RESTRUCTURING MEDICARE FOR THE LONG TERM PROJECT

Interim Report

Securing Medicare's Future:

What are the issues?

March 1997

NATIONAL ACADEMY OF SOCIAL INSURANCE

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The Academy convenes steering committees and study panels that are charged with conducting research, issuing findings and, in some cases, reaching recommendations based on their analyses. Members of these groups are selected for their recognized expertise and with due consideration for the balance of disciplines and perspectives appropriate to the project.

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FOREWORD

The pending insolvency of the Hospital Insurance Trust Fund, pressure to control federal spending (particularly health care spending), and the aging of the Baby Boom generation will require that policymakers consider seriously and in a systematic fashion alternative approaches to restructuring the Medicare program.

The National Academy of Social Insurance has mounted a project, *Restructuring Medicare for the Long Term*, which is designed to produce objective and timely analyses of some of the most important questions facing those who will be charged with restructuring Medicare. For this purpose, the Academy has assembled a diverse Steering Committee and study panels of experts from fields including economics, finance, law and public policy, medicine, gerontology, public health, and sociology. The comprehensive study agenda of the project will be carried out over a three-year period. Each of the four study panels is addressing 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. Each panel will produce its own report, drawing policy-relevant conclusions based on analysis of available evidence. In addition to coordinating the work of the study panels, the Steering Committee will synthesize the results across the project in its own reports and help disseminate findings.

As described in this Interim Report of the Steering Committee, Medicare's most significant long-term challenges include assuring the program's long-term fiscal health, its ability to protect beneficiaries adequately against the costs of needed health care, and the provision of such social goods as the training of medical professionals and the maintenance of health facilities for uninsured and underserved populations.

This report also outlines the project's framework for addressing the key research and policy questions these challenges pose for policymakers and describes work already underway as part of the project. An appendix provides a brief overview of salient Medicare program characteristics that provide context for our study panels. The intent is to raise questions and to introduce issues that can, even before the project's work is done, inform discussions among policymakers, including members of Congress, their staff, and executive branch officials, as well as researchers, policy analysts, and anyone else interested in the future of Medicare.

The National Academy of Social Insurance would like to acknowledge the Robert Wood Johnson Foundation, the Pew Charitable Trusts, the Henry J. Kaiser Family Foundation, Kaiser Permanente, and The Commonwealth Fund who have provided generous financial support for this project. In addition, the substantial time and effort given by members of the Steering Committee and Study Panels have been essential in making the project possible. Ampersand, Incorporated provided graphic design for this report, and Regina Tosca copy edited the final text.

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EXECUTIVE SUMMARY

Medicare, which has successfully provided health insurance to people over 64 and to people with disabilities, remains highly popular after 30 years. In 1997, Congress is considering changes in the program as part of an effort to balance the federal budget and to avoid insolvency by 2001 in one of the trust funds that finances Medicare. These changes will likely leave the basic structure of the program intact and will not address several significant long-term challenges to Medicare. What are these long-term challenges?

THE CHALLENGE OF MEDICARE'S LONG-RANGE FINANCING

Without significant restructuring of the program, Medicare spending is projected to rise from 2.6 percent of national income (gross domestic product) in 1996 to 7.8 percent in 2035 and 8.8 percent in 2070. This increase will be the result of two factors:

1. an aging population, and
2. increases in the costs of health care resulting in part from the largely unconstrained adoption of advances in medical science (both technology-intensive innovations and care for chronic conditions) and from lack of consensus about when and how to control those costs.

As Medicare's costs increase, revenues into the program under current policy will not keep pace. Medicare's Hospital Insurance (HI) Trust Fund receives the vast majority of its income from payroll taxes on employers and workers. As the Baby Boom retires, the number of workers per Medicare beneficiary will drop sharply. Medicare's Supplementary Medical Insurance (SMI) Trust Fund that pays for physicians and outpatient services receives 75 of its funds from general tax revenues.

The federal government may slow the growth in Medicare costs by continuing to reduce how much it pays physicians, hospitals, and other providers. But at some point, such cuts may affect beneficiaries' quality of care. Relying on health maintenance organizations (HMOs) and similar health plans to slow cost increases is unlikely to produce needed savings. On average, Medicare currently pays HMOs more than it would under the traditional fee-for-service program. If the government were to substantially reduce its payments to HMOs and leave fee-for-service Medicare unchanged, plans might be willing to invest less to serve the Medicare market, making these plans potentially less attractive to beneficiaries.[1]

PROTECTING AGAINST OUT-OF-POCKET HEALTH CARE EXPENSES

An original goal of Medicare was to finance medical care for people aged 65 and older. 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.

[1] This is not to deny emerging evidence of exemplary health plans that may provide appropriate, quality services (particularly for chronic care) that beneficiaries find attractive while containing costs. Such examples offer researchers the opportunity for further study and potential replication.

Health care needs and medical practice have changed significantly since then:

1. the population has aged and will continue to do so,
2. beneficiaries with chronic and long-term care needs represent a larger portion of the Medicare population than they did at the program's inception, and
3. health care given to 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.

The net effect is that Medicare now pays for a lesser share of its beneficiaries' total health care costs than it did at its inception, and, on average, beneficiaries devote a larger share of their income to out-of-pocket health care expenses than they did at the program's inception. Further, policymakers may wish to consider whether the program's benefits should be restructured to pay for a more effective package of health care services that *maintain health*, rather than just *treat illness*.

MEDICARE'S SUBSIDIZATION OF OTHER SOCIAL GOODS

Medicare subsidizes other policy objectives, including the training of new medical personnel and the support of health care facilities that treat large numbers of individuals without health insurance. These institutions, which the government has deemed to perform 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 total payments to hospitals.

Traditionally, "disproportionate share" and teaching hospitals have depended on private insurance, in addition to Medicare, for support. However, HMOs and other types of managed care's selective use of these higher cost institutions reduces revenues to disproportionate share and teaching hospitals. HMOs bear a smaller share of the costs of treating the uninsured, leaving Medicare to bear a greater share of the responsibility for their costs.

The expansion of managed care increases the urgency of long-range questions about if and how Americans want to subsidize medical education and the availability of facilities to treat low-income patients.

THE ACADEMY'S MEDICARE PROJECT

The Academy's project, *Restructuring Medicare for the Long Term*, convened this Steering Committee to address these long-range challenges through timely, balanced analysis. The Steering Committee is bringing together four expert Study Panels to examine both philosophical and technical aspects of Medicare's future. Once the four Study Panels have released their final reports, the Steering Committee will synthesize their conclusions and disseminate the result to policymakers.

STUDY PANEL I: BUILDING AN INFRASTRUCTURE FOR MEDICARE CAPITATION

Private health insurance has moved from a largely fee-for-service system to one characterized by competitive purchasing of health

insurance in an effort to slow cost increases and to improve quality. Recent proposals incorporate some of these same ideas into Medicare. The principles underlying these proposals 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.

This Academy Study Panel is examining several of the most important issues inherent in establishing the infrastructure for such a system. These include:

- the decisions government faces in establishing a system with greater capitation and beneficiary choice of health plans;
- issues in the implementation of "risk adjustment;"
- the potential for Medicare of "carve-outs" for specific services or populations;
- how to protect consumers from the risks associated with such a system.

The Panel will release its final report and findings in 1997.

STUDY PANEL II: MODERNIZING FEE-FOR-SERVICE MEDICARE

Despite the rapid growth of Medicare's capitated health maintenance organization (HMO) program, about 86 percent of beneficiaries still receive care through the traditional fee-for-service program. Even if the capitated program were to continue to grow, there would likely be a role for fee-for-service well into the future. Some beneficiaries may not find a capitated 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 fee-for-service likely to remain a major part of Medicare, assuring quality of care and efficient management of utilization, costs and administration will remain priorities.

This Study Panel's work has three foci: (1) the applicability of tools for managing care in private fee-for-service insurance for Medicare, (2) how 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 will release its final report and findings in 1997.

STUDY PANEL III: MEDICARE'S LARGER SOCIAL ROLE

A third Panel, convened in January 1997, is exploring the roles Medicare plays in American society. It is focusing on the underlying philosophical principles and rationales for the program and how it interacts with other publicly supported health care programs. Among the topics on its agenda:

- do Medicare's original social insurance principles still make sense after 30 years?;
- potential conflicts between the goals of protecting beneficiaries and the need to keep Medicare fiscally stable;
- the appropriateness of the benefit package, including Medicare's ability to find the most appropriate models of providing

quality care for chronically and terminally ill persons;

- Medicare's role in supporting medical education and health facilities serving uninsured individuals.

The Panel will release its final report and findings in 1998.

STUDY PANEL IV: ISSUES IN MEDICARE FINANCING

The Academy will convene a fourth Medicare Study Panel later in 1997 to explore issues surrounding financing in the next century including:

- What options exist for increasing revenues to the program (from either beneficiaries or workers), and what are their implications?
- What options exist for changing beneficiaries' financial liability, and what are their implications?
- What are the implications of limiting payments to providers over the long run?
- How might eliminating the distinction between Part A and Part B benefits affect the program's financing?

The Panel will examine these questions against the backdrop of issues under consideration by the Study Panel on Medicare's Larger Social Role, including the financing implications of alternative benefits packages and innovative models of care delivery. The two Study Panels may engage in joint analyses of these issues. The Panel will convene in 1997 and release its final report in 1998.

NEXT STEPS

During the first half of 1998, the Academy's Medicare Steering Committee will reflect on both the findings of the four Study Panels and any enacted legislation or other public policy developments to produce one or more final reports of its own. In preparing these documents, the Steering Committee will synthesize the work of the Panels and draw out common themes to foster greater evidence-based, open-minded discussion and policy-making to solve Medicare's long-term challenges.

MEDICARE'S LARGER SOCIAL ROLE: WHAT ARE THE ISSUES?

INTRODUCTION

After 30 years, Medicare remains highly popular with the American people. They judge this social insurance program, which provides primary health insurance to people 65 and over and certain people with disabilities, to be a success (36). During 1997, Congress will likely consider reductions in Medicare spending as part of its plans to balance the federal budget by 2002. In 1996, Medicare expenditures constituted 12 percent of the budget, a figure that has more than doubled since 1975. The amount by which Medicare expenditures exceeded premiums from beneficiaries and other program revenues in 1996 represented about half of the total federal deficit in that year (48). Medicare spending cuts that may be included in deficit reduction actions will likely delay the date of insolvency of the Hospital Insurance (Part A) Medicare trust fund. This trust fund reimburses hospitals, hospices, skilled nursing facilities, and home health care agencies. The most recent estimates by the fund's trustees show that, without action, it will exhaust its reserves and lack sufficient funds to pay for beneficiaries' health care by 2001.

The Clinton Administration's January 1997 proposals to address these problems would leave the basic structure of Medicare largely unchanged. The bulk of savings would be drawn by cutting reimbursements to providers and health maintenance organizations (HMOs) that serve Medicare beneficiaries. In the 1996 election campaign, President Clinton suggested that Congress create a bipartisan commission in 1997 to recommend more substantial reforms. It appears unlikely that the Administration or the Congress are now ready to adopt changes that address long-term, fundamental issues in Medicare.

Thus, even if legislation enacted this year brings the federal budget into balance and extends the life of the Hospital Insurance (HI) Trust Fund, Medicare will still face long-term challenges. What are they?

MEDICARE'S LONG TERM CHALLENGES

Over the next several decades, Americans will need to address long-range challenges facing Medicare including: (1) how to pay equitably for health care for an aging population; (2) whether Medicare is adequately and appropriately protecting families against the cost of health care; and (3) what role Medicare should have in subsidizing the training of new medical professionals and in subsidizing certain types of hospitals and other health care institutions.

THE CHALLENGE OF LONG-RANGE FINANCING

Medicare's costs over the next several decades are projected to grow more rapidly than the economy. In their 1996 report gauging Medicare's short- and long-term financing, the Trustees of the Social Security and Medicare Trust Funds projected that with no changes, total Medicare spending will rise from 2.6 percent of Gross Domestic Product (GDP) in 1996 to 7.8 percent in

2035 and 8.8 percent in 2070 (6).[1] One of the major causes of this expected increase is the growth in the number of beneficiaries. While Medicare beneficiaries represented 14 percent of the population in 1995, they are projected to grow to 22 percent by 2030 (56).

The other major factor that will drive Medicare's costs is the increase in the program's cost per beneficiary. This issue is not unique to Medicare, but rather, emblematic of rising health care costs overall. The private sector and other government programs, including Medicaid, are all attempting to restrain the growth of health care costs.

