
Incremental Health System Reform: Where Medicare Fits In

by Gail R. Wilensky

Our nation has spent the past two years discussing the “big bang” of health care reform—reform that simultaneously changed the rules governing insurance for the private sector; the conditions under which employers contributed to health insurance for their workers and workers purchased health insurance for themselves and their families; the way in which government supported low-income families, medical education, and public hospitals and other “essential” providers; plus a host of other changes. Having done so, we now realize, albeit reluctantly, that health care reform will occur as most other legislative changes occur in this country: piecemeal and incrementally. Ironically, the formal changes in social reforms that work through the legislative process almost always occur in a slow, deliberative manner, while changes taking place in the private sector are happening at a tumultuous rate. Nonetheless, it is appropriate to consider whether and how incremental changes can be made to the Medicare program, in a way that (1) resolves some of the problems facing Medicare and (2) supports and augments the changes occurring among the employed populations that are covered primarily by the private sector.

Medicare: Large, Popular, And Growing

Medicare is the world’s largest insurance company and has been one of this country’s most popular government programs. It was enacted in 1965 to provide coverage for the aged and was later expanded to provide coverage for the disabled as well as patients with end-stage renal disease (ESRD). There are currently thirty-two million beneficiaries who are aged, 3.5 million who are disabled, and about 75,000 who are in the ESRD program.

There are several reasons for Medicare’s popularity. First and foremost, Medicare fulfilled its original mission well. Medicare was enacted to increase and extend access to care for the elderly. Prior to 1965 many elderly persons had great difficulty purchasing health insurance and receiving adequate and appropriate amounts of care. This was in part a poverty problem, because large numbers of elderly persons were living on very little money, but even those elderly who were not poor had difficulty purchasing insurance. When Congress passed the Medicare legislation, its intention was to make Medicare mimic the prevailing structure of health care financing in 1965: the reimbursement arrangements used by Blue Cross and Blue Shield plans. Medicare is generally regarded as having accomplished this objective exceedingly well—some might even say, too well.

Medicare is popular not only because it fulfilled its mission, but also

because it places few restraints on the elderly's consumption of health care. Aside from a few exceptions, mostly concerning coinsurance payments for hospital care after ninety days of care, payments under Medicare are open-ended and come with minimal restraints, at least as far as the elderly are concerned. There is complete choice about which physicians to use, which hospitals to enter, and which home care providers to use. The elderly have little reason to care about the cost of their care and face little or no pressure to seek cost-effective providers or health care plans. Because more than 85 percent of the elderly have either private insurance or Medicaid to supplement their Medicare benefits, the deductibles or coinsurance requirements for Medicare-covered services entail only limited direct financial pressure. Although some have raised concerns about potential future problems of access to physicians as a result of Medicare payment levels, there is no evidence to date that the elderly are having any systematic problems securing access to care with Medicare as the payer.

The Need For Reform

Despite its successes, Medicare has some major weaknesses and is in serious need of reform. The most overwhelming issue is its financing, in both the short run and the long run. In the short term, entitlement spending in general and Medicare spending in particular act as a major drain on the budget and therefore exacerbate the deficit. In the longer term, Medicare is not financially viable, and its future fiscal insolvency raises serious questions about the nature and design of a program that will be sustainable into the next century.

The Hospital Insurance (HI) portion of Medicare, Part A, is funded by the HI Trust Fund. According to the Congressional Budget Office's (CBO's) January 1995 baseline estimates, Part A growth for fiscal year 1995 is 10.2 percent, with growth rates between 7.5 percent and almost 10 percent projected for the remainder of the decade.¹ Hospital spending is projected to grow at rates that vary 6–7 percent per year, but the other components of Part A are expected to grow at much faster rates. Home health, which is projected to grow at 26 percent from 1994 to 1995, is expected to gradually slow to 9 percent annually at the end of the decade, and spending on skilled nursing facilities, which is also projected to grow at 26 percent between 1994 and 1995, is projected to slow to 8 percent by the end of the decade.

