explores six issues revolving around:

1) ways to frame the debate about restructuring Medicare, 2) program benefits, 3) provider reimbursement, 4) program costs, 5) revenue and cost-sharing, and 6) management and program administration. The Study Panels' conclusions about these issues set the dimensions of this final report, *Restructuring Medicare: Next Steps.*

Collectively, the panel reports underscore the need to address Medicare reform in the wider context of how health care is organized, paid for, and used in America. The study panels believe that restructuring Medicare is warranted and desirable, but will entail significant challenges in terms of education, consumer protection, and public understanding of Medicare.

All four study panels concluded that the current Medicare benefits package is inadequate. The study panels explored how different approaches to structuring Medicare benefits could affect beneficiaries, including the possibility that variations in benefits could adversely affect equity in both the Medicare FFS and competitive (Medicare+Choice) systems. The panels also identified supplemental insurance as a factor that adds layers of complexity and uncertainty to the debate about Medicare restructuring.

The panels found that market-based competition raises difficult issues with respect to payment equity and the distribution of risk in Medicare markets, and that these will need to be addressed systematically if the reforms are to be successful.

The study panels generally agreed that, because Medicare program costs reflect the factors and trends shaping health care costs in the nation as a whole, policies designed to constrain Medicare costs significantly below historical rates of growth could undermine the health and financial protection promised to beneficiaries.

The panels focused on developing a framework for evaluating revenue and cost- sharing options that can take into consideration the different values and objectives implicit in the debate about Medicare reform. They concluded among the issues that need to be taken up in public discussion is the extent to which beneficiaries can and should be asked to contribute a larger proportion of Medicare costs.

The panels concluded that, regardless of other program reforms, structural changes would be necessary to give the Health Care Financing Administration (HCFA) the capacity to better manage the health care financed through its FFS program. The study panels also identified significant challenges, in terms of administration and oversight, posed by the implementation of a local or regionally-based system of structured market competition.

Building on the findings, recommendations, and issues raised by the study panels, the Steering Committee plans to organize further Academy analytical work on the future of Medicare in three broad areas:

- How Medicare can address issues of provider payment, equity, and consumer protection in the complex array of locally-structured health care and insurance markets;
- How to assure access to appropriate care for Medicare beneficiaries with complex, chronic, and long-term health care conditions and disabilities; and
- How the administration and management of the program can work effectively in increasingly competitive markets.

Addressing these topics will require careful examination of complex technical issues, but the Steering Committee believes that the breadth and depth of the contributions of the four Academy study panels clearly demonstrate the value of working through these issues as part of a comprehensive effort that remains focused on the purpose and implications of Medicare reform. The debate about the future of Medicare needs to be grounded in the far more difficult public discussions about how much we as a nation are willing to pay for health care for the elderly and disabled, as well as for everyone else, how we want decisions about placing limits on health care spending to be made, and how much of the health care for the disabled and elderly populations should be borne as a collective social responsibility. The Medicare Steering Committee will continue to do what it can to contribute to discussions about how to secure Medicare for future generations.

Introduction

Mounting pressures to curb health care spending, the threat to the solvency of the Hospital Insurance (HI) Trust Fund posed by the retirement of the Baby Boom generation, and concerns about the serious gaps in coverage that leave beneficiaries exposed to potentially devastating health care costs will shape the evolution of the Medicare program over the next three decades. Recognizing the complexity of the issues involved, and convinced that addressing the challenges facing the Medicare program would require objective and systematic review of options for basic structural reform, the National Academy of Social Insurance initiated the *Restructuring Medicare for the Long Term* project in 1995. This effort has drawn on the Academy's expertise in the analytics of health care financing, innovative public policy approaches to delivering health services efficiently, and the institutional and historical context in which the Federal government implements Medicare policies. Overall direction for the project has been provided by a 20-member Steering Committee, which is made up of academic and policy leaders from such fields as economics, finance, law and public policy, medicine, gerontology, public health, and sociology.

Separate study panels of 10 to 15 Academy members and other experts examined four different aspects of Medicare restructuring: competition and choice in managed health care options, modernizing Medicare's fee-for-service (FFS) program, Medicare's larger role in American society, and Medicare financing (See Appendix A for lists of panel members). The project has published an interim report of the Steering Committee (March, 1997) and the final reports of three of the four study panels (released in January 1998, April, 1998, and February, 1999). The fourth study panel, which is examining financing issues, plans to release its final report in the winter of 1999-2000. In addition, the project has commissioned 11 background papers and issued six *Medicare Briefs* and a documentary video and accompanying resource materials on public understanding of Medicare reform (See Appendix B for a list of project publications).

THE RESTRUCTURING PROJECT

As the panels have systematically worked thorough a wide range of philosophical, social, political, administrative, and economic issues that surround the program, some major changes have taken place in both the Medicare program and the policy environment. The Balanced Budget Act of 1997 (BBA) introduced a sweeping set of changes in provider reimbursement and beneficiary contribution provisions designed to slow the growth in program outlays. In addition, the BBA made a new set of health plan options available to beneficiaries as alternatives to the traditional FFS system

The BBA also established a 17 member National Bipartisan Commission on the Future of Medicare, charged with making comprehensive reform recommendations to the President in early 1999. During 1998 and early 1999, members of the project's Steering Committee and study panels and Academy staff provided testimony, briefings, background materials, analyses, and reports to the Bipartisan Commission and congressional staff involved in the effort. After 18 months of deliberations, the Commission

Box 1: The Breaux-Thomas Proposal: Key Provisions

The final (March 16, 1999) plan put before the Bipartisan Commission for a vote proposed a government-chartered national board to administer a system in which privately-run health plans and the
government-run FFS plan would compete for Medicare enrollees on the basis of costs, benefits offered, and quality of service.

1. "A Premium Support System." All plans — including the federal FFS plan — would be required to provide the current Medicare benefits package, as well as a high-option package that included an outpatient prescription drug benefit (to be defined) and an out-of-pocket spending cap. Plans would be able to offer some variations from the required benefits package, but only with the approval of the oversight board. Beneficiary monthly payments would depend on the premium of the plan selected. Beneficiaries would be expected to pay 12 percent of the total cost of standard option plans that charged premiums equal to the national weighted (by enrollment) average premium. For plans with premiums at or less than 85 percent of the average plan price, beneficiaries would pay no premium; for plans with prices above the weighted national price, premiums would include all costs above the national weighted average, in addition to 12 percent of the average premium. Low-income beneficiaries (below 135 percent of the poverty line) would be allowed to enroll in the high-option plan(s) available in their region. For such beneficiaries, the federal/state Medicaid program would pay 100 percent of the high-option plan premiums that were at or below 85 percent of the national average premium of all high-option plans. In areas where there were no high-option plans at or below the 85 percent threshold, the federal government would pay the premium of the least expensive high-option plan for qualified low-income beneficiaries.

2. Short-term reforms. The federal government would provide funding for prescription drug cov-

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disbanded in March 1999 without issuing an official report (see Box 1). The chairmen, Sen. John Breaux (D-LA) and Rep. Bill Thomas (R-CA), could not muster the 11-vote supermajority necessary under the BBA to make their recommendations official. Not long after, the Medicare Trustees issued their 1999 annual report, which projected that, because of increased revenues attributable to strong economic conditions and lower than anticipated program payments to providers, the HI Trust Fund would likely remain solvent for longer than expected previously, that is, until 2015 rather than 2008 as their previous report had indicated.

Having opposed the draft proposal crafted by the chairmen of the Bipartisan Commission, the President unveiled his plan to restructure Medicare in June 1999 (Box 2). The Administration's plan called for an outpatient pharmaceutical benefit, a competitive method of setting the federal payments to capitated health plans, and increased authority for the Health Care Financing Administration (HCFA) to act as a prudent purchaser of services in the FFS component (*e.g.*, through greater flexibility in establishing mechanisms for competitive bidding for supplies or services). As the various proposals define the terms for debate, the future of Medicare promises to be a topic of lively discussion in the presidential and congressional elections in 2000.

The reform options discussed by the study panels included incremental changes such as increasing beneficiary cost-sharing, raising eligibility age, and expanding benefits or modernizing Medicare's administrative structure;

more fundamental restructuring options, including structured competition (with or without defined benefits); and replacing Medicare with individualized medical insurance. The Breaux/Thomas and Clinton proposals would both restructure Medicare to incorporate some version of the structured competition approach labeled "premium support." There is, however, considerable controversy regarding both the underlying assumptions justifying the introduction more market competition in Medicare, and the feasibility of overcoming the technical hurdles inherent in the different restructuring proposals. Some experts, including individuals serving on the Steering Committee, believe that incremental reforms to strengthen and modernize the current Medicare program would be sufficient to secure it for future generations, and that fundamentally restructuring the program could undermine the health and income security of beneficiaries.[1] Others believe that such restructuring is necessary, and could yield significant improvements in the effectiveness as well as efficiency of health care provided to beneficiaries. The debate is further complicated by the rapid changes occurring in the organization and management of the wider health care system. How Medicare's traditional fee-for-service program can, or should, work in tandem with the managed care environment that dominates the employment-based health insurance system is highly controversial.

Neither the panels nor the Medicare Steering Committee endorsed a specific proposal for reforming or restructuring the entire Medicare program. The panels addressed the difficult technical, administrative, and politi-

Box 1 (continued)

erage for beneficiaries up to 135 percent of poverty, and would expand available subsidies for premiums and cost-sharing for low-income beneficiaries. In addition, all supplemental Medigap policies would be required to include basic coverage for prescription drugs, based on model legislation to be developed by the National Association of Insurance Commissioners. The proposal also included provisions to merge Parts A and B into a single Medicare Trust Fund. The current system, in which there are separate cost-sharing provisions for the two parts, with a relatively high ($768 in 1999) deductible for Part A, and a separate $100 deductible for Part B, would be replaced with a single deductible of $400, indexed to Medicare costs over time. Current service-specific coinsurance would be replaced by a uniform 10 percent coinsurance for all services not currently subject to a 20 percent coinsurance. The plan also called for changing the eligibility age for Medicare to conform to scheduled increases in the age at which unreduced Social Security retirement benefits will be paid, *i.e.* phasing in over the 2000 to 2022 period an increase to age 67.

3. Program Solvency. The definition of solvency for Medicare would be changed to conform to the Commission's recommendation that Parts A and B be merged. Under current law, Part A is funded primarily through earmarked payroll taxes which are deposited in the Medicare HI (Part A) trust fund from which expenditures must be paid. The program becomes insolvent when the balances available in the Part A Trust Fund are depleted. Part B cannot become insolvent because it is funded by general revenues and beneficiary premiums. Under this reform plan, the Trustees would publish annual projections of the ratio of general revenues to total funding for Medicare and notify Congress that the Medicare program is in danger of "insolvency" for any year in which general revenues constituted more than 40 percent of total projected Medicare outlays. Upon receiving such notification, Congress would be required to address Medicare funding under an expedited process. Congress would have to vote on any tax increases or spending cuts designed to strengthen the Medicare Trust Fund.

1 See, for example, Marmor, T. and and Oberlander, J., "Rethinking Medicare Reform," Health Affairs 17(1), January/February, 1998.

Box 2: The Clinton Medicare Proposal: Key Provisions

The President's July 1999 Medicare reform plan centered on improving the efficiency of the traditional FFS program, expanding competition on price and quality among managed care plans; modernizing the benefits package; and strengthening Medicare financing through program savings and use of projected budget surplus.

1. Efficiency in Traditional Medicare. For the traditional program, provisions would give Medicare greater authority and flexibility to adopt private-sector practices. These would include a Medicare Preferred Provider Option (PPO); and expansion of the current "Centers of Excellence" program; payments and care systems such as primary care case management and disease management; emphasis on generating information on coverage and services for Medicare beneficiaries also eligible for Medicaid and authorization of a coordinated care demonstration program for this population; innovative purchasing tools and contracting reforms, *e.g.*, competitive pricing, and bundled payments for services provided at a site of care; and a demonstration of bonus payments for physician group practices based on efficiency and quality of care.

2. Competitive Defined Benefit Proposal. Medicare+Choice (M+C) plans would be paid based on competitive prices rather than on fixed prices determined by a formula established in law. M+C payments would be based on what plans would bid for either of two standardized Medicare packages (one with a new drug benefit). Payments to plans would be adjusted to reflect beneficiaries' medical risk and geographic cost variations. For plans that offer prices higher than 96 percent of costs of the traditional program costs, beneficiaries would pay the additional cost; for plans charging less than 96 percent, a beneficiary would pay less than the regular Part B premium; three-fourths of the "savings" from choosing a lower-cost plan would go to the beneficiary and one-fourth to Medicare.

3. Adjustment of Statutory Spending, Payment and Administrative Provisions. The proposal

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cal issues involved in crafting a workable Medicare reform plan from a variety of perspectives, and developed recommendations designed to pave the way for long-term reforms. Drawing on the panels' work, and the important contributions of the Bipartisan Commission, as well as other proposals and problems that came to light during and after the Commission's deliberations, this report provides a structure in which discussions about the future of Medicare can move ahead.

THE ACADEMY'S PERSPECTIVES

The Academy's *Restructuring* project was crafted to address the long-term challenges faced by the Medicare program. These challenges were laid out in the Steering Committee's interim report, *Securing Medicare's Future*, issued in March, 1997:

- The Challenge of Medicare's Long-Range Financing

Medicare spending is projected to consume a larger and larger proportion of national income. In 1999, the Medicare Trustee report projected that, without significant restructuring of the program, Medicare would grow from 2.53 percent of gross domestic product in 1998 to 5.15 percent in 2035 and 5.67 percent in 2070.[2] This increase would reflect a growing aging population to be served by Medicare, as well as increases in the costs of health care resulting at least in part from advances in medical science. As the Baby Boomers retire, the number of workers per Medicare beneficiary will drop sharply. Medicare's HI Trust Fund receives the vast majority of its income from

2 The Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1999 Annual Report of the Federal Supplementary Medical Insurance Trust Fund* (Washington, DC: March 30, 1999).

payroll taxes on employers and workers. The way in which technology-intensive innovations and care for chronic conditions drive health care costs will continue to reflect both costs of developing, manufacturing and applying available technologies, and when and how these services are actually provided. If the history of medical cost increases over the past four decades is a guide to future spending trends, revenues into the Medicare program under current policy will not be sufficient to support the program.

