

MEDICARE BACKGROUND

PHOTOCOPY
PRESERVATION

Medicare: What's Right? What's Wrong? What's Next?

The issue is not whether to restructure Medicare broadly, but when and how.

by Gail R. Wilensky and Joseph P. Newhouse

ABSTRACT: Although future Medicare costs are highly uncertain, reasonable projections of those costs suggest a major financing problem. The Balanced Budget Act of 1997 will provide temporary relief, although it introduced some new problems, including its geographic adjustment of Medicare+Choice rates. For the future we propose a premium-support system and an expanded benefits package. Such a system would provide a more flexible means to adjust the division of the financing burden between the elderly and the nonelderly, potentially gain some efficiencies from greater price competition and less reliance on administered pricing, and partly address the issue of uninsured early retirees.

MEDICARE REMAINS ONE OF this country's most popular social welfare programs, for good reason. Prior to its enactment, seniors had little access to group health insurance, and if they could buy individual insurance at all, it was expensive. Medicare not only provided seniors with insurance but did so on favorable terms: Today's beneficiaries have received much more from Medicare than they paid in. Not surprisingly, then, Medicare has been especially popular with the seniors it serves and also has become an important source of income for millions of providers.¹

For most of this decade, though, there has been a growing sense that Medicare needs serious reform. The impetus for reform may have diminished temporarily as a result of the 1997 Balanced Budget Act (BBA), yet it is generally well recognized that the changes in the BBA are just the beginning.

Much of the motivation for Medicare reform has been financial: a Part A trust fund that, prior to the BBA, was set to run out of funds

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by the middle of the next decade; growth; and the looming retirement of baby boomers starting around 2011. The reform has come from the belief that the way health care is organized is more efficient than continuing to rely on the structures of the 1960s, when the program was created.

Medicare remains dominated by a fee-for-service payment structure that characterizes the insurance plans of the 1960s, which covers inpatient hospital care and 100 days of skilled nursing care financed by a portion of FICA. The Blue Shield analogue is a capitated payment for physician services, home care, stay or home care that does not cover durable medical services, and durable medical equipment. Part B is an earmarked trust fund, Part B's monthly premium that sends about 25 percent of Part B's costs to the general fund.

The Medicare benefits provided to many of today's employer-sponsored employees, including outpatient pharmaceuticals, are not covered by Medicare. It does, however, provide coverage for a hospital stay and skilled nursing care, which is common in employer-sponsored plans. Clearly important to an older population, Medicare's coverage of these services is limited.

Traditional Medicare solves the problem of providing insurance to individuals age sixty-five and older. Moreover, since the program was created, it has been extended to individual physicians and hospitals. Medicare's payment rates for providers that few would dispute are low. Its payment rates lag behind private insurance, and concerns periodically arise that Medicare's lower payment rates might be unwilling to pay for certain services. This has been systematic.

What's Wrong With

■ **Administered pricing** reflects some of the basic problems with Medicare. Unlimited choice of providers and competition in maintaining rates are essential to a sustainable system.

by the middle of the next decade; a rapid rate of Part B spending growth; and the looming retirement of the seventy-eight million baby boomers starting around 2010. But at least part of the drive for reform has come from the belief that Medicare should better reflect the way health care is organized and delivered in the 1990s rather than continuing to rely on the financial and organizational structures of the 1960s, when the program was conceived.

Medicare remains dominated by the traditional indemnity insurance structure that characterized the Blue Cross and Blue Shield insurance plans of the 1960s. The Blue Cross analogue is Part A, which covers inpatient hospital care, the first 100 days of home care, and 100 days of skilled nursing care following a hospital stay. It is financed by a portion of FICA, the Social Security tax on earnings. The Blue Shield analogue is Part B, which covers outpatient care, physician services, home care after 100 visits following a hospital stay or home care that does not follow a hospital stay, clinical lab services, and durable medical equipment. Unlike Part A, with its earmarked trust fund, Part B is funded by general revenues and by a monthly premium that seniors pay. The premium now pays for about 25 percent of Part B expenditures.

The Medicare benefits package also reflects the 1960s. Unlike many of today's employer-sponsored plans, Medicare does not cover outpatient pharmaceuticals, nor does it protect against very large bills. It does, however, provide 100 days of skilled nursing care following a hospital stay and unlimited home care visits, neither of which is common in employer-sponsored plans but which are clearly important to an older population.

Traditional Medicare solved the basic problem it was designed to address: providing insurance for (most) acute care for persons over age sixty-five. Moreover, seniors face few constraints on their access to individual physicians and other health care providers under traditional Medicare. Medicare represents such a large amount of revenue for providers that few turn down Medicare patients, even when its payment rates lag behind those of the private sector. Although concerns periodically arise that physicians in certain specialties or regions might be unwilling to see Medicare patients because of Medicare's lower payments, there has not been any evidence that this has been systematic or widespread.

What's Wrong With Medicare?

■ **Administered pricing systems.** Medicare's financial problems reflect some of the basic attributes that have made it so popular. Unlimited choice of providers has left a minimal role for price competition in maintaining market discipline and has forced reliance on

antiquated system

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administered pricing systems. It is always difficult to get administered prices "right," especially in industries (such as health care) with rapid technological change. Moreover, the structure of these systems has had powerful effects (some unintended and undesirable) on services delivered.

Shorter hospital stays and substitution of postacute care during the past fifteen years, for example, are consistent with the financial incentives of a fixed payment for a hospital admission and additional payment for nursing home days and home health visits. Lenient reimbursement for new skilled nursing, rehabilitation, and long-term hospital providers has resulted in many more such providers. Payment as a function of case-mix has offered hospitals the incentive to code patients in higher-paying categories. Some of these changes may have been beneficial, but all have largely reflected the unintended side effects of various administered-price reimbursement systems rather than deliberate decisions.

■ **Limited plan choice and Medigap.** Unlike choice among institutional and individual providers, the choice among different types of health plans under Medicare has been sharply constrained. Before the BBA the choice was effectively either traditional Medicare, which could be augmented with an indemnity insurance supplement, or the most structured type of managed care, a traditional health maintenance organization (HMO).

The restricted nature of plan choices, together with the limited nature of the benefit package, has meant that almost all seniors supplement traditional Medicare. The supplemental plan may be a retiree program, a privately purchased insurance plan designed to wrap around Medicare (an individual Medigap plan), or Medicaid. Only about 10 percent of seniors have no supplementary plans.²

The use of this two-tier insurance strategy rather than the use of a single (non-HMO) policy to replace all of traditional Medicare has had important consequences. For seniors, especially the half without Medicaid eligibility or employer-provided insurance, it has meant substantial supplemental premium payments. Average premiums for individual Medigap plans now range from \$1,000 to \$3,000 or more per year.³

While filling some gaps, these supplementary plans leave seniors with financial exposure for noncovered medical costs, especially those relating to chronic long-term care and, in a number of cases, prescription drugs. Moreover, the individual policies have high markups over their medical costs, typically 30 percent, whereas private group plans typically have markups of only 10 percent or less, and Medicare itself has only a 2 percent administrative cost rate.⁴ Partly because of the markups in individually purchased plans,

Medigap premiums are large relative to so of seniors whose only (or only) security and who are not eligible for Medicaid. Medigap creates additional costs for seniors in many of the cost categories and hence increase Medicare costs. Supplemental plans, however, do not.

Financing Medicare's F

The incentives associated with Medicare plus supplementary insurance are not particularly attractive, rewarding the most aggressive or at least not rewarding providing negligible incentive to physicians or hospitals, and providing new technologies and procedures.

Given these incentives, with Medicare facing persons under age sixty, it is not surprising that there has been a decline in Medicare. That, as a result, Medicare is projected to grow from 1970 to 1997 the real growth rate of 5.4 percent per beneficiary per year, one-fifth of which is Medicare. These figures roughly correspond to the incentives for Medicare providers. Medicare must ensure that the private sector, to maintain the most recent (1993-1997) financing care for persons aged care, these trends have been personal health care spending per beneficiary has fallen.

The key uncertainty is therefore the magnitude of whether the future growth of those of the private sector will be somewhere between the historical growth rates.

First, a considerable increase in medical spending surely

Medigap

Medigap premiums are large relative to the income of the one-sixth or so of seniors whose only (or main) source of income is Social Security and who are not eligible for Medicaid.

Medigap creates additional costs for Medicare as well. Because Medigap fills in many of the cost-sharing requirements of Medicare, persons with supplemental plans use more Medicare-covered services and hence increase Medicare's costs. Premiums for the supplemental plans, however, do not reflect Medicare's increased costs.

Financing Medicare's Future Costs

The incentives associated with the combination of traditional Medicare plus supplementary insurance have been especially problematic, rewarding the most aggressive health care practitioners, penalizing or at least not rewarding conservatively practicing physicians, providing negligible incentives for the elderly to seek cost-effective physicians or hospitals, and providing incentives to bring onstream new technologies and procedures almost irrespective of cost.

Given these incentives, which as already noted resembled those facing persons under age sixty-five until relatively recently, it is not surprising that there has been a steady escalation of spending and that, as a result, Medicare is facing serious financial problems. From 1970 to 1997 the real growth rate of Medicare spending was about 5.4 percent per beneficiary per year, a bit higher than the 4.3 percent growth in real per person personal health care spending (about one-fifth of which is Medicare). It should not be surprising that these figures roughly correspond.⁵ Historically, Medicare has given providers incentives similar to those of private insurers. Moreover, Medicare must ensure that its rates do not fall greatly below those in the private sector, to maintain access for Medicare beneficiaries. In the most recent (1993-1997) period, however, as the incentives in financing care for persons under age sixty-five moved toward managed care, these trends have diverged. The annual growth rate in real personal health care spending per person has fallen to 2.0 percent—less than half its historical value—while Medicare spending per beneficiary has fallen only slightly, to 4.7 percent.⁶

The key uncertainty in projecting future Medicare costs—and therefore the magnitude of Medicare's future financing problem—is whether the future growth rate in Medicare costs will be closer to those of the private sector in the very recent past or closer to those historical growth rates. Our guess is that the future rate will be somewhere between these two values but probably closer to the historical rate, for several reasons.

First, a considerable portion of the historical trend in overall medical spending surely reflects the increased capabilities of medi-

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"Real growth in Medicare spending after 2010 will average around 5-7 percent per year absent budget constraints."

cine.⁷ Although the revolution in molecular biology may ultimately lower treatment cost, there is no certainty about this (think of the six-figure cost of Ceredase for the treatment of Gaucher's disease). In any event, "ultimately" may be well into the future. Meanwhile, the medical advances are likely to continue. To the degree that people remain willing to pay for these advances, cost growth will and should continue.

Second, to some degree the recent slowdown undoubtedly reflects one-time gains from the changeover to managed care. Although these gains might continue for several more years, we doubt that they can continue very far into the next century.

On the other hand, the spread of capitation and price competition could change the nature of medical innovation. As mentioned above, until recently the financial incentives favored any innovation that could benefit health. Cost is now more of a factor in determining whether to adopt a beneficial but more costly capability and, once adopted, how much to use it. Furthermore, the heightened sensitivity to cost may increase the rate of development of cost-saving innovations. Growth in medical spending thus may remain below historical rates, even after the one-time gains are accomplished.

Compared with these uncertainties, the consequences of demographic changes are much more certain. The Census Bureau projects that the share of the population over age sixty-five will rise from 13.3 percent in 2010, when the first wave of baby boomers turns sixty-five, to 18.5 percent in 2025. Because the total population is projected to grow 0.8 percent per year, the number of elderly will grow 3 percent per year over this period. Medicare spending would grow at roughly the same rate, absent any other change.⁸ For comparison, the growing elderly population from 1950 to 2000 affected spending by only 1.7 percent per year. Our guess is that real growth in Medicare spending after 2010 will average around 5-7 percent per year, absent budget constraints or other direct limits on care. These values are considerably higher than the recent spending projections from the board of trustees of the federal Hospital Insurance (HI) trust fund. The trustees' intermediate projections assume that over the next twenty-five years the growth rate in cost per unit of service (this approximates our growth in real costs per beneficiary) will trend downward from present levels to roughly the growth rate in the economy, approximately 1 percent.⁹ We agree with the trustees'

own characterization of their estimate that their high cost assumption of 1 percent is likely to overstate the un-
but it is difficult to overstate the un-

Even the trustees' intermediate growth in Medicare spending. For care spending will be about 6 percent (GDP) by 2030, up from 2.5 percent about 6 percent of payroll, up from 6 percent in 1995; and Medicare will budget, up from around 11 percent agree with the many other analysts. The uncertainty and volatility of Medicare these numbers seem to us to be m-

A key issue, to which we return, is that increased costs will be shared between the elderly and the nonelderly. Under current arrangements, costs will fall on the nonelderly.

Round One Of Reform: The

The 1997 BBA produced more cuts than occurred in the thirty-plus years of Medicare. Congressional Research Service has analyzed the legislation in detail.¹² Here we refer to the BBA as the "first round" of reform.

The BBA produced an estimated \$115 billion in savings over five years from Medicare spending. The savings were achieved under then current law by: (1) slowing growth in preventive care benefits; (2) increasing the number of health maintenance programs available to seniors; (3) implementing strategies to be implemented in the next five years to reduce the variation in care, and skilled nursing facility rates to reduce the variation in care; (4) modified and delayed payment rates for certain services; (5) reform; and (6) shifted funding from Part A to Part B.

■ Short-run spending effects

\$115 billion primarily slowed spending during the first five years of the BBA. From 1997 to 2002, Medicare spending is to grow at a nominal growth rate of 1.5 percent, rather than the 8.8 percent projected in the 1997 period, however, the Congressional Budget Office projects a growth rate around 8.3 percent in the previous law.¹³ A lower growth rate would freeze or reduce rates of i-

own characterization of their estimates as optimistic; our guess is that their high cost assumption of roughly 3 percent is more likely, but it is difficult to overstate the uncertainty in all such estimates.

Even the trustees' intermediate projections imply substantial growth in Medicare spending. For example, they imply that Medicare spending will be about 6 percent of gross domestic product (GDP) by 2030, up from 2.5 percent in 1995; Part A spending will be about 6 percent of payroll, up from a base of somewhat over 3 percent in 1995; and Medicare will be over a quarter of the federal budget, up from around 11 percent in 1995.¹⁰ Although we certainly agree with the many other analysts who have indicated the uncertainty and volatility of Medicare projections this far in the future, these numbers seem to us to be more likely low than high.¹¹

A key issue, to which we return below, is how the burden of the increased costs will be shared between the nonelderly and the elderly. Under current arrangements the lion's share of the additional costs will fall on the nonelderly.

Round One Of Reform: The BBA

The 1997 BBA produced more changes in Medicare than had occurred in the thirty-plus years since the program's inception. The Congressional Research Service, among others, describes the legislation in detail.¹² Here we refer to only the most significant changes.

The BBA produced an estimated \$115 billion of (net) savings over five years from Medicare spending that otherwise would have occurred under then current law. In addition, it funded several new preventive care benefits; increased the types of Medicare replacement programs available to seniors; required prospective pricing strategies to be implemented for hospital outpatient visits, home care, and skilled nursing facilities; modified the calculation of capitation rates to reduce the variation in payment across various counties; modified and delayed portions of the physician fee schedule reform; and shifted funding for a substantial share of home care visits from Part A to Part B.