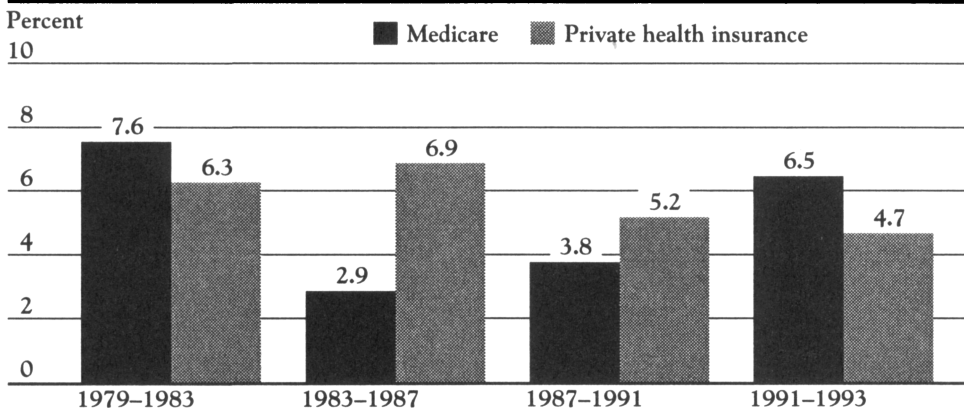
In the simplest terms, the HI Trust Fund is running out of money. Using intermediate actuarial assumptions, which some consider optimistic, the latest HI Trustees Report projects that the trust fund will be bankrupt in the year 2001 and that the imbalance between revenues and cost will grow

rapidly thereafter.² Under current projections, for example, by the year 2020 the cost rate, or outflow of funds from the trust fund, is projected to be more than double the income rate, or inflow, of the program. Thus, although Part A does not have the immediate impact on the deficit that Part B does, because of its trust fund financing, the need for change in the near future is clear and unmistakable.

Supplemental Medical Insurance (SMI), or Part B of Medicare, which is financed approximately three-quarters by general revenues of the federal government and one-quarter by premium payments from the elderly, poses a different set of problems. Instead of draining a trust fund, Medicare Part B has a direct impact on the federal budget. According to CBO baseline estimates, Part B growth is projected to be 10.9 percent for fiscal year 1995, with growth rates of 12–13 percent annually for the remainder of the decade.³ Even growth rates in spending for the physician component, which in fiscal year 1995 is projected to grow at slightly less than 6 percent, are projected to grow 9–12 percent per year throughout the rest of the decade. Growth rates for durable medical equipment, laboratories, outpatient hospital spending, and other Part B spending are projected to grow even more rapidly.

At a time when spending in the private sector appears to have slowed, the increases in spending for Medicare continue to be in double digits. Between 1983 and 1991 Medicare spending grew more slowly than spending in the private sector did (Exhibit 1). But since 1991 Medicare has grown much faster than spending in the private sector—6.5 percent versus 4.7 percent growth in real per capita spending. The differential spending

Exhibit 1
Real Change In Medicare Expenditures Per Enrollee And In Private Health Insurance Per Plan Member, 1979–1993



Source: Prospective Payment Assessment Commission (ProPAC) analysis of data from the Health Care Financing Administration Office of the Actuary.

appears to be even more dramatic for 1993–1994, although most of the data for this period remain preliminary. According to the latest CBO estimates, spending for private expenditures grew at about a 5 percent rate in 1994, while those of Medicare exceeded 10 percent.⁴ There are some indications, however, that spending in the private sector, or at least some segments of the private sector, may have slowed down even more dramatically than the CBO projections suggest. A recent Foster Higgins national survey of employers, for example, indicated that for all firms, health care premiums declined 1.1 percent; the decline was largest for large firms, 1.9 percent, although costs for small firms rose 6.5 percent.⁵ Another indication comes from the changes in the Consumer Price Index (CPI). The rise in the medical component of the CPI was 4.9 percent, compared with a 2.7 percent overall increase in the CPI. For the first time in a long while, the medical CPI is a little short of twice the overall CPI, and a substantial proportion of the upward pressure is coming from Medicare and Medicaid. Whether these indications of even greater differentials in spending rates between Medicare and the private sector are correct, only the future can determine, but it is a fact that Medicare has been growing at least 50 percent faster than the private sector since 1990.