- Protecting Against Out-of-Pocket Health Care Expenses

An original goal of Medicare was to protect older and disabled people and their families from catastrophic medical expenses. Medicare's architects designed the program to resemble the most common private health insurance available to working Americans in 1965. Its package of benefits focused on acute care provided in hospitals and physicians' offices with no coverage of prescription drugs or long-term care. Health care needs and medical practice have changed significantly since then. Health care for Medicare beneficiaries reflects the changes and new medical technology, including complex and costly long-term care to manage disability, new screening technologies, and sophisticated pharmaceutical regimens. Beneficiaries' out-of pocket health care costs include not only the premiums they pay for health insurance (Medicare Part B, plus any additional insurance they may purchase), and the costs of deductibles and coinsurance associated with their health insurance, but also the costs of uncovered services. Increases in all these out-of-pocket costs has resulted in beneficiaries now spending a higher proportion of their after-tax incomes on health care than they did before Medicare was enacted.

Box 2 (continued)

would moderate the cost-containment provisions of the 1997 BBA by postponing or adjusting certain scheduled changes in payments to hospitals, home health agencies, or skilled nursing facilities, and remove the portion of managed care plan payments for indirect medical education and direct these funds to qualifying hospitals. Reform of Medicare management would include increasing Medicare's flexibility to hire experts from the private sector, and fostering accountability through the creation of public/private advisory boards to identify and recommend best management practices, advise on coverage policy, and monitor and evaluate consumer education activities.

4. Modernizing Medicare Benefits. The proposal would add a new Medicare prescription drug benefit that would pay one-half of all prescription drug costs, up to $5,000 per year ($2,500 in Medicare benefits), adjusted by inflation, with full implementation in 2008. Beneficiaries electing the optional drug benefit would pay a monthly premium of $53 per month by 2008 (CBO estimates). The federal government would pay the drug premium and cost-sharing for drugs for beneficiaries with incomes from 100 to 135 percent of poverty, and people with incomes from 135 to 150 percent of poverty would pay a portion of the premium (on a sliding scale tied to income). Those enrolling in M+C plans would be covered through their plans; for the traditional plan, Medicare would contract with private pharmacy benefits management organizations to administer the benefit. Medicare would pay a reduced premium subsidy for beneficiaries who receive coverage through employers' health plans. Cost-sharing for a number of preventive services would be eliminated. Reforms to private supplemental insurance (Medigap) plans would include the creation of a new lower-cost option with nominal cost sharing, and provisions to improve access to Medigap for beneficiaries whose private plans withdraw from Medicare. A Medicare buy-in for certain people aged 55-65 without access to health insurance would be created, to be paid for entirely by premiums ($300- $400 per month); people electing coverage would have to pay a risk-adjusted payment when they reach age 65.

5. Revenues. Fifteen percent of the projected non-Social Security budget surplus would be dedicated to Medicare. The plan would also add a 20 percent copayment for clinical laboratory services and index Part B deductibles to inflation.

- Medicare's Subsidization of Other Social Goods

Medicare subsidizes other policy objectives, including training doctors and providing care to patients who lack health insurance. The institutions which the government has deemed to perform these valuable functions often face higher than average costs. Payments to hospitals for the costs of medical education and the additional payments to hospitals treating disproportionate numbers of low-income patients totaled almost $11 billion in 1996, about 16 percent of Medicare's total payments to hospitals. Traditionally, "disproportionate share" and teaching hospitals have depended on private insurance, in addition to Medicare, for support. However, health maintenance organizations (HMOs) and other types of managed care's selective use of these higher cost institutions decreases revenues to disproportionate-share and teaching hospitals, leaving Medicare to bear a greater share of the responsibility for their costs.

The Steering Committee developed a plan that drew on the diverse expertise available to the Academy to examine both philosophical and technical aspects of these challenges, and created four study panels:

- Study Panel on Medicare Capitation and Choice

A growing body of research and analysis, including work of a number of Steering Committee members[3], pointed to the potential to use existing models for providing employee health insurance based on managed competition among health plans (such as the Federal Employees' Health Benefits Program or the California Public Employees' Retirement System) as a template for restructuring Medicare. Private health insurance has moved from a largely fee-for-service system to one characterized by selective purchasing of health insurance in an effort to slow cost increases and to improve quality. A range of reform proposals would incorporate some of these same ideas into Medicare. The principles underlying these proposals for Medicare include: 1) **capitation** in which purchasers (often employers) pay a fixed amount each year to a health plan to cover needed services, 2) **choice** for enrollees among multiple health plans to foster competition and encourage cost-savings, and 3) arrangements in which the government **shares the financial risk** of enrollees' health care with the health plan, and potentially with providers and enrollees, to limit the government's costs.

The Study Panel on Medicare Capitation and Choice, chaired by Joseph P. Newhouse, John D. MacArthur Professor of Health Policy and Management, Harvard University, was charged with examining options and issues in introducing market-based competition among health care organizations serving Medicare beneficiaries. The panel examined several of the most important issues inherent in establishing the infrastructure for such a system, including how alternative models for

3 For example, Aaron, H.J., and Reischauer, R.D., "The Medicare Reform Debate: What is the Next Step?" *Health Affairs,* 14(4): 8-30, Winter 1995; and Butler, S.M., and Moffit, R.E., "The FEHBP as a Model for a New Medicare Program," *Health Affairs,* 14(4): 8-30, Winter 1995. Additional work commissioned by the Academy includes Feldman, R., and Dowd, B., "Structuring Choice under Medicare," and Robinson, J.C., and Powers, P.E., "Restructuring Medicare: The Role of Public and Private Purchasing Alliances," published in *Medicare: Preparing for the Challenges of the 21st Century,* R.D. Reischauer, S. Butler, and J.R. Lave (eds.) (Washington, DC: Brookings Institution Press, 1998).

structuring markets (*e.g.*, vouchers and premiums support models) might work in the Medicare program; how problems of risk selection could be addressed; and how beneficiaries' access to care and the quality of that care could be protected in more competitive markets. The Study Panel on Medicare Capitation and Choice issued its final report, *Structuring Medicare Choices*, in April 1998.

- Study Panel on Modernizing Fee-For-Service Medicare

Despite the rapid growth of Medicare's capitated managed care program, about 83 percent of beneficiaries still received care through the traditional FFS program at the beginning of 1999. Even if the capitated program were to continue to grow, there would likely be a role for FFS well into the future. Some beneficiaries may not find a health plan in their area that is able to meet their particular health needs adequately. Such beneficiaries may include those with chronic ailments or disabilities. With FFS likely to remain a major part of Medicare, assuring quality of care and efficient management of utilization, costs and administration will remain priorities. The Study Panel on Medicare-for-Service Medicare, chaired by Paul Ginsburg,[4] President, Center for Studying Health System Change, was charged with analyzing options for Medicare's FFS program for the next century. The Panel had three foci: 1) the applicability of tools for managing care in private FFS insurance for Medicare, 2) the ways in which these tools might conflict with other public policies including sunshine laws, due process, procurement and personnel policies, and the need to maintain accountability to the American people, and 3) potential changes in Medicare's administrative structure and authority to incorporate those tools that hold promise. The Panel released its final report, *From A Generation Behind to a Generation Ahead: Transforming Traditional Medicare*, in January 1998.

- Study Panel on Medicare's Larger Social Role

A third panel, convened in January 1997, was charged with a rather different sort of task: to "go back to the basics," and explore the underlying philosophical principles and rationales for the Medicare program and how it fits into the larger social insurance and welfare structures. The Study Panel on Medicare's Larger Social Role, chaired by Rosemary A. Stevens, Stanley. I. Sheerr Endowed Term Professor in Arts and Sciences, University of Pennsylvania, examined a broad range of issues in historical context, including the adequacy of the insurance benefit and public perceptions and understanding of the program. The Panel agreed early in its discussions that its most important contribution could be to provide a clear description of what Medicare is, and how it has been viewed over time by the public and by policymakers. To what extent is it seen as a social insurance program? A health program? A guarantor of income security in disability and old age?

The panel reviewed public opinion data and conducted its own research on how Americans perceive the value of the program to themselves and to their families. It also examined how Medicare functions as a public program, on the one hand, and as a vital support to the largely private health care system, on the other. The panel then developed a set of criteria that can be used to identify values

4 Janet L. Shikles, currently Vice President for Health Care Research and Consulting, Abt Associates, Inc. chaired the Panel on Modernizing Fee-For-Service Medicare from its beginning in the spring of 1996 until February 1997.

people may believe should be preserved or strengthened as Medicare is reformed. The panel's final report, *Medicare and the American Social Contract*, was issued in February, 1999.

- Study Panel on Medicare Financing

The final panel created for the *Restructuring Medicare* project was set up to examine options for financing health care services for individuals over 65 and those with permanent disabilities in the next century. The Study Panel on Medicare Financing, chaired by Marilyn Moon, Senior Fellow, Urban Institute, was able to draw on the previous panels' work as well as on developments in the policy debate to address specific financing and revenue options. The panel identified two major topics: First, what public and private resources are needed and available to meet the health care financing needs of the disabled and elderly over time? The panel is examining this question for the current program as well as for various proposals to change Medicare's structure, eligibility, and benefits. Second, what options exist for financing the health care needs of Medicare beneficiaries? What are the implications of these options for: 1) individual versus social responsibility; 2) intergenerational equity; 3) distribution of resources, including the implications for other public and private payers of health care services; 4) recognition of the need for long term and chronic care not currently covered by Medicare; and 5) the needs of lower-income and other vulnerable populations? An interim report issued as *Medicare Brief No. 5: The Financing Needs of a Restructured Medicare Program*, in Summer of 1999 considers what needs to be financed. It includes projections of the cost of the current Medicare program as well as the cost implications of various options for marginal changes in the current program and proposals for fundamental restructuring. The final report, due later in Winter, 1999-2000, will consider the implications of alternative financing options.

THE STUDY PANELS' CONTRIBUTIONS

Each Academy study panel devised its own approach to exploring the questions with which it was charged, and under the direction of each panel chair, established an analytical agenda. In addition to the work conducted by the panel research staffs and panel members themselves, the panels commissioned background papers, research syntheses, and some special studies, including a set of actuarial analyses, a national poll, and a series of focus groups with Medicare beneficiaries and soon-to-be beneficiaries. The panel reports were drafted independently, and represented the consensus views of the individual panels. There was, however, a set of issues that arose in panel discussions that reflects, in retrospect, many of the key controversies that the Bipartisan Commission identified and which will set the terms for future debate about Medicare. These appear under six major headings, described in the chapters below:

- **Chapter 1: Framing the debate about restructuring Medicare**

  Who (individuals, families; and/or local, state or federal government) pays for what in an aging society?

  What is the appropriate role of social insurance as a means of ensuring adequate access to health care in the changing social, economic and political context of the 21st Century?

- **Chapter 2: Benefits issues**

  What should the Medicare benefits package include (relative to the compre-

hensiveness of health insurance offered to working populations)?

In terms of benefits, what can be done to address the major gaps that undermine comprehensive care management for beneficiaries, *i.e.*, prescription drugs and medical care related to the management of serious chronic disease?

What variations in the benefits package are acceptable and desirable in a national entitlement program, in terms of 1) differences in the types of benefits individual beneficiaries would select for themselves, and 2) differences in benefits (related to variations in costs) that may be offered in different geographic areas?

How will supplemental insurance fit into a restructured Medicare program?

- **Chapter 3: Reimbursement issues**

  In a more competitive system, how can Medicare, or Medicare in combination with other payers, structure payments to health plans and providers to ensure that beneficiaries with extensive health care needs have access to appropriate care?

  How can Medicare structure payments to reward efficiency and quality without unduly disrupting providers' ability to function efficiently in local health care markets?

- **Chapter 4: Program cost issues**

  What are the most significant factors driving Medicare costs?

  How will proposed changes address increasing Medicare costs?

- **Chapter 5: Revenue and Cost-sharing issues**

  How much are beneficiaries paying (Medicare premiums, premiums for supplemental insurance and out-of-pocket) and how are the amounts they will pay likely to change over the next 30 years?

  How much should beneficiaries be expected to pay?

  How much should wage-earners pay though payroll taxes and how much should the general taxpayer pay to sustain the Medicare program?

  How much are others, including former employers and the Medicaid program, paying for health care for Medicare beneficiaries?

- **Chapter 6: Management/program administration issues**

  How will the "traditional" FFS system fit into a restructured program?

  What will the role of HCFA be in a restructured program, and, in particular, in the operation of the FFS component of a restructured program?

  How will the various Medicare+Choice options work for the beneficiary population — what will be needed in the way of oversight and consumer education and protection

The following pages review the research and analysis that the Academy study panels brought to bear on these topics, summarize the conclusions and recommendations the panels were able to reach, and discuss the main areas of "contention" in the panels' deliberation. This summary also identifies the additional work that needs to be done to move ahead in each of these areas. The final chapter of the report presents the Steering Committee's summary conclusions.

Chapter 1:
Framing the Debate About Restructuring Medicare

The debate about the future of Medicare can be framed in very different ways. One approach is to focus on the current program in terms of projections of future program costs and the financing of these costs. This directs attention to how to improve the efficiency of the current system, to reduce the rate of increase in program outlays, or to increase revenues in order to ensure the viability of the program over time. Another approach is to frame the debate more broadly, to revisit the original goals of the program in view of present circumstances and projections of what is likely to happen in the future. The Academy study panels used both these perspectives in framing their discussions. They tried to identify ways in which Medicare could be reformed to be more efficient — better able to use available management tools and to take advantage of the power of competitive markets to control program costs. In doing this, however, they remained focused on the original goals of the Medicare program: to provide a way for the nation's elderly and disabled to enjoy the health and financial security offered by private health insurance.

PANEL FINDINGS AND CONCLUSIONS

Collectively, the panel reports underscore the need to address Medicare reform in the wider context of how health care is organized, paid for, and used in America.

In response to its charge from the Steering Committee, the Social Role Panel delved deeply into the broader political and philosophical as well as economic implications of Medicare reform. The panel's final report describes interconnections between Medicare and the larger health care system, which, along with particular characteristics of the American health care (and political) environment, make the task of restructuring the program daunting. Medicare has grown to account for a large proportion of the total health care system in the United States. A third of all expenditures for hospital care are currently paid by this one program.[5] But from its beginning, the panel noted, Medicare was designed to be "a new, reinforcing pylon in the private American health insurance system. Together with employment-based insurance and supplemental insurance, Medicare forms the foundations of an enormous, interdependent insurance system run (directly or via contract with the government) by the private sector that accounts for a large, and growing, proportion of America's gross domestic product." A second role for Medicare, from its inception, has been as a partner in a network of other public social insurance and social welfare programs, most importantly, Medicaid. Created in the same legislation that established Medicare, Medicaid provides certain services to low-income Medicare enrollees that Medicare does not cover. Together, the two

5 National Health Statistics Group, Office of the Actuary, National Health Expenditures, 1997. *Health Care Financing Review* 20(1), HCFA pub no. 03412 (Washington, DC: U.S. Government Printing Office, March 1999.

programs pay for about 28 percent of all national health care expenditures.[6]

In addition, the panel pointed to other social roles of the Medicare program that have become vital to the wider health care system. That is because, though limited in its population coverage, Medicare is structured to be a form of national health insurance. As such, it carries public burdens over and above the provision of health insurance to its beneficiaries. Medicare paid hospitals about $124 billion in 1997. In addition to basic reimbursement for hospital services, Medicare makes special payments to rural hospitals and other hospitals termed "sole community providers" to help ensure their viability and continued access to care for beneficiaries and others in the community who rely on these institutions. It also subsidizes hospitals that serve a disproportionate share of patients with low incomes who rely on public insurance or resources to pay for their care ($4.5 billion in 1997).

