Medicare Brief

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Restructuring Medicare: A Synthesis of the NASI Medicare Projects

By Reginald D. Williams II

Introduction

This Medicare brief highlights the findings and recommendations of the National Academy of Social Insurance (NASI) Medicare study panels. These reports grapple with the most important policy challenges facing Medicare and its future, including financing, delivery of health services, and the administration of Medicare. Although each study panel had a specific charge, unifying themes emerge. This brief summarizes the findings of each study panel and identifies the common themes found among them.

Overview of NASI Medicare Projects

The growth of the aged population, rising costs of health care, projected insolvency of the Medicare trust funds, and the lack of an appropriate benefits package all pose challenges for Medicare. Recognizing the importance of the issues involved, NASI sought to inform the policy debate with objective, nonpartisan research and analysis.

NASI convened groups of experts from different disciplines and diverse political and philosophical views to help inform the debate about Medicare's future. Seven Medicare study panels were convened under two projects: *Restructuring Medicare for the Long Term* (begun in 1995) and its successor, *Making Medicare Restructuring Work: Policy Decisions for the Next Decade* (begun in 2000). Both were supported by grants from the Robert Wood Johnson Foundation. The study panels conducted background analysis, identified policy options, and made recommendations for consideration by policy-makers.

The first set of study panels framed their work around four issues: capitation and choice, fee-for-service Medicare, Medicare's larger social role, and long-term financing. The subsequent project focused on three topics: governance and management, chronic care in the 21st century, and the role of market forces in Medicare. Six reports have been published so far, and the seventh (and final) report will be published later this year.

Unifying Principles of Medicare Projects

General principles emerged from the study panels that serve as core values in restructuring Medicare. Each report, although different by focus, brought to light over-arching principles:

- Medicare has made invaluable contributions to the health and financial security of beneficiaries.
- Medicare should be preserved as a social insurance program.

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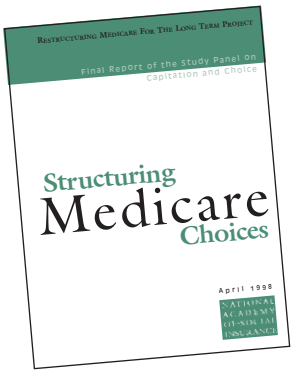
Note: Elements of the study panel reports are excerpted in this brief.

- Reform proposals should seek an appropriate balance between the financial security of Medicare beneficiaries and the need to ensure financing for Medicare's long-term future.
- Medicare's acute care focus should be modified to address the health care needs of beneficiaries, most of whom have chronic conditions.

Study Panel Findings and Recommendations



Study Panel on Capitation and Choice

Structuring Medicare Choices

Joseph Newhouse, Chair

The potential of managed competition among private health plans may help improve Medicare. The study panel examined questions associated with introducing market-based competition to health care organizations serving Medicare beneficiaries. The principles of capitation, choice, and shared financial risk were fundamental to this methodology of Medicare restructuring. The panel identified strategies to improve Medicare's capitated payment options and investigated how the balance of cost containment and offering quality services drives the competition for enrollees.

The study panel concluded that restructuring should maintain Medicare as a social insurance entitlement program, preserve Medicare benefits, and protect beneficiaries against excessive cost sharing. Restructuring should also be based on a thorough analysis of the strengths and weaknesses of market-based competition among health plans; methods for the paying of services equitably, given the health care needs of Medicare beneficiaries; and approaches to ensuring beneficiaries' access to quality health care.

Recommendations

Structuring Medicare Markets

- Model programs offer insight into capitated and fee-for-service options.
- Medicare benefits should be redesigned to meet the health needs of beneficiaries.
- Annual open enrollment periods should be coordinated with other programs.
- Medicare's demonstration authority should allow for comparison among plans.

Paying for Medicare Managed Care

- Medicare should design a system for assigning and adjusting risk.
- Full risk capitation should be prohibited in Medicare.
- Medicare should design experiments to determine the levels of risk sharing.

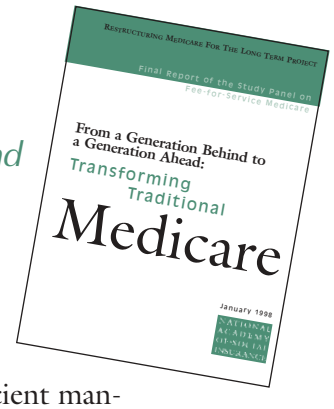
Information Needs and Beneficiary Protection

- All participating plans should provide standard information to make comparisons across plans.
- Medicare "conditions of participation" should be nationally consistent.
- Medicare choice should include adequate resources to support local consumer services.

Preparing for Structured Choice in Medicare

- Medicare Competitive Prepaid Pricing Demonstrations should expedite development and evaluation of group purchasing.
- Defined contribution demonstrations should be established.
- The demonstrations should be structured for three years of preparation and five years of evaluation.