We should not be surprised at this. Medicare is primarily *à la carte*, fee-for-service medicine with government-administered pricing and a volume control on physicians. Hospitals are encouraged to “game” the way inpatient admissions are coded and to increase hospital admissions, both of which increase hospital revenues. Physicians are rewarded for doing more rather than less, when less may be as good or better. There are few incentives for the elderly to seek cost-effective providers or for physicians or medical suppliers to limit the spending on services provided to the elderly. Increased spending has been particularly a problem for hospital outpatient services, clinical lab procedures, home health care, and skilled nursing facilities, but it also has been a problem in efforts to moderate physician spending. An individual physician’s behavior has little bearing on the change in fees for that physician. Rather, fees are determined by the aggregate behavior of all physicians, differentiated only according to whether they are primary care physicians, specialty physicians, or surgeons. Combined with the cost-increasing incentives inherent in *à la carte*, fee-for-service medicine, this means that there are few incentives for physicians to practice cost-efficient and prudent medicine, and no rewards for those who do.

In this world of third-party-financed, fee-for-service medicine, our cost containment efforts can only come from a combination of the following: (1) reducing prices (and guarding against volume increases); (2) tying price changes to spending targets; (3) increasing deductibles and copayments;

and (4) controlling access to providers and technology.

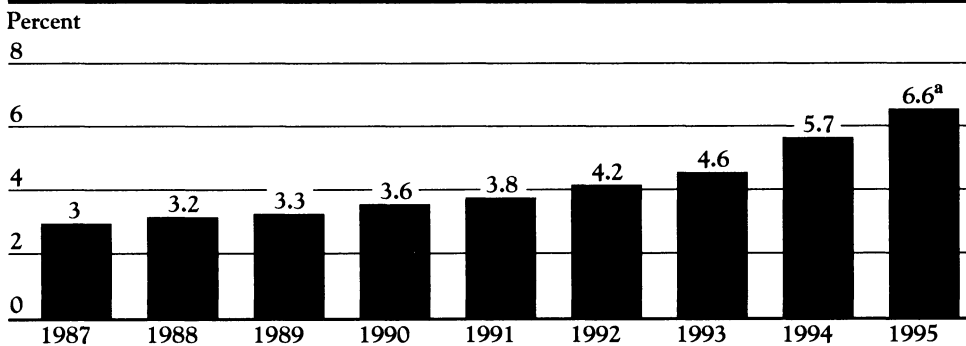
The Medicare program has primarily relied on the first three, and this country has shown little interest in invoking the fourth. Medicare's strategy has been one of direct control, and perhaps we should not be surprised that while direct controls can moderate spending for a few years (particularly when compared with a passive private sector), it appears that this moderating force dissipates after a short period of time.

Present Structure Of Medicare

Despite all of the changes occurring in the private sector, Medicare continues to remain a fee-for-service program, with limited availability of and participation in managed care. The projections for 1995 indicate an expected enrollment of 2.5 million beneficiaries in health maintenance organizations (HMOs), representing 6.6 percent of all enrollees (Exhibit 2). The enrollment in HMOs has grown rapidly over the past few years relative to the non-Medicare population, but that is because the base was so small (Exhibit 3).

There are several reasons that explain the low managed care penetration in Medicare. First, Medicare subsidizes HMOs' main competitors. Fee-for-service "Medigap" coverage is implicitly subsidized, since Medicare ends up paying for most of the increased use in health services that comes from eliminating Medicare's cost sharing. Employer-provided supplemental insurance also is subsidized because it is provided tax free to the beneficiary. In addition, there have been problems with Medicare's payments to HMOs. Inadequate adjustment for risk appears to have produced overpayments to