■ **Short-run spending effects.** Reducing Medicare spending by \$115 billion primarily slowed down the growth rate of Medicare spending during the first five-year budget cycle following enactment of the BBA. From 1997 to 2002 Medicare spending is projected to grow at a nominal growth rate of less than 6 percent per year rather than the 8.8 percent previously projected. By the 2002 to 2007 period, however, the Congressional Budget Office (CBO) projects a growth rate around 8.3 percent, only slightly less than under previous law.¹³ A lower growth rate could continue if the spending freezes or reduced rates of increase specified in the BBA are contin-

ued. However, assuming that spending growth continues in the private sector, a markedly reduced rate of growth would be difficult to sustain over the longer period without creating a substantial gap between the services enjoyed by persons under and over age sixty-five. Moreover, as expensive pharmaceutical advances continue, the pressure for some kind of drug coverage within Medicare is likely to grow—reflecting a cost not contemplated in any previous estimates. As a result, although some of the reduction in spending growth may continue after 2002, as of now Medicare spending will be growing at close to what it would have been growing without the BBA by early in the next decade.

■ **Medicare+Choice.** The BBA allowed for several new types of Medicare replacement plans under Medicare+Choice. These include a Medicare preferred provider organization (PPO); a private fee-for-service plan, which can pay physicians more than the Medicare fee schedule and can charge seniors an extra premium for the standard Medicare package of benefits; a provider-sponsored organization (PSO), in which physicians and hospitals can organize their own risk plan and compete directly with HMOs; and a medical savings account (MSA) option for a limited number of seniors, incorporating a high-deductible plan with an account set up for residual Medicare funds. The BBA also authorized the 1995 HCFA decision to allow HMOs to offer beneficiaries a point-of-service (POS) option.

The proposed rules that HCFA has released thus far indicate that the increase in actual choice may not be as large as it appears. Some of the more loosely organized types of plans, such as PPOs, may not be able to conform to the requirements for information on quality and outcomes.¹⁴ Since such plans have been responsible for most of the growth in managed care among persons under age sixty-five, some of the additional choices included in Medicare+Choice may be more illusory than real. Even so, the CBO is projecting a significant growth in Medicare+Choice (about half of seniors enrolled by 2030).¹⁵

Another important change concerns the calculation of capitation rates. Prior to the BBA, capitation rates followed the level of traditional Medicare spending per beneficiary in the county where the senior resided, adjusted for age, sex, welfare status, and institutional status. Because of differences in cost of living, health status, physician practice style, and use of medical services, per capita spending in traditional Medicare—and thus Medicare HMO rates—varied by more than a factor of three across counties.

To narrow the spread, the BBA placed a payment floor of \$367 per senior per month on payments to Medicare+Choice plans; previously, payments could (in theory) have been as low as \$225 per

senior per month, and some floor was financed by slow HMOs in the higher-rate blend of national and local decrease, however, Congress would increase at least 21 \$367 floor and the minimum factors determining Medi

Reducing variation in coalitions and representation for the past decade. However, reduced variation is likely traditional Medicare and HMO

First, prior to the BBA (adjusted) within a county traditional Medicare and risk may differ by much more ties, for example, spending than in traditional Medicare avoid such counties in the for private fee-for-service spending counties, Medicare much slower rates that could be little at-risk even with spending far from amounts will be spent for benefits (aside from the 1 as extra benefits).¹⁶

Thus, enrollment in traditional Medicare in counties with the low variety of ways to increase themselves, in some cases traditional benefits provided providers could be even if patients remain in traditional occur in counties with traditional although here the move those plans take back growth rates in high money per senior over traditional Medicare and will want to participate aggressive practice style an undesirable and un

senior per month, and some actual payments were under \$300. The floor was financed by slowing annual growth in reimbursement to HMOs in the higher-rate counties by moving toward a fifty-fifty blend of national and local rates. Rather than having actual rates decrease, however, Congress stipulated that rates in all counties would increase at least 2 percent per year. For the first few years the \$367 floor and the minimum 2 percent value will be the overriding factors determining Medicare+Choice payments in each county.

Reducing variation in capitation rates has been a goal of rural coalitions and representatives of states with low Medicare spending for the past decade. However, the manner in which the BBA has reduced variation is likely to change the relationship between traditional Medicare and HMOs, with substantial unintended effects.

First, prior to the BBA, spending per senior (age- and sex-adjusted) within a county differed by only 5 percent between traditional Medicare and risk plans. Now, however, payments per senior may differ by much more within the same county. In the floor counties, for example, spending will be much higher in Medicare+Choice than in traditional Medicare. Although at-risk plans have tended to avoid such counties in the past, they now seem like inviting targets for private fee-for-service plans. By contrast, in the highest-spending counties, Medicare+Choice payments are likely to grow at much slower rates than traditional Medicare. As a result, there could be little at-risk enrollment in these counties. In all counties with spending far from the national average, vastly different amounts will be spent for what is supposedly the same package of benefits (aside from the HMO savings, which are returned to seniors as extra benefits).¹⁶

Thus, enrollment in traditional Medicare may plummet over time in counties with the lowest spending per capita as providers find a variety of ways to increase the funds available for their patients and themselves, in some cases without having to account for the additional benefits provided by the increased funding. Profitability for providers could be even higher, to the extent that their sickest patients remain in traditional Medicare. Comparable distortions may occur in counties with the highest spending in traditional Medicare, although here the movement would be away from capitated plans as those plans take back supplementary benefits. The 2 percent growth rates in high-spending counties will produce much less money per senior over time than what will be spent under traditional Medicare and will make it increasingly unlikely that seniors will want to participate in risk plans in areas that have the most aggressive practice styles. Both of these effects should be regarded as an undesirable and unintended consequence of reducing payment

The vision of a reformed Medicare program has not been clearly articulated through the political process."

differentials across counties in a way that left Medicare nonneutral in the choice between the traditional plan and the other options.

Second, the BBA effectively pulls all counties toward the national mean. Although this is politically convenient, there is no compelling reason to believe that the national mean represents an appropriate spending level. Perhaps the rates in states with more conservative practice styles than the mean, such as Minnesota or Utah, should be regarded as the desired standard, and states with higher spending per capita should receive lower payments. This strategy would reduce payment even below the national mean and put pressure on providers in states with more aggressive practice styles.

Third, although the political attractiveness of increasing capitation payments in counties with low traditional Medicare spending is obvious, it will be important to monitor how the higher rates are used. With the potential availability of private fee-for-service plans and PSOs, most or all of the additional Medicare money in the "floor" counties—those raised to \$367 per month—could go into higher reimbursement for providers rather than additional benefits for seniors. Because providers have been only loosely constrained under traditional Medicare, there is no strong reason to believe that the monies will translate into additional services.¹⁷

Finally, to the degree that health status varies across counties, some variation in payment is appropriate. For example, we know that spending is concentrated in the last year of life—indeed, 11 percent of annual Medicare spending is spent in the last month of life—and that mortality rates among the elderly vary widely among counties, probably for reasons having relatively little to do with medical care.¹⁸ As a result, counties with higher mortality rates among persons over age sixty-five, all else equal, will have higher Medicare spending.¹⁹ Whether a 50 percent weight on local spending will leave the right amount of variation, however, is unclear.

The BBA provides some indication of how difficult it is to introduce structural reform into Medicare. Among the many challenges are HCFA's ability to promulgate regulations in a timely way and to implement change in an orderly fashion, and Congress's ability to withstand pressure from disgruntled providers.

What Is Next For Medicare?

By buying several years of solvency for the Medicare trust funds, the

BBA has made it possible under current law to reform Medicare until the second half of the next decade. However, the insolvency of the Part A trust fund for the first of the baby-boom generation will mean that significant changes have not occurred by the time Medicare reform will become intense.

Aside from the potential political impediments, Medicare several years before a financial crisis, the serious substantive obstacle to such reform is the political process. Until that is changed, it will be difficult to accomplish.

As part of the process of developing goals of a reformed program. Obviously, Medicare for seniors is a given, but several other goals are important. These include (1) a financially stable program, one that does not require frequent increases in the base and, in particular, necessary long-run financing will be required; (2) seniors to choose efficient plans and providers for providing high-quality care; (3) financial incentives that reward providers for providing high-quality care among plans and adequate information to make informed choices; (4) a package that partially covers outpatient care, covers some portion of long-term care that is regarded as fair, to both its beneficiaries and the program. A Medicare program that includes a premium-support program, analogous to the one proposed by Aaron and Robert Reischauer in 1991, in some respects from theirs.²⁰ In the next section, we flesh out our proposal.

Premium support. Seniors currently pay a premium for Medicare, but would receive a governmental guarantee that would be largely invariant to their income. Premium support would vary, however, according to geographic area, health risk status, and age.

Medigap premiums are already paid by a large number of elderly who live in high-cost areas. Because medical costs are likely to rise with general inflation and hence more rapidly than the burden of Medigap premiums on the elderly, will only worsen.²¹ We assume that the burden of Medigap premiums on the elderly group will have to be financed by the federal government.

BBA has made it possible under current law to postpone significant reform until the second half of the next decade, or later. By that time, however, the insolvency of the Part A trust fund will be upon us, and the first of the baby-boom generation will reach age sixty-five. If significant changes have not occurred by that time, the pressure to reform Medicare will become intense.

Aside from the potential political impediment of trying to reform Medicare several years before a financial crisis appears imminent, the serious substantive obstacle to such reform is that the vision of a reformed Medicare program has not been clearly articulated through the political process. Until that happens, major reform will be difficult to accomplish.

As part of the process of developing a vision, we describe some goals of a reformed program. Obviously, continuing access to health care for seniors is a given, but several other objectives also are important. These include (1) a financially stable and viable program (that is, one that does not require frequent increases in tax rates or adjustments to the base) and, in particular, some indication of how the necessary long-run financing will be structured; (2) incentives for seniors to choose efficient plans and/or providers, which implies financial incentives that reward physicians and other health care providers for providing high-quality, low-cost care; (3) choice among plans and adequate information for seniors or their fiduciaries to make informed choices; (4) a more comprehensive benefits package that partially covers outpatient drugs and in the long run covers some portion of long-term care as well; and (5) a program that is regarded as fair, to both its beneficiaries and those financing the program. A Medicare program that would meet these goals is a premium-support program, analogous to that proposed by Henry Aaron and Robert Reischauer in 1995, although our proposal differs in some respects from theirs.²⁰ In the remainder of this paper we flesh out our proposal.

■ **Premium support.** Seniors could choose among health plans but would receive a governmental contribution or premium support that would be largely invariant to the plan chosen. The premium support would vary, however, according to the person's age, sex, geographic area, health risk status, wealth, and use of services.

Medigap premiums are already a considerable burden for the large number of elderly who live mostly or entirely on Social Security. Because medical costs are likely to rise more rapidly than general inflation and hence more rapidly than Social Security benefits, the burden of Medigap premiums, especially for the lower-income elderly, will only worsen.²¹ We assume that additional costs for this group will have to be financed largely by persons under age sixty-

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→ financially stable
→ incentives for seniors to choose
→ choice among plans
→ fair
→ premium support

five and by higher-income elderly persons. Although the number of middle- and upper-income seniors has been limited in the past, this fortunately will not be as true for the next generation.²²

Tying the premium-support payments to income runs the risk of undermining Medicare's political support, although as long as seniors continue to receive substantial sums from the federal government, this problem should not be insurmountable. Although some might disagree, the political dynamic that caused the repeal of the catastrophic provisions of Medicare in 1988 does not seem particularly relevant here because the changes in the catastrophic provisions were redistributive only among the elderly, with no additional financing from the nonelderly. Failing to relate premiums to income will seem even less attractive. The additional financial burden then must be shouldered either entirely by the (then relatively smaller) number of nonelderly, which also could undermine political support for the program, or by the lower-income elderly themselves, which we think is neither feasible nor desirable.²³

Increasing government's contribution for low-income seniors while reducing it for higher-income seniors has the additional virtue of greatly restricting the scope of the separate dual-eligibility program for Medicare/Medicaid recipients and with it the incentive problem caused by the "notch" in Medicaid eligibility.³⁴ By creating the categories of qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs), current policy has already moved in the direction of income-related benefits.

Furthermore, the use of a premium-support program provides a more flexible way to change the Medicare eligibility age. The number of uninsured near-elderly persons has been rising under current law and presumably would do so even more under proposals that raise the eligibility age. The use of a premium-support model, however, would allow an actuarially lower contribution if persons retired before whatever age was regarded as appropriate for full benefits. Raising the age to sixty-seven but allowing for reduced payments before age sixty-five, as is now being done with Social Security, could reduce the number of uninsured.

Finally, we have already pointed out that under current arrangements almost all of the increased future costs would fall on the relatively diminished numbers of nonelderly. Combined with the increased burden of Social Security that also will fall on them, the load may be too great. If Congress wishes to reallocate some of the increased costs to the elderly, a premium-support system offers a much more flexible means for dividing the burden than do the current financing methods.

■ **The benefits package.** Historically, the relevant package of

benefits for seniors has Medicare plus a Medigap replacement package offering additional benefits should be through a Medigap program, not through a Medicare plan. It is unreasonable and very costly to include in Medicare the benefits of a Medigap plan, assuming either that seniors now pay for Medicare coinsurance payments or that a Medigap benefits package should be included in Medicare. Because of the low cost of Medicare, seniors now purchase individual Medigap policies even if they have to pay for them. On the other hand, those who have Medicare benefits more than they now do would be cashed out to shareholders if this

■ Reimbursement

plans poses a variety and some involving major choice between administrative, these discussion risk plans and do not in rates competitively. However, the technical difficulties be underestimated. It markets across the country beneficiary payments, the business of particular markets, as seems likely in the ability of collusion against

■ Risk adjustme

effectively resolved the risk adjustment, or expected or actual needs. Because specific persons, not just sicker-than-average or healthier-than-average, also is an invitation meaning to the phr

Risk adjustment support system or

benefits for seniors has, de facto, included both the benefits from Medicare plus a Medigap or Medicaid package or else a Medicare replacement package offered by an HMO. In a reformed program additional benefits should be provided through the Medicare program, not through a Medigap plan. We believe that it would be unreasonable and very costly to taxpayers, however, to simply include in Medicare the benefits now covered by Medigap without assuming either that seniors continue to pay the average premium they now pay for Medigap or that a higher set of deductibles and coinsurance payments would apply. In other words, broadening the benefits package should not greatly increase the cost to government. Because of the low payouts of their Medigap policies, those who now purchase individual policies are likely to be much better off even if they have to pay the cost of the additional benefits. On the other hand, those who have retiree health benefits could have to pay more than they now do. Ideally, their present supplementary benefits would be cashed out at current value. There would be a windfall to shareholders if this did not occur.

■ **Reimbursement to plans.** Setting reimbursement rates for plans poses a variety of problems, some technical, some political, and some involving matters of equity. A persistent issue involves the choice between administratively and competitively set rates. Unfortunately, these discussions usually take place only in the context of risk plans and do not include traditional Medicare. Although setting rates competitively has clear appeal, especially to two economists, the technical difficulties in moving to this type of system should not be underestimated. It implies bidding rates in many different markets across the country and hence a set of either government or beneficiary payments that vary widely according to the competitiveness of particular markets. Moreover, with small numbers of bidders, as seems likely in most local markets, there is always the possibility of collusion against the government.

■ **Risk adjustment.** One critical technical issue, which must be effectively resolved if beneficiary choice of plans is to work well, is risk adjustment, or adjustments to premium payments to reflect expected or actual differences in health status and thus health care needs. Because spending is so concentrated among relatively few persons, not adjusting for health risk unfairly penalizes plans with a sicker-than-average population and unfairly rewards plans with a healthier-than-average population. Not making these adjustments also is an invitation to bad behavior by plans and could give new meaning to the phrase, "No good deed goes unpunished."

Risk adjustment is an issue whether one moves to a premium-support system or not, but unfortunately there remains disagree-

ment about how best to do it. There is substantial consensus that successful risk adjustment will require encounter data, but obtaining such data in a timely, low-cost way is a challenge. The BBA requirement that the Department of Health and Human Services (HHS) issue a report to Congress on recommended strategies for risk adjustment in 1999 and implement risk adjustment based on health status in 2000 is likely to force additional thinking as well as decision making in this area.