Medicare made Direct and Indirect Medical Education payments of $7.1 billion in 1997. As these payments have become an intrinsic part of the revenues subsidizing academic medical centers, they have taken on a critical role in supporting a vast national system of basic biomedical as well as clinical research. Medicare also pays for research and innovation through its support of demonstrations and evaluations of payment methods and delivery system reforms, and through the subsidization of the design, implementation, and maintenance of data systems essential for health services research.

Interactions between Medicare and the larger health care system are extremely difficult to explicate, much less anticipate for the future. Changes in Medicare could, for example, directly affect the medical research infrastructure, but changes in provider payments or reimbursement levels could also influence the rate of adoption and diffusion of medical technologies, and the extent to which beneficiaries are granted access to medical innovations and advanced technologies. At the same time, the changing structure of private and employer-based insurance markets is changing relationships among health care organizations and practitioners. New sorts of compensation and reimbursement to physicians, along with contracting and subcontracting among provider groups can complicate the coordination of services and creates new administrative and oversight challenges for Medicare. In many health care markets, payers and provider organizations have responded to increases in health care costs by restricting or reducing coverage and benefits, as well as by developing management techniques designed to control utilization of services and promote efficiency in care delivery. Most Americans with employer-based health insurance are enrolled in some form of managed care. But while Medicare has offered some managed care options for over a decade, only about 17 percent of beneficiaries are currently enrolled in managed care plans. The potential benefits as well as risks of managed care for Medicare, and for its beneficiaries, are at the core of the debate about restructuring the program.

The Fee-for-Service (FFS) Medicare, Capitation and Choice, and Social Role

6 Smith, S., et al., "The Next Decade of Health Spending: A New Outlook," *Health Affairs* 18(4): 86-95, July/August 1999.

panels all discussed aspects of the implications of the evolution of managed care for the organization and delivery of health care services for the Medicare program. All cited the potential benefits, if realized, to the beneficiary population of managed care's emphasis on the effective use of preventive services, coordination of care, and efficiencies in management and administration. The FFS Medicare Panel cited the importance of building on and expanding HCFA's research and demonstration program to evaluate the potential for using health care management methods and technologies to improve the effectiveness of health care provided to beneficiaries. These include allowing states to seek waivers from federal requirements in order to coordinate care for beneficiaries dually eligible for Medicare and Medicaid, and experimenting with bundling payments from Medicare and Medicaid to test new approaches for coordinating care for the frail elderly or people with chronic illnesses or disabilities.

As part of its deliberations, the Capitation and Choice Panel reviewed the evidence from HCFA demonstrations, including programs for providing capitation payments for people with End-Stage Renal Disease (ESRD), and the Program for All-Inclusive Care for the Elderly (PACE). That panel also commissioned a paper that reviewed how managed care "carve-outs" for specialized services might be provided under separate capitation arrangements for beneficiaries with certain care needs or conditions.[7] Both the Capitation and Choice and Social Role panels also discussed potential problems that might be associated with managed care, particularly for people with extensive health care needs; people who might have difficulties understanding how to navigate a market-based system due to functional limitations (*e.g.*, physical or cognitive impairments), low literacy levels, or inability to speak or read English; or people who, by income or geographic isolation, are limited in their ability to "shop around" for a health plan that will meet their needs.

The BBA expanded the range of managed care options available to Medicare beneficiaries, under the provisions called "Medicare+Choice." It also changed the mechanisms for determining capitation payments to plans. Under the previous payment methodology, which was designed to reflect local average per-beneficiary Medicare costs (in the FFS program), payments to plans in some areas of the country often significantly exceeded the costs of providing covered benefits for those actually enrolled in the plans. If a plan's expected revenues exceed costs (plus allowable profits), it is required to return the excess to the government, or to use it to provide additional benefits. Many plans have, as a result, been able to provide supplemental benefits without passing the costs of those benefits on to beneficiaries. These benefits, including prescription drug coverage, routine physical check-ups, eye exams, and other services, are valued highly by enrollees, and have helped plans recruit new members. The payment reforms in the BBA were designed to bring payments to plans in line with plans' costs for providing the mandated Medicare benefits. This will reduce plans' ability to offer supplemental

7 Beeuwkes, M., and Blumenthal, D., "Carve-outs for Medicare: Possible Benefits and Risks," *Medicare: Preparing for the Challenges of the 21st Century,* R.D. Reischauer, S. Butler, and J.R. Lave (eds.), (Washington, DC: Brookings Institution Press, 1998)

benefits, and could affect the willingness of plans to participate in Medicare.[8]

Different concepts of how managed care organizations and Medicare can and should work together result in critically important differences among restructuring proposals. The Social Role Panel divided the approaches to reform into three general categories. The first — labeled "fine-tuning"— includes reforms designed to keep program spending within acceptable bounds. These reforms could include reducing the rate of increase in provider payment, increasing revenues or beneficiary cost-sharing, limiting eligibility or coverage; modernizing the program, through administrative reforms, adjusting the benefits structure, or expanding the enrollment pool. A second approach to reform — structuring competitive Medicare markets — entails basic reform of the mechanism by which Medicare pays for health insurance, *i.e.*, replacing the current administered pricing system and indemnity insurance with a system in which the federal government pays a formula-based capitated payment to health plans that compete for Medicare enrollees based on the cost and quality of the service they provide. The third approach — individualizing Medicare — refers to approaches that would replace the current system with one that would be based on "pre-funded" individual medical savings accounts (MSAs).

8 By the end of 1998, more than 40 Medicare health plans decided not to renew their contracts with HCFA, and another 52 decided to reduce their service areas, affecting more than 400,000 beneficiaries in 371 counties. In 1999, another 41 plans decided to withdraw, and 58 announced plans to reduce their service areas, affecting an estimated 327,000 beneficiaries. Most of the beneficiaries affected lived in areas in which other plans still served Medicare beneficiaries, but some (an estimated 51,000 affected by the withdrawals announced in 1998, and 79,000 more in 1999) were left without a managed care option after the retrenchments. Many plans have also indicated that they will provide less generous benefits in the next year, and charging higher premiums (above the Part B premium). In 2000 there will be about 3,000,000 fewer beneficiaries who will have access to a plan that charges no additional premium than there is in 1999, and the average premium (weighted by enrollment) will increase from $5.35 to $15.84. The proportion of plans that will have annual caps on drugs benefits of $500 or less will increase from 21 percent to 32 percent, and copayments for drugs will increase significantly (on average, 21 percent for brand-name drugs and 8 percent for generics). (HCFA, *Medicare+Choice: Changes for the Year 2000,* [Baltimore, MD: September 1999]). A survey conducted by the American Association of Health Plans indicated that more than one-third of the beneficiaries in the managed care plans surveyed would face increases of more than $20 per month, and almost 60 percent would see reductions in the drug benefit provided by their plan (American Association of Health Plans, Press Release: *Insufficient Government Funding for Beneficiaries Forces Medicare HMO Cutbacks,* July 1, 1999.) A 1999 study by the U.S. General Accounting Office, however, found that BBA payment revisions had reduced, but not fully eliminated excess payment to plans, and that, overall, the actual enrollment in Medicare managed care plans was expected to increase slightly in 1999. (Statement of William J. Scanlon, Director of Health Financing and Public Health Issues, Health, Education and Human Services Division, U.S. General Accounting Office, "Medicare+Choice: Impact of the 1997 Balanced Budget Act Payment Reforms on Beneficiaries and Plans," before the Committee on Finance, U.S. Senate, June 9, 1999. [GAO/T-HEHS-99-137.]) This estimate was reinforced by HCFA's September,1999 report (*op. cit.*) which stated that even with the plan withdrawals, about a net average of 28,000 new beneficiaries has been enrolling in Medicare managed care plans per month throughout 1999, and the rate of growth in Medicare+Choice plans still exceeds the rate of growth in the number of beneficiaries entering the Medicare program overall. It is also important to note that the rate of terminations of contracts by managed care organizations remain well below the rate of withdrawal from Medicare experienced in the 1980s, and that market withdrawals are commonplace in other insurance markets as well. For example, in 1998, about 20 percent of participating HMOs withdrew from the Federal Employees Health Benefits Program (HCFA, *op. cit.*).

The Clinton "Competitive Defined Benefit" proposal includes elements of both the fine-tuning and structured market approaches. In addition to payment reforms, and provisions designed to "modernize" Medicare benefits and administrative systems and authorities, the plan would expand market competition. Under this initiative, plans would compete against each other, with the federal contribution pegged to a rate slightly below the costs of the traditional fee-for-service program. Beneficiaries choosing to enroll in plans that cost more than the threshold amount would pay the increment. If beneficiaries choose plans costing less than this threshold amount, the beneficiary and the government would split the savings (75 percent of the savings would go to beneficiaries, applied as reductions in their monthly Part B premium). People who opt to remain in the FFS program would pay no more than they would without the reform, but would forego any rebate associated with enrollment in a capitated plan that offered the same (or enhanced) benefits at a lower cost. This provision, which in effect means that beneficiaries choosing to remain in traditional fee-for-service Medicare are "held harmless," is politically important. Many experts are concerned that the FFS option in Medicare could become too expensive for many beneficiaries if the government's payments were pegged to the average cost of FFS and Medicare+Choice plans, as in the Breaux/Thomas proposal, especially if the risk adjustment methods to be implemented do not work well enough to prevent adverse selection in the plans. The Clinton proposal maintains the current system for establishing the government contribution to premiums for the traditional plan, which is set in statute (with beneficiary premiums calculated to cover 25 percent of Part B FFS costs). In this approach, the role of Medicare+Choice plans would be determined by the extent to which these plans could offer a better deal than the traditional program.

In "premium support" models such as the Breaux/Thomas Proposal, or in the model described in the Study Panel on Capitation and Choice's final report (*Structuring Medicare Choices*), a standard Medicare benefits package would be available to all beneficiaries through participating health plans. The competitors would include the traditional Medicare FFS plan, or some similar indemnity plan(s) along with other managed care options. In the Breaux/Thomas proposal, all plans would provide statutorily-defined Medicare benefits, but plans could obtain permission (from the Medicare Board established to oversee the program) to vary the benefits package within a limited range of options, specified in the proposal as not more than 10 percent of the actuarial value of the standard benefit package; approval of variations would be contingent on the Board finding that the overall package remains consistent with statutory objectives and that it would not lead to adverse risk selection problems. The specification of standard benefits in law differentiates this approach from some versions of a "defined contribution" model, in which beneficiaries are provided with a voucher that can be used to purchase whatever insurance the beneficiary chooses (and can afford). The federal contribution toward the cost of whatever coverage the beneficiary selects, however, would be based on a formula that reflects the premium costs of the competing plans (a "defined contribution").

In the Breaux/Thomas approach to structured competition, the traditional Medicare program competes directly with the other

plans. The federal contribution toward all beneficiaries' premiums (with appropriate adjustments for heath risks) would be based on some average of all plan costs, or some other rate reflecting a "typical" or middle-range plan's cost. If costs were higher for the population in fee-for service (as is currently the case), then beneficiaries in FFS may have to pay higher premiums than those enrolling in lower-cost plans. Moreover, if the costs of premiums were to rise more rapidly than beneficiaries' incomes, people with limited resources might, over time, find themselves unable to afford higher-cost options (including FFS). Many of the Bipartisan Commission on the Future of Medicare members who opposed the Breaux/Thomas Proposal expressed concerns that this approach would undermine the basic protections offered by Medicare as a social insurance program, by relegating lower-income beneficiaries to lower-cost, and possibly lower-quality, plans.

In individual account approaches, people would use accumulated funds to purchase insurance after retirement. This type of reform is based on the theory that these future costs should be prefunded, and that the best way to accomplish this is through individual accounts. According to proponents, the government should not become too directly involved in private investment markets, and individuals can earn a higher rate of return on their own investments than public programs. In addition, they argue that private insurance markets can induce greater efficiency than administered pricing systems, *i.e.*, that retirees' individual accounts could provide them with more resources for buying a better insurance product. Providers would work directly with insurers to establish payment rates, and individuals would take on greater responsibility for using services efficiently, because "it is their own money." Under these assumptions, the private health care market would take on all of the responsibility for administering and managing health insurance for the beneficiary population, and the government would assume a basically regulatory role. The actual design of individual accounts systems, however, involve a number of important complications, including how to guarantee a baseline level of saving for health insurance, how to account for possible health insurance price increases that might occur after beneficiaries retire, and the potential implications for Medicaid of inadequate Medicare or private individual saving.[9]

The study panels believe that restructuring Medicare is warranted and desirable, but will entail significant challenges in terms of education, consumer protection, and public understanding of Medicare.

How Medicare beneficiaries will actually make decisions about insurance and the use of health care services, as well as how competitive the health care marketplace of the future will be are matters of speculation. The Social Role Panel found that there are significant gaps, for beneficiaries and the public at large, in understanding Medicare — and Medicare managed care in particular. Reform proposals that rely on consumers making good choices about health plans and their

9 Policymakers would also need to consider whether the administrative costs of managing individual accounts would offset possible rate-of-return advantages from allowing workers to invest their Medicare contributions in stocks and bonds. Individual accounts are discussed in Medicare Brief No. 3, *Individualizing Medicare*, authored by Deborah Chollet, Alpha Center. The *Brief* is based on a paper commissioned by the Financing Panel.

use of health services, the panel concluded, "assume a basic level of sophistication regarding Medicare coverage and the purchase and use of health insurance that current research suggests simply is not there."

Enabling beneficiaries to make good choices (or protecting them from the possibly serious consequences of bad choices) and being accountable to taxpayers could require new local, regional and national oversight and information systems. Constructing, operating, and regulating such systems could increase, rather than decrease government involvement in health care markets, and create additional strain on the relationship between managed care organizations and the Medicare program. The analysis conducted by the Social Role Panel led its members to conclude that it will be essential to find better ways to inform the public about the implications of Medicare reform, and the ways in which changes in Medicare are related to the revolution occurring in the organization and delivery of health care in America. Devising policy changes that could be effective, equitable, and workable may not be sufficient, if policymakers do not know how to explain those changes to the public, or if the policies do not take into account the deeply-held social and political values that Americans bring with them to discussions about Medicare.