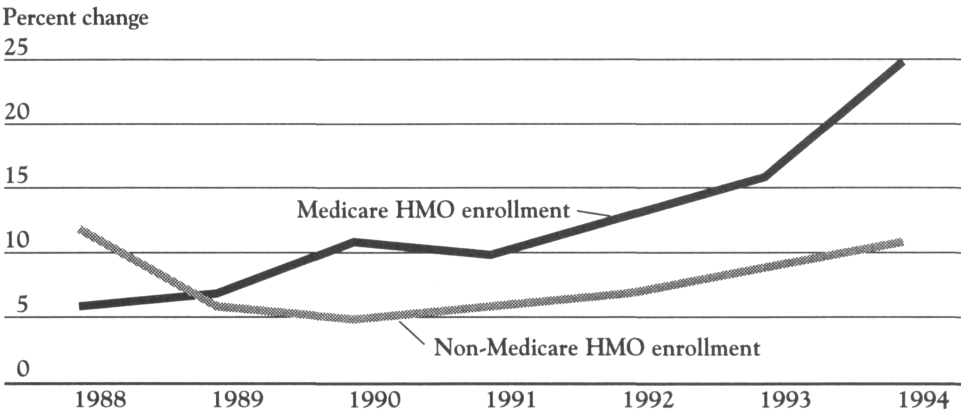
Exhibit 2
Percentage Of Persons Eligible For Medicare Enrolled In Health Maintenance Organizations, 1987–1995



Source: Health Care Financing Administration.

^a Projected.

Exhibit 3
Percent Change In The Growth In HMO Enrollment In Medicare And Non-Medicare Populations, 1988–1994



Source: Health Care Financing Administration, Office of Managed Care; and Group Health Association of America.
Note: HMO is health maintenance organization.

some HMOs and probably underpayments to others. However, this is more of a problem for the Health Care Financing Administration (HCFA), and it explains why there appears to have been little savings associated with the HMO growth to date, although that finding has been subject to some dispute. Of greater relevance is the substantial variation in payment levels between counties and in payment levels from year to year. Questions also have been raised about the accuracy of HMO payments in terms of its component measurements and about the effects of a potential “spillover” on Medicare from having a large HMO enrollment in the non-Medicare population.

What is probably the most significant deterrent to managed care growth, however, is the limited types of non-HMO managed care options that are available to the Medicare population, the very population that most needs and probably most desires flexibility. Medicare Select, a preferred provider organization (PPO) offering, was limited to fifteen states, with a three-year sunset provision. That authority is being renegotiated, but its need for reauthorization reflects the difficulty that managed care plans have had within the Medicare framework. Point-of-service plans, which allow patients to opt out of their network and choose other physicians or facilities, are not allowed. Risk-based “carve-outs,” like the package-price heart bypass demonstration, also are not allowed except on a demonstration basis. And HMO group-only contracts, which would permit employers to establish an HMO/competitive medical plan (CMP) hybrid that enrolls only their own retirees who are Medicare beneficiaries, are not allowed either.

If the Medicare program is to significantly increase its managed care

enrollment, the first requirement must be to make available the more varied and flexible options that have been and are in the process of being developed in the private sector. But availability alone will probably not be sufficient. To see substantial growth in managed care, the elderly's incentives also must be changed.

Goals And Strategies For A Reformed Medicare Program

Changing a popular program is always difficult, and changing a popular program involving the elderly is especially difficult because change raises fears and concerns about the future. The income of the elderly generally has been determined by past actions and cannot easily respond to new incentives or rules. This means that we must be clear about our goals for a reformed Medicare program and our strategies for accomplishing the goals. These goals should include at least the following: (1) increasing consumer choice for the elderly; (2) providing incentives for accessible, high-quality, patient-oriented care; (3) encouraging cost-conscious decision making by the elderly; (4) incorporating innovative, cost-reducing delivery system reforms from the private sector into the Medicare program; and (5) laying the groundwork for a fiscally solvent Medicare program.

To achieve these goals, it will be necessary to change the basic incentive structure associated with Medicare, open up the options available to the elderly, and provide the elderly with the information they need to make choices that are appropriate for each person. There is now little incentive for an elderly person to seek out cost-effective physicians or hospitals or to use lower-cost durable medical equipment, laboratories, or outpatient hospitals. Similarly, hospitals and physicians have little reason to provide the most cost-effective care if there is any medical gain to be had from providing more services, and some reason to fear legal repercussions if they do less than they might have done and the patient has an adverse outcome. Ultimately, we need to reward the elderly for choosing more cost-effective health care, provide incentives for physicians and hospitals to practice cost-effective medicine, and be willing to share the savings that an aggressive reorganization of health care can produce.