Because of the imperfect nature of any risk-adjustment strategy in the near term and because of the potential for skimping in a fully capitated system, we think that a partial capitation system would be desirable.²⁵ Under such a system a portion of the government payment would reflect the capitation payment otherwise calculated, and the remaining portion would vary with actual services used. In addition to mitigating the incentives to engage in risk selection, paying plans something rather than nothing for delivering more services also reduces the incentive to skimp.

The effects of moving away from payment that is independent of use obviously depend on how far away one moves. Weights between the capitation rate and the services-used component might be on the order of seventy-five/twenty-five, but some experimentation would be required to assess the effect of various weights.²⁶

■ **Consumer Information.** A system of choices also requires that reliable information be presented in a clear and timely way. Work in this area is already under way because of the BBA and the move to an annual enrollment system in Medicare by 2002. The difficulties of preparing information that most seniors or their caregivers—especially the oldest old—can understand are formidable, but they do not seem insuperable. After all, seniors have been choosing among providers for decades and among Medigap plans for the past thirty years, and many have had a choice between traditional Medicare and risk plans for the past decade, all with little informational help from the government. The experience with Medigap before 1990, however, where ownership of multiple, duplicative policies was not uncommon, illustrates the potential pitfalls in this area. Moreover, implementing choice among the cognitively impaired poses obvious problems. The effort being exerted to meet this portion of the BBA requirements should improve the situation markedly, imperfect though it be.

■ **The transition.** How fast to move to the new system will depend partly on how long the nation waits to decide where it wants to go and how much (if any) infrastructure change has occurred in the interim. Much of the necessary infrastructure for a premium-support system will develop over the next decade as a

result of changes already moving to such a system technical. One possibility for Medicare after a certain How rapidly to move exit difficult. One approach we tribution, although perhaps eligible.

WHATEVER THE proposal, a str proceed. Although another decade or so, the after 2010 means that me known it is unlikely to st

The views expressed here are Medicare Payment Advisory

NOTES

1. R.J. Blendon et al., "The American Medical Association," Blendon et al., "Voters," American Medical Association.
2. Physician Payment Review: PPRC, 1997.
3. Consumer Reports (September).
4. Some discussions seem that the administrative expense is greater value if its administration has a different comparison is only patient prescription drug.
5. Authors' calculations, "National Health Expenditures, 1996," Health Care Financing Administration (November/December 1998). Report of the President's Council on Health, United States, February 1998).
6. J.P. Newhouse, "An Act of Congress" (Supplement 1993).
7. We have ignored the over-age-sixty-five to make our calculations served was \$4,000 ages seventy-five to Health Care Financing. Also, our calculations (ESRD) portions of

result of changes already included in the BBA. The constraint in moving to such a system therefore may be as much political as technical. One possibility would be to enroll those becoming eligible for Medicare after a certain date, say 2002 or 2005, in a new system. How rapidly to move existing seniors to a new system is more difficult. One approach would be to move gradually up the age distribution, although perhaps not beyond a certain age for those now eligible.

WHATEVER THE MERITS or demerits of this particular proposal, a strategy of standing pat is unlikely to succeed. Although muddling through could well work for another decade or so, the magnitude of the likely fiscal problems after 2010 means that modest tinkering with Medicare as we have known it is unlikely to succeed.

The views expressed here are those of the authors and not necessarily those of the Medicare Payment Advisory Commission (MedPAC).

NOTES

1. R.J. Blendon et al., "The Public's View of the Future of Medicare," *Journal of the American Medical Association* (22/29 November 1995): 1645-1648; and R.J. Blendon et al., "Voters and Health Care in the 1996 Election," *Journal of the American Medical Association* (16 April 1997): 1253-1258.
2. Physician Payment Review Commission, *Annual Report to Congress, 1997* (Washington: PPRC, 1997).
3. *Consumer Reports* (September 1998): 34-38.
4. Some discussions seem to assume, absurdly, that any positive rate of administrative expense is excessive. The current Medicare program might obtain greater value if its administrative expenses were higher.
5. This comparison is only intended as a rough guide. Personal health care spending has a different composition than Medicare; for example, it includes outpatient prescription drugs, chronic long-term care services, and dental care.
6. Authors' calculations from data in K.R. Levit et al., "National Health Expenditures, 1996," *Health Care Financing Review* (Fall 1997): 161-200; K.R. Levit et al., "National Health Expenditures in 1997: More Slow Growth," *Health Affairs* (November/December 1998): 99-110; National Center for Health Statistics, *Health, United States, 1998* (Hyattsville, Md.: NCHS, July 1998); and *Economic Report of the President, 1998* (Washington: U.S. Government Printing Office, February 1998). Chain-weighted GDP deflator used to convert to real dollars.
7. J.P. Newhouse, "An Iconoclastic View of Cost Containment," *Health Affairs* (Supplement 1993): 152-171.
8. We have ignored the effects of differences in the age distribution within the over-age-sixty-five group, which, with the growth of the oldest old, will tend to make our calculations conservative. In 1994 the average amount per person served was \$4,000 for those ages sixty-five to seventy-four, \$5,400 for those ages seventy-five to eighty-four, and \$6,300 for those age eighty-five and older. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1996*, 210. Also, our calculations assume that the disability and end-stage renal disease (ESRD) portions of the program maintain their current share of roughly 15

percent of total spending, but our calculations are not sensitive to moderate errors in that assumption. For more complete discussion of the effect of demographics, see D. McKusick, "Demographic Issues in Medicare Reform," *Health Affairs* (January/February 1999): 194-207.

9. Specifically, the trustees assume that growth in Part A will trend down to growth in real earnings (0.9 percent) and that growth in Part B will trend down to the growth rate in gross domestic product (1.3 percent).
10. Calculated from Table III.B.1 (page 78) and Table I.F.1 (page 13) of the 1998 Trustees Report on the Hospital Insurance Trust Fund. We assume that the federal budget as a share of GDP remains at 21 percent.
11. See, for example, H. Aaron and R. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs* (Winter 1995): 8-30; and J. White, "Uses and Abuses of Long-Term Medicare Cost Estimates," *Health Affairs* (January/February 1999): 63-79.
12. J. O'Sullivan et al., "Medicare Provisions in the Balanced Budget Act of 1997 (P.L. 105-33)" (Washington: Congressional Research Service, 18 August 1997).
13. U.S. Congress, Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1999-2008* (Washington: CBO, January 1998), 123.
14. Medicare Program, Establishment of the Medicare Choice Program, 63 *Federal Register* 34968 (26 June 1998).
15. CBO, *The Economic and Budget Outlook*, 125.
16. This assumes that the (nominal) rate of spending increase considerably exceeds the 2 percent minimum guaranteed to all counties.
17. Although additional providers may well be attracted to areas with low payment rates, it is not clear that the number of providers is constraining services below appropriate levels.
18. J.D. Lubitz and G.F. Riley, "Trends in Medicare Payments in the Last Year of Life," *New England Journal of Medicine* (15 April 1993): 1092-1096.
19. Indeed, variation in mortality rates at the state level for the fifteen leading causes of death explains 40 percent of the variation in standardized costs per enrollee. See Prospective Payment Assessment Commission, "State Variation in the Resource Costs of Treating Aged Medicare Beneficiaries," Intramural Report no. I-96-01 (Washington: ProPAC, 19 June 1996), 19-21.
20. Aaron and Reischauer, "The Medicare Reform Debate."
21. This is also true, of course, for Part B premiums, to the degree that the federal share remains constant.
22. CBO, *Baby Boomers in Retirement: An Early Perspective* (Washington: CBO, September 1993).
23. Workers per beneficiary will fall from around 3.4 today to 2.0 in 2030, using the intermediate projections of the Medicare trustees.
24. The "notch" occurs when an additional dollar of income renders a person ineligible for Medicaid, thereby creating much more than a 100 percent tax on that dollar. In the near term the dual-eligible program would be eliminated only for those acute care costs covered by Medicare, but in the longer term it would be desirable to integrate financing for long-term care with Medicare. The expansion of home health care benefits in the 1990s has effectively begun to provide some chronic care benefits through Medicare.
25. See J.P. Newhouse, M.B. Buntin, and J.D. Chapman, "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs* (September/October 1997): 26-43; and J.P. Newhouse, "Risk Adjustment: Where Are We Now?" *Inquiry* (Summer 1998): 122-131.
26. See E. Keeler, G.M. Carter, and J.P. Newhouse, "A Model of the Impact of Reimbursement Schemes on Health Plan Choice," *Journal of Health Economics* (June 1998): 219-240, for some supportive evidence.

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What the
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by Marilyn

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Will The Care Be There? Vulnerable Beneficiaries And Medicare Reform

What the government can and should do to make sure that Medicare continues to cover those who most need coverage.

by Marilyn Moon

ABSTRACT: The Medicare program is on the verge of major change. The proof of the value of reforms will not rest in how well the program meets the needs of the healthy and wealthy, but rather in whether they preserve or improve upon protections for those who would not be well served by an unregulated private sector—persons with low incomes and/or substantial health problems. This paper examines four key issues: Which beneficiaries will likely be best served by a system oriented around choice; what role traditional Medicare should continue to play and what changes will be needed; what protections are necessary for persons with low and moderate incomes; and how these reforms could be incorporated into broader changes to make Medicare more viable over time.

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ONE OF MEDICARE'S GREATEST SUCCESSES has been its achievement of universal access to care for its beneficiaries. Consequently, in considering any proposal for changing Medicare, reformers should consider how well any changes would meet the needs of the most vulnerable beneficiaries. The goal of this paper is not to offer a fully developed proposal, but rather to bring into focus criteria that should be used in evaluating both the suggestions for change made here and proposals by others.

Despite considerable rhetoric to the contrary, many people remain vulnerable. The official 1998 poverty guidelines for eligibility for public programs are \$8,050 for single persons and \$10,850 for couples. Given the average of \$2,600 in health care costs that individuals must bear over and above what Medicare and other insurers pay, that is surely too low a benchmark for vulnerability.¹ Setting the level at 150 percent of poverty—about \$12,000 for a single per-

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son—would include ten million persons or 30 percent of all Medicare beneficiaries.

Also, many Medicare beneficiaries have substantial health problems. Nearly one-fifth of those in Medicare's fee-for-service (FFS) program were in poor physical health in 1993. A total of 23.2 percent of beneficiaries listed problems with cognitive functioning, including mental retardation, mental disorder, Alzheimer's disease, or difficulties in handling money or talking on the phone. Combined, 31.6 percent of all beneficiaries have one or both types of these impairments.²

But Medicare reform options also need to be assessed in the context of a broad set of goals. These should include assuring a stable source of high-quality care to elderly and disabled persons, assessing how excluded persons will get care if eligibility is limited, and ensuring that the program is designed and administered efficiently. Even the most efficient program will need resources to serve a doubling of Medicare's population and a near doubling of the share of the U.S. population served by Medicare. Thus, as a final goal, the system to pay for such care should spread burdens fairly.

Recent Legislative Changes

The Medicare program, as modified in 1997 by the Balanced Budget Act (BBA), is likely to increasingly become two separate, and perhaps unequal, programs. The traditional FFS portion of Medicare will remain for the foreseeable future, still expected to serve about half of all beneficiaries in 2030.³ Because of the BBA, a substantial tightening of access to some services may occur, and in some cases, the program's efficiency will improve. But the BBA also requires changes in treatment of home health and other services that some fear will go too far in limiting care for the vulnerable.

The second portion, the new Medicare+Choice or Part C, builds upon Medicare's long-standing managed care option. A range of new private plans will be allowed, extending beyond traditional health maintenance organizations (HMOs). Some of these new plans may work to the disadvantage of vulnerable beneficiaries. These new plans are slated to start in January 1999, well before other reforms to establish protections for the vulnerable will be in place.

To protect the vulnerable, it is essential to have a private plan payment mechanism that adequately adjusts for the varying costs of beneficiaries who enroll. The current system is inadequate; consequently, plans face a strong incentive to discourage enrollment by persons with substantial health problems and to encourage those who develop problems to disenroll.⁴ The payoff to selecting less costly patients is now higher than the returns from efficiently man-

aging care for such patients. payment adjusters, but this problem.⁵ Further, enrolls in private plans. Thus, Medicare loses money.

The BBA also raises costs for Medicare. For example, the premium for the new plan will be about \$106 per month, projected before the 1999 \$10,000 (which then gets a 10 percent increase in benefits), this premium is more than 9 percent higher than the current premium.

Despite considerable income beneficiaries, protections for low-income beneficiaries through 2002. Person in the 100 percent of poverty may be at risk. The current system is insufficient to protect incomes between 120 and 150 percent of poverty.

Early assessments of the BBA have correctly downplayed the impact of the changes set in motion. The narrow focus on the ways, and the jury is still out on whether the changes are planned and what the impact will be.

What Should Be Done?

Focusing on vulnerable beneficiaries, reform suggests both that the current system stand up well to scrutiny and that low incomes and slow growth in the future place too much emphasis on the future. It will be a challenge to traditional Medicare, including extra protection for the vulnerable for greater beneficiary protection, recognizing the difficulty of financing to keep the system solvent.

■ The clash between the two systems

Under even the current system, making its private plan option (holding down costs for care needs). This requires requiring beneficiaries to enroll in traditional Medicare.

aging care for such patients. The BBA requires development of new payment adjusters, but no approach yet has satisfactorily resolved this problem.⁵ Further, because a healthier mix of patients now enrolls in private plans, plans are, on average, paid too generously.⁶ Thus, Medicare loses money on each new enrollee.

The BBA also raises premiums across the board for Part B of Medicare. For example, the basic monthly premium is expected to be about \$106 per month in 2008, \$45 higher than the premium projected before the BBA.⁷ For a beneficiary with an income of \$10,000 (which then grows at the rate of projected Social Security benefits), this premium will nearly double as a share of income (to more than 9 percent) by 2008.

Despite considerable rhetoric about further protecting low-income beneficiaries, the BBA falls short. Modestly expanded protections for low-income beneficiaries were included, but only through 2002. Persons with incomes between 120 percent and 175 percent of poverty may receive protections, but the amount allocated is insufficient to reach even a portion of eligible persons with incomes between 120 percent and 135 percent of poverty.⁸

Early assessments of Medicare reforms contained in the BBA incorrectly downplayed the significance of the changes that have been set in motion. The nature of the basic program is changing in critical ways, and the jury is still out both on whether reforms will work as planned and what their impact will be on the most vulnerable.

What Should The Future Hold?

Focusing on vulnerable beneficiaries in evaluating approaches to reform suggests both needed changes and what options do not stand up well to scrutiny. For example, if we care about those with low incomes and substantial health problems, reforms should not place too much emphasis on the "market." Second, for the foreseeable future it will be important to rely upon and strengthen traditional Medicare, including improving the basic benefits and adding extra protection for low-income beneficiaries. Third, requirements for greater beneficiary contributions need to be carefully targeted, recognizing the diversity of the population. Finally, broad-based financing to keep up with greater future needs will be required.

■ The clash between markets and vulnerable beneficiaries.

Under even the current setup, Medicare faces major problems in making its private options work to the advantage of both taxpayers (holding down costs) and beneficiaries (effectively meeting health care needs). This suggests a go-slow approach. Yet voucher options, requiring beneficiaries to choose among private plans and eliminating traditional Medicare, have been seriously proposed as a solution

"It is unlikely that Medicare can or should turn back the clock and eliminate private-plan options."

to Medicare's long-run problems.⁹ This would require thirty-three million beneficiaries to switch insurance arrangements.

What is the justification for adopting vouchers? Belief in the private sector's ability to hold down costs of care is a primary motivator, reflecting a strongly held philosophical viewpoint, but not one backed up with facts. Since 1970 Medicare's cumulative rate of cost growth has been lower than that of private insurance, even including the 1990s, when the successes of private plans have been strongly touted.¹⁰ Medicare has been more successful while retaining a mainly FFS system and absorbing large numbers of new beneficiaries.