ISSUES FOR FURTHER CONSIDERATION

Engaging the American people in a meaningful debate about the future of Medicare will require a great deal of work. Drawing on the findings and conclusions of the study panels, the Steering Committee believes that additional research and analysis focused on two critically important questions will be needed

Decisions about Medicare's future, including its ability to deal with health care utilization and costs, will not (and cannot) be made on purely economic or medical criteria. Medicare has become part of America's infrastructure. It reflects deeply-held social and political values (including value conflicts), and reform policies must recognize these if they are to be successful.

- Medicare is a remarkably popular program, in large part because the public understands that the risks facing the Medicare-eligible population cannot be met in the private health care market at a price that most people can afford.
- The public cannot play a useful and meaningful role in the debate about the future of Medicare, and might, on the contrary, react in ways that could undermine needed reform unless concerted efforts are made to provide people with clear, usable information regarding the implications of reform, including how reforms will affect different individuals and population groups' health and economic security over time.

to help frame the context for constructive debate:

- How can knowledge about the ways in which people make decisions about health care and insurance inform the design of policies to restructure Medicare?
- How can the issues and options for Medicare reform be explained in a simple and objective way to the public, including people who, when they retire or become disabled, may be most directly affected by changes to the program?

Chapter 2: Benefits Issues

Medicare was enacted in 1965; program benefits were designed to be substantially the same as the benefits provided by the dominant employer-based health insurance system. Since that time, the nature of medical care has changed dramatically, but Medicare benefits have, with only limited exceptions, remained essentially the same as they were when the program was created.

PANEL FINDINGS AND CONCLUSIONS

All four study panels came to the conclusion that the current Medicare benefits package is inadequate.

In all of the study panels' reports, the argument is made, in one form or another, that improvements in the Medicare benefits package are necessary not only to provide beneficiaries with the protection from financial destitution originally promised to Americans when they become elderly or disabled, but also to allow health care providers to manage more effectively the kinds of health care problems found in the beneficiary population.

The Fee-for-Service (FFS) Panel focused in particular on the obstacles to effective care management created by the current benefits structure:

> Disability and chronic care needs among FFS Medicare's beneficiaries causes difficulties in managing the volume and quality of services for which FFS Medicare pays. These needs underscore the limitations of Medicare's benefits package. Beneficiaries must rely on supplemental insurance or family resources to pay for needed chronic services, especially pharmaceuticals. Alternatively, foregoing needed chronic care can cause avoidable acute care problems that become the responsibility of FFS Medicare. For example, improper monitoring, diet, and pharmaceutical treatment of hypertension can lead to stroke. A lack of regular preventive care and monitoring of diabetics can lead to serious complications. Furthermore, the FFS Medicare payment system focuses on payment for individual services. While appropriate for treating acute illnesses within a discrete period of time, it may not be well-designed for managing care for chronically ill patients who need longer-term care management over an open-ended period of time. FFS Medicare gives providers few incentives to coordinate the array of inpatient, outpatient and other services that can constitute chronic care over time. *(Transforming Traditional Medicare)*

The FFS Panel developed a set of recommendations designed to allow HCFA greater flexibility in the design, testing and implementation of new approaches for managing chronic illness, including disease management programs that might include benefits not otherwise covered by Medicare (see below).

The Social Role Panel came to very similar conclusions. However, drawing on a broad historical perspective as well as commissioned work specifically focused on the changing health care needs of the beneficiary population, the panel concluded that the debate about Medicare should include discussion of all the interconnected aspects of health care and care management facing an aging population, including long-term as well as chronic care:

> From a beneficiary perspective, the inadequacies of the benefits and increases in cost-sharing are causing Medicare to fall behind in its goal of providing financial security to beneficiaries and their families. The current package no longer reflects the way that medicine is practiced; the access to care and protection from financial ruin promised by Medicare is being eroded by the costs of prescription drugs and potentially catastrophic levels of cost-sharing. While expanding benefits would likely increase program costs, broader benefits might also facilitate better management of chronic and long-term illness and disability, and reduce some of the inefficiencies associated with the current patchwork of supplemental insurance. It is the view of the Panel that options for securing the Medicare program for the future must address the fundamental issues of what health care services Medicare will pay for, what mechanisms will determine how coverage and benefits will be adjusted to meet future circumstances, what portion of those costs can and should be borne by individual beneficiaries, and how the costs of care for those beneficiaries who cannot afford their share of payments will be allocated across other public programs, particularly Medicaid. *(Medicare and the American Social Contract)*

Addressing the benefits package from the perspective of structural reform of the Medicare program, the Capitation and Choice Panel concluded that effective competition among health plans would be far more likely if the plans could offer a Medicare benefits packages that more comprehensively met beneficiaries' insurance and health care needs. Citing the inefficiencies associated with the supplemental insurance that most beneficiaries obtain (discussed in later sections of this paper), either through policies sponsored by former employers, the private Medigap market, or Medicaid, the panel concluded that "reconsidering the Medicare benefits design in the light of the health care needs of the current and future beneficiary populations is essential for successful Medicare reform." More specifically, the panel outlined enhancements to the benefits package that it believed would be needed if the Congress decided to move ahead with the design and testing of a premium support model for Medicare. The benefits should, the panel stated, "more closely approximate the coverage that beneficiaries seek through supplementary insurance now, *i.e.*, some coverage of prescription drugs, catastrophic coverage for total Part A and Part B and somewhat lower Part B copayments."

As it began its work to estimate Medicare's financing needs under alternative scenarios, the Financing Panel adopted the premise that health care costs for Medicare beneficiaries

are shared by federal and state programs, employer-sponsored insurance, and beneficiaries and their families. In the process of sorting out the various implications of changes in financing needs over time, the panel quickly identified problems with the benefits package as central to their deliberations as well. Among the first products generated by the panel was commissioned work estimating the costs of alternative drug benefit designs (see *Medicare Brief No. 1*).

The importance of the design issues raised in the brief were illustrated by the difficulties encountered by the Bipartisan Commission when it grappled with this issue; in the end, the Breaux/Thomas proposal called for all Medicare plans to offer a "high-option" that included a drug benefit, but did not specify the details of that plan. The lack of a comprehensive outpatient prescription drug benefit was a major factor in two Commissioners' decisions to vote against the plan. The Financing Panel examined the distribution of drug costs being borne by beneficiaries, and commissioned estimates of the costs of five illustrative drug benefits. Available data indicate that about 29 percent of non-institutionalized beneficiaries in FFS Medicare (about 9.3 million beneficiaries) have out-of-pocket drug expenses of more than $500 annually, and 14 percent (about 4.5 million beneficiaries) have out-of-pocket expenses of more than $1,000. The work done for the panel indicated that a drug benefit could add between 7 and 13 percent to Medicare costs over the next decade, depending on the design of the benefit and other factors such as the rate of growth in prescription drug costs.[10]

The Financing Panel also developed estimates of the costs of restructuring Medicare cost-sharing in a manner that would provide better protection against out-of-pocket liabilities for deductibles and coinsurance, as well as catastrophic expenses. According to the analysis commissioned by the panel, changing Medicare's cost-sharing could simplify and rationalize Medicare's current system of copayments and deductibles without increasing total Medicare spending. For example, changing the provisions so that beneficiaries would face a $300 Part B deductible indexed to the consumer price index (CPI), 10 percent home health coinsurance, no more than one hospital deductible annually, no hospital coinsurance, and a $5,000 catastrophic stop-loss (also indexed to the CPI), would be essentially cost-neutral through 2030 (See *Medicare Brief No. 5*).

The study panels explored how different approaches to structuring Medicare benefits could affect beneficiaries, including the possibility that variations in benefits could adversely affect equity in both the Medicare FFS and competitive (Medicare+Choice) systems.

The wide variations in local health care markets and in the way in which medicine is practiced across the nation have always posed challenges for Medicare as a national entitlement program. Underlying this issue is the question of whether a public program should

10 The Financing Panel modeled five alternative drug benefit plans: 1) $200 deductible, 20 percent coinsurance, and$2,000 maximum payment ($1,000 in Medicare payment); 2) $200 deductible, 50 percent copayment, and $3,000 stop loss (with the plan paying all approved charges after the limit was reached); 3) $200 deductible, 50 percent coinsurance, and $1,000 stop loss; 4) $200 deductible, 50 percent coinsurance; and $2,000 stop loss; and 5) $500 deductible, 20 percent coinsurance, and $2,000 stop loss. The Clinton Medicare plan required no deductible, a 50 percent coinsurance, and $5,000 maximum payment ($2,500 in Medicare payments).

pay for different services or procedures that have no proven effect on health care and do not reflect differences in health care needs. Regional variations have complex political as well as economic implications. In the FFS program, benefits and coverage issues have been influenced by the complicated structure of local and regional administration and regional latitude allowed in the interpretation of program rules. Claims processing contractors have had the discretion to set local coverage policy in areas where national policy has not been set.[11] Accordingly, there have always been some regional or local variations in coverage determinations.[12]

Variations in Medicare coverage policy raised different concerns in the several study panels. From the perspective of the FFS Panel, the inadequacy of the benefits — together with the program's relatively inflexible administrative process — limits its ability to devise innovative approaches for managing the health care of beneficiaries. For some populations, being able to provide benefits not normally covered by Medicare could be cost effective in the management of some high-cost illnesses. For this reason, the panel recommended that HCFA have much greater flexibility to try such strategies, to integrate the successful ones into the regular Medicare program, and to promptly abandon or revise experiments that do not achieve the desired results. Similar provisions were included in the Clinton Medicare proposal (see Box 2 above).

However, the FFS Panel also expressed an array of concerns about whether programs requiring considerable discretion and managerial expertise can be administered effectively within the constraints of a federal agency such as HCFA (addressed separately in this report). Some panel members had serious questions about equity and freedom of choice for beneficiaries if HCFA were given greater authority to experiment with benefits designs. If enhanced benefits were available only to beneficiaries with specific conditions, others with equally serious medical management problems would be disadvantaged in a relative sense. If special programs designed to provide enhanced benefits as a means of improving the effectiveness of care for specific conditions were organized in such a way as to make use of a specially qualified provider group (*i.e.*, through selective contracting, or contracting with "centers of excellence"), beneficiaries with those conditions might have to choose between using the selected providers (and receiving enhanced benefits) or using the providers of their choice, which could mean waiving enhanced benefits. Both consumer advocates and health care providers did in fact express a range of concerns when the Clinton administration included the "modernization" provisions originally outlined in the July 1999 Medicare reform proposal in

11 In April 1999, HCFA announced a new process for national coverage decisions designed to make the process more accountable and to strike a better balance between providing timely access to medical advance and ensuring that new technologies and treatments are "reasonable and necessary." However, under this new system, there will still be an option to allow the newly-created Medicare Coverage Advisory Committee or another independent technology assessment body designated by HCFA to permit local contractors discretion to make decisions about the coverage of treatments or technologies.

12 See, for example U.S. General Accounting Office, *Reliability of Medicare Part B Claims Processing* (Washington, DC GAO/PEMD-93-27, 1993).

draft legislation in October, 1999. From a consumer perspective, there were concerns that beneficiaries living in areas where local hospitals did not qualify as "centers of excellence" or "preferred providers" might find their access to care reduced. Health care providers feared that "centers of excellence" would likely attract sicker patients, but that, since it would be very difficult to structure Medicare payments to reflect the costs associated with high-quality care for sicker-than-average patients, the competition among providers would ultimately reward mediocre quality care offered by low-cost providers.[13]

Because of these concerns, the panel proposed that any expanded authority to experiment and implement care management methods should preserve beneficiaries' freedom of choice, including a requirement that no beneficiary should, as the result of the adoption of care management methods, be eligible for fewer covered services than those provided normally under the FFS program. In effect, this would mean that participation in care management programs would be voluntary, because beneficiaries could always opt to receive benefits through the regular FFS system. The Clinton proposal included these provisions.

From the perspective of the Capitation and Choice Panel, variations in the Medicare benefits package raised critically important and contentious issues. In part, the issues are an artifact of the payment methodology that shaped the evolution of Medicare managed care. Because the method for determining capitation payments is linked to local cost and service utilization, wide variations have developed in the payments Medicare makes to Medicare managed care plans. This, in turn, has led to variations in the benefits packages that plans have been willing or able to offer in different parts of the country. Fundamentally, however, questions about the standardization of benefits are central to the design of any structured competition system.

The interplay between variations in benefits and risk selection is critically important for Medicare. If beneficiaries have different preferences and different needs for services, then they will, logically, sort themselves into plans that are "right for" them. This leads to segmented risk pools, which create serious problems for Medicare, which must devise ways to compensate for the differences in risk and cost that are fair to beneficiaries and to providers. One of the advantages of standardizing benefits is that it discourages such risk segmentation. In addition, standardization of benefits facilitates consumer choice, because beneficiaries have an easier time comparing standard products on price and quality. The Capitation and Choice Panel did not, however, reach consensus on whether, as a principle, benefits packages offered in a Medicare system of structured competition should be standardized. Instead, they chose to take a two-pronged approach that reflected the majority view that a significant level of standardization of benefits would be beneficial.

- First, the panel recommended that HCFA "use its demonstration authority to assess options for standardizing the ways in which benefits are described to facilitate comparisons among plans, and to explore options for developing and evaluating the marketing of a small set of basic plus supplemental standardized benefits sets through the

13 Pear, R., "Clinton Proposes a Discount System on Medicare Costs," *New York Times,* October 19, 1999.

In competitive markets, it makes economic sense to allow plans to compete for members by offering a variety of optional benefits. Beneficiaries have different needs and preferences for health services. How variation affects the ability of markets to serve beneficiary needs, however, is subject to debate. On the one hand, a vast array of optional benefits, each defined by individual plans, makes it very difficult for consumers to compare benefits and service options. If drug benefits vary according to the size of the deductible and/or copayment, whether drugs must be prescribed from a restricted formulary, whether specific drugs must be purchased through the plan pharmacy, and so forth, beneficiaries may find it very difficult to calculate how each plan will work for their particular needs. If each of the supplementary benefits varies across a range of cost and utilization criteria, the alternatives expand geometrically. For beneficiaries (or couples both on Medicare) with extensive or chronic health care needs, the attractiveness of the options can become extremely difficult to sort out. On the other hand, limiting the variety of benefit options also means limiting beneficiaries' ability to pick benefits that match their needs and could discourage innovation by plans that have to meet regulatory requirements.