Experts usually identify advances in medical science (both technology-intensive innovations and care for chronic conditions) as well as when and how these services are provided as significant factors in explaining why per capita medical costs have grown faster than per capita income over the last three decades (56, 46). Cost-increasing innovation is projected to continue over the long term. Using data from the 1996 Trustees report and the Social Security Administration's (SSA) actuaries, the Congressional Budget Office (CBO) projects that per capita Medicare costs will continue to grow at an average of 8 percent per year through 2010 but slow to 5.4 percent per year thereafter (56).

Under current policy, revenues flowing into the Medicare's HI Trust Fund will not keep pace with its increasing disbursements, eventually making the fund insolvent even if spending reductions enacted in 1997 delay the date of insolvency. The HI Trust Fund receives most of its funds from a tax of 1.45 percent of earnings that is paid by workers and matched by their employers for a total tax of 2.9 percent of payroll.[2] As the Baby Boom retires, the number of workers per Medicare beneficiary is projected to drop from 3.9 in 1995 to 2.2 in 2030 and to 2.0 in 2060, thus reducing revenues per beneficiary (6). Figure 1 shows the Trustees' best estimate of the growing gap between costs and revenues in the HI Trust Fund, expressed as a percentage of taxable payroll.

While the Supplemental Medical Insurance (SMI) Trust Fund that pays for physician services and outpatient medical procedures cannot become insolvent, it is projected to represent a growing share of the federal budget. The SMI Trust Fund now receives 75 percent of its monies from general tax revenues and 25 percent from monthly premiums deducted from beneficiaries' Social Security checks.[3] Under current law, increases in the SMI premium after 1998 will be limited to increases in the cost of living as measured by the Consumer Price Index. Consequently, assuming that Congress does not change this provision, the general fund will pay a larger percentage of total SMI costs after 1998. Figure 2 shows the Trustees' best estimate of how the SMI Trust Fund's financing needs will grow over the next several decades.

Although Congress might attempt to slow projected cost increases by continuing to cut

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[1] See Appendix B for a summary of the structure and role of the Medicare trust funds and projections of their financial status.

[2] A small percentage of beneficiaries who do not qualify for HI benefits through their work history opt to pay a premium for coverage; these premiums go into the HI Trust Fund. In addition, some revenue from taxation of Social Security benefits is earmarked for the HI Trust Fund.

[3] Currently, the premium is set to equal 25 percent of the average Medicare spending for each *elderly* beneficiary.

reimbursements to hospitals, physicians, and other health care providers in future years, such a strategy may have limits. At some point, additional reductions in provider payments would adversely affect beneficiaries' access to and quality of care. As reimbursements fall, doctors and hospitals may be less willing to treat Medicare patients, or the quality of care that would be provided may not keep pace with that available to the rest of the population.

Another strategy proposed for containing costs, enrolling greater numbers of Medicare beneficiaries in HMOs, will not save money without substantial restructuring of the program. Some studies suggest that under the current method of paying HMOs that serve Medicare beneficiaries through "risk contracts," Medicare may spend, on average, between 5 and 8 percent more than it would under the traditional fee-for-service component of Medicare for those enrolled in HMOs (49, 69).[4]

If Congress were to substantially cut payments to HMOs (while continuing to tie such payments to fee-for-service reimbursements), HMOs might invest less to serve the Medicare market, making them potentially less attractive to beneficiaries. Currently, almost all Medicare HMOs provide benefits not included in the traditional Medicare benefit package such as preventive services and outpatient prescription drug coverage. In 1995, 51 percent of Medicare HMOs charged beneficiaries no premiums for these extra benefits, and another 25 percent charged a lower premium than enrollees would have paid for private insurance that supplements Medicare (64). Cuts in payments to HMOs may reduce health plans' willingness to provide such benefits, leading fewer Medicare beneficiaries to enroll in HMOs. Furthermore, while the experience of HMOs for the privately insured in certain areas of the country appears to have been successful in helping to bring down health care costs, they can require a significant investment in administrative capacity and concerns about quality of care continue to be raised (74).[5]

IS MEDICARE ADEQUATELY PROTECTING AGAINST OUT-OF-POCKET HEALTH CARE EXPENSES?

Medicare beneficiaries pay more for their health care than they did 30 years ago. Large cuts in payments to providers could further undermine program objectives of protecting beneficiaries and their families against the costs of health care and assuring the delivery of appropriate benefits.

In 1965, the benefit package that Congress adopted for Medicare was adequate for the times. The program's architects modeled it to resemble the most common private health insurance provided by employers to working Americans (40, 3). This package focused on acute care — diagnostic and therapeutic services provided in hospitals and physicians' offices. Neither Medicare nor the typical pri-

[4] Looking beyond these averages, actual payments to HMOs by the federal government for each Medicare enrollee vary across the country according to the current payment formula. Appendix B summarizes current opportunities for Medicare beneficiaries to enroll in HMOs and similar plans as well as the formula used to determine Medicare's payments to these health plans.

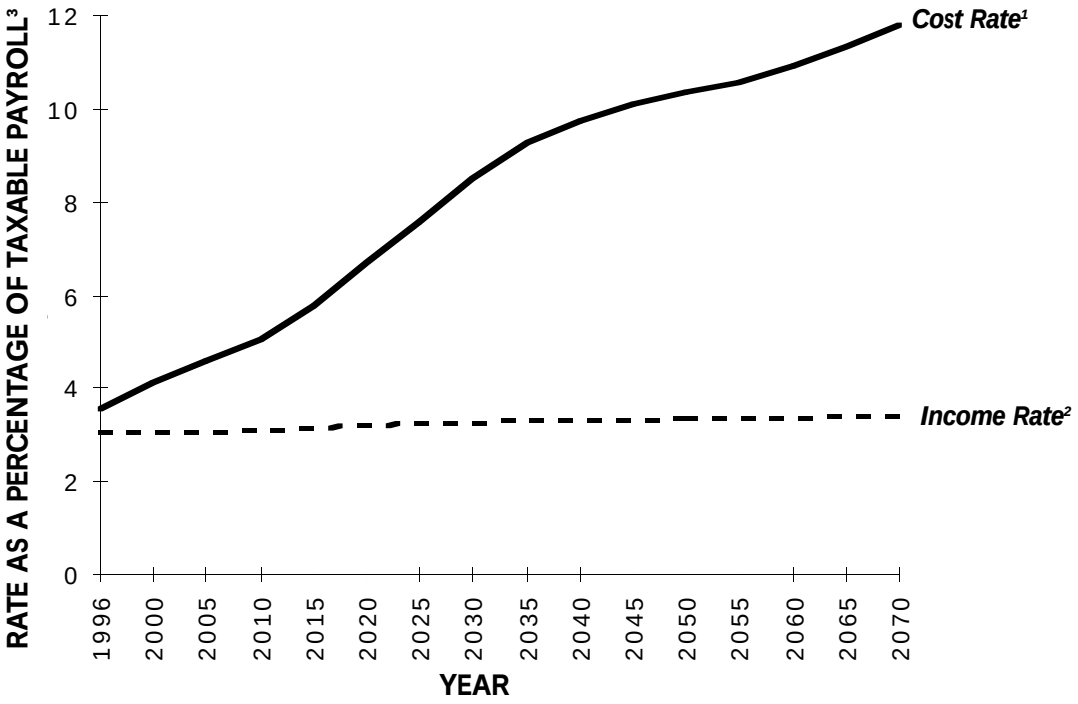
[5] This is not to deny emerging evidence of exemplary health plans that may provide appropriate, quality services that beneficiaries find attractive (particularly for chronic care) while containing costs. Such examples offer researchers the opportunity for further study and potential replication.

vate insurance package provided coverage against catastrophic medical expense, prescription drugs, or other services likely to be used by individuals with chronic conditions. These benefit packages also reflected the predominant way in which physicians practiced medicine in the mid-1960s, with an emphasis on curative care provided in hospitals and by physicians in solo and small group practices (52, 23).

Health care needs and medical practice have changed significantly since the mid-1960s:

- The population has aged. The growth in the proportion of the population over age 65 has resulted from increases in life expectancy and decreases in fertility. Expected years of life remaining at age 65 rose from 12.9 years for men and 16.3 years for women in 1965 to 15.4 and 19.2 years respectively in 1992 (64). At the same time, fertility rates (measured as the number of live births per 1000 women age 15-49) fell from 118.0 in 1960 to 70.9 in 1990 (58). The primary factor lying behind the aging of the population in the first half of the next

FIGURE 1
MEDICARE'S HOSPITAL INSURANCE (HI) TRUST FUND: LONG-TERM INCOME AND COSTS



Notes:

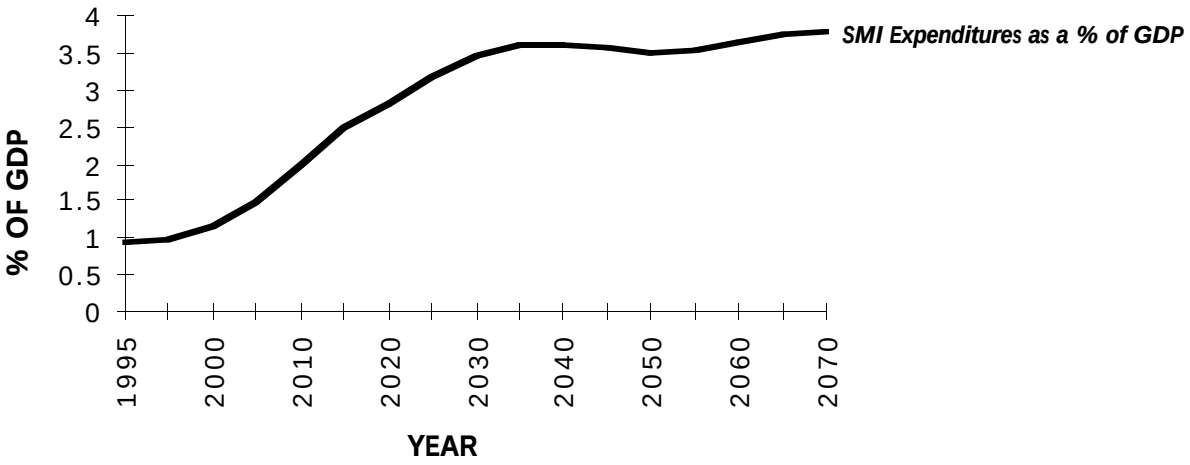
1 The ratio of Medicare expenditures to taxable payroll.

2 The ratio of Medicare tax income to taxable payroll.

3 Taxable payroll is the earnings in covered employment that are taxable under Medicare. This measure is used to allow comparisons between different time periods along a common standard since the value of the dollar changes over time.

Source: 1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.

FIGURE 2
MEDICARE'S SUPPLEMENTARY MEDICAL INSURANCE (SMI) TRUST FUND: LONG-TERM EXPENDITURES AS A PERCENTAGE OF GDP[1]



Notes:

[1] SMI Expenditures are displayed as a percentage of Gross Domestic Product, a measure of all the goods and services produced in the United States, to indicate the increasing burden to the economy of SMI benefits. SMI costs are not expressed as a percentage of taxable payroll because general revenues and beneficiary premiums finance the program, not taxable payroll.

The dip in the curve after 2035 reflects projections of smaller increases in per capita health care costs in later years; SMI expenditures as a percentage of GDP rise again after 2050 reflecting the impact of demographic projections.

Source: 1996 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.

century will be the large number of Baby Boomers, who will begin to turn 65 around 2010. The percentage of the population over age 65 was 9.5 percent in 1960, but is expected to climb to 13 percent in 2000 and 21 percent in the year 2040. The portion of the population over age 84, which was 1 percent in 1980, is projected to grow to 4 percent by 2040 (30).

- **Medicare beneficiaries have more chronic conditions and long-term care needs than they did at the program's inception.** Because the oldest of the old (the fastest growing part of the Medicare population) are more likely than others to have chronic illnesses or disabilities (41), the proportion of beneficiaries with chronic and long-term care needs in the Medicare population has increased. The development of medical technology which has brought about the increase in life expectancy also turned conditions like heart disease that were often quickly fatal into manageable chronic ailments that beneficiaries live with for many years, but that require ongoing monitoring and treatment.
- **Health care services received by Medicare beneficiaries reflect these changes and the availability of new medical technology.** Medicare beneficia-

ries are more likely than in the past to require and receive long-term care including assistive services to manage disabilities. Advances in medical science have led to a better understanding of the need for and benefit of detecting and treating many chronic illnesses like hypertension and high cholesterol. These conditions can be treated effectively by pharmaceuticals in ways they could not in 1965. Hence, Medicare beneficiaries are more likely to use such prescription drugs than they were when the program began. Other innovations in technologies and services mean that health care can offer Medicare beneficiaries more diagnostic and therapeutic services than it could 30 years ago.