Can we expect the private insurance market to do better than Medicare at controlling health care costs in the future? Competition among private plans does not magically lead to lower costs. It is what plans do that matters, and as the current disaffection with managed care for the younger population demonstrates, many techniques now used by private insurers are viewed with hostility for emphasizing the management of costs rather than managing care. Over time, progressive plans may be able to improve techniques for managing care effectively, thereby establishing a case for further privatization, but the evidence does not yet support a full restructuring of Medicare. Voucher approaches mean that if private plans are unable to hold the line on health care costs, beneficiaries would face the dilemma of choosing less care or supplementing Medicare's payment. Ultimately, vouchers are ways of shifting both risk and financing to beneficiaries.

What are the benefits of a market-oriented approach? Giving beneficiaries more flexibility would allow choice between less expensive but more restrictive plans and plans offering more freedom at higher cost. But this tradeoff would be limited to beneficiaries with income levels sufficient to afford reasonable choices. One likely outcome is different plans for rich and poor, splitting up beneficiaries in a way that Medicare thus far has successfully avoided. Moreover, allowing plans to offer differing packages of benefits may exacerbate risk-selection problems. Until mechanisms for establishing premiums can be greatly improved, few plans are likely to actively recruit people with health problems. How many health plan advertisements feature seniors in wheelchairs or hospital beds instead of playing golf or tennis?

It is unlikely that Medicare eliminate private-plan option their performance and to allow save money while meeting benefit payment mechanisms and further for example, constitute step privatization. Of necessity, a to undo mistakes, so before care, it is critical to identify all private-sector changes should proceed cautiously.

■ **Working with the transition** important challenges facing the program work together. These efforts are less dramatic at least for some period of time place to meet the needs of the

Better oversight is essential and quality in the provision reform to make it a more viable times has been dismissed as projected share of the gross (B premium) in 2020 from 5. BBA provisions expire after some of these provisions are care's FFS portion can continue operation and quality of service could help to mitigate the

Given a choice, the sickest disproportionately remain substantial challenges for this those likely to remain in the cognitive problems. Such spending of persons in transition likely to consider switching age eighty-five and older. in the medically impaired to enroll in private plans to however, may constitute a to join private plans in the

A third group is those fills in the gaps in Medicare away a major selling point Medicaid now will not

It is unlikely that Medicare can or should turn back the clock and eliminate private-plan options. Rather, time is needed to improve their performance and to allow plans to demonstrate that they can save money while meeting beneficiaries' needs. Development of new payment mechanisms and further work on improving risk adjusters, for example, constitute steps necessary before considering more privatization. Of necessity, a public program cannot quickly change to undo mistakes, so before making substantial changes in Medicare, it is critical to identify and verify private market successes. Not all private-sector changes represent improvements, and Medicare should proceed cautiously.

■ **Working with the traditional Medicare benefit.** The most important challenges facing Medicare are to make the two pieces of the program work together and to improve traditional Medicare. These efforts are less dramatic than a full-fledged overhaul, but, at least for some period of time, traditional Medicare should remain in place to meet the needs of the most vulnerable.

Better oversight is essential, to ensure efficiency, accountability, and quality in the provision of care, and traditional Medicare needs reform to make it a more viable competitor. Although the BBA sometimes has been dismissed as minor tinkering, it lowered Medicare's projected share of the gross domestic product (GDP) (net of the Part B premium) in 2020 from 5.44 percent to 4.08 percent.¹¹ Since many BBA provisions expire after 2002, there is room for further savings if some of these provisions are extended. Only time will tell if Medicare's FFS portion can continue to adopt policies to assure efficient operation and quality of service. Greater adaptability to innovation could help to mitigate the well-known problems of FFS medicine.

Given a choice, the sickest and poorest beneficiaries are likely to disproportionately remain in traditional Medicare, creating substantial challenges for this part of the program.¹² Nearly one-third of those likely to remain in the FFS system have substantial physical or cognitive problems. Such persons account for more than half of the spending of persons in traditional Medicare. A second group less likely to consider switching out of traditional Medicare is persons age eighty-five and older. Adding such persons who are not already in the medically impaired group raises the share of those less likely to enroll in private plans to 37.4 percent of beneficiaries. (This group, however, may constitute a transition population that is more willing to join private plans in the future.)

A third group is those with Medicaid coverage. Since Medicaid fills in the gaps in Medicare for low-income persons, it may take away a major selling point of private plans. Moreover, in many states Medicaid now will not pay private plan premiums. Adding this

group brings the total share of beneficiaries unlikely to enroll in private plans to 43.3 percent, and expenses to nearly two-thirds of the total.

■ **Benefit Improvements.** One of the most difficult and essential pieces of reform is expansion of Medicare's basic benefit package. Private supplemental (Medigap) plans are becoming unaffordable for beneficiaries with average incomes. Costs of policies rise rapidly as the risk pool becomes more heavily weighted with beneficiaries with health problems.¹³ Moreover, plans have moved away from community-rated premiums to arrangements in which premiums rise dramatically with age. Consequently, these experience-rated Medigap plans shift costs onto those beneficiaries least able to absorb them. Further, efficiencies could be gained from having beneficiaries rely on only one plan.

A more rational Medicare cost-sharing package would not have to be extraordinarily expensive, especially if it increased cost sharing in areas such as the Part B deductible that are likely too low now, while reducing the unusually high hospital deductible and adding stop-loss protection.¹⁴ In addition, the other most crucial element for a more up-to-date benefit package is a prescription drug benefit. Those purchasing Medigap plans can at best obtain limited prescription drug protection (and increasingly many private managed care plans also restrict these benefits). Drugs are viewed as an essential part of today's health care treatments. But they also represent a particularly strong way to select on risks; private plans that offer prescription drug benefits find that they attract sicker patients.¹⁵ Thus, to assure future availability, prescription drugs are a crucial piece of an expanded benefit package.

Expanded benefits could be coupled with increased premiums, likely resulting in lower net costs than the current combination of Medicare and Medigap premiums. A key question, however, is whether to make an expansion voluntary or mandatory. A voluntary program is likely to attract higher-risk beneficiaries, causing the problems noted above. An intermediate approach would create a two-tier premium: a mandatory premium based on Medicare's current Part B premium, and an optional premium covering expanded benefits. The mandatory premium could be considerably higher than today's Part B premium to help subsidize the voluntary benefits. In the same way that the current voluntary Part B premium attracts beneficiaries because it is a good deal, participation in a subsidized, expanded-benefits option should be less subject to risk selection. Persons with employer-provided retiree insurance—who might object to higher premiums for increased benefits—could opt out of the voluntary portion.

■ **Low-income protection.** Making it even more difficult for low-income beneficiaries to obtain Medicare protections, moving income and asset cutoff levels would mean that low participation in the program without unduly burdening those with the lowest incomes while those higher up the income ladder only the required premium gradually than the current

■ **Universality versus means-testing.** The proposal for the greater expansion after 2010 is to find other ways to make Medicare more efficient to oversee. However, there is value in a means-tested program, because the most vulnerable are considered political advantages. They should be required to indicate their income.

One possible change is to raise the age for Medicare, making it available to those above some threshold. Higher-income individuals could be offered the option of higher-income rates or precluded from participation, keeping the program's cost. Medicare subsidy (described below) could be used to raise the age of eligibility.

Raising the age of eligibility would reduce the size of the program. The program has increased by almost 50 percent since 1965, which offers one justification. However, if actual retirement age increases, the program would be smaller.

This approach also has advantages. Persons who are not currently insured to obtain insurance; age-related health care costs would likely be lower. Higher-income individuals would have higher insurance costs. As a consequence, there would be greater income redistribution, thereby place greater burden on those producing goods and services, and if the number of beneficiaries is reduced, the program would be smaller.

■ **Low-income protections.** Higher beneficiary premiums would make it even more important to find ways to expand low-income protections, moving the current inadequate Qualified Medicare Beneficiary and related programs from Medicaid to Medicare and raising the income and asset eligibility cutoffs. Putting these protections under Medicare would likely help to increase the current low participation in these programs.¹⁶ Raising the income and asset cutoff levels would make it more feasible to raise premiums without unduly burdening those with the lowest incomes. Further, if Medicare were to adopt a two-tier premium structure, persons with the lowest incomes could receive full premium protections, while those higher up the income scale could receive a subsidy for only the required premium. This would phase out protections more gradually than the current system does.

■ **Universality versus eligibility changes.** One "solution" often proposed for the greater numbers of persons turning age sixty-five after 2010 is to find other ways to limit eligibility for Medicare. However, there is value in sustaining a universal program: Not only is it more efficient to oversee and administer than is, for example, a means-tested program, but universality helps to ensure that the most vulnerable are considered "mainstream." Universality also carries political advantages. Finally, any proposal to limit eligibility should be required to indicate how the excluded will get care.

One possible change in eligibility would be to fully means-test Medicare, making it available only to persons with resources below some threshold. Higher-income elderly and disabled persons could be offered the option of buying into the system at a nonsubsidized rate or precluded from participating. For a number of practical reasons, keeping the program universal but modifying the level of the Medicare subsidy (described below) is a more feasible approach.

Raising the age of eligibility for Medicare is another proposal offered to reduce the size of the beneficiary population. Life expectancy has increased by about three years since Medicare's passage in 1965, which offers one justification for delaying eligibility.¹⁷ Moreover, if actual retirement ages rise, this option becomes more viable.

This approach also has disadvantages. Without private insurance reform, persons who are out of the labor force might find it difficult to obtain insurance; again, a buy-in to Medicare at reasonable actuarial levels would likely be needed. Some employers, faced with potentially higher insurance costs, might cut back on retiree benefits. As a consequence, if the number of uninsured persons rise and thereby place greater burdens on public hospitals, if the costs of producing goods and services rise to pay greater retiree health benefits, and if the number of young families supporting their older

Finally, each age group of the population contains a substantial share of vulnerable beneficiaries who would need special protections, since they are less likely to be served by the private market, but protections would lower public savings.¹⁸ If public financing of Medicare becomes a major problem, age of eligibility may be a piece of a final reform package; its acceptability depends on what other adjustments are made to protect those excluded from Medicare.

The easiest way to raise additional revenues from beneficiaries is through an across-the-board increase in the Part B premium. Small increases generate large amounts of resources, although increases added by the BBA mean that Medicare beneficiaries will be paying about 12 percent of the total costs of the program by 2008, up from 9 percent in 1998. A higher premium would likely be more acceptable if it were combined with an improvement in Medicare benefits (as discussed above).

An alternative, subtle means of shifting the burden to individuals—but often not scrutinized in the same way—is through a voucher system. If the voucher were constrained to grow at a fixed rate over time, it could generate a regressive impact as low- and moderate-income beneficiaries found it difficult to obtain reasonably priced insurance for the voucher amount. Further, eliminating government's stake in health care costs would mean one less player concerned about reducing those costs over time.

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• Ultimately, the issue of beneficiaries and taxpa

An alternative income-rebates—all or in part—as a personal income tax. This is a much more complicated kind and are not traditional benefits not only would raise more aware of the "value" option would add considerably argue that it is unfair to Adopting either such tax can be justified as a symbolic care's financing problems.

■ **Additional public financing** The issue of who will pay much of the cost of Medicare will require a change in the way that the program is financed. Even with beneficiaries grows from 1 percent in 2030, it is apparent that the federal budget to pay for Medicare from other sources will be higher costs to Medicare care's critics.²¹

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"Ultimately, the issue of who will pay must be divided between beneficiaries and taxpayers."

An alternative income-related approach would treat Medicare benefits—all or in part—as income and subject to the federal personal income tax. This is analogous to taxing Social Security, although more complicated because these benefits are received "in-kind" and are not traditionally viewed as income. Taxation of benefits not only would raise revenue but also would make beneficiaries more aware of the "value" of Medicare benefits. However, this option would add considerably to Medicare's complexity, and critics argue that it is unfair to tax some in-kind benefits and not others. Adopting either such taxation or an income-related premium may be justified as a symbolic gesture as part of the solution for Medicare's financing problems.

■ **Additional public financing for Medicare.** Ultimately, the issue of who will pay must be divided between beneficiaries and taxpayers. Even with beneficiary contributions, the long-run costs of Medicare will require additional public funds. As the number of beneficiaries grows from 14 percent of the population in 1997 to 22 percent in 2030, it is appropriate for Medicare's share of both GDP and the federal budget to rise.²⁰ The share of the population getting insurance from other sources will fall, at least partially offsetting higher costs to Medicare over time—a fact often ignored by Medicare's critics.²¹

The payroll tax share for Medicare Part A at 2.9 percent of earnings (reflecting the combined employer and employee amounts) has not risen since 1986.²² If the percentage of payroll devoted to Medicare were increased by a factor just to account for growth in the share of Americans covered by Medicare, the combined tax rate should be 4.2 percent by 2020. But for Part A, for example, rate increases could be lower for some time to come. The Medicare actuaries have estimated that a one-percentage-point tax increase (bringing the combined total to 3.9 percent of payroll) would be enough to extend the life of the trust fund to 2030.²³ With reasonable restraints on spending and other policy changes as described above, such a tax increase would keep the program in balance even longer. Revenues for Part B also will have to be increased, through general revenues or perhaps new dedicated taxes. Although painful, these changes are of an order of magnitude that taxpayers might accept as the price of keeping the Medicare program intact for the foreseeable future.

IT HAS BECOME SO EVIDENT THAT Medicare is an out-of-control, out-of-control program that "insider" policy analysts now demand major structural changes in the program. The program is unsustainable. But much of what is said is unfair—that the private insurance market is better than Medicare, that beneficiaries are clamoring for private health plans, and that we cannot afford Medicare—has not held up well to scrutiny. Medicare cannot be sustained as it has been since 1966, but reforms need to be made to ensure a broader health system change—and control the growth of the costs and benefits of new strategies.

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Restructuring Medicare For The Next Century: What Will Beneficiaries Really Need?

Medicare reform should go beyond financing to address the ways in which the program can better serve older Americans.

by Christine K. Cassel, Richard W. Besdine, and Lydia C. Siegel

ABSTRACT: Medicare coverage falls short of its original mandate of access to modern medicine and protection against the high costs of medical care. These shortfalls destabilize both health outcomes and the economic viability of older adults and their families. Our proposed revisions would promote, rather than discourage, optimal care for beneficiaries. By replacing incentives for fragmented, episodic care with an orientation toward functional status, care management, and integration with long-term care, we can make an invaluable investment in a successfully aging society.

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations.

President Lyndon B. Johnson, at the signing of the Medicare legislation, July 1965.

MEDICARE HAS ENABLED MILLIONS of older Americans to enjoy longer, healthier, and more independent lives. Indeed, the much-hailed trends in "healthy aging" derive in part from numerous Medicare-covered interventions: joint replacement, cataract surgery, and bypass surgery, to name a few. Yet although Medicare ensures access to many essential forms of care, the program's current benefit structure is poorly matched to elements of optimal care for its main beneficiary population—older adults. The program was modeled after employer-sponsored insurance, which

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has since expanded in scope beyond its acute care emphasis; Medicare has not similarly changed. Medicare discourages management and coordination of care, omits prescription drug coverage, favors acute care over interventions for functional status, and permits medical costs to impoverish older adults and their families.

Moreover, Medicare has not kept pace with medical advances, new care strategies, and accompanying coverage needs, including interventions for sensory impairment and psychiatric care. Optimal management of chronic illness requires close coordination with long-term care services, but today's financing policies encourage fragmentation and cost shifting. Excluded services, including basic medications, often are unaffordable. Supplemental insurance cannot adequately bridge these gaps, particularly for lower-to-middle-income populations.