Second, it is possible that optional benefits, when included in "basic" benefits packages marketed by health plans, can contribute to biased selection. The popular example is plans offering health club memberships to attract younger, healthier Medicare beneficiaries. It is also possible, however, that if plans are properly reimbursed, some that elect to focus on groups with certain characteristics or care needs may be more efficient.

Third, some have argued that if it is not possible to sort out "standard" Medicare benefits from optional benefits, Medicare can end up paying for a better benefit package for some beneficiaries than others. The Medicare reforms introduced in 1997 do not require standardization of plans benefits or supplemental benefits. In theory, allowing competition among plan options within a market area, including fee-for-service, should result in greater program efficiency. If plans can provide a richer package of benefits, then their competitors will have to provide comparable service to avoid losing enrollees. Medicare will, in effect, be able to provide more without increasing outlays. Equity in a national insurance program financed by a national payroll tax and general tax revenues is, however, politically and ethically complicated. In effect, it comes down to, from one perspective, whether beneficiaries who live in areas where it is possible to get "a better deal" on health care should get as large a Medicare "subsidy" on "core" health insurance as those living in less competitive or higher-cost areas. Conversely, it could be argued that the market should be allowed to "work" even if it works better some places than others.

Medicare+Choice program, analogous to the standardized supplementary benefits packages created under provisions of Omnibus Budget Reconciliation Act of 1990."

- Second, in its broader recommendation for a major demonstration of a premium support model, the panel proposed that, in that demonstration, the benefits packages offered by participating plans, including Medicare fee-for-service plan(s), be limited to an enhanced set of basic Medicare benefits (including a drug benefit) and a small number of standardized optional supplemental benefits.

The study panels identified supplemental insurance as a factor that adds layers of complexity and uncertainty to the debate about Medicare restructuring.

All four panels broached the subject of supplemental insurance. The Financing Panel identified supplemental insurance as an integral part of the Medicare debate. A paper commissioned by the panel, "Problems with the Supplemental Insurance System: Implications for Medicare Reform"[14] provided it with an overview of existing supplemental insurance options, an assessment of the increasing unsettled supplemental market, and an analysis of the extent to which problems with supplemental insurance would be ameliorated, or exacerbated, by different Medicare restructuring options.

There has been a market for supplemental insurance since Medicare was created, and most people enrolled in Medicare have some sort of supplemental insurance. Between one-fourth and one-third of beneficiaries receive some form of supplemental insurance through their former employers, and a similar percent buy some kind of supplemental insurance in the private Medigap market.[15] Based on estimates from available data, about 13 percent receive some package of supplemental benefits through the Medicare managed care plans in which they are enrolled (this figure does not fully reflect significant increases in managed care enrollment over the past three years), and about 12 percent of Medicare beneficiaries with low incomes receive supplemental benefits through Medicaid. About 14 percent, according to recent estimates, have Medicare only.[16]

The basic reason most people have supplemental insurance is that it is essential for protecting the financial security of most people on Medicare. More than half of elderly beneficiaries have family incomes under $25,000. The current benefits package leaves beneficiaries liable for high front-end costs associated with major illness, including a hospital deductible ($768 for a stay of one to 60 days), a deductible of $100 for doctors' services and outpatient hospital services, along with a 20 percent copayment for physician bills, including costs of surgery, and several other sorts of copayments for other covered services, such as outpatient mental health vis-

14 Academy *Medicare Brief No. 6* based on the paper, *Supplemental Health Insurance for Medicare Beneficiaries*, authored by Thomas Rice and Jill Bernstein was released in December 1999.

15 There are a variety of individually-purchased insurance products that can supplement Medicare, including Medigap, hospital indemnity, specified disease, and long-term care policies. Only those policies that meet certain federal requirements can be marketed as "Medigap" policies.

16 *Medicare and the American Social Contract*, 1999.

its, and physical and occupational health services. In addition Medicare leaves beneficiaries without any coverage for the catastrophic costs associated with very long hospital stays (those over 100 days).

Over time, however, the role of supplemental insurance in protecting beneficiaries has become increasingly complex. As the nature of medical care has evolved, the burden of beneficiary costs has shifted from inpatient hospital to outpatient services. While the incidence of balance-billing for physician services has declined (reducing beneficiary liability for some office-based care), liability for increased costs for outpatient and post-acute care services increased, along with out-of-pocket spending for non-covered services, most notably prescription drugs. Supplemental coverage has filled in some of all of these gaps, but beneficiaries and regulators have had to sort through a tangled web of policies designed to protect against different sorts of Part A and Part B cost-sharing, along with assorted policies covering only hospital costs (indemnity policies charging fixed monthly fees for hospital care, sold without regard to other coverage an individual may have), disease-specific policies (most often to pay for care if enrollees contract cancer), and other insurance products.

Concerns about abuses in the marketing and operation of some Medigap products led to the establishment of voluntary certification standards for private Medigap products (the "Baucus Amendments" of 1980), which were adopted by most states. In 1990 provisions in the Omnibus Budget Reconciliation Act (OBRA-90) stipulated that all Medigap policies conform to one of 10 particular sets of benefits.[17] All 10 policies cover basic benefits (*e.g.*, Part A coinsurance for a lifetime of 365 days after Medicare benefits end, Part B coinsurance, and costs for three pints of blood per year). The policies differ with regard to coverage for skilled nursing facility coinsurance, the Part B deductible, coverage for costs incurred during foreign travel, excess charges over Part B approved amounts (balanced billing) preventive care, and prescription drug coverage.[18]

For the portion of the beneficiary population who buy coverage on their own, the Medigap reforms put in place a system that has important consequences for Medicare as a whole. First, supplementary insurance can shield beneficiaries from a large portion of out-of-pocket expense when they use Medicare services. Research indicates that people with Medigap coverage use more services, particularly non-urgent Part B services (mostly physician services, and diagnostic tests).[19] Medigap also "bundles" different sets of supplemental benefits together. If a beneficiary wants to buy a supplemental policy that includes a prescription drug benefit, the only standard Medigap options available also include most of the other benefits offered in the more comprehensive plans.

17 OBRA-90 allowed beneficiaries to continue to renew existing non-standardized policies they had enrolled in before passage of the law.

18 The two Medigap plans with the "basic" drug benefit (in 1999) pay 50 percent of drug costs up to $1,250 (*i.e.*, the policy pays up to $500), after a $250 deductible. The one extended coverage drug plan available pays 50 percent after a $250 deductible but the maximum benefit is $3000 (with half paid by the policy).

19 See *Structuring Medicare Choices*; also see U.S. Physician Payment Review Commission, "Private Supplemental Insurance for Medicare Beneficiaries," *PPRC Update # 13* (Washington, DC: March 1997)

Because these plans offer broader coverage, and because people who are more concerned about protecting themselves against high out-of- pocket costs may be those with greater health care needs, the high-end plans are prone to adverse selection. If sicker people buy more comprehensive plans because they will need more services, they will drive up the cost of those plans. In 1999, the average cost of Medigap plans that included a basic drug benefit for beneficiaries over age 75 more was over $4,000 per year in some markets; a comparable Medigap plan without drug coverage cost less than half as much, even though the maximum insurance payout for drugs under the plan was $1250, after a $250 deductible and 50 percent beneficiary coinsurance (*Medicare Brief No. 1*).

Second, some Medigap policies have become very expensive, particularly for older beneficiaries. Most Medigap policies now include "age-attained pricing" provisions, and policies for older beneficiaries are substantially higher than for younger beneficiaries in some markets. For example, in 1998 a Medigap plan C premium from one insurance insurer cost 65 years old in Cincinnati $1,022, while the same plan cost a 75 year old $1,366; in Detroit, a Plan C premium that cost a 65 year old $1,259, compared to $1,796 for a 75 year old.[20]

Finally, even with the 1990 reforms, the system remains complicated and often confusing for beneficiaries, most of whom have to deal with two separate insurance systems (Medicare and supplemental). Multiple policies also increase administrative expenses, not just in processing claims, but in managing multiple systems engaged in product development, marketing and other business activities.

Employer-sponsored supplemental insurance shares some important characteristics with Medigap policies: it shields its beneficiaries from out-of-pocket costs at the time of service. Moreover, some employer-sponsored retiree plans provide far more generous coverage, particularly of prescription drugs, than Medigap plan options, usually at considerably lower cost, reflecting employers' ability to buy at group rates. There is evidence, however, that employer-sponsored coverage is being offered to fewer retirees than in the past, that the terms of the coverage are being scaled back, and that a larger proportion of costs are being borne by retirees (see *Medicare Brief No. 6: Supplemental Health Insurance for Medicare Beneficiaries*).

Each of the study panels discussed the link between the inadequacy of the benefits package and the demand for supplemental insurance, as well as the way in which the particular forms that supplemental insurance has taken on may have created distortions in the marketplace. The Social Role and the Financing panels also focused on the implications for beneficiaries of the decline in employer-sponsored supplemental insurance and the rapidly increasing costs of private Medigap insurance. These panels, along with the Capitation and Choice Panel, stressed that changes in the payment mechanism for Medicare managed care plans could also reduce incentives for Medicare plans to provide supplemental benefits at little or no additional premium cost. This would further

20 "Medicare: New Choices, New Worries," *Consumer Reports,* September 1998.

limit the ability of low or moderate income beneficiaries to supplement basic Medicare with additional coverage at an affordable price.

Considering how supplemental insurance would fit into a restructured Medicare program led to some difficult questions for the Capitation and Choice Panel in particular. For competition to work well, the panel concluded, supplemental insurance would have to play a more limited role than it currently does in paying for beneficiary health care.

The Panel acknowledges the complexity of designing and implementing an enhanced benefits package that would supplant a significant portion of supplemental insurance. The Panel believes, however, that the additional costs would be less than the cost of purchasing that coverage in the private market. It is also possible that a better- designed benefits package could reduce incentives for beneficiaries to seek out supplemental coverage, then select first-dollar coverage options, which are believed to contribute to higher utilization rates. Medicare fee-for-service coverage that looks more like insurance available in the employment-based market might actually "level the playing field" among plan options, encouraging beneficiaries to compare costs and benefits of managed care and fee-for-service plans directly, without having to factor in additional supplemental coverage. At the same time, the Panel recognizes that an expanded benefit package could trigger changes in employment-based supplemental coverage, and in state and federal responsibilities for beneficiaries eligible for Medicaid.

ISSUES FOR FURTHER CONSIDERATION

The success of structural reform of Medicare will hinge on decisions about what Medicare pays for, and what has to be purchased separately, either by or on behalf of beneficiaries, in order to provide them with financial protection and access to appropriate heath care. One set of goals could be to structure a benefits package that 1) will better fit beneficiary needs, 2) can be made understandable to beneficiaries so that they can make informed choices about buying the insurance they need and respond to incentives to use health services carefully, and 3) can be used in a way that minimize administrative expenses. The role of supplemental insurance is just as important in reforms to modernize the FFS program as it is for structuring a system that is based on competition among private plans. The issues are both technical and political:

- How are current trends, as well as proposed Medicare reforms, likely to affect the availability and generosity of employer-sponsored and Medicare managed care supplemental coverage, and how is this, in turn, likely to affect beneficiaries, private supplemental markets, and demands on Medicaid?
- What would be the implications of public policies that limited the scope of and/or variations among supplemental insurance options for the employer-sponsored supplemental market, the private Medigap market, Medicare managed care plans, and Medicaid? What types of insurance rating (*e.g.* age rating) are appropriate in a reformed supplemental insurance market? What regulatory issues would need to be resolved (state and federal)? What issues in tax policy would need to be considered?
- If Medicare provides "core" benefits, and Medicare "high-option" supplements are created (as in the Breaux/Thomas or Clinton reform proposals), how would the program deal with the likely adverse selection that could lead sicker beneficiaries to choose more expansive supplemental packages, and to possible spiraling cost increases in these optional supplements? Could risk adjustment methodologies be effective in reducing adverse selection when multiple supplemental insurance options are available? How would federal subsidies for low-income beneficiaries affect program equity and costs?

Chapter 3: Reimbursement Issues

Restructuring Medicare cannot be successful unless providers are paid fairly and are willing to participate in the program. Technical issues in provider reimbursement in the Medicare FFS service program were not addressed in any detail by the study panels. Rather, the panels focused on issues of equity and participation in a market-based system. The Study Panel on Capitation and Choice addressed in considerable detail conceptual as well as technical payment issues that need to be addressed in Medicare reform.

As in other insurance markets, the distribution of health risk in the Medicare market is quite skewed; a small proportion of people account for a high proportion of costs. Among the Medicare population, however, the very high medical costs associated with serious acute and chronic illness among elderly and disabled persons are more likely to be protracted. Capitated payment systems that do not adjust for extensive patient health care needs put health plans at risk for very expensive care over time; this could pose real threats to health plans' economic viability, and therefore to patients' access to appropriate care. However, risk has not been randomly distributed among sectors of the Medicare market. There is consistent evidence to indicate that, on average, people enrolled in Medicare managed care are healthier — that is, need and use few health care services — than people who have remained in the traditional FFS plan (See *Structuring Medicare Choices*). Determining how to compensate plans enrolling people who are, or may become, high-cost users of the health care system is therefore critically important.

PANEL FINDINGS AND CONCLUSIONS

The Capitation and Choice Panel devoted a significant portion of its deliberations to questions about how to structure payments to providers in a competitive market environment. Some of these same issues were examined from somewhat different perspectives by the Social Role Panel.

The panels found that market-based competition raises difficult issues with respect to payment equity and the distribution of risk in Medicare markets, and that these will need to be addressed systematically if the reforms are to be successful.

Ensuring that Medicare beneficiaries have access to appropriate health care regardless of their health status was axiomatic for the study panels. Without effective risk adjustment, plans would encounter significant financial incentives to avoid enrolling beneficiaries with significant health care needs, and to stint on care for beneficiaries already enrolled. After reviewing technical issues and the available risk-adjustment methods in detail, the Capitation and Choice Panel concluded that the most robust methods currently available for Medicare are those based on diagnostic encounter and/or administrative information detailing diagnosis and service use. The panel endorsed HCFA's ongoing efforts to implement a risk adjustment system, in conformance with the provisions of the BBA. In addition, the panel called on HCFA to work with other public and private sector research organizations to support a broad-based research and evalua-

tion program to use the data required for risk adjustment to examine issues of cost-effectiveness, outcomes, and quality of care.

The Capitation and Choice Panel did not, however, conclude that a reasonable risk-adjustment system would be entirely effective in addressing the full spectrum of problems posed by the uneven distribution of medical risk in the Medicare population.