While the health care needs of Medicare beneficiaries have become more chronic, the benefit package has remained largely acute in its focus.[6] When Congress has added limited preventive chronic care benefits to Medicare, it has done so in a piecemeal and unsystematic manner — coverage of certain screening tests and immunizations, coverage of certain drugs (e.g., for beneficiaries who have had organ transplants), coverage for a particular health condition (i.e., end-stage renal disease), and some limited long-term care (e.g., hospice, respite care). This has resulted in a complicated and potentially uneven set of benefits beyond the program's coverage of acute services.

The typical private health insurance package, on the other hand, has expanded to include coverage for many of the interventions medicine can now provide. For example, most private health plans now include some form of prescription drug coverage (66, 67) and catastrophic coverage limiting the insuree's total out-of-pocket expenditures. Medicare now pays for less of its beneficiaries' total health care costs than it did at its inception, and beneficiaries' out-of-pocket health care costs, as a percentage of their income, have risen (42).

In 1994, Medicare paid for 79 percent of total spending on hospital services for older persons, 59 percent of spending for physician services, and none of the $12 billion spent on outpatient prescription drugs for older persons (29). In addition, for services covered by Medicare, the average beneficiary's cost-sharing (the amount not paid by Medicare) increased 56 percent in real dollars between 1977 and 1993 (59, 20).

Medicare beneficiaries have increasingly come to rely on supplemental insurance to pay Medicare deductibles and copayments and to cover some of the services not included in the Medicare benefit package. In 1993, 89 percent of Medicare beneficiaries had such a policy, including those eligible for Medicaid (64).[7] Although some retirees can rely on their former employers to pay at least part of the premiums for this supplemental insurance, their out-of-pocket costs for this insurance were still, on average, $728 in 1992. Those who purchase their own supplemental insurance pay premiums that average $1,014

[6] Appendix B describes Medicare's benefits in greater detail.

[7] Among beneficiaries over age 64, 31 percent had employer sponsored policies, 32 percent had individual Medigap policies, 8 percent had both employer and individual policies, 7 percent were enrolled in an HMO, 13 percent had Medicaid coverage, and 9 percent had no coverage to supplement Medicare. Among disabled beneficiaries under age 65, 8 percent had employer-sponsored policies, 20 percent had individual Medigap policies, 2 percent had both employer and individual policies, 3 percent were enrolled in an HMO, 41 percent had Medicaid coverage, and 26 percent had no coverage to supplement Medicare (64).

per year (12). Poor, near poor, and those with impoverishing medical expenses may have Medicaid coverage to supplement Medicare or to pay their cost-sharing obligations. However, out-of-pocket expenses as a percentage of income rise as income falls among Medicare beneficiaries 65 and over. Those with incomes less than the poverty line pay 30 percent of their income, while the average for all persons over 65 is 21 percent (42).

As pointed out in the previous section, the Medicare Trustees project that per capita Medicare costs will grow at 8 percent a year until 2010 and 5.4 percent a year thereafter. They project that after 2004, inflation will average 4 percent per year. If Social Security, the main source of income for most beneficiaries, is held to the rate of inflation while the cost of supplemental insurance continues to grow at a rate approximating that of Medicare, then out-of-pocket health care costs for Medicare beneficiaries will consume ever greater portions of their income in the future.[8] The potential strain on beneficiaries' income underscores that policymakers will have to take action over the long term to avert these projected trends.

Beyond the question of whether Medicare is adequately protecting families against the cost of health care, some have suggested that the program should be reoriented so that it pays for not only *treating illness*, but also for *maintaining health* by covering services that prevent illness (19). These include preventive services such as more disease screening, counseling in the home to avoid injuries common to older persons, or to improve nutrition, and other non-medical support services to assist those limited in their daily activities or to help keep beneficiaries from needing acute care (4). Recent analyses have also noted the lack of sufficient knowledge about the health needs of older people and the outcomes of health care provided to them. In recommending that researchers systematically address these issues, these recent reports stress the value of outcomes data in designing a clinically appropriate Medicare program and in assuring quality of care (44, 32).

The changes that Congress and the President might adopt this year are not likely to address either the appropriateness of Medicare's benefit package in a systematic way or whether Medicare is adequately protecting beneficiaries and their families against the costs of health care. Furthermore, any expansion of Medicare coverage to lower out-of-pocket expenses for beneficiaries, or to add benefits, would increase Medicare costs and exacerbate the program's long-term fiscal imbalance. Consequently, in any restructuring process, policymakers will be forced to grapple with conflicting objectives.

CHALLENGES POSED BY MEDICARE'S SUBSIDIZATION OF OTHER SOCIAL GOODS

Medicare payments to hospitals subsidize other activities in the health care system that are deemed desirable. These activities include the training of new medical personnel and supporting health care facilities that treat high proportions of low-income, uninsured individuals. Hospitals that take on these

[8] If Congress were to cut benefits, Medigap costs for beneficiaries could grow even faster as they begin to cover benefits no longer part of Medicare.

responsibilities have higher costs than other institutions.

Medicare subsidizes hospitals that take on these activities in three ways: disproportionate share (DSH) payments, indirect medical education (IME) payments, and direct graduate medical education (GME) payments.

Hospitals receiving DSH payments have higher costs because of their location (often in urban areas), the greater health care needs of their patients, and the fact that their patients are more likely than patients in other hospitals to lack insurance or other resources to pay for their care (71). Over time, the DSH program has come to be viewed as a mechanism to preserve access to care for low-income populations (70). Many DSH hospitals are also teaching hospitals which are facing significant financial problems related to competition, and to reductions in funding and subsidies at the state and local levels (70). DSH payments totaled about $4.3 billion or about 5.9 percent of all funds provided under Medicare's Prospective Payment System (PPS) for hospitals in 1996 (57).[9]

IME payments compensate hospitals for the higher indirect costs associated with services provided, case mix, and training new physicians and other medical personnel. Such hospitals tend to have sicker patients with more complicated illnesses, and they tend to provide more expensive services than the average hospital. The IME payment to each hospital increases with the number of residents and interns per hospital bed, which is a measure of the intensity of the institution's training activities (71). IME payments also totaled $4.3 billion in 1996 and represented another 5.9 percent of PPS payments.

GME payments to hospitals directly support physicians and other medical professionals in training. The payments depend on six factors: (1) the hospital's reported training costs when PPS was first introduced in 1984; (2) an annual update of this figure; (3) the number of interns or residents trained; (4) their medical specialties; (5) how far along they are in their training; and (6) Medicare's share of all care provided in the hospital. In 1996, GME payments totaled $2 billion for training physicians, with another $300 million for training nursing and other health professionals (71).

Medicare is not the only source of revenue to support these activities. Hospitals also depend on other public and private insurers explicitly or implicitly to cross subsidize training and the treatment of low-income patients (22). As HMOs and other types of managed care more selectively use low-cost hospitals, they divert patients from higher cost institutions like teaching hospitals and those with a disproportionate share of low-income individuals. Consequently, revenues to teaching and disproportionate share hospitals decline and Medicare bears a greater share of the responsibility for their costs (17, 22).

In addition, the growth of HMO enrollment *within* Medicare further erodes funds available for training and disproportionate share institutions. The formula for determining how much Medicare pays HMO enrollees implicitly includes DSH, IME, and GME payments.[10] But, the Medicare HMOs are not necessarily using teaching and dispropor-

[9] See Appendix B for a description of PPS.

[10] See Appendix B for a description of how Medicare determines these payments to HMOs.

tionate share hospitals, and even if they are, they are not necessarily passing on the payments to these facilities (70, 33).

Throughout its history, Medicare has been a convenient and effective mechanism to help fund graduate medical education and assure the availability of hospitals for vulnerable populations. Rapid changes in the health care system are shifting a greater burden to fee-for-service Medicare to accomplish these objectives. These changes pose significant questions for the future:

- what kind of health care work force and facilities will we need in the next century?;
- what should be the roles of the federal government and the private market in helping to assure their availability?; and
- is Medicare the federal government's best tool for doing so, and if not, how else might the federal government fulfill the role it deems appropriate in securing these public goods?

THE ACADEMY'S MEDICARE PROJECT

The Academy's project, *Restructuring Medicare for the Long Term*, convened a Steering Committee to address these long-range challenges. The Steering Committee is bringing together four expert Study Panels to address specific aspects of Medicare's long-term future. These include both the broad, philosophical underpinnings of this social insurance program and more narrowly focused technical questions. The first two Study Panels are examining technical questions that need to be sorted out if Medicare were to:

- place greater reliance on "capitated" health plans which beneficiaries would have to choose among; and / or
- modernize the traditional fee-for-service component of Medicare to incorporate some of the management tools being deployed in private health insurance (69, 1, 41, 9).

The third Study Panel is analyzing the social roles Medicare has played over the last 30 years and the policy implications of alternative philosophical bases for Medicare for the next several decades. The fourth Study Panel, which will begin in 1997, will examine issues surrounding long-range Medicare financing.

The Study Panels will begin to release their findings in 1997. The Steering Committee will then synthesize conclusions from all four Study Panels and disseminate the results to policymakers. Appendix A lists the members of the project's three Study Panels whose work is currently underway.

STUDY PANEL I: BUILDING AN INFRASTRUCTURE FOR MEDICARE CAPITATION

Private health insurance has moved from a largely fee-for-service system to one characterized by capitated plans in a competitive market using a variety of purchasing techniques in an attempt to control costs and improve quality of care (18). Some have proposed incorporating these ideas into Medicare (31, 1, 9, 14). These principal features of such a Medicare system would include:

- capitation, in which a fixed amount is paid to a health plan for each Medicare beneficiary enrolled in the plan for all covered services needed in a specified period of time (69);

- a choice among health plans which will offer enrollees several plans from which to choose, with the aim of stimulating competition among health plans to promote efficiency in the delivery of care and to slow the growth of health care costs; and
- risk-sharing arrangements in which the government limits its financial contribution for enrollees' health care, which would make beneficiaries and health care providers become more financially responsible for their health care decisions (34).

If future Medicare reforms were to incorporate these principles, policymakers would need to develop the infrastructure to make them work. Study Panel I is examining issues inherent in establishing that infrastructure:

- the options for government to equitably and efficiently structure beneficiaries' greater choice of health plans;
- implementation and management of mechanisms to avoid "risk selection" in which capitated health plans seek only the healthiest, least costly patients; and
- ways to protect beneficiaries against the consequences of uninformed or unfortunate choices of their health plans.

Structuring Choice

There are many ways in which to structure a Medicare program that incorporates greater choice among capitated health plans. The Study Panel is identifying the decisions policymakers will have to make and the implications of alternative structures.

The questions that policymakers will face include:

- How might the federal government's and beneficiaries' contributions to premiums be determined? Would the government's contribution to plans be an administrative price determined by the federal government through a formula, or would it be determined through some type of competitive bidding process? Would beneficiaries in a region all face the same premium or face different premiums depending on their choice of plan? Should plans be able to charge beneficiaries above the Medicare-paid premium?
- What plans might be allowed to participate? Would all qualified plans be allowed to participate, or only a small number? Which criteria would determine who could participate?
- How often would beneficiaries be allowed to change health plans? How long would they be locked in to their choices? Would beneficiaries have an annual or a monthly open enrollment period in which to choose a plan? Would beneficiaries be locked-in for a month, or a year? A longer lock-in creates a more stable market, but restricts movement between plans by beneficiaries.
- What new administrative infrastructure might be needed to implement and administer the program? Would Medicare's administration differ greatly from the current system? What role would the Health Care Financing Administration (HCFA), states, and other public and private agencies play? How would fee-for-service Medicare be administered?
- What would be the implementation and administrative costs? Would the system be expensive, offsetting savings to Medicare?

- What transitional issues emerge? What are the implications of gradual versus rapid implementation?
- What would be the role of traditional fee-for-service Medicare under the new system? Would it be treated as another equal choice or as a residual program? Would there be a role for Medigap and other private supplemental insurance policies?
- What might be the implications for beneficiaries' private supplemental insurance? What would be the role of employers in a new system? What should HCFA do if a health plan subsidizes the HMO premium for enrolled retirees?