A health insurance program with these shortcomings must be examined closely, and the current debate on the future of Medicare presents an opportunity to do just that. We argue that the content of Medicare coverage must be considered alongside any cost containment proposals. The tight political and fiscal constraints surrounding Medicare reform cannot be ignored, but the powerful social ramifications of Medicare policy also must not be overlooked. Indeed, in planning for an unprecedented demographic shift, we face an important choice. One option would allow current and future generations to enter the existing system of fragmented and poorly prioritized care, which has proved to impose heavy cost burdens on families and society. The other would structure health care policy in a way that promotes healthy and successful aging, enabling older adults to remain productive and independent.

Our knowledge base in geriatric medicine has expanded dramatically since Medicare's inception. We now have a set of proven interventions and approaches to care that foster optimal outcomes in older adults, involving continuity of care, early intervention, health promotion and disease prevention, and care management. Coverage based on these principles, combined with care delivered by providers trained in geriatric medicine, are essential steps toward achieving a successfully aging society.

Restructuring Medicare toward this goal, and coordinating the program more closely with other funding sources, may be possible without huge increases in cost, but this paper expressly does not put forward a financing proposal. Today's fiscal and political climate is a major constraint, resisting sweeping change. These realities should not be underestimated, but here we begin from the perspective of known standards of geriatric medicine.

Because Medicare is designed to protect older adults and their

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families from impoverishment, it is necessarily intertwined with social policy. Therefore, it is essential to examine Medicare's context within a broader continuum of care, its role in society and the economy, and its influence on the geriatric medicine workforce. We outline two sets of recommendations, one oriented toward direct health outcomes, and the other toward broader systemic viability in our aging society. Our recommendations constitute a profound shift in Medicare's historical focus and overall philosophy, from a catastrophic health insurance program to a more comprehensive, proactive health care system. The current policy climate tends to discourage such fundamental rethinking, particularly since these proposals may increase some costs. However, reorienting Medicare coverage to promote optimal health and protect older adults and their families against impoverishment is one of the most important steps we can take, so that our aging society can become a success story rather than a social problem.

Health Outcomes

Our ability to forestall acute illness, complications of chronic diseases, and functional decline through an integrated continuum of care has radically reshaped our perspectives on aging and medicine. Although diagnosis and treatment of disease remain important, management of multiple chronic disorders has emerged as the central challenge in geriatrics, raising striking issues for both researchers and clinicians. A traditional approach that considers each surgical intervention or disease category in isolation does not adequately address the patterns of illness in older adults. Care protocols for this population must take into account numerous variables in complex combinations (for example, optimal care following hip replacement will vary depending on the presence of other chronic illnesses or disabilities).

Geriatric medicine defines an approach specific to a patient population with a high prevalence of chronic illness and vulnerability to age-related functional losses. Substantial scientific evidence has led to the development of core principles in geriatric care: interdisciplinary team assessment; care management; continuity of and access to care; adequate custodial home care; appropriate use of medications; assistive devices for mobility, hearing, and vision; and dignity and relief from suffering at all stages of illness. Medicare coverage must be updated to promote these types of care. The two foundations of better care for an aging population are knowledgeable providers and flexible systems of care. Geriatric expertise and interdisciplinary teams are essential, since flexible service use according to highly individualized needs requires excellent clinical

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■ Preserving function.

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Yet Medicare, which dures, does not adequa and interdisciplinary Nearly 90 percent of pe

judgment and communication among multiple providers. Capitation, one potential vehicle for this care, is discussed below in terms of potential benefits and challenges.

■ **Preserving function.** Functional status must be carefully monitored in older adults, since activity-limiting disabilities and chronic conditions are common and sensitive indicators of disease. Many simple interventions can slow or prevent functional losses in older adults. Prevention, widely interpreted as immunization or screening, takes on new meanings in geriatric care, where prevention of functional decline is a fundamental treatment goal. However, Medicare coverage excludes many interventions that detect or treat functional loss, including most routine physical examinations and related tests, most routine foot and dental care, prescription drugs, and examinations to prescribe and fit eyeglasses and hearing aids.

Interventions and assistive devices for sensory impairment are basic elements of care that Medicare should cover. Visual loss can lead to near-total dependency in otherwise healthy persons but can be corrected or slowed with eyeglasses. Hearing loss, which affects nearly 40 percent of people over age sixty-five, can lead to isolation, productivity loss, and withdrawal from the workforce.¹ Sensory impairment is a risk factor for depression, deconditioning (loss of muscle function from disuse), and inability for self-care; simple interventions can forestall this cascade of functional decline.

Paradoxically, Medicare covers walkers, canes, and wheelchairs for mobility loss related to musculoskeletal illnesses but excludes coverage for sensory losses; this signals the need for better rationalization of coverage. Medicare is also poorly aligned in the area of rehabilitation services. Following stroke, amputation, or hip fracture, coverage is contingent on improvement. Numerous studies demonstrate that rehabilitation is highly appropriate for patients whose conditions remain stable, given its ability to prevent further decline, yet this crucial maintenance function is not covered.²

■ **Care management.** Care management is a comprehensive treatment strategy that includes anticipatory management of chronic illness, communication among interdisciplinary providers, and adjustment of care with changes in condition. This strategy is particularly important in the care of older patients, whose multiple medical conditions present complexities that are not adequately addressed by conventional disease management guidelines and care pathways oriented toward a single illness.

Yet Medicare, which covers hundreds of intensive medical procedures, does not adequately reimburse the range of care management and interdisciplinary coordination that geriatric care demands. Nearly 90 percent of people age sixty-five and older have at least one

chronic condition, and 70 percent have more than one—most commonly, arthritis, hypertension, heart disease, sensory and mobility impairments, diabetes, and dementia.¹ Care protocols vary markedly, depending on comorbidities, polypharmacy, functional level, social resources, and patients' values. However, reimbursement policies favor fragmented care among several providers rather than ongoing management by a unified team. Consequences of noncoordinated care include missed or inaccurate diagnoses, harmful drug interactions, and overmedication.

Care management by a skilled and knowledgeable team of providers can address these complexities. Creating a reimbursable care management category under Medicare, or providing adequate rates for capitated systems, could encourage the forms of care that we now know are appropriate: coordination of care, telephone time, referrals to social service providers, and so forth.

Our ability to address chronic illness is a central challenge to the viability of our aging society with respect to independent functioning and survival itself. Diabetes causes a number of severely disabling complications, including blindness, kidney failure, heart disease, stroke, and circulatory problems that can necessitate amputation. Recent evidence that tight blood-sugar control can delay onset of complications has led to new treatment protocols. New treatments, including insulin analogues and implantable insulin pumps, are also increasingly effective. However, Medicare reimbursement remains inadequate for the close management and intensive, team-based care that these strategies require.

Management of ischemic heart disease also is changing rapidly. Emerging medication protocols may reduce disability and the need for surgery or hospitalization but require close monitoring to avoid overmedication or harmful drug interactions. Hypertension management also requires ongoing monitoring of multiple stroke-prevention medications; new research on cholesterol-lowering medications may greatly alter prevailing ideas of age-appropriate treatments for heart disease. Meticulous, skilled, and informed interdisciplinary care is required for treatment of these conditions, at a level of monitoring that Medicare coverage does not support.

Nonmedical services, such as social work, often are essential to health outcomes in older patients, and an interdisciplinary team approach also can address this range of needs. Patient interviews are more time-consuming because of complex issues, hearing problems, multiple caregivers, possible cognitive impairment, and depression. Older patients may miss appointments because of transportation problems. Adherence to medications is a problem, since many patients face cognitive or financial limitations; adverse drug effects are

a major risk. Older patients with physical activity limitations, transportation problems, malnutrition, and weight loss, is a grave risk for frail patients with multiple chronic conditions. Institutionalization, lack of physician contact in rural areas, and untrained social workers are barriers, enabling more

Capitated systems for this care management could encourage adequate risk adjustment and multiple creative approaches to functional outcomes.

■ Prescription

One of the most conspicuous problems in medical, pharmaceutical, and health care is to broaden our ability to manage chronic disease. It can slow the progression of disease, postpone hospitalization and surgery, often hinder admission to nursing homes, health maintenance coverage for prescription drugs, and this benefit at

Several new medications for the treatment of Alzheimer's disease, estrogen and non-estrogen hormone therapy, progression of Alzheimer's disease, onset. Parkinson's disease, that increases disability, additional drug therapy, protective medication, survival. Management of disability but not

Arthritis is the most common chronic disease among sixty-five and older adults. Pharmacological therapy for arthritis reaches of many patients leads to hip and knee disability or death. Medications that pro-

a major risk. Older patients may face barriers to maintaining dietary or physical activity regimens because of problems with home settings, transportation, financial resources, and burdens on caregivers. Malnutrition, whether as a result of poverty or inability to prepare meals, is a grave risk, precipitating declines in health; linking vulnerable patients with nutrition resources can minimize acute care and institutionalization. Such problems rarely emerge through physician contact in routine office appointments. A team that includes a trained social worker can identify solutions with patients and families, enabling more successful evaluation and treatment.

Capitated systems, with more flexibility, theoretically can cover this care management function. However, adverse selection and inadequate risk adjustment are strong disincentives for plans. Multiple creative approaches to financing these services are needed, with functional outcomes measures studied for evaluation.

■ **Prescription drug coverage.** Prescription coverage is the most conspicuous deficiency in the Medicare benefit. Advances in medical, pharmaceutical, and biotechnology research continually broaden our ability to treat age-related conditions. Many new drugs can slow the progression of a number of age-related illnesses, facilitate management of chronic conditions, and minimize the need for hospitalization and other costly interventions. However, high prices often hinder adherence to recommended treatment. Medicare health maintenance organizations (HMOs) are reluctant to include coverage for prescription medications, and Medigap policies offering this benefit are prohibitively expensive for many beneficiaries.

Several new medications can improve aspects of cognitive function in Alzheimer's disease, and more are on the horizon. Randomized trials are now under way to determine the effectiveness of estrogen and nonsteroidal anti-inflammatory drugs in slowing the progression of Alzheimer's disease and reducing the likelihood of onset. Parkinson's disease is another neurodegenerative disorder that increases dependence and need for care. In addition to traditional drug therapy to restore declining dopamine levels, new neuroprotective medications have improved symptoms and overall survival. Management of heart disease and hypertension can minimize disability but requires costly medications to do so.

Arthritis is the most commonly reported chronic condition at age sixty-five and older and causes major losses in productivity.⁴ Pharmacological therapy can decrease disability but is priced out of the reach of many arthritis patients. Osteoporosis, which frequently leads to hip and vertebral fractures, is associated with high risk of disability or death. Hormone replacement therapy and newer medications that prevent bone demineralization are available but

vent this condition but require access to prescription drugs and continuity of care for medical monitoring.

Older adults' mental health receives insufficient attention but is a major determinant of overall health. Depression, both common and highly disabling, can exacerbate other chronic illnesses and hasten decline. New medications with fewer side effects are effective in older adults but are much costlier than older antidepressants. Treatments for other psychiatric illnesses common in older adults, such as psychosis, bipolar disease, anxiety, and obsessive-compulsive disorders, also require expensive medication, as well as counseling or psychotherapy, to minimize related disability. None of these forms of treatment is adequately covered by traditional Medicare. Psychiatric services are targeted by the most vigorous gatekeeper models in managed care, yet denial of needed care has grave consequences: productivity losses, family burdens, and institutionalization.

Systemic And Societal Issues

■ **Managed care.** Managed care and capitated systems may be ideal for permitting the flexibility that good geriatric care requires, as outlined above. However, in today's competitive marketplace managed care companies face powerful disincentives for providing excellence in care for chronic illness. Even with risk adjustment, coordination with long-term care services is difficult on a large scale. Will capitated systems address the needs of at-risk elders through appropriate investments in maintaining functioning and coordinated systems of care, or will adverse selection result in a sicker and therefore more expensive population to cover? And will lack of geriatrics expertise allow rapid declines in the population under care, with predictable large increases in costs?

Our nation's recent experience with managed care illustrates the ramifications of these challenges all too clearly. Although more than 80 percent of Medicare beneficiaries have remained in fee-for-service (FFS) arrangements, a significant proportion enrolled in managed care during the 1990s, seeking lower costs and comprehensive benefits. However, older Americans now face a potentially serious problem: Several HMOs have recently withdrawn from Medicare, citing financial losses. Capitation raises important concerns for quality of care, however, given financial incentives to minimize services in the interest of cost-effectiveness. We also will need to develop accurate measures for outcomes and quality of care, for both fiscal accountability and consumer well-being. A quality-of-care approach, based on outcomes, is an important benchmark for older adults.⁵

Contemporary definitions of health care quality are numerous,

...an emphasis on outcomes of care—those consistent with scientific knowledge and those desired by patients and families. Access to care and satisfaction are also major elements in assessing cost-effectiveness and care based on available guidelines. Major purchasers of care, especially the Health Care Financing Administration (HCFA), emphasize education as part of their reformulations, to enable beneficiaries to make better choices among both provider systems and available treatments.

HCFA cannot now provide measurements that allow us to compare the quality of care provided in various managed care or FFS settings, with regard to specific outcomes. Most data show no significant differences, but some studies suggest that outcomes for old, frail, and disabled persons with chronic disease are better in traditional FFS settings. Quality-of-care data collection for both systems is in dire need of improvement. HCFA and independent organizations that monitor quality of care need far greater capacity to provide this information. One promising step is already under way: the collection and application of performance measures across sites for older persons with substantial burdens of chronic disability. In 1997 the Health Plan Employer Data and Information Set (HEDIS, version 3.0) has included a functional status measure, a measure of the "health of seniors," along with six other relevant quality-related process measures, is now mandatory for those managed care plans with Medicare contracts.⁸ In addition, HCFA is working to apply similar measures of quality in the FFS setting, albeit with necessary adjustments.

Integration of acute and long-term care. Long-term care, whether based in the home or in institutions, becomes increasingly important with advancing age. This form of care is inseparable from the medical aspects of health status, since appropriate levels of assistance with the activities of daily living (ADLs) can forestall institutionalization. Lack of long-term care coverage permits a pattern of care that undermines the provision of appropriate, cost-effective care. We are not proposing that Medicare expand to cover long-term care services; however, we argue that better integration of long-term care with acute care can mitigate this problem.

About 72 percent of Medicare beneficiaries report their health as excellent or good, but more than one-sixth of all older adults require long-term care.⁹ Specifically, long-term care services provide assistance with ADLs, including dressing, bathing, transferring from bed to chair, feeding oneself, using the toilet, and walking; and with instrumental ADLs (IADLs), including going outside, handling finances, shopping for and preparing meals, taking medication, using the telephone, and doing light housework. Seven million persons

"Older adults with a lifelong work history can become dependent on Medicaid when health problems multiply and worsen."

need assistance with ADLs as a result of chronic illness or disability, a number that may double by the year 2020.¹⁰ The disability rate for the group ages sixty-five to seventy-nine years is 47 percent, but the rate rises to 72 percent for persons age eighty and older.¹¹ The over-eighty-five age group is the fastest-growing segment of the population, which highlights the importance of this issue.

Home health and skilled nursing facility (SNF) care are important forms of long-term care. However, Medicare coverage contains restrictions that can limit their effectiveness in providing good care. Continuity of care is essential, and maintaining function can delay institutionalization. Adequate home health coverage could have a favorable impact by helping seniors to avoid more serious complications. Notably, nearly one-third of all Medicare spending pays for care used by only 13 percent of beneficiaries: those with substantial long-term care needs.¹² Adjusting benefits for more appropriate duration and forms of care could decrease the likelihood of future hospitalization.