One set of concerns centered on incentives for providers working for or subcontracting with health care organizations that use capitated payment systems. In some of the more established managed care markets, particularly in California, physician groups contract with health plans, assuming full risk for the costs of covered services. If competition or unexpectedly high patient care costs result in inadequate capitation payments to these groups, they may become insolvent, leading to disruptions in patient care.[21] Many of the individual practitioners working in these groups are also paid a flat capitation rate for each patient they accept for their "panel." This payment method can be especially risky for practitioners contracting with new organizations, which may not have a large enough enrollment to spread risk across a provider's patient panel. The panel recommended that "the extreme case, full-risk capitation for all services applied to individual physicians or other providers, should be prohibited in the Medicare program." The study panel also urged that there be close monitoring and full disclosure of arrangements in which individual physicians or other individual providers are substantially at risk, particularly for services that are not directly under their control.

The Capitation and Choice and the Social Role panels both expressed broader concerns about the ability of available risk adjustment systems to fully protect Medicare beneficiaries. After reviewing the options, the Capitation and Choice Panel called for focused research and demonstrations to evaluate the potential of mechanisms such as partial capitation, which would base payments on a combination of risk-adjusted capitation payments and reimbursement for actual use of services for individual beneficiaries, as a means of structuring appropriate payments to Medicare providers.

From its broader philosophical perspective, the Social Role Panel focused on how the effectiveness of risk adjustment methods could vary under different approaches to structuring Medicare markets. The panel outlined key differences between systems in which risk-adjusted payments to a health plan would be based on the cost of a defined, comprehensive benefit, versus approaches in which the contribution would be structured as a "voucher" that beneficiaries could apply toward the cost of insurance available in the marketplace. In a voucher, or pure "defined contribution" approach in which plans

21 In 1999, the California Medical Association reported that over one third of the 300 independent physician groups in the state had gone bankrupt, and 90 percent of the remaining groups were on the verge of bankruptcy, at least in part due to steep reductions in the capitation rates the plans were able to negotiate with health plans. By the late 1990s, capitation rates fell by more than one third from the rates paid to groups early in the decade. Two large groups' bankruptcies resulted, according to the Association, in care for two million patients being delayed or disrupted, and thousands of physicians being left with over $100 million in unpaid bills for care. Kent, C., "Hard Times," *Physician's Weekly* XVI (40), October 25, 1999. The Capitation and Choice panel noted in its final report that some experts believe that as managed care markets mature, payers may move toward systems which base payment to physician groups on a mix of capitation and cost-based reimbursement.

offered different benefits packages, risk-adjustment might not provide adequate protection to beneficiaries with greater health care needs, because the value of the voucher, even if it were risk-adjusted, might not keep pace with increases in the costs of health care. This could lead to adverse selection (even if plan payments were risk-adjusted): those most in need of health care might choose plans that offer the most comprehensive benefits, while those with limited needs opt for low-cost plans, resulting in spiraling costs for the sickest beneficiaries.

ISSUES FOR FURTHER CONSIDERATION

As specific restructuring proposals are developed, the details of how providers will actually be paid will become critically important. Two inter-related issues, compensating for adverse selection in plan enrollment (not paying plans with healthier enrollees too much) and adjusting for the health risks of individual beneficiaries (making higher payments to plans for sicker enrollees), will require particular attention. These issues, moreover, need to be addressed from the perspectives of

Until an effective risk adjustment system, as well as quality and consumer protections, are fully in place across the full range of Medicare options, incentives to stint on care in capitated systems will remain a serious concern. A variety of methods including reinsurance, stop-loss protection, special payments for high-cost cases and special capitation arrangements for high-cost conditions or patient populations have been devised. The Panel's review of carve-outs, in which separate entities with distinct sets of providers assume risk for specific medical conditions, patients, benefits, or procedures, identified some limited potential for this approach to increase the quality and effectiveness of care for some beneficiaries. The Panel encourages the continued evaluation of all these approaches.

The Panel believes, however, that partial capitation payment may have some advantages for Medicare. Combining risk adjusted capitation with payments linked to actual use of services of individual beneficiaries could maintain some incentives for efficiency while reducing incentives to under serve enrollees with the most costly health care needs. Because some of the utilization data needed for risk adjustment could also provide the information needed to partially reimburse based on service use, a blended payment system may not require extensive additional administrative burdens compared to outlier or high-cost case sharing methods (*e.g.*, risk-sharing above threshold levels). The potential effects on provider incentives to do more will, however, need to be assessed carefully.

payers, plans, practitioners and Medicare beneficiaries.

- How will restructuring and/or the modernization of Medicare benefits affect risk selection in plans and in the supplemental insurance market?
- How will a restructured program deal with the exceptionally complex and expensive cases ("outliers"), including cases involving the management of serious chronic illnesses, particularly if very high cost beneficiaries are enrolled in small or newly-established Medicare+Choice plans?
- If Medicare plans include options such as preferred provider organizations, how will risk adjustment affect practitioners signed up with multiple plans? What types of checks on subcapitation will be needed?

Chapter 4: Program Cost Issues

The fundamental importance of devising policies to address the issue of increasing program costs shaped the work of all the study panels.

PANEL FINDINGS AND CONCLUSIONS

The study panels generally agreed that, because Medicare program costs reflect the factors and trends shaping costs in the nation as a whole, policies designed to constrain Medicare costs significantly below historical rates of growth could undermine the health and financial protection promised to beneficiaries.

Two study panels concluded that Medicare costs reflect the high per capita health care costs that have characterized all of American health care. The growth in the beneficiary population as members of the Baby Boom retire will mean that it is unlikely that the rate of growth of Medicare program expenditures could be reduced to the rate of growth in the domestic economy, or to the growth in national health care expenditures, without cutting the level of benefits or increasing the share of Medicare costs borne by beneficiaries.

From the perspectives of the Fee-for-Service (FFS) and Capitation and Choice Panels, the goal was to devise strategies that would increase program effectiveness and efficiency. The FFS Panel noted that private-sector insurers have focused initially on using managed care tools to control costs, *e.g.*, through extracting discounts or applying limits on utilization, rather than broader applications designed to improve quality of care. In recent years, however, some private insurers have begun to implement disease management techniques, including programs to screen for preventable, treatable conditions, to increase treatment compliance, and closely manage the complications of chronic disease. The panel found that the success of some of these techniques suggests that managed care tools may have the potential over time to reduce costs and improve the quality of care for Medicare beneficiaries. But while both panels concluded that reforms could create incentives for providers and beneficiaries to use health care services more efficiently, and could facilitate the development of better ways to manage patient care, neither chose to develop estimates of specific savings that could be generated from structural reforms.

The other two panels focused on the broad context of health care costs for the Medicare-eligible population. The Social Role Panel framed its conclusions around the central proposition that Medicare costs are being driven primarily by an increase in per capita health care spending associated with the use of medical technologies and treatments that help people live longer, more active lives. These cost increases are not exclusive to Medicare, but are in effect amplified in the Medicare population, given the increased need of the elderly and disabled for health care. From the Social Role Panel's perspective, increases in health care costs are a national issue, which cannot be successfully or equitably addressed solely within the confines of the Medicare program. Comparing increases in per beneficiary costs to those in the private health insurance market, the panel concluded that, while there are clearly some

aspects of Medicare's administered pricing system that have contributed to inefficiency and overpayment, Medicare's record has been neither consistently worse nor better than the records of private insurance markets with respect to controlling costs overall. Consequently, the panel was not convinced that market-based reforms would generate significant savings. This view in turn led the panel to concerns about the long-term effects of restructuring options on beneficiaries' health and financial security:

> From a program perspective, projected health care expenditures exceed the revenues available to fund the Hospital Insurance program as it is currently structured much beyond the next decade; expenditures for Part B account for a growing drain on the total domestic budget. Although the aging of the population has contributed to the problems that Medicare is facing, the major factor driving the relentless increase in Medicare outlays is the increasing use of services for the average beneficiary. As it turns out, neither demography nor inflation is the main cause of Medicare's fiscal problems; it is the intensity of services per beneficiary. Failing to address this fundamental issue could lead to policies that, over time, might deny much of the Medicare population the benefits of future medical advances, whether by rationing by price, by beneficiaries' ability to pay, or by excluding coverage for some services. *(Medicare and the American Social Contract)*

The Financing Panel examined Medicare cost issues in terms of total health care spending and total beneficiary spending as they are likely to play out over the next 30 years, when the Baby Boomers become beneficiaries and nearly one in four Americans (compared to one in eight Americans today) comes to rely on the program as his or her primary health insurance. Although the panel did not comment in detail on the assumptions used by the Bipartisan Commission staff or the HCFA actuaries in estimating potential savings that would be generated by implementation of the Breaux/Thomas Proposal, it did assess the adequacy of those estimated savings for Medicare. Based on the Commission's own analysis, the entire package of cost-containment provisions in the Breaux/Thomas Proposal — including restructuring options designed to increase market competition, further cuts in Medicare (primarily designed to control the rate of growth in payments to providers) such as those contained in the BBA, new cost sharing requirements for the traditional FFS component of the program, adding an income-related premium "surcharge" and raising the age of eligibility — would lower program spending by 11.2 percent over the period 2000-2030. The panel noted that, using 1998 baseline projections established by the Medicare Trustees, this would still leave a revenue shortfall that would require taxpayer contributions to Medicare to increase by 83 percent, from the current level of 2.45 percent of gross domestic spending to 4.49 percent of GDP over the next thirty years.

The Clinton Medicare proposal included a provision to dedicate 15 percent of the projected budget surplus to Medicare, adding an estimated $374 billion over 10 years.

Increased cost sharing (adding a new 20 percent copayment for clinical laboratory services, and indexing the Part B deductible to inflation) was estimated by the Administration to reduce net expenditures by $11 billion. The proposal also estimated savings of $72 billion over 10 years from the introduction of innovative health care management tools developed in the private sector into the traditional FFS program. On net, the Administration estimated that its proposal would extend the life of the Medicare Part A Trust Fund by 12 years (to 2027) beyond its current projection.

The Financing Panel's analytical approach also included laying out alternative scenarios incorporating different policies to constrain costs, add revenues, or augment the benefits package. It concluded that a prescription drug benefit and modest changes in cost sharing (designed to make the benefits package more adequate to the needs of beneficiaries and to simplify coinsurance and deductibles) could increase program costs substantially. Under current law, by 2030 these costs could raise the taxpayer costs for the program from 2.45 percent to 5.09 percent of GDP.

Although the outlook for Medicare's long-term financial stability improved in the 1999 Medicare Trustees' report, the panel noted that the slowdown in spending growth also means that some of the savings from various reform proposals are therefore now implicitly incorporated into the baseline estimates. Savings from these reforms will therefore be of a smaller magnitude than in the past, so that a gap between revenues and spending is likely to remain. "Consequently," the panel concluded, "as policymakers search for new ways to reform Medicare, the potential inclusion of new revenue must be part of the discussions." (*Medicare Brief No. 5*)

ISSUES FOR FURTHER CONSIDERATION

As the study panels went about their work, they found that addressing relevant "cost" issues from the perspective of trust fund solvency or program expenditures alone was inadequate. Instead, each ended up placing cost issues in the wider context of total health care costs for the beneficiary population, including costs for appropriate medical care currently not covered by Medicare, and costs to payers other than Medicare, *i.e.*, Medicaid, other public payers, private insurance, and beneficiaries and their families. Constraining Medicare costs by restricting coverage or reimbursement not only passes costs on to other payers (including back to the government), but also inhibits the development of integrated health care management strategies that could result in more cost-effective, better quality health care.

Collectively, the panel reports point to a need for a broad reassessment of health care costs for the elderly and disabled as part of the process of restructuring Medicare.[22]

22 Although the legislation establishing the Bipartisan Commission on the Future of Medicare included a charge to examine issues related to the impact of chronic disease and disability trends on future costs and quality of service under the current system, this topic was not a major focus of attention. The final version of the Breaux/Thomas proposal called for a study, to be conducted by the Institute of Medicine, to analyze options for financing long-term care. The Clinton Medicare proposal called for the development of methods to structure primary care case management to promote coordination of care for certain diseases and increased efforts to promote coordination of care for beneficiaries dually eligible for Medicare and Medicaid.

This would include:

- Revisiting the complicated issues involved in defining chronic and long-term health care, and the appropriate roles of public and private health insurance — including Medicare — in providing necessary, appropriate, and cost-effective care for the full range of health care and related care needs of elderly and disabled populations, and
- Exploring trends in aging, workforce participation, the health and economic status of the elderly, and access to health insurance and health care in order to provide context for framing discussions about what proportion of domestic resources should be devoted to Medicare and other public programs.

Chapter 5:
Revenue and Cost-sharing Issues

Two study panels addressed how to pay for Medicare over the long term. To begin this work, the Social Role Panel reviewed the basic facts and figures, and the overview of program revenues and cost-sharing issues developed by the panel was used as a starting point by the Financing Panel.

PANEL FINDINGS AND CONCLUSIONS

The panels focused on developing a framework for evaluating revenue and cost-sharing options that can take into consideration the different values and objectives implicit in the debate about Medicare reform.

The Social Role Panel examined the various financial, political, and social implications of specific reforms designed to stabilize Medicare's finances as part of its broader review of reform options. In its final report, the panel discussed a set of five general approaches to controlling spending or increasing program revenues: reducing payments to providers through various technical changes in payment methodologies; increasing the Medicare payroll contribution rate; increasing beneficiary cost-sharing (premiums, copayments, or deductibles); increasing cost-sharing for "high-income" beneficiaries; and increasing the age at which beneficiaries receive Medicare benefits (in coordination with increases in the age of eligibility for full Social Security benefits; this reform was included in the Breaux/Thomas Proposal).

The Social Role Panel final report presented a framework for comparing tradeoffs among these options in terms of values that Americans bring to bear in evaluating public policy about health care (see box, p. 40).

Applying these criteria to the general revenue options allowed the panel to lay out their potential benefits and costs systematically. The panel's goal was not to endorse or reject specific options, but rather to illustrate how the application of these criteria could be used to weigh the options in terms of different policy goals. Its analysis led the panel to conclude that:

> None of the reform options currently being debated can increase the financial security of beneficiaries and simultaneously solve the problem of health care costs in an aging society…Incremental reforms that increase beneficiary cost-sharing could undermine the basic financial protections that Medicare was intended to provide; increasing revenues or reducing benefits would also not address the fundamental system-wide problem of health care costs, and how decisions about access and quality of care are to be made. *(Medicare and the American Social Contract)*

The Financing Panel is continuing to examine options for generating revenues to support the Medicare program, and plans to issue its final report in Winter, 1999-2000.

The study panels concluded that an open discussion should take place about the extent to which beneficiaries can and should be asked to contribute a larger proportion of Medicare costs.