The Academy has commissioned two background papers by experts with different perspectives to help address these issues and serve as a starting point for the Study Panel's own discussions. In answering the above questions, the authors of the papers and the Panel will draw on the experiences of public and private sector models that attempt to make use of these same principles (e.g., Buyers Health Care Action Group in Minnesota, Pacific Business Group on Health, California Public Employees Retirement System).

Risk Selection

"Risk selection" and "biased selection" describe a situation in which health plans attract enrollees with disproportionately high or low needs for health care services. Risk selection becomes a problem in Medicare if these differences are not accounted for in the formula that determines the plans' payment from the federal government for each Medicare enrollee. Risk selection can occur through actions by both beneficiaries and health plans. Healthier beneficiaries may prefer HMOs over traditional Medicare, or HMOs may take actions to attract healthier (less costly) beneficiaries. Alternatively, plan or market features may affect beneficiaries' preferences. For example, plans affiliated with academic medical centers specializing in high cost cases may attract a large number of sicker beneficiaries (21).[11]

Because of the wide range of costs associated with the Medicare population (61), plans have the potential to earn high profits by actively seeking low-cost, healthier beneficiaries as long as the payment formula rewards them for doing so. A plan may design its benefits package to attract more low-cost beneficiaries than high-cost ones. For example, under the current program that allows Medicare beneficiaries to be part of the Medicare Risk program, an HMO may advertise supplemental benefits such as free exercise classes and other services that tend to attract healthier beneficiaries (1, 35).

Most studies show that the Medicare risk HMOs as a whole have enrolled a higher proportion of low cost beneficiaries than has fee-for-service (FFS) Medicare. Sicker beneficiaries may prefer FFS Medicare, which allows greater access to specialists and assures that beneficiaries can continue to see familiar primary care physicians. Under current rules, beneficiaries can leave HMOs with 30 days notice if they are dissatisfied. Medicare Risk HMOs are paid 95 percent of the adjusted average per capita cost (AAPCC) that is paid for FFS beneficiaries' in their county (69). But, if beneficiaries enrolled in these HMOs have average costs that are only 85 to 90 percent of those for traditional Medicare enrollees, as some estimates indicate (10),

[11] Appendix B describes current opportunities for Medicare beneficiaries to join HMOs.

then Medicare loses money by paying HMOs 95 percent of the average FFS beneficiary's costs. The current AAPCC methodology, which uses geography, age, gender, Medicaid status, nursing home status, and employment status to adjust payments to HMOs, has not worked well in predicting health costs across beneficiaries. Hence, available research suggests that the AAPCC methodology has given some plans the latitude to risk select (72).

Researchers and policymakers are attempting to develop tools to remedy this risk selection problem. These tools include quantitative models that predict individuals' health care expenses and then adjust capitated payments to health plans accordingly. Some models predict health care expenses for the coming year and use that information to "risk adjust" payments to plans (25, 72, 16). Other models adjust payments based partly on services actually incurred (i.e., on an "experience rating" basis) and partly on a capitated basis (a method known as "partial capitation"). Still other approaches trigger additional payments to plans only if an enrollee has certain high-cost diseases or conditions or if a beneficiary's (or group of beneficiaries') costs exceed a certain threshold (i.e., through "reinsurance" or other fixed payments for high cost cases).

Any risk adjustment that might be adopted for Medicare would require adequate data and careful administration. To date, very few of these quantitative models have been used in a real-life setting. Also, very little attention has been given to the practical issues of implementing ways to minimize risk selection and make them both effective and fair. The Study Panel is focusing on the following issues:

- Data requirements. What data would Medicare need to collect, and how would Medicare get that data?
- Privacy and confidentiality concerns with the data. Who would have access to the data, and what potential problems would be created through the collection?
- Start-up and transitional issues to institute a new system. What infrastructure would need to be in place for the system to work? What are the potential problems? Should Medicare implement the change all at once or phase it in gradually?
- Detection of cheating by health plans. Could audits or other checks catch abuse by health plans so that they would not be able to influence the data collection process for financial gains?
- Administrative duties of HCFA. What would HCFA have to do to assure that the system runs smoothly?
- Costs to plans and HCFA. What would be the types of costs of starting-up and running a new system?

Carve-Outs

The Panel is also looking at the potential of carve-outs to mitigate risk selection and to achieve other policy goals. A carve-out is a formal arrangement in which a payer for health care contracts with another entity to manage care for patients with a particular condition or to provide particular types of covered services to its members. In exchange, the payer gives a set amount for each patient thus minimizing its financial risk for these patients or services. The contractor then has an incentive to manage care for the patient

efficiently (5). For example, a person with diabetes in a plan that had carved-out that condition would receive treatment through the carve-out entity for care associated with diabetes; under some structures that patient may receive care not associated with diabetes through the carve-out entity as well. Conditions (particularly high cost ones[12]), procedures, or diseases, not persons, are often prime candidates for carve-outs. In addition, services such as vision, dental, mental health, and pharmacy benefits often are provided through carve-outs.

The Panel is drawing on available evidence to investigate the potential benefits and drawbacks of using carve-outs in managed care for Medicare beneficiaries. The Panel will consider whether carve-outs could mitigate the problem of risk selection. By eliminating high-cost diseases or services from the packages of services provided by the beneficiary's primary health plan, the health plan would have less incentive to avoid patients who incur those expenses.

The Panel is looking at carve-outs as a means to control health care costs and improve quality of care for those with specialized health care needs. The Panel is also addressing the potential adverse impact of carve-outs on continuity and coordination of care, which could become fragmented in carve-out arrangements. The Panel is examining the impact of carve-outs on vulnerable populations as well.

Consumer Protection

Increasing the number of choices of plans and the availability of capitated payments can create potential challenges to consumer protection. The Panel's analysis builds on the recent work of other policy groups and draws on the experiences of states, the Medicare Risk program, Medigap, and large benefit plans such as the California Public Employees Personal Employee Retirement System (CalPERS).

Specifically, the Panel is examining areas of potential risks in a Medicare program with greater capitation and choice. Some of the potential problem areas to consumers that the Panel is analyzing include the following:

- Marketing practices by plans: problems related to marketing materials and sales agents;
- Due process protections for beneficiaries: types of grievance and appeals procedures;
- Monitoring and oversight of plans: Consumer protection laws only work if they are adequately monitored and enforced. Inadequate monitoring and oversight could hurt consumers;
- Delivery of services and quality of care: Unlike in traditional fee-for-service medicine, capitation offers incentives for plans to reduce the number of services since any expenditures for providing services decrease net profits (50). However, plans also compete on perceived quality of services. The exact relationship of patient care outcomes and financial risk in HMOs is mostly unknown (13);

[12] This is analogous to high-cost case management that has evolved in some FFS systems.

- Information for beneficiaries (e.g., on access, quality, benefits, premiums, etc.):
  1. *Beneficiaries over 65 who are not knowledgeable about how managed care works.* Unlike the working population with health insurance (37),[13] many older persons have had little experience with capitation and managed care. Potential problems exist in interpreting covered benefits and medical necessity;
  2. *Beneficiaries with special needs.* The Medicare population includes many people with serious or complex medical conditions, and those who suffer from cognitive or mental impairments that require high-technology or extensive nursing care. Providing appropriate information to this population and / or caregivers is particularly challenging.

     The Panel is assessing the likelihood and consequences of each type of risk involved with increased choices, as well as the strengths, weaknesses, and costs of alternative mechanisms to mitigate these risks.

Study Panel I will release its final report and findings later in 1997.

STUDY PANEL II: MODERNIZING FEE-FOR-SERVICE MEDICARE

Despite the rapid growth of Medicare managed care, about 86 percent of beneficiaries still receive their care on a FFS basis. Even if Medicare were to adopt a system making greater use of capitated arrangements as described in the preceding section, there would likely remain a substantial role for FFS well into the future. Not only would it remain through a transition period, there may likely continue to be populations not adequately served by the choice of capitated health plans available in their areas. If so, FFS may provide a safe harbor for such beneficiaries for some period of time. Prime among these vulnerable populations may be people with disabilities and those with chronic illnesses (35). With FFS likely to remain a major part of Medicare for the foreseeable future, assuring quality, managing utilization and costs, and fostering efficient, accountable administration will remain priorities.

The Panel's work has two main foci: (1) the applicability to Medicare of tools for managing care in private FFS insurance, and (2) whether changes would be needed in Medicare's administrative structure and authority to incorporate those tools that hold promise for controlling costs or improving quality.

Managing Care in Fee-for-Service Medicare

One analysis is examining the applicability of various tools developed in private-sector health plans for managing care and assuring quality. To date, most attempts to control costs in FFS Medicare have focused on controlling the amounts paid to health care providers, i.e., the "price" of services. Among private FFS plans, however, insurers have increasingly incorporated tools used by HMOs and other capitated health plans to focus on utilization, the volume of services delivered and their appropriateness as well as approaches that focus on both price and utilization simultaneously. These include greater administrative and clinical scrutiny of certain

[13] In 1995, 75 percent of all workers with health insurance were in some form of managed care: 33 percent were HMO enrollees, 26 percent were in preferred provider organizations (PPOs), and 16 percent were in point of service (POS) plans (37).

procedures before they are performed, retrospective data analysis of services provided, competitive purchasing of supplies and services, payment for more inclusive bundles of services, greater use of preventive services, centers of excellence, preferred provider arrangements, case management, and related techniques.

In its work, the Panel is:

- defining each of these techniques;
- briefly reviewing how they have been used to-date in the private sector and by Medicare and with what results; and
- identifying whether and how their adoption by Medicare may conflict with other public goals and policies. As a public program, Medicare is subject to restrictions that serve other public goals but may inhibit its ability to make use of some of these tools. For example, sunshine laws, due process, and procurement policies may present barriers to using tools such as purchasing through competitive bids to the extent to which the private sector uses such tools. The Panel will explore these and other potential barriers in greater depth.

What Is Needed to Modernize Fee-for-Service Medicare?

The second piece of the Panel's work is exploring what would be required for Medicare to balance the competing objectives identified in the first analysis to incorporate appropriate tools of managed indemnity insurance. In particular, the Panel will focus on the administrative structure and authority granted to HCFA. To what extent could HCFA adopt innovations in FFS management now? What changes would require greater statutory authority or an increased administrative budget? Should capitated Medicare (whatever its eventual extent or form) be run by the same organization that manages FFS Medicare? To what extent should Medicare's administration be in the public sector as opposed to the private sector? What are the costs and risks associated with changing HCFA's statutory authority or its organizational structure and purview?

For each of the innovations that the Panel considers, it will identify the types of changes in law or regulation that would be required for adoption and implementation. Furthermore, it will consider the other resources that would be required. It is also examining the benefits and drawbacks of four alternative organizational structures for the future administration of FFS Medicare. These structures range from marginal changes in the structure and authority of HCFA all the way to a quasi-public corporation, possibly analogous to the U.S. Postal Service.

In early 1997, the Panel will release the two working papers it commissioned to help it begin its thinking on these topics. The papers, written by Peter Fox, a health economist and consultant, and by David Smith, a Swarthmore College political scientist who has studied Medicare's political evolution, will present the points of view of the authors. Later in 1997, the Study Panel will release its own findings in a final report.

STUDY PANEL III: MEDICARE'S LARGER SOCIAL ROLE

The Academy's third Panel, convened in January 1997, is exploring the roles that Medicare plays in American society. The Panel is examining the underlying philosophical principles and rationales of Medicare and how the program fits into the larger social insurance and welfare structures. The Panel's work is focusing on two basic aspects of Medicare's role: the underlying "social contract" that Medicare represents, and the public goods that the program has come to provide.

To begin its work, the Panel is addressing the broad context in which Medicare was designed by:

- examining the social, political and economic values and agreements that shaped the initial development of Medicare, and how the social contract between workers and beneficiaries shaped its evolution;
- documenting how trends in American society, including changes in industrial organization and labor force participation, demographic changes, developments in medical technology, and the restructuring of health care delivery systems, have affected the context of that social contract;
- formulating alternative conceptions of a social contract that can accommodate the needs of elderly and disabled populations in the 21st century; and
- identifying the implications of new conceptions of the social contract in terms of eligibility, benefits design, financing, management, and oversight for a restructured Medicare program.