A better-designed adjusted average per capita cost (AAPCC) payment, the payment now used for HMOs, could become the basis of a voucher or Medicare certificate that would encourage cost-effective choices. To make this transformation, it would be necessary to redesign the determinants of the AAPCC to make it more stable, to take better account of the risk selection that appears to occur, and to open up more choices toward which that payment can be made. Ultimately, it may be appropriate or desirable to vary the amount of the payment with the income and/or wealth of elderly

persons, thus transforming Medicare into an income-related voucher or payment system. However, that decision need not be made in 1995.

In an effort to achieve incremental reforms this year or soon thereafter, I recommend the following specific changes: (1) Allow Medicare Select, the preferred provider option, to be available in all fifty states. (2) Allow point-of-service plans. (3) Allow partial capitation or risk-based "carve-out" plans. (4) Refine and revise the capitation rate, to break the link to fee-for-service spending, to experiment with basing Medicare's contribution to the premium on a competitively bid level and use this amount for Medicare's contribution for fee-for-service plans as well, and to experiment with alternative calculations of the capitation payment for areas that cannot support competitive bids. (5) Move to an annual open enrollment period for all changes in Medicare-related policies; discontinue thirty-day disenrollment policy for HMOs. (6) Remove the fifty/fifty rule for HMOs serving Medicare beneficiaries; require outcomes-based reports plus consumer satisfaction measures to be available to all potential enrollees. (7) Allow HMOs to price below the Medicare payment and rebate savings to the elderly (and share savings with the government).

These changes would greatly increase the availability of managed care to the elderly, remove provisions that inhibit managed care growth, and, where appropriate, give elderly persons some incentives to choose the most cost-effective health care plans. To the extent that the payment is set at the level of the "lowest-cost plan" in the area or determined by the difference between the lowest-cost and the average-cost plan, Medicare would provide a strong incentive for the elderly to choose cost-effective health care plans that meet their needs and demands, which may or may not turn out to be managed care plans.

In the short term, the need to realize savings from Medicare will have an impact on congressional decision making. Because some proposed changes are consistent with the move to a more incentive-based choice structure, some are neutral, and some would move the system in the wrong direction, the choice of which changes are adopted will have important ramifications in the long run. For example, adding a 10 percent coinsurance payment for home health care, or a fixed copayment for rehabilitation hospital admissions, would raise some additional revenues, lower utilization in these areas, and make managed care options more attractive. Similarly, "bundling" postacute care services and capitating those areas of Part A that have been growing very rapidly over the past several years and will continue to grow more rapidly than the remainder of Part A for the rest of the decade also will make managed care plans that tend to cover these components more attractive and discourage their use in the fee-for-service world. Reducing payments to indirect or direct medical education would be neutral with

respect to the effect on the elderly's choices of cost-effective health care plans, although it obviously will affect academic health centers and teaching hospitals. But large reductions in overall physician fees could lead physicians to compensate with large volume increases, which would mitigate some of the savings and exacerbate the divisions between fee-for-service and at-risk medical practice.

I believe that it is possible to accommodate the need for short-term revenue increases while setting the stage for the more fundamental changes in the incentives, information, and options that are needed to reform the Medicare program. It will take some time to realize the gains from restructuring and reforming Medicare, so it is important that these reforms be begun as soon as possible. This session of Congress is none too soon to start.

NOTES

1. Congressional Budget Office, unpublished fact sheet on Medicare (December 1994).
2. G. King, "Health Care Reform and the Medicare Program," *Health Affairs* (Winter 1994): 39–43.
3. CBO, unpublished fact sheet.
4. Ibid.
5. Foster Higgins, 1994 National Survey of Employer-Sponsored Health Plans (New York: A. Foster Higgins and Company, April 1995).