As the beneficiary population increases in size relative to the working population, the capacity of those receiving Medicare benefits to pay for a larger portion of the program costs becomes an increasingly important policy consideration. Both the Social Role and Financing panels reviewed the evidence about the financial resources of the beneficiary population, along with trends in beneficiary cost-sharing and the implications of changes in cost-sharing over time. Both found the growth in beneficiaries' out-of-pocket costs for medical care and insurance, which analyses indicate has reached 19 percent of family income for the typical elderly beneficiary, to be an indicator of the serious gaps in the financial protection that Medicare was created to provide.

If beneficiaries had to pay the monthly premium set at the value of Medicare Part A insurance, (currently $309 per month) and the full cost of Part B ($182), Medicare premiums would be close to $5,900 for each beneficiary in 1999. Even with beneficiaries paying only one-fourth of the full Part B premium ($45.50 per month, totaling $546 per year in 1999), the costs of health care and insurance still constitute a large, and growing, proportion of household income. Further, as Part B expenditures increase as a proportion of Medicare spending, beneficiary

Criteria for Evaluating Medicare Reform Options

Financial Security: The degree to which Medicare (under the current program or as a reformed program) provides financial security to the elderly and disabled (and their families across generations) as they incur costs for medical care.

Equity: The degree to which Medicare is able to serve all populations fairly, including beneficiaries and future beneficiaries, regardless of age, health, gender, race, income, place of residence or personal preferences.

Efficiency: The ability of Medicare to promote the use of appropriate and effective medical care for the beneficiary population, i.e. care that is technically efficient and minimizes the use of ineffective or unnecessary services, is consistent with the preferences of patients, and recognizes the real costs of services. Efficiency also includes the degree to which administration of the program is timely and responsive to the needs of consumers and providers, and the application of financing methods that are not unnecessarily burdensome.

Affordability over time: The degree to which the costs of Medicare can be borne without diverting public revenues needed for other important public priorities.

Political accountability: The degree to which the information needed to determine whether the program is achieving its goals is available, and mechanisms are in place to identify problems and institute corrective actions in a timely manner that is fair to all beneficiaries, to providers, and to taxpayers.

Political sustainability: The degree to which the Medicare program enjoys the support of the American population, regardless of the state of the economy, political climate, or social atmosphere.

Maximizing individual liberty: The extent to which Medicare policies, including incentives structured to promote efficiency, allow individual beneficiaries to exercise their own judgment and individual preferences in making choices about their health care.

liability increases. The availability and generosity of employer-based supplemental insurance is declining, and the cost of Medigap insurance appears to be increasing rapidly. Without any change in policy, the share of beneficiary income needed to pay for medical care and insurance could rise to nearly 30 percent of income by 2025 if health care costs continue to outpace income growth (*Medicare Brief No. 5*).

A paper commissioned by the Financing Panel (summarized in *Medicare Brief No. 4*) illustrated several significant aspects of the economic status of the beneficiary population. This analysis indicated that the economic status of the elderly has improved markedly since the 1960s, in terms of poverty rates, real cash income, and broader measures that include capital gains, sheltered savings from home equity, and in-kind benefits. However, it also points out that many elderly Americans remain substantially dependent on Social Security, leaving them little capacity to absorb additional health care costs. The poorest 40 percent had incomes of less than $13,000 in 1996; Social Security provided over 80 percent of their cash income, while those in the second highest income quintile, labeled the "upper middle income group" (with incomes between $20,000 and $33,800 per year) received nearly half of their income from Social Security. Although recent analyses indicate that future retirees are earning more than their parents did at the same age, and that they seem to be saving more relative to earnings than their parents did, there are reasons to be cautious about the well-being of future retirees. Two trends that improved the status of current retirees — a dramatic run-up in asset prices and increases in Social Security benefits — are not likely to recur for Boomers.

More importantly, while the elderly today are less likely than the average American to be poor, they remain likely to be near poor (with incomes of less than 150 percent of the poverty level), and the relative size of economically vulnerable groups, including minorities and people living alone, is growing among the retiree population. The analysis indicates that despite the gains made over the past 30 years, a not insignificant portion of the elderly will be at serious risk of living the last years of their lives in poverty (especially persons living alone, the oldest old, the poorly educated, and those without housing equity). Women, especially minority women, are particularly at risk. Many poor and near poor individuals do not qualify for Medicaid. For many women living alone, incomes and assets will be inadequate to meet their normal needs, and completely inadequate to handle the expenses of catastrophic illness or long-term care.

Other work commissioned by the Academy focused on higher-income beneficiaries' ability to contribute more to Medicare revenues. In *Medicare Brief No. 2 (Should Higher Income Beneficiaries Pay More for Medicare?),* analysis conducted for the Academy using the AARP/PPI Benefits Simulation Model illustrates how the distribution of employer-sponsored supplemental benefits creates financial (and tax) advantages for higher-income beneficiaries. The *Brief No. 2* provides an overview of existing ways in which higher-income people now pay more for Medicare: the uncapped payroll tax contribution (also applied to the exercise of stock options), income taxes that fund three-fourths of Part B, and the income tax paid on a portion of Social Security benefits. Revenues from the taxation of Social Security benefits accounted for 4 percent of the HI Trust Fund revenues

in 1998. The *Brief No. 2* also presents poll data on public opinion regarding income-relating Medicare premiums, including data that suggest that 1) the public is ambivalent about the desirability of income-relating Medicare beneficiary costs, and 2) there is no clear association between income level and views about income-relating Medicare, *i.e.*, that higher-income Americans are not markedly more opposed, nor low-income Americans significantly more in favor of, having high-income seniors pay more.

In addition, *Brief No. 2* presents some estimates of the revenues that might be obtained by charging higher premiums to higher-income beneficiaries. An estimate developed by HCFA indicated that an income-related premium included in the initial proposal circulated by Senator Breaux would increase Medicare revenues by about 2.7 percent over five years. This proposal called for beneficiaries with incomes above 300 percent of the poverty line ($24,000 for individuals and $30,000 for couples) to pay a surcharge on health plan premiums. The surcharge would begin at 1.5 percent of the premium for the health plan selected by each individual over the income threshold, and increase incrementally to a maximum of 15 percent of the premium for those with incomes over 500 percent of poverty ($40,000 for individuals and $50,000 for couples). About 18 percent of all elderly beneficiaries have family incomes over the threshold. The Breaux/Thomas Proposal considered requiring extra contributions of about $4.00 per month per percentage point assessment (each one percentage point increase from 1.5 percent up to 15 percent), or up to $60 per beneficiary per month. The Health Care Financing Administration projected that this income-related premium would increase Medicare revenues by about 2.7 percent over five years,[23] (minus the administration costs of implementing an income-based premium system). This is considerably less than the Medicare revenues currently obtained from the taxation of Social Security benefits for higher-income beneficiaries. Academy analysis shows this would raise about the same amount of revenue as raising premiums for all beneficiaries by about $13.00 per month.

The *Brief No. 2* also discusses more fundamental issues regarding the role of income-testing in a social insurance program. From one perspective, there is an important distinction between progressive levies assessed on the population as a whole as they pay into a social insurance program, and costs (premiums, copayments, or deductibles) that beneficiaries must pay to "use" the program. Income-related provisions could undermine Medicare's status as a highly-valued, earned "entitlement," that is, social insurance.[24] Under most definitions of social insurance, everyone who qualifies by paying into the program (no matter how progressive the rules may be) should receive the same insurance coverage, regardless of health care needs or ability to pay. From this perspective, public support for Medicare rests in large part on the understanding that the program is there for everyone who paid in, and everyone

23 J. Lemieux, *Preliminary Staff Estimates of Senator Breaux's Medicare Proposal,* memo to the Bipartisan Commission on the Future of Medicare, February 16, 1999. On www at http//thomas.loc.gov/medicare/jeff.html.

24 Medicare's status as a social insurance program is complicated by the fact that Part B is financed through general revenues, rather than a separate trust fund financed by employer and worker contributions, and participation is not dependent on meeting the eligibility requirement for Part A benefits.

receives the same benefits. This support might erode if Medicare comes to be viewed as a "means-tested" program, or if higher-income people know that they will contribute more to the program during their working lives, then have to pay more to enroll (that is, pay higher monthly premiums). Others view the issue of income-relating beneficiary cost-sharing as no different from other broad principles of progressive taxation, *i.e.* people with more resources should pay more. The *Brief* concludes that implementing a policy that would require greater financial contributions from higher income beneficiaries would involve difficult tradeoffs in terms of revenue gains, burden on beneficiaries, and political support for the Medicare program.

ISSUES FOR FURTHER CONSIDERATION

When Medicare was created, the costs of health care and health insurance were beyond the means of a large proportion of the elderly and disabled in America. Even with Medicare, health care costs are a serious problem for a growing number of elderly. Because only a small portion of the beneficiary population is "wealthy," the potential for increased revenues is limited. Alternative sources of additional revenue include increases in payroll taxes; increased funding from general revenues; taxes earmarked to alcohol or tobacco or to providers, as well as value-added taxes; changes in current tax codes provisions governing the treatment of health insurance or health care expenditures, provisions affecting program beneficiaries; and greater reliance on other federal or state programs (primarily Medicaid but also public health or "safety-net" programs, as well as Department of Veterans Affairs and Department of Defense health care programs).

The Social Role Panel looked in detail at how the public views options for increasing Medicare revenues.[25] The Financing Panel is addressing the technical aspects on financing and revenue options in some detail. Generating estimates of revenues to be gained from these sources is only a first step in analyzing them in terms of their costs and benefits relative to broader public policy considerations:

- What are the likely distributional effects, including the implications for different age cohorts, income groups, and regions and localities, of policies designed to slow the rate of increase in Medicare spending?
- How would proposed reforms of the Social Security program interact with changes in Medicare's financing?
- How will changes in Medicare financing affect other publicly and privately-financed programs? What would happen — to beneficiaries, families, localities, and states — if Medicare could not afford to pay for the benefits that the elderly and disabled need?

25 *Medicare and the American Social Contract*, Chapter 3; also see Bernstein, J., and Stevens, R.A., "Public Opinion, Knowledge, and Medicare Reform," *Health Affairs* 18(1): 118-131, January/February 1999.

Chapter 6: Management/Program Administration Issues

Medicare is a very large, overwhelmingly complex program. Although the program has made significant contributions in research and the development and evaluation of health services delivery and financing, program resources devoted to administration and management are significantly less than investments in administration and management in large private sector health care organizations. Both the Capitation and Choice and the Fee-for-Service (FFS) panels devoted considerable attention to examining the administrative systems, oversight, and managerial expertise that would be needed to implement reforms successfully. Both cited the need for ambitious research, development, and demonstration programs in support of Medicare reform, which would place additional requirements on HCFA's staff and budget. More importantly, both concluded that reforms would be needed to ensure that HCFA (or any other agency) has the resources, authority, or flexibility to manage a restructured Medicare program effectively. The panels also raised some more basic questions about how a federally-administered program can successfully adapt to a constantly changing health care environment.

PANEL FINDINGS AND CONCLUSIONS

The panels concluded that, regardless of other program reforms, changes in HCFA's administrative structure would be necessary to give the agency the capacity to better manage the health care financed through its FFS program.

Medicare's traditional indemnity insurance system is used by the great majority of current beneficiaries. Unless there are fundamental changes in the organization of Medicare, the indemnity system is likely to remain as the largest component of Medicare for decades to come. The FFS Panel spent a significant portion of its time exploring the potential for integrating private sector approaches in order to improve program efficiency and effectiveness in FFS Medicare.

The panel found that private health plans are beginning to experiment with a broad array of managed care tools. Although evidence of their extent and impact is still limited, the panel concluded that some might be worthy of adaptation and experimentation by FFS Medicare. The panel identified three categories of managed care "techniques" that hold promise: case and disease management, incentives to use selected providers, and competitive procurement. The panel also found, however, that statutory and administrative changes would be needed to provide HCFA with the capacity to take a leadership role in developing and implementing innovative approaches for managing care for elderly and disabled beneficiaries. The panel found that the administrative structure of FFS Medicare today largely reflects choices made in the 1960s and 1970s, and that statutory provisions, procedural requirements, procurement policies, and politics limit fee-for-service Medicare's management and innovation capabilities. The panel concluded that fundamental changes in the way that the FFS program operates are essential:

A modern FFS Medicare program should have the capacity to apply new knowledge from research and the private sector about how best to manage health benefits for older Americans and those with disabilities, especially as the number of beneficiaries with chronic conditions continues to grow. The changes in FFS Medicare needed to bring about this fundamental change will require strong leadership and bipartisan consensus among our elected officials. *(Transforming Traditional Medicare)*

Some provisions of the BBA and several HCFA demonstrations will test innovations in FFS Medicare; however, these activities are limited in the number of beneficiaries who

Box 3: How would the Panel's recommendations work?

(Panel on Modernizing Fee-For-Service Medicare, materials submitted to the Bipartisan Commission on the Future of Medicare, June 1998)

1. Developing an Innovation Management Plan. HCFA would establish an advisory group of experts including representatives of provider organizations, health plans, and consumer organizations to review research and the experience of private health plans to identify promising new approaches to delivering services to Medicare beneficiaries. At least once a year, HCFA would develop a management plan for innovation in consultation with the expert advisory group. This plan would establish priorities among disease conditions, groups of beneficiaries, and local areas that would benefit most from innovation in the delivery of FFS Medicare.

2. Soliciting and Evaluating Proposals. By publicizing its innovation management plan through the *Federal Register*, contacts between its regional offices and provider communities and other means, HCFA would solicit proposals to provide services to FFS Medicare beneficiaries in ways that may improve cost and quality outcomes. In cases where HCFA identifies a specific innovation that it believes is promising in a particular geographic area, it would encourage potential providers to submit a proposal.

3. Establishing Specific Innovations. HCFA would approve as many feasible proposals as possible within its resources. Using its new waiver authority, HCFA would establish appropriate contractual, payment, and data collection arrangements on a case by case basis and within a specified period of time.

4. Monitoring and Refining Innovations. Organizations contracting with HCFA would provide data to monitor the impact of each innovation on an on-going basis. HCFA would have the authority to renegotiate or cancel the terms of each contract annually as the results become clear. It could also encourage the replication of successful innovations in other promising locales. Results would help refine priorities in the innovation management plan developed for the next year.

5. Annual Reporting. The Secretary of Health and Human Services would report to Congress annually about how it has used its new authority. The report would: (1) describe HCFA's overall FFS innovation plan, (2) review waiver projects undertaken, and (3) present evidence of how well HCFA is transforming FFS Medicare from a bill-paying program to one accountable for quality and costs of services. The Medicare Payment Advisory Commission would comment on this report and recommend to Congress any changes Congress ought to make in HCFA's FFS innovation waiver authority.

will be affected. Moreover, experience proves the difficulty of incorporating successful demonstrations into regular program management. The panel's recommendations set out an explicit approach for broadening HCFA's authority to experiment and to integrate successful innovations into the FFS program, including the establishment of an advisory group to help identify and prioritize promising areas for research and experimentation, a systematic process for soliciting and evaluating demonstrations, streamlined mechanisms for expanding on successful innovations and refining or ending unsuccessful ones, and provisions to ensure public accountability (see Box 3 opposite).