This Panel is exploring the potential conflicts between controlling the long-range cost of Medicare and protecting beneficiaries against out-of-pocket costs of health care. It is also reviewing the benefits Medicare provides, how responsibility for the aged and disabled should be shared between Medicaid and Medicare, whether the program is more properly viewed as a vital government function or as insurance that in some circumstances could be offered equally well by the private sector, the role of supplemental insurance (Medigap, employer-sponsored retiree policies, and Medicaid), and the role of Medicare in paying for long-term care.

The Panel has begun to assess the extent to which the chronic and long-term health care needs of the beneficiary population can be met through current provisions or through creative applications of home and community-based care programs. Background work on Medicare's role in the care provided at the end of life has begun. The Panel also plans to focus on special concerns of women — both beneficiaries and their primary caregivers.

Simultaneously, the Panel is preparing background papers on Medicare's contribution to the wider health care system, by supporting graduate medical education, hospitals and clinics serving uninsured populations, and facilities in rural areas where health services are scarce. The Panel will consider the utility of these broader functions, and whether Medicare should continue to support these public goods.

The Panel expects to produce several background papers that contribute to the public debate about Medicare's social role. Drawing on its analyses, the Panel's final report, to be

released in early 1998, will address the question: "What social values are we trying to pursue through Medicare, recognizing that the federal government relies on other programs in addition to Medicare to help the aged and disabled?"

STUDY PANEL IV: FINANCING MEDICARE FOR THE LONG TERM

The fourth Study Panel to be convened as part of the Academy's Medicare initiative will focus on Medicare's financing in the next century. Panel members will include individuals with expertise in public finance, Medicare policy, economics and tax policy. The group will also bring a diversity of institutional experience and philosophical perspectives.

Among the questions this Panel will likely consider are:

- What options exist for increasing revenues to Medicare (from either beneficiaries or workers), and what are their implications? In addition to changes in the current payroll tax contributions, the Panel will consider the pros and cons of other types of revenue sources including estate taxes, taxes on certain federal benefits, and broad-based taxes.
- What options exist for changing beneficiaries' financial liability, and what are their implications?
- What are the implications of limiting payments to providers over the long run?
- How might the elimination of the distinctions between Part A and Part B benefits affect Medicare's financing?

The Panel will examine these issues against the backdrop of the larger philosophical questions considered by the Study Panel on Medicare's Larger Social Role, especially the implications of proposals to move Medicare away from being a defined benefit social insurance program toward a defined contribution program with limited financial liability for the government. Consequently, these two Study Panels may engage in some joint analytic work. The Panel will convene in early summer 1997 and release its final conclusions in 1998.

NEXT STEPS

The impending insolvency of the HI Trust Fund and the desire to balance the federal budget have focused the nation's attention on Medicare's future. The public and their elected officials have begun to understand the challenges facing the largest insurance program in the country. Potential solutions are being debated. This debate over Medicare's future involves both complex technical issues and compelling philosophical questions about Americans obligations to each other. During the first half of 1998, the project's Steering Committee, drawn from diverse philosophical, institutional, and disciplinary backgrounds will reflect on the findings of the project's four individual Study Panels in light of recent policy developments. In one or more final reports of its own, the Steering Committee will synthesize the work of the Study Panels and draw out common themes among these experts' work. Through all of these groups' efforts, the Academy seeks to foster relevant evidence-based, open-minded discussion and policymaking as the debate over Medicare's future continues.

Appendix A
Members of the Academy's Medicare Study Panels

STUDY PANEL ON MEDICARE CAPITATION AND CHOICE

Joseph Newhouse, Harvard University, *Chair*

Richard Anderson, Kaiser Foundation Health Plan
Robert Berenson, National Capital Preferred Provider Organization
Stuart Butler, The Heritage Foundation
Geraldine Dallek, Families USA Foundation
Judith Lave, University of Pittsburgh
Harold Luft, University of California at San Francisco
Christine Petersen, Prudential HealthCare Group
Charlie Pryde, Ford Motor Company
Alice Rosenblatt, WellPoint Health Networks
John Rother, American Association of Retired Persons
Cary Sennett, National Committee For Quality Assurance

STUDY PANEL ON FEE-FOR-SERVICE MEDICARE

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

Janet Shikles, Powers, Pyles, Sutter and Verville, *Chair (through January 1997)**
Mark Chassin, Mt. Sinai Medical School
Lynn Etheredge, Consultant
Jon Glaudemans, Aetna Health Plans
Sheila Leatherman, United HealthCare Corporation
Suzanne Mercure, Southern California Edison
Alan Nelson, 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.

Judith Moore, Health Care Financing Administration, *ex-officio***

*Paul Ginsburg assumed the duties of Study Panel Chair when Janet Shikles left the U.S. General Accounting Office and took her current position in February 1997.

**Formerly a private consultant and full Panel member, Judith Moore became an *ex-officio* member when she took her current position in August 1996.

STUDY PANEL ON MEDICARE'S LARGER SOCIAL ROLE

Rosemary 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, U.S. General Accounting Office
David Meltzer, University of Chicago
David Moss, Harvard Business School
Thomas Paine, Consultant
Uwe Reinhardt, Princeton University
Louis Sullivan, Morehouse School of Medicine
Kathleen Utgoff, Center for Naval Analyses
Fredda Vladeck, International Brotherhood of Teamsters

Appendix B
Overview of the Medicare Program in 1997

WHAT BENEFITS DOES MEDICARE PROVIDE?

The Medicare program consists of two parts, Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Part A coverage is automatic for those who qualify and it pays for inpatient hospital care, skilled nursing facility care, intermittent home-health care, and hospice care. Beneficiaries pay deductibles and coinsurance for Part A services they receive. Table B-1 describes the benefits and beneficiaries' financial obligations under Part A in greater detail.

Participation in Part B is voluntary for eligible individuals and carries a monthly premium ($43.80 per month in fiscal year 1997) and a deductible of $100 per year. It covers physician services (including office visits, surgeries, and consultations); lab and other diagnostic tests; outpatient services at hospitals; and mental health services. Table B-2 describes the benefits and beneficiaries' financial obligations for Part B in greater detail.

As mentioned in the text of this report, most beneficiaries have insurance that supplements their Medicare coverage. Supplemental insurance includes both privately purchased policies as well as Medicaid for certain low-income Medicare beneficiaries. In addition, the Federal government has established two programs that use Medicaid funds to help other low-income elderly pay Medicare premiums, deductibles and coinsurance. Qualified Medicare Beneficiaries (QMBs) have incomes below the federal poverty line and resources at or below twice the level allowed for participation in the federal Supplemental Security Income (SSI) program. Medicaid pays for QMB's Medicare premiums as well as cost-sharing obligations of both Parts A and B. Specified Low-Income Medicare Beneficiaries (SLMBs) meet the same resource test as QMBs, but have incomes between 100 percent and 120 percent of the poverty line. They receive Medicaid subsidies to help pay only their Part B premiums.

WHO ARE MEDICARE BENEFICIARIES?

Eligibility

Persons are eligible for Medicare if they (or their spouses) have worked for at least 10 years in Medicare-covered employment, are at least 65 years old, and are citizens or permanent residents of the United States. Younger individuals can qualify for Medicare if they have worked a sufficient amount of time in Medicare-covered jobs and they have dialysis-dependent end-stage renal disease (ESRD) or they have received Social Security disability benefits for two years. Disability beneficiaries include disabled workers, disabled widows older than age 50, and adults disabled since childhood and whose parents are veterans, disabled, or deceased. Persons who do not have sufficient work history to qualify can still purchase Medicare if they are over 65, disabled, or have ESRD by paying an actuarially fair premium.

Data About Beneficiaries

Medicare provides health care coverage for nearly 97 percent of the elderly (33 million). The remainder of the Medicare population includes 4 million disabled individuals, and about 210,000 persons with end-stage renal

Table B-1. Medicare Part A, 1997

Services	Benefit	Medicare Pays	Beneficiary Pays[1,2]
HOSPITALIZATION Semiprivate room and board, general nursing and other hospital services and supplies	First 60 Days 61st to 90th Day 91st to 150th Day[3] Beyond 150 Days	All but first $760 All but first $190 a Day All over $380 a Day Nothing	First $760 $190 a day $380 a day All Costs
SKILLED NURSING FACILITY CARE Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies: if it follows within 30 days of a hospitalization of 3 or more days and is certified as medically necessary	First 20 Days Additional 80 Days Beyond 100 Days	100% of Approved Amount All over $95 a Day Nothing	Nothing Up to $95 a Day All Costs
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services	Unlimited as long as beneficiary meets Medicare conditions	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for Services; 20% of approved amount for durable medical equipment
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill	For as long as doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited costs for outpatient drugs and inpatient respite care
BLOOD When furnished by a hospital or skilled nursing facility during a covered stay	Unlimited if medically necessary	All but first 3 pints per calendar year	First 3 pints[4]

Source: National Academy of Social Insurance based on U.S. Department of Health and Human Services, Health Care Financing Administration, *The Medicare Handbook*, Washington, DC: U.S. Government Printing Office, 1996, updated for 1997.

[1] 1997 Part A monthly premium: $311 with fewer than 30 quarters of Medicare-covered employment; $187 with more than 30 quarters but fewer than 40 quarters of covered employment. Most beneficiaries do not have to pay a premium for Part A.

[2] Either beneficiary or his or her supplementary insurance company are responsible for paying the amounts listed in the "Beneficiary Pays" column.

[3] This 60-reserve-days benefit may be used only once in a lifetime.

[4] Blood paid for or replaced under Part B of Medicare during the calendar year does not have to be paid for or replaced under Part A.

Table B-2. Medicare Part B, 1997

Services	Benefit	Medicare Pays	Beneficiary Pays[1,2]
MEDICAL EXPENSES Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, and other services	Unlimited if medically necessary	80% of approved amount (after $100 deductible) Reduced to 50% for most outpatient mental health services	$100 deductible, plus 20% of approved amount and limited charges above approved amount for each office visit or procedure
CLINICAL LABORATORY SERVICES Blood tests, urinalyses, and more	Unlimited if medically necessary	Generally 100% of approved amount	Nothing for services
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services	Unlimited as long as beneficiary meets Medicare conditions	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury	Unlimited if medically necessary	Medicare payment to hospital based on hospital cost	20% of whatever the hospital charges (after $100 deductible)
BLOOD Unlimited if medically necessary	Unlimited if medically necessary	80% of approved amount (after $100 deductible and starting with fourth pint)	First three pints plus 20% of approved amount for additional pints (after $100 deductible)[3]
AMBULATORY SURGICAL SERVICES Unlimited if medically necessary	Unlimited if medically necessary	80% of pre-determined amount (after $100 deductible)	$100 deductible, plus 20% of pre-determined amount

Source: National Academy of Social Insurance based on U.S. Department of Health and Human Services, Health Care Financing Administration, The Medicare Handbook, *Washington, DC: U.S. Government Printing Office, 1996.*

[1] 1997 Part B monthly premium: $43.80 (premium may be higher if beneficiary enrolls late.) The beneficiary pays a single $100 deductible for all covered services in a year.

[2] Either beneficiary or his or her insurance company are responsible for paying the amounts in the "Beneficiary Pays" column.

[3] Blood paid for or replaced under Part A of Medicare during calendar year does not have to be paid or replaced under Part B.

disease (ESRD), a Medicare-eligible category that was added in 1972 (61). These numbers will continue to increase. In 1990, Medicare covered 12.2 percent of the population, and by 2030, the program is projected to cover 19.8 percent of the population. As described in the text of this report, the growth in Medicare beneficiaries to-date reflects increased longevity and decreased fertility.

The Medicare population is also becoming more disabled. The fastest rate of enrollment growth in the program has been among the ESRD population and people with disabilities. Between 1980 and 1994, the number of people with ESRD grew from 65,678 to 254,626, a 74 percent increase from 1980. The number of disabled enrollees under 65 years old rose from 3.0 million in 1980 to 4.2 million in 1994, a 40 percent increase (61). In 1993 about one fourth of elderly beneficiaries and more than half of disabled beneficiaries rated their own health status as "fair" or "poor" (64).

Most Medicare enrollees have limited incomes. In 1993, 72 percent of elderly beneficiaries reported annual incomes of less than $25,000, including 30 percent who reported incomes of less than $10,000. Of the disabled beneficiaries, 40 percent reported incomes of less than $10,000 (64). Thirteen percent of the older beneficiaries and 41 percent of those with disabilities are also eligible for Medicaid, another indicator of many beneficiaries' low-income status.