Study Panel on Fee-for-Service Medicare



From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare

Paul Ginsburg, Chair

Ensuring quality of care, efficient management of utilization, and costs and administration of the program are priorities for Medicare. Fee-for-service (FFS) Medicare is the dominant means of payment in Medicare. The panel analyzed potential options for improving the management of FFS Medicare to incorporate promising innovations of private health insurance.

The study panel found the evolution of private health insurance from a bill-paying orientation to the adoption of managed care principles could be instructive for Medicare. It believed that the principles of disease and case management, incentives for using select providers, and competitive procurement hold particular promise for FFS Medicare. These principles could provide improved management by decreasing variances in care and costs, reducing threats to quality, and minimizing difficulty of meeting chronic care needs. However valuable, these changes in Medicare's management require statutory authorization. The historical dominance of Medicare as a social insurance program and the slow rate of change in large government agencies create non-statutory barriers to improvement.

Recommendations

- Congress should mandate that FFS Medicare move beyond its traditional role as a bill-payer to become accountable for the quality and costs of services provided to beneficiaries.
- Congress should direct the Centers for Medicare & Medicaid (CMS, then called the Health Care Financing Administration) to pursue innovation in FFS Medicare on an ongoing basis.
- In order to carry out these experiments in the management of FFS Medicare, CMS should have the authority to waive some statutory requirements.
- Congress should require the Secretary of Health and Human Services to report annually on how CMS has used its authority to innovate and with what results for quality, costs, and access. Congress should designate an advisory body to respond to this report and advise Congress about potential improvements.
- To help Congress hold CMS accountable to the public, it should require that each experiment obtain evaluation data in order to learn quickly from the initiative.

Study Panel on Medicare's Larger Social Role

Medicare and the American Social Contract

Rosemary A. Stevens, Chair

In search of a better understanding of the philosophical principles and rationales for the Medicare program, this study panel explored the social values underlying Medicare. The panel focused on four major tasks: a historical review of why Medicare was created and how it has evolved; an assessment of the principles of social insurance as embodied by Medicare, including other public goods paid for by Medicare such as graduate medical education; a public opinion research project to understand how Americans view Medicare; and a framework for the discussion on criteria used to evaluate options for Medicare reform that incorporate the social values and policy concerns of the American public.

Key Findings

- Medicare was created as a response to a serious problem: The private market did not and could not work for a large proportion of the nation's elderly and disabled population.
- Medicare was originally designed as a social insurance program, rather than as a social welfare program.
- Decisions about Medicare's future, including its ability to deal with health care utilization and costs, will not (and cannot) be made on purely economic or medical criteria.

Seven criteria should be considered and, when necessary, weighed against each other, as values and public policy concerns are important to debating Medicare's future:

- Financial security
- Equity
- Efficiency
- Affordability over time
- Political accountability
- Political sustainability
- Maximizing individual liberty

Study Panel on Medicare's Long Term Financing

Financing Medicare's Future

Marilyn Moon, Chair

Building upon the work of previous study panels, this panel examined financial strategies associated with various Medicare reform approaches. Essential to the panel's analysis was a basic understanding of the purpose of Medicare and its function in society. It was explicit in supporting Medicare as a social insurance program designed to spread the financial risk of medical care for beneficiaries across the population. This fundamental tenet is being threatened by the rising costs of health care. Furthermore, impending reform efforts will affect Medicare's ability to spread risk.

The study panel commissioned projections of Medicare spending based upon several conditions: leaving Medicare unchanged; making changes to the program to produce savings; expanding benefits in the program; and changing the cost sharing in Medicare. The results of these analyses demonstrated that all of these possible scenarios would create a substantial need for new revenues.

Suggestions and Observations

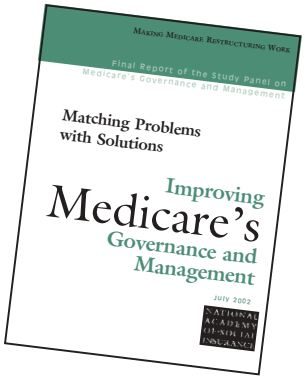
Possible Approaches to Meeting Medicare's Projected Financial Needs

- Reducing program costs through efficiencies
- Asking beneficiaries to pay more
- Using the budget surplus
- Raising revenues through taxes

Observations from the Analysis of Approaches

- Securing additional financing is necessary to maintain Medicare's role as a financial protector of health care costs to the elderly.
- The ultimate solution to Medicare reform will involve trade-offs. However, that should not limit policy-makers from taking action.
- Raising taxes is neither popular nor without drawbacks. A decision between generating new revenues or eroding financial protections needs to be made.
- The role of timing in public finance reform decisions is crucial. Making a decision sooner rather than later will be more financially and politically palatable and lessen the magnitude of change required.

Study panel on Medicare's Governance and Management



Matching Problems with Solutions: Improving Medicare's Governance and Management

Sheila Burke, Chair

The Medicare reform debate has raised questions about the institutional structures and management procedures of Medicare. The efficiency of the program's administration is crucial to the program's success in meeting the needs of beneficiaries. The study panel chose to base its work on an evaluation of the current Medicare system. It established the criteria of capacity, accountability, and credibility to evaluate Medicare's governance and management.