The panel recommendations were discussed in detail with the Bipartisan Commission on the Future of Medicare, and some of the ideas presented in the panel report appeared in the draft recommendations debated by the Commission. The provisions of the Clinton Medicare Proposal were modeled on the FFS Panel recommendations.[26]

The Social Role Panel drew on the work of the FFS Panel in its discussion about the ways in which Medicare interacts with the larger health care system, noting that:

> Private health insurance companies budget for effective management, innovation, and research as well as the costs of doing business on the health care industry, such as risk management and utilization review. Determining how to reinvent Medicare so it can make use of comparable management tools should be part of the debate about the future of the program. *(Medicare and the American Social Contract)*

"Modernizing" the FFS program, however, involves questions about politics (and values) as well as technical aspects of public administration. The Social Role Panel noted that even if there is agreement about the need for better management and administration of Medicare, there are serious disagreements about how, or even if, this can be accomplished:

> Modernizing the Medicare program, by redesigning the benefits package, making fundamental changes in its administration and operations, and making sure that program eligibility makes sense given the demographics of the retiree population, could begin the process of establishing an infrastructure that can help support a more efficient health care system that serves the needs of the elderly and disabled. This is no easy task. It means taking the lead in research and development of methods of managing health care effectively, regulating markets, and helping beneficiaries make good decisions in a complex marketplace. Building a "better and smarter" Medicare program in an era in which government is often assumed to be the enemy will be difficult. Between the lines, much of the debate about the future of Medicare is about whether a major public program can be

26 *President's Plan to Strengthen and Modernize Medicare for the 21st Century,* National Economic and Domestic Policy Council: p. 1, July 2, 1999.

> administered efficiently. To be fair, policy makers need to recognize that Medicare has not yet had much of a chance to do what needs to be done. The reform debate needs to include an objective discussion of the pros and cons of allowing Medicare to use more of the management and administration tools available to the private sector organizations that are reshaping health care markets across the United States. *(Medicare and the American Social Contract)*

The study panels identified significant challenges, in terms of administration and oversight, posed by the implementation of a local or regionally-based system of structured market competition.

The Capitation and Choice Panel emphasized the importance of building an administrative infrastructure to support structured competition in Medicare. Its report noted that Medicare's responsibilities for oversight and beneficiary protection extend beyond those of other insurance sponsors, because it is responsible for enforcing regulations designed to protect beneficiaries and the Medicare program itself from fraud, abuse, deceptive practices, and discriminatory practices as well as for ensuring access to and quality of care. The BBA greatly expanded Medicare's responsibilities for obtaining and disseminating a wide range of information for beneficiaries to use in choosing among health plans. In a premium support system, the panel concluded, collecting, validating, and disseminating this information in ways in which it can be used by beneficiaries to make informed choices among health plan options is critically important, and developing this capacity will require significant investment in local, regional and national systems and organizations.

The Capitation and Choice Panel also noted that Medicare's responsibilities with regard to ensuring and improving quality of care are unique. In addition to establishing and regulating quality review standards for plans, Medicare supports a large external peer review system. Medicare is, moreover, the largest single force shaping national conceptions of what is appropriate and necessary medical care. Decisions about Medicare's coverage of medical technologies, procedures, or treatment regimens have national consequences. The panel concluded that the necessary infrastructure for incorporating these functions should be part of a restructured Medicare program:

> The basic standards for the types of information that need to be obtained from plans for quality oversight and for informing consumers should be national Medicare standards. National standards for ensuring meaningful choice are also needed in a restructured Medicare program. The standards should be designed to ensure equity in protections for all Medicare beneficiaries, including the right to obtain health care that is needed, when it is needed, at affordable costs. *(Structuring Medicare Choices)*

The Capitation and Choice Panel therefore recommended that:

> Medicare "conditions of participation" should be nationally consistent across Medicare choice entities. Appropriate standards

should be adopted in the areas of marketing; access to care (including specific rules regarding access to specialty care), continuity of care, and adequacy of provider networks; confidentiality; nondiscrimination; performance measurement and reporting, quality review and sanctions; utilization review and systems for appeals and grievances; and criteria for nonallowable physician incentive payment arrangements and disclosure of such arrangements. Regional entities should be authorized to institute additional or alternative requirements (that conform to national standards) with the approval of the Secretary of Health and Human Services. *(Structuring Medicare Choices)*

Drawing on the previous panels' deliberations, the Social Role Panel directed its attention to the broader policy implications of administrative reforms. While greater flexibility and increased capacity to implement change might be necessary for creating the "level playing fields" for effective competition among health care plans or providers, the panel raised questions about the complex issues involved in using the size of the Medicare program to leverage change in particular health care markets:

> Administrative reforms…would require not only additional statutory authority, but a reorientation in HCFA's approach to managing the program, away from operating primarily as a bill payer, toward assuming broader responsibility for Medicare beneficiaries' overall health. One major issue relates to Medicare's importance in many health care markets. The fee-for-service program has been open to all qualified providers; reforms that would limit the number or type of participating providers (in order to secure services from the most efficient in particular markets) could result in substantial, or even fatal losses to some provider organizations. This could clearly generate major political problems in specific areas. Further, to become an organization that actively managed health care, HCFA would need resources and staff with fairly specialized skills. It is not at all clear whether these resources would be made available, or whether a large executive branch agency would be given the autonomy to carry out an aggressive program of innovation and experimentation in an environment in which government is viewed negatively. Further, if experiments do not work out well, as is often the case in many other areas of the economy, it is not only the consumers and stockholders of the health care companies providing services who may pay the price, but the government and its taxpayers. *(Medicare and the American Social Contract)*

ISSUES FOR FURTHER CONSIDERATION

Two sets of inter-related issues associated with management and administration of a restructured Medicare program emerge from the panel reports.

First, there are specific questions that need to be addressed regarding the implementation of reforms affecting management of both FFS and structured competition in Medicare:

- Drawing on experience from competitive bidding demonstrations and other public and private sector experience with managed competition, selective contracting, and other arrangements, what administrative structures, authorities, and oversight mechanisms would be needed to implement structural reforms on a *national* basis?
- What legal issues, including anti-trust law and other provisions affecting health care providers and health insurance, might impede the implementation of restructured systems in local markets?
- In a premium support system, what should be the roles of HCFA, an independent public agency, or other public or quasi-public agency or board in making policy about benefits, coverage, or program administration and oversight? How would different configurations work, what resources would be needed, and how would these organizations interact with Congress and the executive branch in the operation of a system that is a publicly financed entitlement?

Second, there are basic questions about the administration of a public program as large and as complex as Medicare. Restructuring could add even greater complexity.

- If Medicare is restructured to take better advantage of local market competition, will HCFA's current structure, which includes only a skeletal presence in regional offices, be adequate? Would HCFA benefit from more extensive cooperation/involvement in the local and regional office structure Social Security has developed?
- What would be the practical implications of changing the standards by which performance of the FFS program is judged? How will policy makers decide whether increased program flexibility results in better care for the beneficiary population?
- How will Medicare deal with variation in services, prices, or plan performance across different market areas or regions of the country? Is it practical to hold the program to national performance standards for health as well as for efficiency?

Chapter 7:
Steering Committee Conclusions

The Medicare policy debate has moved forward over the past four years. Taken as a whole, the Academy study panel reports present a set of findings and recommendations that call for structural change of Medicare in order to preserve and strengthen it as a national social insurance program. At the same time, the issues and concerns that the panels pointed to the extreme difficulty of the task at hand. Policy makers will need to make explicit decisions about the extent to which Medicare beneficiaries should be asked to respond to, or be protected from, the consequences of competition in the health care marketplace. Tradeoffs must be made that involve the affordability of the reforms, enhanced efficiency in the delivery of services, beneficiaries' freedom to choose among health care providers and treatment options, and the government's responsibility to protect beneficiaries' health and financial security. The BBA and the work of the Bipartisan Commission helped to focus the debate about Medicare's future; discussion now has to move from whether the program should be restructured to how the policy-making process can build on an open and fair assessment of what reforms will mean for beneficiaries, providers, and taxpayers.

Major restructuring proposals, including the Breaux/Thomas Proposal and the Clinton Medicare Proposal have incorporated key recommendations from the Academy's study panel reports. The basic concept underlying these approaches to restructuring Medicare rests on making more use of the power of market competition to increase efficiency and effectiveness in health care for the elderly and disabled served by Medicare:

- Effective price competition among plans might be able to reduce the rate of increase in Medicare spending, if participating plans were able and willing to 1) increase productivity through innovations or improved administration, 2) make better use of purchasing power, and, 3), perhaps most importantly, develop more cost-effective approaches to the medical management of beneficiaries' health care.
- Because beneficiaries would pay higher premiums for high-cost plans, and lower premiums for lower cost plans, they should have clear incentives to seek out more efficient health care plans that meet their needs. If beneficiaries are willing to act on this information, this could reinforce market incentives to restrain costs and provide services and levels of quality valued by enrollees.
- Greater efficiency, and possibly lower overall costs, could be achieved by adopting a more adequate Medicare benefits package. Reforms that mitigate the need for supplemental insurance could reduce beneficiary demand for services (including those that are unnecessary or non-beneficial) and could reduce administrative costs associated with supplemental coverage.

The Academy study panels also identified serious concerns that need to be examined in greater depth if Medicare is to move toward replacing the traditional program with one

that would create financial incentives for both beneficiaries and providers to make more cost-conscious decisions about health care. Responsible debate about the costs and benefits of restructuring Medicare requires examining how the underlying concepts of structured competition can be applied in a national social insurance system.

Building on the findings, recommendations, and issues raised by the study panels, the Steering Committee plans to organize future Academy work on the future of Medicare analysis into three broad topic areas:

- How Medicare can address issues of provider payment, equity, and consumer protection in the diverse array of locally-structured health care and insurance markets;
- How Medicare can address assuring access to appropriate care for people with complex, chronic, and long-term health care conditions and disabilities; and
- How the administration and management of the program can work effectively in increasingly competitive markets.

Addressing these broad topics will require careful examination of complex technical issues, but the Steering Committee believes that the breadth and depth of the contributions of the four Academy study panels clearly demonstrates the value of working through these issues in the context of a comprehensive effort that remains focused on the purpose and implications of Medicare reform. The debate about the future of Medicare needs to be grounded in the far more difficult public discussions about how much we as a nation are willing to pay for health care for the elderly and disabled, as well as for everyone else, how we want decisions about placing limits on health care spending to be made; and how much of the health care for the disabled and elderly populations should be borne as a collective social responsibility. The Medicare Steering Committee will continue to do what it can to contribute to discussions about how to secure Medicare for future generations.

Appendix A

National Academy of Social Insurance Study Panel on Fee-For-Service Medicare

Paul Ginsburg, *Chair* (from February 1997)*
Center for Studying Health System Change

Janet Shikles, *Chair* (through January 1997)*
Abt Associates, Inc.,

Mark Chassin
Mt. Sinai Medical School

Lynn Etheredge
Consultant

Jon Glaudemans
Aetna U.S. Healthcare

Sheila Leatherman
United HealthCare Corporation

Suzanne Mercure
Barrington & Chappell

Judith Moore
National Health Policy Forum**

Alan Nelson
American College of Physicians-American Society of Internal Medicine

Steven Ringel
University of Colorado Health Sciences Center

Thomas Scully
Federation of American Health Systems

Lynn Shapiro Snyder
Epstein Becker & Green, P.C.

* Paul Ginsburg assumed the duties of Study Panel Chair when Janet Shikles left the U.S. General Accounting Office in February 1997. She is currently Vice President, Health Care Research and Consulting, Abt Associates, Inc., Washington, DC.

** Formerly a private consultant and full Panel member, Judith Moore became an ex-officio member when she took a position at the Health Care Financing Administration in August 1996. She is currently Senior Fellow, National Health Policy Forum, Washington, DC.

National Academy of Social Insurance Study Panel on Capitation and Choice

Joseph Newhouse, *Chair*
Harvard University

Richard Anderson
Kaiser Foundation Health Plan

Robert Berenson*
Health Care Financing Administration

Stuart Butler
The Heritage Foundation

Geraldine Dallek
Georgetown University

Judith Lave
University of Pittsburgh

Harold Luft
University of California at San Francisco

Charlie Pryde
Ford Motor Company

Alice Rosenblatt
WellPoint Health Networks

John Rother
AARP

* Robert Berenson was Medical Director, National Capital Preferred Provider Organization through the completion of the Study Panel's final report. He took his current position at the Health Care Financing Administration in April 1998. He is currently Director, Center for Health Plans and Providers, HCFA

National Academy of Social Insurance Study Panel on Medicare's Larger Social Role

Rosemary A. Stevens, *Chair*
University of Pennsylvania

Lawrence Brown
Columbia University

David Blumenthal
Massachusetts General Hospital

Norman Daniels
Tufts University

Merwyn Greenlick
Oregon Health Sciences University

Marsha Lillie-Blanton
Johns Hopkins University

David Meltzer
University of Chicago

David Moss
Harvard Business School

Thomas Paine
Consultant

Uwe Reinhardt
Princeton University

Kathleen Utgoff
Center for Naval Analyses

Fredda Vladeck*
Consultant

* International Brotherhood of Teamsters through September 1998

National Academy of Social Insurance
Study Panel on Medicare's Long-Term Financing

Marilyn Moon, *Chair*
The Urban Institute

Sheila Burke
Harvard University

Judith Feder
Georgetown University

Robert Helms
American Enterprise Institute

William Hoffman
Oster Enterprises

Walter Maher
Daimler-Chrysler Corporation

Martha Phillips
The Concord Coalition

Anna Rappaport
William M. Mercer, Inc.

William Scanlon
U.S. General Accounting Office

James Tallon
United Hospital Fund of New York

Robert Valdez
University of California at Los Angeles

Appendix B
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M.E. Gluck and P. Ginsburg, (eds.), *From A Generation Behind to a Generation Ahead: Transforming Traditional Medicare,* Final Report of the Study Panel on Fee-for-Service Medicare (Washington, DC: National Academy of Social Insurance, January 1998).

J. Bernstein and J.P. Newhouse, (eds.), *Structuring Medicare Choices.* Final Report of the Study Panel on Capitation and Choice (Washington, DC: National Academy of Social Insurance, April 1998).

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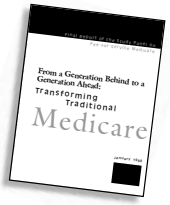

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