PROGRAM ADMINISTRATION

The Department of Health and Human Services' Health Care Financing Administration (HCFA) is the federal agency with primary responsibility for the Medicare program. Its responsibilities are to:

- select and oversee carriers and fiscal intermediaries; (Carriers are organizations that process claims and make Medicare payments to health care providers for most Medicare Part B benefits. Intermediaries are organizations that make Medicare payments for Part A and certain Part B benefits to hospitals and other providers of services and perform related functions.)
- formulate general policies and guidelines for the coverage and payment of services (although carriers and intermediaries make initial payment decisions on individual cases);
- develop conditions of participation and the certification of providers; and
- maintain and review utilization records.

Other federal agencies also have some responsibility for Medicare's administration. The Social Security Administration (SSA) makes initial determination of an individual's eligibility for Medicare and maintains the master beneficiary record. The Department of the Treasury manages the Health Insurance (Part A) and Supplemental Insurance (Part B) Trust Funds (see section on Medicare Trust Funds) and transfers funds to pay Medicare bills. A Board of Trustees — composed of the Secretaries of the Department of Health and Human Services (USDHHS), the Department of Labor, the Department of the Treasury, the Commissioner of Social Security, and two public-appointed members — oversees the trust funds and reports annually to Congress on their status and operation.

In order to participate in the Medicare program, providers and suppliers of health services must comply with Conditions of Participation, the statutory and regulatory requirements pertaining to the health and safety of Medicare beneficiaries. State agencies, usually under agreements with HCFA,

inspect provider institutions and supplier facilities or institutions that wish to participate in the Medicare program (61).

PAYMENT POLICY AND ADMINISTRATION

HCFA uses different reimbursement methods for Part A and Part B services.

Part A

Until the adoption of Medicare's prospective payment system (PPS) in fiscal year 1984, the federal government based reimbursements for inpatient hospital care on a retrospective, cost-based payment system. This method continues to be the basis for reimbursing skilled nursing facilities and home health agencies, although limitations apply. In addition, four classes of specialty hospitals (children's, psychiatric, rehabilitation, and long-term) as well as distinct psychiatric and rehabilitation units within some general hospitals are excluded from PPS. The federal government reimburses these facilities according to reasonable and allowable costs as defined by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 98-21).

Under PPS, hospitals receive payments based on diagnosis-related groups (DRGs) for inpatient services provided to Medicare beneficiaries. The DRG system is a clinically based set of categories that classifies patients upon discharge from the hospital. As the name suggests, each of the 495 DRGs identifies by a particular diagnosis and represents a relatively narrow range of treatment costs. Intermediaries pay hospitals the predetermined amount for each Medicare discharge assigned a given DRG. The federal government adjusts DRG payment rates for a geographic area, indirect costs of patient care associated with hospitals that have teaching programs, and costs related to treating disproportionately large shares of low-income patients. Additional payments are made for cases called outliers, that involve extremely long hospital stays or are otherwise very expensive. The PPS payment for a given case is considered full payment for the care received, except for the annual Part A deductible and coinsurance amounts paid by the beneficiary. By adopting PPS, the federal government gave hospitals the incentive to provide efficient care since the payment for each discharged patient with a given diagnosis does not vary regardless of how many specific services the patient receives.

Part B

For Part B services, physicians can elect to be paid directly by the carrier, a process called "assignment." By accepting assignment, the physician agrees to accept the allowed Medicare charge as payment in full. In 1995, 72 percent of physicians treating Medicare patients accepted assignment, and 90 percent of all Medicare claims were assigned (69). Medicare reimburses 80 percent of the allowed charge (after the beneficiary has met the annual deductible amount), and the beneficiary is responsible for the 20-percent coinsurance amount, as required by law. If the physician does not accept assignment, the beneficiary is responsible for paying the difference between the physician's submitted charge (which can be no more than 115 percent of the Medicare-allowed charge) and the Medicare-allowed charge, as well as any deductible or coinsurance amounts.

Since 1992, the federal government has used the Medicare Physician Payment Reform Program (MPPRP) to determine the allowed charge for each Part B service. MPPRP affects about 500,000 physicians and 110,000 other medical professionals, including dentists, optometrists, podiatrists, and chiropractors who bill Medicare for services. It consists of:

- a national Medicare fee schedule (MFS) for more than 7,000 covered services based on a resource-based relative value scale and geographic adjustments for justifiable differences in physicians' costs of practice. Medicare pays 80 percent of the physicians' actual charges or the MFS amount, whichever is lower.
- a volume performance standard (VPS) to restrain the annual rate of increase in Medicare physician payments. The VPS system provides a mechanism to adjust fee updates for the MFS based on how annual increases in actual expenditures compare with previously determined performance standard rates of increase.
- a restriction that prevents non-participating physicians (those who do not accept assignment) from charging Medicare beneficiaries more than 115 percent of the MFS amount.
- a standardized claim form for physicians and other suppliers of Medicare services.

During MPPRP's five-year implementation period, health care providers received payments based on a transitional formula that attempted to spread out payments more evenly across physician specialties than they had been spread in the past. By 1996, all Medicare physicians were paid the MFS amount.

MEDICARE TRUST FUNDS

Two trust funds established in 1965 by the Social Security Act finance the Medicare program. The Hospital Insurance (HI) Trust Fund pays for Part A services, and the Supplemental Medical Insurance (SMI) Trust Fund pays Medicare Part B benefits.

The trust funds are a mechanism by which revenues are credited to the funds in the form of government securities while expenditures for benefits are debited against the funds (54). Under present law there is no authority for the government to pay program benefits if the assets of the trust funds become depleted (6). The HI Trust Fund receives income principally from a tax on earnings of 1.45 percent paid by employees and matched by their employers for a total contribution of 2.9 percent of payroll. Interest on the securities held by the trust fund and taxes on certain Social Security benefits form most of the remaining income. The SMI Trust Fund's assets consist of beneficiary monthly premiums ($43.80 in 1997), contributions from the government's general revenue, and interest on the trust fund assets.

The Board of Trustees annual report to Congress projects the funds' financial outlook over the short term (10 years) and the long term (75 years.) As described in the text of this report, the Trustees' 1996 best estimate is that the HI Trust Fund will be depleted early in 2001. The HI deficit over the 75-year period is equivalent to a payroll tax rate increase in 1996 of 2.26 percent for employers and employees each (6).

The Trustees' reports act as an early warning device of potential shortfalls in the program's financing. Short-term estimates signal the need for immediate legislative action whereas the long-range estimates indicate the need for attention to more distant structural problems (2). In 1995, expenditures of the HI Trust Fund exceeded income for the first time (although a surplus from previous years remained), and the Trustees projected in 1996 that the fund's surplus would be exhausted in early 2001. Without corrective legislation, the federal government would not have authority to pay for beneficiaries' covered health care. The SMI Trust Fund does not produce a deficit because it receives unlimited federal general revenues to cover program expenditures. Nonetheless, SMI expenditures are projected to grow significantly as a share of GDP.

HMOS FOR MEDICARE: THE RISK PROGRAM AND RELATED DEMONSTRATION PROJECTS

Beneficiaries can choose to enroll in a Medicare Risk Health Maintenance Organization (HMO) instead of traditional fee-for-service (FFS). This section provides background about HMOs and the current Medicare Risk Program, Medicare Select, and several related demonstration projects that experiment with other forms of managed care for Medicare beneficiaries. It also describes the major issues currently facing the Medicare Risk Program.

HMOs

A Health Maintenance Organization (HMO) provides a defined set of health care services through a specified network or panel of providers. The HMO makes decisions about where and how health services are provided and negotiates payment levels with its providers in return for a set amount of money each year for each enrollee (26).

In Medicare, HMOs are either staff model, group model, or independent practice association (IPA) model. Staff-model HMOs directly employ doctors and other providers, who serve only patients enrolled in the HMO. Group model HMOs, by contrast, contract with a group of providers. Finally, in an IPA model (the most common model in Medicare), the HMO contracts with providers and / or provider groups, who can serve both HMO enrollees and non-enrollees.

Medicare Risk Program

While Medicare has included managed care options since its inception, the Medicare Risk Program was Medicare's first capitated payment option. Implemented in 1985, the Tax Equity and Financial Responsibility Act (TEFRA) of 1982 allowed federally qualified HMOs and other plans that met specified requirements in Medicare law (competitive medical plans, or CMPs) to enter Medicare risk contracts and provide all Medicare covered services (Part A and B) for a fixed, or capitated, rate per beneficiary per month (69). Health plans entering risk contracts assume full risk for the cost of providing Medicare benefits.

An HMO integrates the financing and delivery of health care, so it is expected to take an active role in managing a person's care, rather than merely acting as a third-party bill-payer. In theory, then, health care can be administered at lower costs in an HMO than in the fee-for-service (FFS) sector, where providers are reimbursed for the cost of services rendered. For this reason, the govern-

ment pays HMOs less per enrollee than the estimated cost of providing services to the average FFS beneficiary. Currently, the federal government determines the federal payment in the risk program through the Adjusted Average Per Capita Cost (AAPCC) method. Once a year, HCFA projects the cost of treating the average beneficiary under FFS Medicare in the country, an estimate known as the United States Per Capita Cost (USPCC). HCFA then derives the AAPCC through "localizing" the USPCC estimate for each county by adjusting for geographic differences in input costs (i.e., wages and prices of inputs such as medical supplies and land), and for the overall health risk of beneficiaries.[1] The government pays HMOs an amount that is 95 percent of the local AAPCC. AAPCCs are computed separately for the over age 65 population, the disabled, and the end-stage renal disease (ESRD) beneficiaries.

Medicare Risk HMOs provide all Medicare covered benefits for enrollees in exchange for capitated payments (i.e., 95 percent of the local AAPCC). Medicare Risk enrollees pay the part B premium, but may pay an additional premium to the HMO to receive both covered and supplemental services (e.g., prescription drugs). Because federal law requires Risk HMOs to return any savings they realize to beneficiaries, these HMOs often offer additional benefits beyond those in Part B at no extra premium.

The Medicare Risk Program has grown rapidly in recent years, in terms of both plan participation and beneficiary enrollment. As of December 1996, 241 risk plans participated, up from 183 at the end of 1995, a growth of 31.7 percent in one year. Medicare Risk HMOs had over 4.1 million enrollees, up from 3.1 million enrollees in December 1995, approximately a 33 percent increase in one year. Altogether, Medicare HMO enrollees made up almost 11 percent of the overall Medicare population (64). Since 1989, Medicare Risk enrollment's annual rate of growth has exceeded that of the non-Medicare population (64).

Point-of Service (POS) Option

Recently, HCFA issued guidelines for HMOs to offer a Point-of-Service (POS) option in the Medicare Risk contract program. Plans can now offer selected medical services that the beneficiary may receive outside the HMO's network of physicians and other providers. POS plans in the private sector allow enrollees to go out of network to receive care, but the enrollee must pay a higher copayment when they do so. POS plans have become popular in the private sector due to their greater flexibility in allowing enrollees to see non-network providers. HCFA hopes that introducing a variant of the POS model, an option as yet in its infancy for Medicare beneficiaries, will increase participation in managed care.

Medicare Select

Congress established Medicare Select as a 15-state experimental program in 1990 to increase beneficiary participation in managed care. The program allows beneficiaries in traditional Medicare FFS to use managed care organizations for their supplemental (Medigap) insurance. Medicare Select plans provide the supplemental insurance coverage

[1] To attempt to correct for differences among beneficiaries' costs, Medicare currently adjusts payments to HMOs according to beneficiaries' age, gender, Medicaid status, nursing home status, and whether or not they currently work.

through Preferred Provider Organizations (PPOs). A PPO is a group of providers and hospitals that contracts with a third party to provide health services to covered enrollees on a FFS basis at specified (generally discounted) prices. Beneficiaries enrolled in a PPO can visit an out-of-network provider, but must pay a higher copayment than if they were to visit a provider in the network. The government hopes Medicare Select familiarizes more beneficiaries and providers with the use of defined provider networks (27).

Medicare Demonstration Projects

HCFA has several other demonstration projects currently underway that expand the presence of managed care in Medicare and provide beneficiaries with a greater range of choices. These variants on the risk program may provide insights in the eventual long-term restructuring. Two major demonstrations are Medicare Choices and Social HMO (S/HMO).