End-of-life care is an essential part of the equation; some costs attributed to long-term care actually represent high costs for care of dying patients. Medicare-funded hospice care is successful for those who use it, yet fewer than 15 percent of Medicare patients who die are cared for in a hospice program.¹³ These patients must be part of any solution for better coordination of medical and social services for appropriate end-of-life care.

Medicare's incentives are weighted against arranging at-home supportive care in favor of nursing home admission, an event that transfers the cost burden to families or to Medicaid, after impoverishment. Long-term care thus remains a "dumping ground," because these costs have virtually no impact on Medicare. Closer integration must be achieved to realign these incentives. At the very least, we need to reverse incentives weighted toward institutionalization and work toward a more integrated system that acknowledges the need. The creation of a viable reimbursement mechanism for physician care in nursing homes would enable continuity of care.

Medicare's restrictions on long-term care coverage do not free federal and state governments from these fiscal burdens but instead contribute to a cost-shifting pattern that masks the true costs of care for older adults. Medicaid has become the largest provider of long-term care coverage, for middle-class as well as low-income

populations. As of 1995 Medicare paid 68 percent of nursing home costs for all nursing home care beneficiaries also are in the population with long-term care needs. Eligible beneficiaries rise as the population with long-term care becomes more widespread; inability to afford care is impoverishing; older adults become quickly dependent on family and worsen. Continuing from the Medicare benefit, a requirement for long-term care is a requirement for poverty.

Increases in Medicare spending for long-term care, such as home health and nursing home care. However, the answer is not to increase the gap between coverage and need, but to define this high-cost problem in terms of the social cost to society.

The best model in the country for long-term care is the PACE program, developed in 1982 in San Francisco. PACE pools Medicare and Medicaid funds and then flexibly uses conventional coverage for a multidisciplinary team of services. PACE supports home visits, evaluation, and a comprehensive array of services that include in-home skilled nursing, occupational therapy, meal delivery, and therefore embodies the concept of a single entity responsible for all financial aspects of care. An exemplary system of long-term care tested in larger populations.

Reversing Medicare's incentives for long-term care who could be treated at home could reduce acute care costs, dramatic savings, but essential for the well-being of the single right answer, but we have now—which is long-term care in a way that

populations. As of 1995 Medicaid paid for the care of approximately 68 percent of nursing home residents and covered more than 50 percent of all nursing home costs.¹⁴ Currently, 16.5 percent of Medicare beneficiaries also are covered by Medicaid.¹⁵ However, in the population with long-term care needs, the proportion of Medicaid-eligible beneficiaries rises to 45 percent, which demonstrates a widespread inability to afford this care.¹⁶ Long-term care costs often are impoverishing; older adults with a lifelong work history can become quickly dependent on Medicaid when health problems multiply and worsen. Continuing to exclude long-term care coverage from the Medicare benefit will only exacerbate this problem; making poverty a requirement for long-term care coverage is not a viable option.

Increases in Medicare spending for more involved forms of care, such as home health and SNF care, have caused justifiable concern. However, the answer is not blanket spending decreases but closing the gap between coverage provisions and actual needs. Precisely defining this high-cost population's medical needs, and separating them from the social costs, is a major policy challenge.

The best model in the United States for integrating acute and long-term care is the Program of All-Inclusive Care for the Elderly (PACE), developed in 1972 at a community-based nonprofit entity in San Francisco. PACE employs a unique funding mechanism that pools Medicare and Medicaid benefits into a fixed monthly rate. Funds are then flexibly allocated to a wider range of services than conventional coverage restrictions allow. Based in a day care center, a multidisciplinary team provides medical, rehabilitative, and social services. PACE supports transportation to day care centers, doctor visits, evaluation, and socialization through capitated dollars. The comprehensive array of acute and long-term care services also can include in-home skilled nursing or personal care, physical and occupational therapy, meal delivery, and other services as needed. PACE therefore embodies the best principle of managed care: One entity is responsible for all financial and medical aspects of care. This model, an exemplary system of care for frail older persons, must now be tested in larger populations.

Reversing Medicare's current incentive to hospitalize patients who could be treated more appropriately in a subacute care facility could reduce acute care costs. Such a shift is unlikely to produce dramatic savings, but coordination among systems of care will be essential for the well-being of patients and families. There is no single right answer, but a better approach can be found than the one we have now—which separates medical and social costs of long-term care in a way that promotes discontinuity, redundancy, and

gaps in care.

■ **Protection from impoverishment.** The misalignment between needs and coverage places a heavy financial burden on older adults and their families. In this sense, too, Medicare fails to meet its mandate. Out-of-pocket health care costs have grown dramatically, far outstripping the ability of most older adults to pay for needed care. These costs now consume a larger proportion of older adults' income than in 1965. Further, there is no maximum spending cap in Medicare to protect against catastrophic costs.

Many older Americans are in a fragile economic position. Advancing age often brings some combination of retirement, widowhood, or changes in housing—major life events that affect socioeconomic status. Of the 31.4 million Americans age sixty-five or older who reported income in 1997, 79 percent reported income of less than \$25,000, and 37 percent reported income of less than \$10,000.¹⁷ One-fifth of all older women live below the poverty line; 60 percent of women age eighty-five and older are poor or near-poor, and many lack the economic, physical, and emotional supports needed for independence and good quality of life.¹⁸ Other older subgroups likely to live in poverty include minorities and persons in rural areas.

There is a strong, well-documented correlation between economic disadvantage and health risk factors, which increases the importance of appropriate coverage. Persons of lower socioeconomic status generally fare less well in the health care system, as measured by access and preventive care, along with poorer outcomes regarding accuracy of diagnosis, treatment efficacy, follow-up, and hospital readmission.¹⁹ This population also has a higher prevalence of illnesses that often result in permanent activity-limiting conditions, such as asthma, diabetes, hypertension, and heart disease.²⁰

Although many persons purchase supplemental coverage (Medigap policies), others cannot afford the high premiums. The 1997 Balanced Budget Act (BBA) raised Part B premiums, which will increase the burden on low-income older adults. Assistance for low-income persons also will be capped, thereby creating further hardship.²¹ Most older persons, regardless of socioeconomic status and often independent of financial planning, face staggering health care costs that few families can absorb. In one important study almost one-third of surveyed families reported losing most or all of the family's savings for a relative's care. Common adjustments included moving to a less expensive home or forgoing education or medical care for other family members. Notably, 96 percent of patients in this study had hospitalization insurance, which is strong evidence of the heavy burden of costs associated with nonacute care.²² In

reforming Medicare, transferring costs to families is not an option.

■ **Better training and provider workforce.** A major and growing need; providing incentives to manage a range of high-quality geriatric care in the home; utilization rates for more intensive care; reimbursement inadequacies for the geriatric workforce. Proficiency in geriatric care; variable symptoms often present; can be further complicated by

Comprehensive assessment and physical functioning, is a powerful preventive tool, particularly for cognitive decline common in older adults; early intervention to avoid intensive treatment. Although providers without geriatrics training; inclusion and appropriate use of

Only subtle differences in the course of illness and of irreversible illness, and falls are easily interpreted, rather than as potential underlying illness such as myocardial infarction. Physicians' health-related quality of life; patients and families on issues of preventive interventions or comfort

Our aging population will need more health care professionals trained in geriatrics. Aging Research forecasts that the number of geriatricians by 2030, when our population will be sixty-five million.²³ The United States needs more geriatricians, and the retirement of

Reductions in Medicare payments for geriatric training (GME) will further weaken the medical training pipeline. Geriatric medical training does not adequately address the management skills, and in the context of geriatric care demands; curricula for this essential form of training; reimbursement patterns, in the context of geriatric care and management, ex-

reforming Medicare, transferring additional costs to beneficiaries and their families is not an option.

■ **Better training and research in geriatric medicine.** A provider workforce trained in the field of geriatric medicine is a major and growing need; providers must have the expertise and incentives to manage a range of interventions in complex patients. High-quality geriatric care improves health outcomes and lowers utilization rates for more intensive forms of care. Current reimbursement inadequacies for the scope of geriatric care services are a powerful disincentive to the training and retention of an adequate workforce. Proficiency in geriatrics enables providers to identify the variable symptoms often present in older persons, where diagnosis can be further complicated by comorbid conditions.

Comprehensive assessment, which involves monitoring cognitive and physical functioning, is a vital element of care management and a powerful preventive tool, particularly in frail populations. Physical or cognitive decline commonly signals disease; assessment enables early intervention to avoid serious conditions that require more intensive treatment. Although assessment is covered by Medicare, providers without geriatrics training are frequently unaware of its inclusion and appropriate use.

Only subtle differences may separate the presentations of treatable illness and of irreversible functional decline. Confusion, lethargy, and falls are easily interpreted as "old age" by untrained providers, rather than as potential signals of harmful drug interactions or underlying illness such as hypothyroidism, pneumonia, or silent myocardial infarction. Physicians also must possess expertise on health-related quality of life and treatment choices, to advise patients and families on issues such as the appropriateness of aggressive interventions or comfort care.

Our aging population will exacerbate the existing shortage of health care professionals trained in geriatric care. The Alliance for Aging Research forecasts the need for more than 36,000 geriatricians by 2030, when our older adult population will total about sixty-five million.²³ The United States now has fewer than 9,000 geriatricians, and the retirement rate exceeds the training rate.

Reductions in Medicare support for graduate medical education (GME) will further weaken this underpopulated specialty. Most medical training does not address the complexity of medical issues, management skills, and interdisciplinary coordination that good geriatric care demands; cuts to GME funding will restrict access to this essential form of training. The disincentives in physician reimbursement patterns, in the form of inadequate payment for evaluation and management, extend far beyond professionals already in

practice. Physicians-in-training, who observe that procedures requiring acute care skills are better reimbursed, are reluctant to enter specialties that require time-consuming, unpaid coordination efforts.

The resource-based relative value scale (RBRVS), implemented in the early 1990s, promised to replace customary charges with a reasonable system of reimbursement, structured according to the difficulty of the work involved. Unfortunately, political interests and high stakes have prevented the RBRVS from leveling the playing field. Payments for some overvalued services have been reduced, but surgical services are still reimbursed at a disproportionately high level compared with the evaluation and management services needed to coordinate interdisciplinary care for older persons.

Legislation proposed in recent years would increase Medicare GME payments in geriatric medicine and psychiatry. In addition, each year of training for geriatrics certification would count as a year of service for federal loan repayment. The Department of Health and Human Services (HHS) also would establish five demonstration projects that integrate geriatrics with traditional hospital-based training in skilled nursing facilities, hospices, rehabilitation facilities, and other community-based programs. Medicare reforms that support these aims would diminish the gap between supply and demand.

A PRODUCTIVE, SUCCESSFULLY AGING SOCIETY is within our reach, and ignoring the issues discussed above will impose heavy costs: lost productivity, overwhelming economic burdens on families, and potentially avoidable disability. Realigning Medicare coverage to encourage optimal care strategies is one of the most important steps we can take. In light of other unknowns, including longer-term demographics and biomedical progress, flexibility in our approach to the future will be imperative. The wisest course may be to build into Medicare the capacity to respond to the changing dimensions of medical possibility and demographics through a dynamic, forward-looking system with adaptive flexibility to ensure unhindered access to the optimal care that modern medicine can provide, now and into the future.

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Medicare's Choice Explosion? Implications For Beneficiaries

Even if more managed care plans come on board, many beneficiaries may not get the care they need.

by Patricia Neuman and Kathryn M. Langwell

ABSTRACT: Medicare+Choice was established under the Balanced Budget Act of 1997 to expand the range of health plan options available to beneficiaries and to encourage plans to compete on the basis of price and quality, with potential savings to beneficiaries and the program. However, it is unclear whether the envisioned positive outcomes will occur. This paper reviews the rationale for expanding choices under Medicare. It considers how the rapidly changing health insurance market poses uncertainties for beneficiaries and concludes with a discussion of safeguards that may be necessary to assure that the program continues to work well for beneficiaries with diverse needs and circumstances.

MEDICARE CHOICES

AS THE NATIONAL BIPARTISAN COMMISSION on the Future of Medicare focuses on financing health care for future generations of Medicare beneficiaries, Medicare is poised for structural change as a result of the Medicare+Choice provisions in the 1997 Balanced Budget Act (BBA). The BBA establishes a framework to increase private health plans' role under Medicare and to encourage plans to compete on the basis of price and quality.

However, early evidence suggests that the predicted, rapid growth of private health plan options under Medicare may not occur unless Congress and the administration intervene. Only a small number of plans, other than Medicare health maintenance organizations (HMOs), have applied for contracts to serve beneficiaries. Several HMOs with experience in the Medicare market are withdrawing from selected areas or terminating their Medicare line of business entirely. Unless a large number of Medicare+Choice plans

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submit new application (HCFA) for 1998 total number of new program from the trend in recent years predicted not occur continue character

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Plan required to the

the law and plans under health insurance uncertainties for the future.

In this paper we review the Medicare program and the help Medicare beneficiaries. trends in the Medicare HMO significant expansion in the is likely to occur under Medicare evidence on Medicare beneficiaries choices among health plan necessary to maintain adequate future.

The Theory Of Choice

Under Medicare+Choice, HMOs, provider-sponsored provider organizations (PPO) and, on a limited basis, health with tax-preferred medical

To encourage the emergence of the country, the BBA requires payments to plans and requires establishes a payment flow intended to boost participation low payment levels. A minimum payments is guaranteed for all erage and benefits in are the majority of current Medicare

submit new applications to the Health Care Financing Administration (HCFA) for 1999, there will not be a significant increase in the total number of private plan options available to beneficiaries as the new program gets under way. This would be a marked departure from the trend of rising Medicare HMO plan participation observed in recent years.¹ If the number of plans does not increase, then the predicted rapid growth in Medicare managed care enrollment may not occur. Moreover, if Medicare+Choice plans are unable to continue offering relatively generous supplemental benefits, while charging low or no premiums, enrollment may be further constrained, in that beneficiaries cite lower costs and better benefits as the main reasons for joining Medicare HMOs.²

It is possible that plans will enter the market more aggressively in the future but are moving cautiously now in response to the new law and the implementing regulations. Whether the role of private plans under Medicare expands, plateaus, or contracts, the changing health insurance environment presents both opportunities and uncertainties for the Medicare population.

In this paper we review the rationale for expanding choice in the Medicare program and the conditions under which choice could help Medicare beneficiaries. We examine recent evidence from and trends in the Medicare HMO program and the issue of whether a significant expansion in the number or types of health plan options is likely to occur under Medicare+Choice. Finally, we review the evidence on Medicare beneficiaries' ability to make appropriate choices among health plans and discuss safeguards that may be necessary to maintain adequate coverage for beneficiaries in the future.

The Theory Of Choice

Under Medicare+Choice, Medicare will be able to contract with HMOs, provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), private fee-for-service (FFS) plans, and, on a limited basis, high-deductible insurance plans coupled with tax-preferred medical savings accounts (MSAs).

To encourage the emergence of Medicare+Choice plans throughout the country, the BBA makes a number of changes affecting payments to plans and requirements for plan participation. The law establishes a payment floor (\$367 per enrollee in 1998) that is intended to boost participation of plans in rural areas with historically low payment levels. A minimum 2 percent annual increase in payments is guaranteed for all Medicare+Choice plans, to preserve coverage and benefits in areas with higher-than-average costs, where the majority of current Medicare HMO enrollees reside.³ Changes in

plan requirements also are intended to attract private organizations to the program. Examples include eliminating the "fifty-fifty" rule—which required at least half of any Medicare HMO's members to be non-Medicare beneficiaries—and easing entry requirements for PSOs by permitting them to seek federal approval rather than state licensure.

These changes may result in the emergence of plans in some areas of the country where they did not exist before. But other payment reforms in the BBA, coupled with new regulatory requirements governing Medicare+Choice plans, may discourage health plans from participating in Medicare, which would result in fewer choices for beneficiaries.