The study panel conducted a historical assessment of Medicare from its inception to the present. Medicare has become a much larger and complex program than envisioned at its inception. This growth resulted from the fact that Congress has dramatically increased its responsibilities over time and from the increasing complexity of medical care and rapid advances in medical technology. In management, the study found that a shortage of resources and Congressional micro-management, along with increased responsibilities, have prevented the agency from fully discharging all of its responsibilities. The panel also evaluated alternate governance models but found none to be clearly superior.

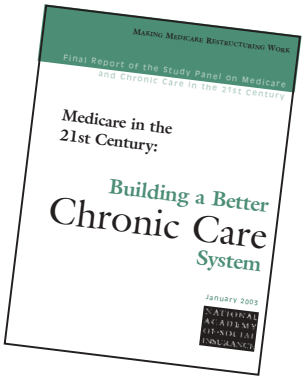
Recommendations

- Medicare policy-makers should address administrative and management problems regardless of broader Medicare reform.
- A panel should be appointed to analyze Medicare's transition as an agency.
- Congress should increase administrative funding.
- Congress should not enact major changes in the near term because CMS does not have either the resources or capacity to implement major changes.
- Congress should consider removing from CMS some functions not directly related to Medicare or Medicaid.
- Congress should furnish CMS with new multi-year funding to develop and implement improved information systems.
- Congress should authorize the President to appoint with Congressional approval the administrator of CMS to a fixed term.
- Congress should increase the salary of the administrator to better reflect the stature and responsibilities of the position, commensurate with the Commissioner of the Social Security Administration.
- Congress should grant CMS some relief from limitations on salary and civil service personnel rules to recruit and retain staff with highly specialized skill.
- Congress should create a joint committee to serve as a center of information and analysis.
- CMS should have flexibility in contracting organizations to process Medicare claims.
- Congress should provide resources to CMS to provide real-time assistance to beneficiaries.
- Congress should provide adequate funding for the National Medicare Education Program.

Study Panel on Medicare and Chronic Care

Medicare in the 21st Century: Building a Better Chronic Care System

David Blumenthal, Chair



During the mid-1960s, acute care—not chronic care—was the major focus of medicine. Since then, good chronic care and comprehensive coverage have become crucial to Medicare beneficiaries. Though some improvements have been made to Medicare, major changes in the provisions and financing of chronic care for Medicare beneficiaries are needed. Medicare has the potential to refocus its program—as well as the nation's health care system—and should take a leading role in improving chronic care.

The study panel recommended the addition of new benefits and changes in the way Medicare interprets policies. Additionally, Medicare has no limit on out-of-pocket spending, which jeopardizes the financial security of many beneficiaries with high medical costs. To address this, the study panel recommended that a reasonable limit on annual out-of-pocket spending be set. Medicare policies have also frequently been interpreted in ways that impede the care of beneficiaries with chronic conditions. These policies do not help beneficiaries with chronic conditions maximize independence, or maintain or slow deterioration of function. The study panel recommends that these and similar administrative policies be revised.

Recommendations

Provide beneficiaries with financial protection from chronic conditions

- Limit cost sharing by adding an annual cap on out-of-pocket expenditures on covered services.
- Cover services necessary for beneficiaries' chronic care needs.

Support the continuum of care beyond those services presently covered by Medicare

- Address gaps in Medicare's benefit structure (e.g., prescription drugs and preventive health services).
- Strive to include services related to function and health-related quality of life.
- Adequately involve families of beneficiaries.

Promote new models of care

- Foster delivery system change.
- Increase providers' knowledge of chronic and geriatric care.
- Payment should support new models of care.

Strengthen CMS' role as a purchaser of care

- Measure and report on the quality of chronic care.
- Designate Medicare Partnerships for Quality Services demonstration for select chronic conditions.

Support enhanced information systems

- Foster implementation of electronic information systems.
- Promote the collection and standardization of health and functional assessment data.

Implement and support funding for research and demonstration projects

- Sponsor chronic care research and demonstration projects that incorporate successful elements into Medicare.
- Focus projects on multiple chronic conditions.
- Redefine budget neutrality for the purpose of approving proposed demonstrations.
- Increase CMS' budget for research and demonstrations to improve chronic care.

Study Panel on Medicare and Markets

Forthcoming Report

Mark Schlesinger, Chair

Central to many reform proposals is greater reliance of market forces to control program costs. The prospect of increased competition in health care and insurance markets raise a series of issues related to provider payment, equity, and consumer protection. The study panel has conducted policy analyses, reviewed evidence on the differences between FFS and the Medicare+Choice program, and commissioned data analysis to inform its findings and recommendations. The report's release is anticipated for the spring of 2003.

Next Steps

NASI seeks to maintain its role as a leader in the health policy debate by continuing to address issues related to Medicare's future. These issues include the long-term care system and health insurance coverage of the disabled and dually eligible persons who received both Medicare and Medicaid.

Sources

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