Medicare Choices

HCFA designed the Medicare Choices demonstration to offer Medicare patients a variety of managed care delivery options (e.g., PPOs and provider-sponsored networks) that are currently not available to Medicare beneficiaries as their primary sources of coverage. The demonstration project, announced in June of 1995, also plans to test different payment methods (e.g., reinsurance, partial capitation). Most of the managed care plans chosen to participate in the demonstration project are located in market areas that currently have limited enrollment in risk contracts. HCFA's Office of Research and Demonstrations (ORD), responsible for implementing the project, expects the demonstration to last three to five years (60, 62).

Social HMO (S/HMO)

The S/HMO is a demonstration currently being conducted at three sites. Over 50,000 enrollees have participated over the past 12 years. The model adds home and community-based services and short-term nursing home care to the Medicare HMO's basic benefit package. Initially, the first set of S/HMOs experienced developmental problems, including cost over-runs and risk selection problems. Over time, however, studies demonstrated that frail S/HMO members live in the community with home and community-based services longer than other members under a risk contract, and use less nursing home care.

A broad cross-section of the Medicare population is enrolled, and the Social HMOs offer a comprehensive package of acute care and ancillary benefits, including prescription drugs. Enrollees who need supportive services are identified by resource coordinators through population screening and internal referral systems. The resource coordinators act to help ensure enrollees are assessed for appropriate service utilization across the continuum of acute care and limited home and community-based coverage.

The S/HMO combines acute care, as well as home and community-based care into an integrated health service delivery system. The HMO is reimbursed by Medicare, Medicaid, and private premiums on a prepaid, capitated funding basis. The three original demonstration sites are all financially viable and expanding. The fourth dropped out after 10 years of operations after the growth in Medicare payments failed to keep pace with the growth in costs.

Moving into its second generation, the S/HMO will emphasize a geriatric service model with a case management approach. The model will be designed to identify individuals who are at high risk for both illness and disability. HCFA has asked six new sites to submit proposals, and one site is operational. Financing methodology has also changed for the second generation of S/HMO sites. The first-generation sites supplemented their standard payment formula with a special rate category for disability, while the second round will use a new formula that takes into account a variety of health, functional, and demographic factors (24).

MAJOR ISSUES OF MEDICARE RISK

Geographic Variation

In 1994, nearly three quarters of all Medicare beneficiaries had at least one Medicare managed care option available (45). However, the bulk of enrollees in Medicare Risk plans is highly concentrated in relatively few regions of the country. As of December 1996, six states made up over 70 percent of overall enrollment in Risk plans, with California making up 31.8 percent of enrollment alone. Many states still have a very small percentage of their Medicare population enrolled in a Medicare Risk plan. As of December 1996, 27 states had 3 percent or fewer of their Medicare beneficiaries enrolled in a Risk HMO. Of those 27, 13 had no Medicare Risk enrollees at all (63).

In 1996, about 45 percent of the country's HMOs participated or anticipated participating in the Medicare Risk program. However, enrollment has also been highly concentrated in a relatively small number of large HMOs, although the level of concentration has started to decline. In 1995, five plans alone (four of which were located in California) had approximately 30 percent of the entire Medicare Risk program in their enrollment (73).

States with the highest enrollment in Medicare Risk HMOs often have high AAPCCs (32), which, in turn, reflect high FFS costs. If plan payments exceed the projected costs, federal law requires that the savings must be returned to the federal treasury or to beneficiaries in the form of additional benefits (71). This overpayment may be so great that Risk HMOs in some counties can provide multiple (sometimes costly) supplemental benefits at no added premium to the beneficiary. The most common supplemental benefits include routine physicals, immunizations, eye exams, and ear exams, each of which are currently offered by at least three quarters of Medicare Risk HMOs as part of their basic option package. Prescription drug coverage is offered by three-fifths of all plans. Additional benefits include health education, foot care, dental care, lenses, and hearing aids (64).

States with a mature, highly penetrated managed care market often have the larger Medicare Risk market (although low AAPCCs may hinder growth in the Medicare market in some regions with high non-Medicare market penetration). California, for example, has a very mature managed care market, which includes high penetration in both non-Medicare and Medicare populations (73). Non-Medicare HMO penetration has exceeded Medicare HMO penetration in all but a few states (64).

Studies have also shown that Medicare Risk HMO enrollment growth has been due in part to changes in the complexion of employment-based health insurance coverage for retired workers (32). Many firms have revised their employee/retiree health benefits by increasing cost-sharing for beneficiaries

(especially among traditional indemnity plans). As a result, enrollment in HMOs among retirees has increased. Their coverage has generally been structured so that the HMO options have lower retiree costs and more comprehensive coverage.

Payment Variation

Because the AAPCC is calculated at the county level and used as the basis for payments to Medicare Risk HMOs, HMO payments are directly linked to costs in the Medicare FFS sector (by paying 95 percent of the local AAPCC to the HMO). AAPCC rates reflect differences in health status, practice patterns, input prices, availability of services, special payments (e.g., graduate medical education or disproportionate share), and the use of other government facilities (VA and Department of Defense) (38) .

The AAPCC varies greatly across different counties throughout the United States. For 1997, the payment rates to Risk HMOs range from $221 monthly for plans in Arthur, Nebraska to $767 monthly in Richmond, New York. AAPCCs often differ greatly even for two counties very close to one another geographically. For example, Prince George's County in Maryland has an AAPCC of $602 monthly for 1997, while nearby Fairfax County, Virginia has an AAPCC of $401 monthly (38).

AAPCCs often fluctuate greatly from one year to the next. Between 1996 and 1997, 99 counties had payment increases of at least 15 percent, while 214 counties had rate decreases that large (38). Rural counties, with sparse populations, often have the most volatile AAPCCs. Many rural areas have low AAPCCs, thus creating a disincentive for those plans to enter into Medicare Risk Contracts (53).

Much of the variation in the AAPCC reflects large geographic differences in services provided to beneficiaries. The use of services varies for both discretionary reasons (e.g., provider practice styles) and non-discretionary reasons (e.g., patient characteristics and health status). Traditional FFS providers are reimbursed irrespective of either discretionary or non-discretionary differences.[2] However, capitation puts plans at financial risk for differences in service use. Thus, capitation creates incentives for plans to decrease the level of service use due to discretionary factors, and may also lead plans to avoid patients with high non-discretionary use by actively seeking healthier beneficiaries (i.e., risk selection) (69).

Under current AAPCC calculations, capitation payments reflect historical variations in FFS payments. Severing this capitation payment-FFS costs link would remove the legacy of past inefficiencies that are built into current payment rates, but new problems will likely emerge. Setting the capitation rates to reflect the costs of the most efficient HMOs will ultimately reflect service use, since costs are a function of use (both discretionary and non-discretionary). Determining appropriate variations in the use of services across enrollee populations is a challenge that policymakers must face in restructuring Medicare.

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[2] The Resource Based Relative Value Scale (RBRVS) fee schedule used in Medicare physician payment was designed in part to change economic incentives in physician practice so that, for example, physicians were given greater incentives to spend time on visits, rather than performing discretionary diagnostic procedures. Nevertheless, physicians are still paid more for doing more in FFS.

Appendix C
Medicare Milestones

The following is a chronological overview of major legislative and administrative milestones in Medicare's history:

July 30, 1965 In signing the Social Security Amendments of 1965, President Lyndon Johnson made the Medicare program law, establishing a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

1972 P.L. 92-603 extended Medicare benefits to disabled persons who received benefits under Social Security or Railroad Retirement programs for at least 2 years and individuals with end-stage renal (kidney) disease (ESRD).

1982 Medicare implemented hospice care coverage for terminally ill beneficiaries whose life expectancy is 6 months or less.

P.L. 98-21, or the Tax Equity and Fiscal Responsibility Act, established Medicare's prospective payment system (PPS) to offset the increasing costs of inpatient hospital services. The law also established the Risk HMO program and the Prospective Payment Assessment Commission (ProPAC) as an independent panel to monitor and update the new payment system.

1985 P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, extended mandatory Medicare coverage to nearly all state and local government employees hired after December 1, 1985. Also, Medicare was made secondary payer for all workers aged 65 or older and their spouses who elected to be covered by health insurance from an employer with 20 or more employees.

1986 Under the Omnibus Budget Reconciliation Act (OBRA) of 1986, Medicare was made secondary payer for all disabled Medicare beneficiaries who elected to be covered as current employees (or family members of such employees) by health insurance from an employer with at least 100 employees. The Act also provided that outpatient drugs furnished to transplant patients be covered for one year after the transplant.

1987 OBRA 1987 permitted previously disabled individuals, after a period of employment, to resume Medicare coverage without an additional two-year waiting period when they reestablished their disability requirement. Medicare was required to be the secondary payer to employer-based insurance for ESRD. Also, the maximum payment for mental health services was increased and certain outpatient mental health services were covered along with the services of certified nurse-midwives, clinical social workers, clinical psychologists in rural health clinics, and physician assistants in rural health manpower shortage areas.

1988 P.L. 100-360, or the Medicare Catastrophic Coverage Act (MCCA) provided the largest expansion of benefits since the program's inception. Medicare would now protect the elderly and the disabled from the costs of catastrophic medical bills. The act also provided broad coverage of outpatient prescription drugs. The new benefits were to be financed by two premiums: an increase in the Part B premium and an income-based premium for persons eligible for Part A.

1989 P.L. 101-234, or the Medicare Catastrophic Coverage Repeal Act repealed the Medicare catastrophic benefits outlined in the previous year's MCCA, restored Medicare benefit levels to those available before January 1, 1989, and canceled both catastrophic premiums.

P.L. 101-239, or OBRA 1989, revised the Medicare physician payment system. The new fee schedule would be phased in over a 5-year period beginning January 1, 1992. The fee schedule was based on a resource-based relative value scale that measured the time, training, and skill required to perform a given service and was adjusted for overhead costs and geographical differences. The Act also: (1) limited what physicians could charge beneficiaries over and above the Medicare allowed fee; (2) increased coverage of mental health services; (3) eliminated the limit on mental health benefits; and (4) extended coverage to services of clinical psychologists and social workers.

1989 OBRA 1989 provided an opportunity to continue Medicare coverage to individuals under age 65 who are no longer entitled to Social Security benefits because their earnings exceeded the substantial gainful activity level, but who continued to be disabled. These individuals would now have the option to purchase Medicare coverage during specified enrollment periods. The amount of the monthly Part A premium would be the same as the premium charged for Medicare's Part A benefits for uninsured individuals. The Part B premium is the same for all individuals (51).

1989 In response to a court decision (Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988)), HCFA revised its requirements for determining Medicare home health eligibility. The revision made it possible for more beneficiaries to qualify for Medicare home health services and more home health agencies to receive payment for higher numbers of visits and for longer periods of care (68).

1990 P.L. 101-508, or OBRA 1990, specified further payments to hospitals and physicians, legislated the Part B premium for 1991 through 1995, and increased payments by Medicare beneficiaries by increasing the Part B deductible amount from $75 to $100. It also established 10 standard Medicare supplemental insurance (Medigap) policies to be offered to beneficiaries and established guidelines for their marketing.

1993 P.L. 103-66, or OBRA 1993, mandated that for wages and self-employment income received after December 31, 1993, the wage base cap subject to the Medicare hospital insurance tax was removed entirely (in 1993, the maximum amount of income subject to the hospital insurance tax was $135,000). Part A premiums were reduced on a phased-in basis for individuals and their spouses who have at lease 30 quarters of Social Security coverage. (These premiums apply to beneficiaries not eligible for Social Security or Railroad Retirement benefits.) Premium reductions began at 25 percent in fiscal year 1994 and increased by five percentage points for the next four years. Beginning in fiscal year 1998, the reduction will remain at 45 percent. The Act also set the Part B premium to cover 25 percent of program costs for aged beneficiaries for 1996 through 1998. OBRA 1993 also applied cost restraints on payments to urban and rural hospitals under the PPS, to certain PPS-exempt hospitals, physician services (except for primary care services), skilled-nursing facilities, hospices, laboratory services, anesthesia care teams, other services, and expense computations. It also required employers to file new health insurance information on an updated W-2 form. OBRA 1993 also expanded a ban on physician referrals to clinical laboratories in which they hold an ownership interest (51).

1996 P.L. 104-191, the Health Insurance Portability and Accountability Act of 1996, includes Medicare provisions that give the Health Care Financing Administration flexibility in contracting with private firms that process Medicare fee-for-service claims. The statute also strengthens sanctions against Medicare HMOs that fail to meet contractual obligations, and establishes new mechanisms for combating fraud and abuse in Medicare and other federally supported health care programs. Additional provisions clarify policies regarding regulations designed to prevent the duplication of services in Medigap policies, including a provision specifying that policies offering only long-term nursing home care, home health care or community-based care are allowed to coordinate benefits with Medicare.