Economic theory suggests that giving choices to consumers results in greater efficiency and lower costs. In an expanded choice environment, Medicare plans compete to attract and retain members. This competitive environment provides incentives for plans to be more efficient and cost-conscious in their management of health care. In turn, this emphasis lowers beneficiaries' costs and reduces Medicare spending growth.

In fact, the Medicare risk-contract program has been successful in lowering costs and improving benefits for HMO enrollees. In 1998, 72 percent of all beneficiaries covered under a Medicare HMO were enrolled in "zero-premium" plans. In the same year 68 percent of Medicare HMOs offered prescription drug benefits, 71 percent offered hearing care, and 83 percent offered vision care.⁴ This was achieved in many market areas with premiums that typically were well below the amount charged by Medigap insurers for roughly similar coverage. Medicare beneficiaries have responded to these offerings by enrolling in Medicare HMOs at a rapid rate, especially between 1994 and 1998.

Competition, as it is structured under Medicare+Choice, may not produce the benefits predicted by economic theory. Much of the evidence from the past fifteen years suggests that health plans have been able to offer generous benefits and low premiums primarily because they are located in areas with relatively high Medicare payment levels and have enrolled beneficiaries who are healthier than average.⁵ Thus, the health plans have received generous payments to serve Medicare beneficiaries with lower-than-average expected health costs. The combined effect of Medicare's payment structure and favorable selection has created surpluses for plans to compete on the basis of benefits, premiums charged to beneficiaries, quality, and amenities. It is not yet clear whether the recently enacted changes in Medicare's payment methodology for plans will drive plans to operate more efficiently or withdraw from Medicare.

Uncertainties In The More-Or Fewer-Choice

Recent evidence suggests the wide range of choices available under Medicare+Choice, as indicated by the popular press indicate that experienced HMOs, are withdrawing from Medicare markets from their service areas. Medicare's 347 risk plan contracts for 1999 they will be reducing the expected to affect coverage for enrollees, which is close population and about (Exhibit 1).⁶

A closer look at the beneficiaries who are Medicare payment rates for-profit health plans is affected by plans' choices.

EXHIBIT 1 Distribution Of Medicare Or Reducing By Selected Plan Characteristics

Characteristic

1999 payment rates^a

\$300-399

\$400-449

\$450-499

\$500-549

\$550-599

\$600-649

\$650 or more

Type of ownership

Not-for-profit

For-profit

Total

SOURCES: Health Care Financing Administration, 1999 Medicare+Choice Payment Rates for nonrenewing plans and plans with new contracts.

NOTE: HMO is health maintenance organization.

^aPer member per month.

Uncertainties In The Market: Will There Be More—Or Fewer—Choices?

Recent evidence suggests that Medicare+Choice may not result in the wide range of choices anticipated in the BBA. Reports in the popular press indicate that a number of HMOs that have been operating under Medicare risk contracts, including some of the most experienced HMOs, are not profiting from Medicare and therefore are withdrawing from Medicare or dropping selected unprofitable markets from their service areas. As of November 1998, forty-three of Medicare's 347 risk plans announced that they will not be renewing their contracts for 1999. Another fifty-four plans announced that they will be reducing their service areas. Together these changes are expected to affect coverage for about 406,000 Medicare HMO enrollees, which is close to 7 percent of the current Medicare HMO population and about 1 percent of the total Medicare population (Exhibit 1).⁶

A closer look at the data indicates a disproportionate impact on beneficiaries who are enrolled in plans with relatively low 1999 Medicare payment rates and on beneficiaries who are enrolled in for-profit health plans. More than half (53 percent) of all beneficiaries affected by plans' withdrawing from the market or reducing their

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EXHIBIT 1

Distribution Of Medicare Risk Enrollees Affected By Plans' Withdrawing From Medicare Or Reducing Their Service Areas, And Total Medicare Risk Enrollees, By Selected Plan Characteristics, 1998

Characteristic	Beneficiaries enrolled in nonrenewing plans or plans reducing their service areas		Beneficiaries enrolled in risk-contract HMOs	
	Number	Percent	Number	Percent
1999 payment rates ^a				
\$300-399	50,770	12.5%	267,034	4.8%
\$400-449	96,097	23.7	526,586	9.6
\$450-499	69,748	17.2	839,621	15.2
\$500-549	71,814	17.7	1,626,530	29.5
\$550-599	67,383	16.6	1,039,697	18.9
\$600-649	33,281	8.2	608,530	11.0
\$650 or more	17,083	4.2	599,164	10.9
Type of ownership				
Not-for-profit	51,872	12.8	1,867,888	31.6
For-profit	354,304	87.2	4,053,278	68.4
Total	406,176	100.0	5,921,166	100.0

SOURCES: Health Care Financing Administration (HCFA), *Medicare Managed Care Contract Report*, September 1998; HCFA, *1999 Medicare+Choice Payment Rate File*; HCFA, *Market Penetration Report*, September 1998; and HCFA, unpublished data on nonrenewing plans and plans filing for a reduction in service area.

NOTE: HMO is health maintenance organization.

^aPer member per month.

service areas were enrolled in plans that would have received less than \$500 per member per month in 1999, compared with fewer than a third of all Medicare enrollees. Eighty-seven percent of all beneficiaries affected by the retrenchment of plans are enrolled in for-profit HMOs, compared with 68 percent of the total Medicare HMO population. Two companies—United HealthCare and Aetna/U.S. Healthcare—account for nearly a quarter (24 percent) of all Medicare HMO enrollees affected by plans' withdrawing from Medicare or reducing their service areas. Seven companies—United HealthCare, Aetna/U.S. Healthcare, Humana, NYLCare, PacificCare, Oxford, and Prudential—account for 60 percent of all Medicare beneficiaries affected by the pullout.⁷

This recent evidence suggests that HMOs may have made decisions about Medicare participation based on inadequate or insufficient information on the difficulties of managing the health care use of the Medicare population. A similar pattern emerged during the initial years of the Medicare risk-contract program: A large and growing number of HMOs contracted with Medicare between 1985 and 1989, and nearly half of these HMOs subsequently dropped out. The rise and fall of plan participation in the late 1980s was the result of a number of factors, including many plans' inability to compete, low enrollment, inexperience in managing Medicare enrollees' service use, and financial losses.⁸

Although some HMOs have succeeded in the Medicare risk-contract market, their success has been the result partly of the very high payment levels in some geographic areas and partly of the fact that healthier Medicare beneficiaries have been most likely to join HMOs. As payment reforms are implemented, HMOs that operated in market areas that previously received very high payments will face constraints on increases in the future. This comes at a time when health care costs are projected to grow more rapidly over the next several years than they have in the past.⁹ As payment levels decline relative to costs in future years, and as a more representative mix of Medicare beneficiaries joins HMOs, it is possible that fewer plans will be able to operate profitably.

If formally structured, experienced HMOs are unable to operate successfully in the Medicare market, there is reason to question whether more loosely structured entities, such as PPOs, can do so. It is unclear whether plans with less experience managing use of services for an elderly population, contracting with providers, and negotiating fee arrangements can structure a product that can attract Medicare beneficiaries and achieve financial viability. This concern may, in part, explain why few non-HMO plans have applied to HCFA for the Medicare+Choice program thus far.

"A more competitive market for Medicare beneficiaries to choose a plan"

A significant contracting market in which a growing number of plans may be exacerbated by the potential for failure of the Medicare+Choice program could lead to a disruption of care and concerns may be exacerbated by the potential for failure of the Medicare+Choice program which could affect the Medicare population that remain covered under traditional Medicare.¹⁰ If Medigap rates continue to erode, and Medicare+Choice plans, or withdraw from the Medicare market, a share of beneficiaries could be left without coverage.

Opportunities, Challenges

If more health plan options are available, as the law intends, Medicare+Choice plans could improve the benefits covered by Medicare+Choice for beneficiaries. However, a more competitive market for Medicare+Choice plans presents challenges for beneficiaries to meet their needs. The Medicare population will determine the success of Medicare+Choice in terms of financial and access problems.

■ **Knowledge about Medicare+Choice**—that a significant portion of the Medicare population has difficulty obtaining additional Medicare program benefits, a need for supplemental coverage. For example, a recent study found that 60 percent of Americans age sixty and older have traditional Medicare and more than half (55 percent) do not cover long-term care. About a quarter of elderly (25 percent) have a greater choice of health plans and hospitals.

Other studies have

"A more competitive marketplace for beneficiaries to choose a plan that meets their needs."

A significant contraction of the potential for failures under the Medicare+Choice program could be a market in which a growing disruption of care and concerns may be exacerbated which could affect the market. If Medicare rates continue to erode, and Medicare+Choice plans, or withdraw from the Medicare market, a significant share of beneficiaries could be underinsured in the future.

Opportunities, Challenges, And Risks

If more health plan options become available under Medicare+Choice, as the law intends, competition among private Medicare plans could improve the quality of patient care, expand the range of benefits covered by Medicare plans, and produce savings for beneficiaries. However, a more competitive marketplace also presents new challenges for beneficiaries to choose a plan that is most likely to meet their needs. There is some risk that a significant share of the Medicare population will not make good choices, which could undermine the success of the program and result in potentially serious financial and access problems for beneficiaries.

■ **Knowledge about Medicare.** Considerable evidence suggests that a significant proportion of Medicare beneficiaries may have difficulty obtaining and understanding information about the traditional Medicare program, gaps in the benefit package that generate a need for supplemental coverage, and managed care alternatives. For example, a recent survey found that more than one-third of Americans age sixty-five and older (37 percent) do not know that traditional Medicare does not cover outpatient prescription drugs, and more than half (56 percent) do not know that Medicare does not cover long-term nursing home care.¹¹ The same survey found that about a quarter of elderly Americans are aware of Medicare+Choice, but only 9 percent understand that it provides beneficiaries with a greater choice of health plans, rather than a greater choice of doctors and hospitals.

Other studies have documented that a large proportion of Medi-

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care beneficiaries who need care—HMOs—are under Medicare majority give the Medicare program in 80+.

care beneficiaries—including those who are covered by Medicare HMOs—are confused or lack basic knowledge about managed care under Medicare.¹² In addition, several studies have found that minority groups are less likely to understand basic elements of the Medicare program.¹³ The high level of confusion today, in an environment with relatively few choices, suggests the potential for even greater confusion if health plan options expand under Medicare+Choice.

To help beneficiaries make informed health plan decisions, HCFA now provides descriptive and comparative information about the various options available in each area. This information is intended to help beneficiaries, and their advisers, assess trade-offs involving quality, performance, satisfaction, benefit, and cost data. Beginning in November 1999 HCFA will conduct annual "health information fairs" to disseminate standard information about all Medicare+Choice plans, and the new structure for enrollment and disenrollment, before every open-enrollment period.

■ **Beneficiaries with diverse needs and circumstances.** Beneficiaries with certain limitations may have difficulties operating in the new, more complex Medicare marketplace. Nearly four of ten beneficiaries with less than a high school education, for example, may find new comparison charts and performance data confusing and difficult to use.¹⁴ Beneficiaries with serious health problems also may have difficulties choosing and using a health plan under Medicare+Choice. Nearly a quarter of all Medicare beneficiaries (23 percent) have problems with cognitive functioning that are likely to compromise their ability to understand key differences between plans or make good choices.¹⁵ Those who are in relatively poor health (29 percent) also may find annual health insurance decisions burdensome yet critical, because they are high users of health care services and face serious consequences if their care is disrupted, if they lose access to specialists, or if they cannot afford the care that they need.

Low-income Medicare beneficiaries face a different set of challenges because they may not have the financial resources to choose a plan based upon quality, access to doctors, or benefits. Rather, their choices are likely to be dictated primarily by price, which could result in disruption of care, poorer quality of care, and lower levels of satisfaction. Low-income Medicare beneficiaries also are likely to be disproportionately affected by any future increases in Medicare+Choice or Medigap premiums.

The poorest of this group who are eligible for both Medicare and Medicaid already face complex interrelationships between the federally administered Medicare program and the state-administered

Medicaid program, make the program a fully tailored information source to make good decisions to coordinate benefits coverage they are entitled to.

The importance of the 2003 when beneficiaries choose a plan for a fixed period. Although the enrollment process makes enrollment decisions, a plan does and does not, and how well the health conditions are managed if they expand because they are used.

Policy Implications

The BBA has a number of plan choices, encouraging areas where there is reducing Medicare contradictory. If pay constrained increases may lead to benefits and high New types of health care because of cost affect their financial are permitted to the Medicare+Choice savings.

Medicare beneficiaries drawing from the ages by becoming "deals" initially. The plan market also encourages beneficiaries to obtain be confident that.

As the federal Medicare service balance between by private plan

Medicaid program, and managed care under both programs.¹⁶ To make the program work, these beneficiaries are likely to need carefully tailored information to understand their options and assistance to make good choices. In addition, safeguards will be needed to coordinate benefits so that dual eligibles actually receive the coverage they are entitled to under both programs.

The importance of making good decisions will become critical in 2003 when beneficiaries will be "locked in" to their Medicare+Choice plan for a full year, until the following open-enrollment period. Although the annual open season is expected to simplify the enrollment process, it also may pose problems for beneficiaries who make enrollment decisions without fully understanding what the plan does and does not cover, which providers are in the network, and how well the plan performs. For beneficiaries with serious health conditions, their health status could be severely compromised if they experience disruption of care or avoid seeking care because they are unable to effectively use managed care systems.

Policy Implications Of Increased Choice

The BBA has a number of objectives: increasing beneficiaries' health plan choices, encouraging health plans to participate in Medicare in areas where there are currently few if any choices available, and reducing Medicare costs. To some extent, these objectives are contradictory. If payments to health plans in some regions are to be constrained increasingly in the future, then the reductions in payments may lead to lower health plan participation and to reduced benefits and higher premium costs for beneficiaries in those areas.¹⁷ New types of health plans may be reluctant to participate in Medicare because of concerns that future payment reductions could affect their financial viability and profitability. If payments to plans are permitted to rise more rapidly than the law now permits, then the Medicare+Choice program will not achieve projected budgetary savings.

Medicare beneficiaries may respond to news of HMOs' withdrawing from the Medicare market or reducing their benefit packages by becoming more wary about joining plans that offer "good deals" initially. Continuing changes and flux in the Medicare health plan market also will make it even more difficult for Medicare beneficiaries to obtain necessary information about their options and to be confident that their decisions will be good ones in the long run.

As the federal government delegates responsibility for providing Medicare services to private-sector organizations, striking the right balance between establishing rules to protect beneficiaries covered by private plans while promoting the efficient operation of these

"The changing insurance environment could disproportionately affect those with low incomes and serious health problems."

plans may be difficult to achieve. A major question is whether the Medicare program has the resources and management approach needed to achieve this balance. An equally critical question is whether HCFA has the capacity to monitor compliance and enforce requirements for Medicare+Choice plans.

One component of the program's new set of responsibilities is providing beneficiaries with information about plans and tailoring that information to the specific, differing needs of subgroups of the Medicare population. To simplify these choices, policymakers may want to consider establishing limits on variations in benefit packages offered by Medicare+Choice plans to help beneficiaries make "apples-to-apples" comparisons of benefits across plans. Large employers, such as Southern California Edison, and large employer groups, such as the Health Insurance Plan of California (HIP), offer employees health plans with standard benefit packages to help them to compare the value of benefits covered by available health insurance options.¹⁸ Medigap insurers also offer standard benefit packages, as required by federal law, to help beneficiaries to compare products and premiums. Similar approaches could be pursued to help beneficiaries compare the value of benefits, such as prescription drug coverage, offered by Medicare+Choice plans.

Because Medicare+Choice ultimately will require beneficiaries to remain in a plan for a full year, some consideration should also be given to assuring the stability of that plan by requiring a "lock-in" that applies to all parties—beneficiaries, plans, and providers. In essence, the plan selected by a beneficiary during the open-enrollment period should maintain benefits and providers throughout the year so that beneficiaries are not penalized for future changes in the plan.