Appendix D
Abbreviations and Glossary of Terms

ABBREVIATIONS

AAPCC	Adjusted Average Per Capita Cost
CalPERS	California Public Employees Personal Employee Retirement System
CBO	Congressional Budget Office
CMP	Competitive Medical Plan
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPI	Consumer Price Index
DME	Durable Medical Equipment
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospitals
ESRD	End-Stage Renal Disease
FFS	Fee-for-Service
GAO	General Accounting Office
GDP	Gross Domestic Product
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HI	Hospital Insurance
HMO	Health Maintenance Organization
IME	Indirect Medical Education
IPA	Independent Practice Association
MCCA	Medicare Catastrophic Coverage Act
MFS	Medicare Fee Schedule
MPPRP	Medicare Physician Payment Reform Program
OBRA	Omnibus Budget Reconciliation Act
ORD	Office of Research and Demonstration, HCFA
POS	Point of Service
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PSN	Provider Sponsored Network
RBRVS	Resource-Based Relative Value Scale
S/HMO	Social HMO
SMI	Supplemental Medical Insurance
SNF	Skilled Nursing Facility
SSA	Social Security Administration
USDHHS	United States Department of Health and Human Services
USPCC	United States Per Capita Cost
VPS	Volume Performance Standard

GLOSSARY OF TERMS

Assignment: A process whereby a Medicare beneficiary assigns his or her right to payment from Medicare to the physician or supplier. In return the physician or supplier agrees to accept Medicare's reasonable or allowed charge as payment in full for covered services. The physician (or supplier) bills Medicare directly and receives an amount usually equal to 80 percent of Medicare's reasonable or allowed charge. The physician (or supplier) may not charge the beneficiary more than the applicable deductible and coinsurance amounts.

Acute Care: Medical treatment for health problems of a short-term or episodic nature.

Adjusted Average Per Capita Cost (AAPCC): A formula used in calculating payments to Medicare Risk HMOs. The AAPCC is the per capita fee-for-service Medicare expenditure for a county, adjusted for the attributes of its Medicare beneficiaries in terms of age, gender, medical status, nursing home status, and employment status. HMOs receive 95 percent of the AAPCC for each Medicare enrollee.

Biased Selection: See "Risk Selection."

Capitation: A method of payment for services in which a provider (e.g., a physician, hospital, or other agency or individual) receives a fixed amount for each person served regardless of the actual cost of services provided for the person, in a specified period of time.

Carve-Out: A formal arrangement in which a health plan contracts with another entity to manage care for patients with a particular condition or to provide particular types of covered services to its members. The primary health plan pays a set amount for each patient, thus minimizing the health plan's financial risk for these patients or services.

Case Management: The monitoring and coordinating of health services to enhance care and manage costs for patients with specific diagnoses, or for those who require high-cost or extensive services.

Catastrophic Medical Expenses: Extraordinarily high medical expenses, usually for severe or lengthy illnesses, unusually costly treatments, or disability.

Center of Excellence: A health care facility that specializes in providing a high volume of particular procedures or care for specific conditions, such as coronary artery disease treatment or orthopedic joint replacements, in order to lower costs and / or assure quality.

Chronic Conditions: Long term or continuing health problems.

Coinsurance: The percentage of covered health care expenses, after subtraction of any deductible, for which the insured person is responsible.

Competitive Medical Plan (CMP): A health plan eligible to enter into a risk contract with Medicare to provide beneficiaries with covered medical services in return for a capitation payment.

Competitive Purchasing: A purchasing method that allows a bidding process to establish efficient payment rates (usually the low bid).

Conditions of Participation: Statutory and regulatory health and safety requirements to which providers and suppliers of health services must comply to participate in Medicare.

Consumer Price Index (CPI): The Consumer Price Index is a relative measure of inflation and refers to the CPI for Urban Wage Earners and Clerical Workers.

Defined Benefit Program: An insurance program in which premiums are paid in return for a guaranteed and specified set of benefits.

Defined Contribution Program: An insurance program in which premiums are paid in return for a specific dollar contribution toward covered benefits without guaranteeing the provision of those benefits.

Diagnosis Related Group (DRG): Entries in a taxonomy of types of hospitalizations based on groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs have been mandated for use in establishing payment amounts for individual admissions under Medicare's prospective hospital payment system as required by the Social Security Amendments of 1983 (Public Law 98-21).

Disproportionate Share Hospitals (DSH): Hospitals that serve a relatively large volume of low-income patients.

Durable Medical Equipment (DME): Medical equipment, such as wheelchairs, respirators, and oxygen tanks, whose use may be over an extended period of time.

End-Stage Renal Disease (ESRD): ESRD refers to kidney disease that requires lifetime dialysis or kidney transplant. ESRD patients are eligible for Medicare benefits and may qualify for Social Security payments if they are determined to be disabled.

Fee-for-Service (FFS): A method of paying for medical services in which each service performed by an individual provider bears a related charge. This charge is paid by the individual patient receiving the service or by an insurer on behalf of the patient.

Fertility: The average number of live births to women of child bearing age (15 to 49 years) in a defined population.

Gross Domestic Product (GDP): A measure of national income that is the value of all goods and services produced in the United States.

Group Model HMO: An HMO that pays a medical group a negotiated, per capita rate, that the group distributes among its physicians, often as salary.

Health Care Financing Administration (HCFA): The federal agency within the Department of Health and Human Services that administers Medicare and, together with the states, Medicaid.

Health Maintenance Organizations (HMOs): A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Benefits are typically financed through capitation with limited copayments, and services are furnished through a system of affiliated providers.

Home Health Care: Health services delivered in the home to aged, disabled, ill, or convalescent individuals who do not need institutional care.

Hospice: A program that provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. The whole family is considered the unit of care, and care extends through their period of mourning.

Hospital Insurance (HI) Trust Fund: A federal account that receives payroll taxes and other specified revenues and pays for services covered under Part A of Medicare, including in-patient hospital care, home health care, skilled nursing facility care, and hospice care.

Independent Practice Association (IPA) Model HMO: An HMO where individual physicians or small physician groups provide services to beneficiaries at a negotiated per capita or fee-for-service rate. The physicians may contract with other HMOs and fee-for-service patients and maintain their own offices.

Indirect Medical Education (IME) Payments: Payments to hospitals to compensate for overhead and other indirect costs associated with training new physicians and other medical personnel. Such hospitals tend to have sicker patients with more complicated illnesses, and they tend to provide more expensive services than the average hospital.

Life Expectancy: The average number of years of life remaining for a person in a particular cohort at a given age.

Long-Term Care: A continuum of health care, personal care, and social services required by the chronically or mentally ill or the disabled on a long-term basis.

Managed Care: A system of health service payments or delivery arrangements where the health plan attempts to control or coordinate the use of health services by its enrolled members in order to contain health expenditures and / or to improve quality.

Medicaid: A program of federal matching grants to the states to provide health insurance for categories of the poor and medically indigent. States determine program eligibility, payments, and benefits consistent with federal standards.

Medical Savings Account: A health insurance option consisting of a high deductible insurance policy and a tax-advantaged savings account in which individuals may accumulate contributions to pay for medical care or insurance.

Medicare Choices: A HCFA demonstration project, announced in June 1995, designed to offer Medicare beneficiaries a variety of managed care delivery options that are currently not available to beneficiaries as their primary sources of coverage.

Medicare Fee Schedule (MFS): A schedule of charges allowed by Medicare for physician services based on the RBRVS with geographic and other adjustments. Medicare pays 80 percent of the allowed charge, which is either the physician's actual charge or the MFS amount, whichever is lower.

Medicare Risk Program: A program that allows qualifying HMOs to enroll Medicare beneficiaries and assume full financial risk for their Medicare benefits in exchange for a monthly capitated payment.

Medicare Select: A program established in 1990 that allows beneficiaries in traditional fee-for-service Medicare to lower their out-of-pocket expenses for supplemental (Medigap) insurance by using providers in designated preferred provider organizations.

Medigap: Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include services not covered by Medicare and payment of Medicare deductibles or coinsurance costs. Medigap insurance must conform to one of ten standardized policies.

National Income: See "Gross Domestic Product."

Open Enrollment Period: A period of time in which an insuree may enroll in or change health plans and during which insurers must accept all applicants. Open enrollment periods assure that insurers, especially prepaid plans, do not enroll only good risks.

Out-of-Pocket Health Care Costs: Costs, such as copayments, coinsurance, and deductibles, incurred by insurees when they receive health care services.

Part A (Hospital Insurance) Benefits: The set of Medicare benefits that includes coverage for inpatient hospital services, home health care, skilled nursing facility care, and hospice care, financed by the Hospital Insurance Trust Fund.

Part B (Supplementary Medical Insurance) Benefits: The set of Medicare benefits that includes coverage for physician services, outpatient hospital services, laboratory and other diagnostic tests, financed by the Supplementary Medical Insurance Trust Fund.

Partial Capitation: A method of risk adjusting payments to prepaid health plans based partly on capitation and partly on fee-for-service.

Physician Payment Review Commission (PPRC): Commission created in 1985 to advise and make recommendations to the Congress on methods to reform payment to physicians under the Medicare program.

Point of Service Plan (POS): A managed care plan in which enrollees may select among delivery options (i.e., HMO, PPO, and FFS) at the time care is needed. Enrollees typically face lower out-of-pocket costs when they choose HMO providers than when they choose PPOs or providers with whom the plan does not have a contract.

Preferred Provider Organization (PPO): A formally organized network of providers who furnish health care services to purchasers according to a predetermined negotiated fee. The patient can choose either a network or non-PPO physician, but has a financial incentive to choose a PPO physician.

Prospective Payment Assessment Commission (ProPAC): Commission created in 1983 to advise Congress and the Secretary of Health and Human Services about implementation and subsequent changes in Medicare's DRG-based prospective payment system.

Prospective Payment System (PPS): A method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for a certain time period. Organizations receive the pre-determined amounts regardless of actual costs incurred.

Provider Sponsored Network (PSN): Affiliations of providers organized and operated to offer an integrated network of health care providers to insurance companies, HMOs, or other health plans. Employers and other organizations may contract with the PSN for health care services for their covered individuals.

Reinsurance: The resale of insurance products to a secondary market thereby spreading the costs of underwriting a policy and protecting the primary insurer against catastrophic expenses.

Resource Based Relative Value Scale (RBRVS): The methodology used to determine the MFS based on the relative value of resources used in performing each covered procedure.

Risk Adjustment: A process where premium dollars shift away from prepaid health plans that have relatively healthy enrollees to other prepaid plans with more high-cost members. The purpose of risk adjustment is to minimize prepaid health plans' incentives to attract only relatively healthy enrollees and to fairly compensate providers for care given to patients with more expensive health care needs.

Risk Contracts: See "Medicare Risk Program."

Risk Selection: Occurs when a disproportionate share of high or low users of care join a health plan.

Skilled Nursing Facility (SNF): A nursing care institution that participates in the Medicare and Medicaid programs and meets specified requirements for services, staffing, and safety.

Social HMO (S/HMO): A HCFA demonstration project that provides beneficiaries both acute and long-term care services. S/HMOs attempt to maintain the enrollment of high-cost, frail beneficiaries in managed care through the use of community support services and a capitated payment with funds from Medicare, Medicaid, and private premiums.

Staff Model HMO: An HMO where physicians work only for the HMO in exchange for a salary.

Supplemental Insurance: Health insurance that offers benefits, such as prescription drug coverage and preventive care, for services not covered by Medicare. See "Medigap"

Supplemental Medical Insurance (SMI) Trust Fund: A federal account that receives 25 percent of its revenues from beneficiary premiums, and the rest from general tax revenues. The SMI Trust Fund pays for Medicare Part B services, which include physician services, outpatient hospital services, laboratory and other diagnostic tests.

Teaching Hospitals: As defined in law and regulation, these are hospitals that have at least four physician interns and residents for each bed and that train medical personnel, conduct research, and often provide specialized or relatively intensive patient care.

United States Per Capita Cost (USPCC): The national average cost per Medicare beneficiary. Developed annually by HCFA's Office of the Actuary, it contributes to the calculation of the AAPCC.

Volume Performance Standard (VPS): A system used to adjust the Medicare Fee Schedule based on comparisons between increases in actual expenditures and predetermined performance standard rates of increase.

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