More broadly, if Medicare+Choice results in a significant expansion of health plan options, then the current infrastructure to support decision making should be strengthened to help elderly and disabled beneficiaries to make good choices. These beneficiaries are likely to need assistance from trained counselors who can ask the right questions to help them to find a suitable plan. The Health Insurance Counseling and Assistance Programs do not have sufficient resources to support the millions of Medicare beneficiaries who may need help sorting through new options.

Even if choices do not expand under Medicare+Choice, safe-

guards may be affected by the changing insurance environment. Rates and the impact of these changes will be both for those with Medicare+Choice and for those with traditional private Medicare. This could disproportionately affect those with serious health problems. The market makers should be encouraged to provide a true Medicare population.

The Medicare organizations that serve frail beneficiaries need to be able to provide the benefits of Medicare that are needed to exit the market and to cover costs, coverations to reform the evidence structure that

The authors gratefully acknowledge the Barents Group, Jack Hoadley, and the Secretary for Planning and Management of the Regime. The contents of this report are not necessarily representative of the Barents Group LLC.

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guards may be needed to promote a more stable health insurance environment for beneficiaries. The recent rapid increase in Medigap rates and the decline of retiree health benefits pose serious problems both for those beneficiaries who do not have the option to join a Medicare+Choice plan and for those who prefer to remain in the traditional program. The changing health insurance environment could disproportionately affect those with low incomes and serious health problems. If the Medicare+Choice and supplemental insurance markets prove to be unreliable sources of coverage, policymakers should consider strategies to strengthen the traditional Medicare program by improving its benefit package. This would provide a true safety net for the most vulnerable segments of the Medicare population.

The Medicare+Choice program expands the role of private organizations to provide care to our nation's oldest, sickest, and most frail beneficiaries. However, it is unclear whether the envisioned benefits of Medicare+Choice will be achieved. Additional research is needed to examine why HMOs are withdrawing from the Medicare market and to assess the implications for beneficiaries, in terms of costs, coverage, and access to care. As policymakers consider options to reform the Medicare program for the twenty-first century, the evidence to date suggests caution in moving rapidly toward a structure that expands choice further.

The authors gratefully acknowledge the contributions of Christopher Topoleski, Barents Group LLC; Michelle Kitchman, Henry J. Kaiser Family Foundation; and Jack Hoadley, Office of the Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation; the comments of Judith Feder; and the assistance of Regina Twyman and Wanja Gikonyo in preparation of the manuscript. The contents of this paper are the sole responsibility of the authors and do not necessarily represent the views of either the Kaiser Family Foundation or Barents Group LLC.

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GRANTS

Chronic Care

Alzheimer's Disease and Related Disorders Association, Inc., Chicago, IL. This funding helps to support a \$6.8 million demonstration project, in collaboration with the National Chronic Care Consortium (NCCC), "to determine the most successful methods of integrating the complex needs of people with Alzheimer's disease into the framework of managed care," according to a November 1998 press release from the Helen Bader Foundation. The NCCC is a broad group of thirty-four health care systems. The project, which aims, ultimately, to create comprehensive care guidelines that are nationally replicable, will begin in spring 1999 in eight communities (mostly urban areas). It "is expected to create a prototype for the delivery of health care and support services in a Medicare managed care setting for persons with dementia." Katie Maslow, project codirector, told *Health Affairs* that funds raised will be used "for implementation at the eight local sites, the national evaluation, national administration, and dissemination of materials and outcomes." The California HealthCare Foundation has awarded a three-year, \$993,000 grant for the project. The grantee has contributed \$780,000 to the project thus far. The project also has received funds or in-kind donations from various other entities and an individual. Most of the funds are targeted to specific sites.

\$600,000 over three years. Funded by the Helen Bader Foundation.

Environmental Health

Union of Concerned Scientists, Cambridge, MA. Citing data reported in the 7 May 1998 *New England Journal of Medicine*, the Joyce Foundation's September 1998 newsletter said that more than 40 percent of antibiotics produced in the United States are used for animals, and 80 percent of them goes into their feed "to help chickens, hogs and cattle bulk up

for market." With this funding, the grantee will gather documentation on the potential relationship "between antibiotic-resistant diseases and farm use [of antibiotics], and press for policies to safeguard antibiotics for protecting the public health." The grantee plans advocacy efforts targeted to several audiences including Food and Drug Administration and Environmental Protection Agency staffers, the public, and even industry, Margaret Mellon, project director, said in a telephone interview.

\$110,000 over one year. Funded by the Joyce Foundation.

Information Dissemination

Center for Policy Alternatives (CPA), Washington, DC. The grantee is using this contract for work associated with Community Voices: Healthcare for the Underserved, "the largest philanthropic effort aimed at improving health care access and quality in the U.S.," according to a CPA press release. (This grant is part of the \$55 million authorized for the Community Voices initiative, described in *Health Affairs*, "GrantWatch," July/August 1998.) The CPA is providing technical assistance on policy to all thirteen community health learning laboratory sites across the nation and serving as an information clearinghouse for the initiative, Nancy Epstein, CPA project director, said in the release.

\$1.6 million over five years. Funded by the W.K. Kellogg Foundation.

WQED Pittsburgh, Pittsburgh, PA. "[I]t is important to have in-depth coverage of issues that is comprehensible to the average person," according to Jewish Healthcare Foundation (JHF) of Pittsburgh materials. But no area television outlet "is routinely engaged in reporting on the health policy developments that determine the quality, cost, and accessibility of care." This grant supports regional health policy segments on WQED, a public television station. They will be aired, beginning in April 1999, on the *Pittsburgh Magazine*

program. Possible topics include children's health insurance, managed care oversight, and privacy in genetic testing. The program will start as a weekly show and eventually will air nightly. Although no editorial control by the JHF is permitted or implied, it says that it will bring key issues to WQED's attention and point out useful "resources for developing effective stories."

\$150,000 over twenty-eight months. Funded by the Jewish Healthcare Foundation of Pittsburgh.

Medicare

International Longevity Center-USA, Ltd., New York, NY. This grant supports establishment of the Center for Medicare Education. Its aim is to provide resources and support to organizations that work with seniors so that these groups can help Medicare beneficiaries to make crucial health care choices. The grantee will collect information on existing efforts to teach beneficiaries how to make wise decisions. Examples of best practices around the nation that teach "beneficiaries how to navigate the increasingly complex health care system" will be distributed at conferences and via mailings, audiotapes, videotapes, and a Web site, according to Robert Wood Johnson Foundation (RWJF) materials. The grantee also will "sponsor efforts to identify best practices for educating special populations—the low literate, the homebound, and minorities" and will hold regional meetings to train trainers. The Medicare Rights Center is a subcontractor for training. In a telephone interview, Beth Stevens, who directs the project, said that its aim is to reduce both costs for and duplication of efforts by groups working with the elderly.

\$5,460,001 over four years. Funded by the Robert Wood Johnson Foundation.

University of California, Los Angeles (UCLA), Los Angeles, CA. Enrollment in Medicare managed care is expected to increase, according to a Congressional Budget Office memorandum, and this rise "is likely to have a significant impact on the premiums

and sales of supplemental Medigap policies in the fee-for-service market," the Commonwealth Fund explained. Managed care plans often cover services covered by Medigap policies. Researchers, directed by Thomas Rice, will analyze how Medigap is affected by managed care and whether the Medigap market will be viable in the future. They will use Medicare Current Beneficiary Survey and Medical Expenditure Panel Survey data. If project staff find that managed care growth is making or might make "Medigap premiums unaffordable for vulnerable elderly beneficiaries, Medicare officials and policymakers would be alerted," according to foundation materials. Research staff also will look at possible options for assuring that "fee-for-service remains a choice for Medicare beneficiaries, especially for the chronically ill."

Up to \$202,689 over twenty-one months. Funded by the Commonwealth Fund.

Rural Health Care

George L. Mee Memorial Hospital, King City, CA. The grantee will use this planning grant "to develop a coordinated regional delivery system in Southern Monterey County," according to James Irvine Foundation materials. Many area residents are poor and dependent on Medi-Cal (California Medicaid). "The need for cooperation among local providers is now even more urgent" because Medi-Cal managed care will soon begin in the county, Irvine explained. Project goals are to maximize use of resources and improve access to care for low-income residents in this rural section of the county. This project also aims to educate providers about changes in the delivery system. In a telephone interview, hospital Chief Executive Officer Walt Beck said that there has been "an incredible response" from the provider community. He added that "other small successes unrelated to the grant" have resulted "because of the increased communication." The hospital is providing in-kind donations to the project.

\$105,000 over nine months. Funded by the James Irvine Foundation.

GRANT OUTCOMES

Outcomes Of Grants

The American Association of Health Plans (AAHP) released a breast cancer report (part of a series called *Best Practices in Women's Health: Identifying Exemplary Care*) in August 1998. The Commonwealth Fund supported the series under a grant awarded in 1996 "to identify models of delivering care to women through [managed care] plans," the concise report explains. Derived from a longer, technical report, it provides ten key questions that women can ask their health plan to find out if it uses exemplary practices and features of four model programs. One thousand health plans were invited to submit information about their breast cancer treatment approaches. Some 400 plans responded; forty of those—many of the large plans—made it to the equivalent of semifinal status. AAHP President and Chief Executive Officer Karen Ignagni explained at a Washington press conference.

For details, see the report, which is available from the AAHP's Web site, www.aahp.org. "For Consumers." The association is located in Washington, D.C.

Genome Horizons: Public Deliberations and Policy Pathways, a May 1998 conference, was funded by the Greenwall Foundation, the National Institutes of Health (NIH), the University of Michigan, and Michigan State University. The conference is part of the two universities' project, *Genome Technology and Reproduction: Values and Public Policy*, funded by the NIH with a \$1 million grant. Project goals were to develop "policy recommendations through the process of rational democratic deliberation" and disseminate findings, according to Principal Investigator Toby Citrin in the thought-provoking conference proceedings. The project also showed "the potential of the community dialogues process for developing policies in [the reproductive decisions] area which is complex, divisive, and heavily laden with deeply held personal views, religious principles, and values." Citrin also notes the "relative lack of involve-

ment [in the dialogues] by people typically underrepresented in decision making," that is, low-income and minority persons. Leonard Fleck, who directed this phase of the project, explains that "the type of people who showed up" were 85 percent Caucasian and mostly college graduates, and "we could not have forced others into it." If the NIH awards additional funding for the project (and Citrin told *Health Affairs* that he was cautiously optimistic about getting the funding), the staff will strive for more inclusiveness.

For a copy of Project Reports and Conference Proceedings, call Toby Citrin at the University of Michigan, 734-936-0936; e-mail: tcitrin@umich.edu.

Grantmakers in Health (GIH) held "Mental Health and Managed Care: A Briefing for Foundations" 1-2 October 1998 at a Dallas/Fort Worth Airport hotel. The California Wellness Foundation, Hogg Foundation for Mental Health, and John D. and Catherine T. MacArthur, Meadows, and Paso del Norte Foundations supported the short conference. Speakers included Bernard S. Arons, director, Center for Mental Health Services of the federal Substance Abuse and Mental Health Services Administration (SAMHSA); author, journalist, and mental health advocate Kathy Cronkite, who suffers from clinical depression; and Mary Jane England, president of the Washington Business Group on Health. Arons suggested that foundations fund data analysis and education of legislators and their staffs to "help orchestrate a fair telling of what's known in the field and what's becoming known." Laurie Garduque of the MacArthur Foundation noted that they have already funded an initiative on getting value for money spent on mental health care.

For more information, call GIH, 202-452-8331, or Charles Bonjean at the Hogg Foundation for Mental Health, 512-471-5041.

In a national survey focused on underage drinking, released in October 1998, 96 percent of respondents said that they are con-

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used on underage ober 1998, 96 per- that they are con-

cerned about drinking by teens. The survey shows that the American public "wants to see policies put in place that will help prevent" teen drinking, said Nancy Kaufman of the Robert Wood Johnson Foundation (RWJF), funder of the survey, in a press release. The support for strong measures "cuts across all demographic lines," the release said. For example, 82 percent of respondents "would be willing to raise alcohol taxes by 5 cents per drink if the funds were used to pay for programs to prevent minors from drinking and to increase alcohol treatment programs." Eighty-two percent also believe that bars and stores "are too lax" about preventing teens from purchasing alcohol. Mathematica Policy Research, under the direction of Alexander C. Wagenaar at the University of Minnesota, conducted the poll in 1997.

For more information, contact Linda Loranger at Burness Communications, lindalo@burnessc.com (e-mail) or 301-652-1558, ext. 106 (phone).

Lessons Learned is a brief report resulting from Opening Doors: Reducing Sociocultural Barriers to Health Care, a national program. This report concerns the program's first phase, which was funded by the RWJF and the Henry J. Kaiser Family Foundation. An accompanying press release noted that "in the face of the nation's growing diversity, these barriers pose a daunting challenge to a rapidly changing health care system." This \$5.5 million first phase funded twenty-three projects—research projects designed to identify sociocultural barriers, as well as strategies to reduce them, and service projects. The report, released in October 1998, summarizes outcomes from several projects in each category. Lessons on strategy include: "Lack of respect [from health care personnel] is a major sociocultural barrier to care"; both community health workers and interpreters can reduce such barriers; and cultural sensitivity training for providers and other staff can be effective. The report also contains lessons learned about conducting minority health surveys. Opening Doors has improved utilization patterns, for example, by "reducing unnecessary

emergency room visits in a rural immigrant community." Although the program's grant-making phase has ended, it recently launched a resource center in Washington, D.C., on overcoming sociocultural barriers. The center has received additional RWJF support.

For a free copy of the report, contact the Opening Doors National Program Office, in Washington, D.C., 202-974-4694, e-mail: info@opening-doors.org.

Results from the National Survey on Medicare: The Next Big Health Policy Debate?

were released 20 October 1998. According to the press release, "While most Americans know Medicare faces fiscal problems, they are not ready to support changes that would produce major savings." According to this Kaiser Family Foundation/Harvard School of Public Health survey, when respondents were given arguments for and against various reform proposals "to deal with Medicare's financial problems," only one proposal, requiring "seniors with higher incomes—over \$75,000 per year—to pay more for their health care through higher premiums, co-pays, or deductibles," was favored by a majority of respondents. (Experts say that this alone will not yield enough savings to ensure the solvency of the Medicare trust fund in the future, the release noted.) Forty-three percent of respondents age sixty-five or older said that they knew "only a little" about Medicare reform options; 20 percent said that they knew nothing about them. Few respondents knew about Medicare+Choice: Only 20 percent of all respondents (and just 24 percent of seniors) said that they have "seen, heard, or read anything" about the new program. There, the need to educate the public is quite apparent, noted Drew Altman, Kaiser president, at a Washington press conference. Princeton Survey Research Associates conducted the survey in August and September 1998.

Kaiser released three useful fact sheets in July 1998: "Medicare at a Glance" (Pub. no. 1066), "Medicare Managed Care" (no. 2052), and "Medicare+Choice" (no. 1422).

For free materials on the survey (Pub. no. 1442) or fact sheets (order by above numbers), call the Kaiser Fam-

ily Foundation's publication request line, 800-656-4533, or visit its Web site, www.kff.org.

The Role of Medicare in Successful Aging, a forum held in Washington, D.C., was sponsored by the Center for the Advancement of Health, Gerontological Society of America, and John D. and Catherine T. MacArthur Foundation. Its major message was that Medicare reform should include incentives for wellness promotion (in the form of reduced premiums) and coverage for more preventive care. Speakers advocating these approaches at the June 1998 event included Sen. Jack Reed (D-RI) and John W. Rowe, president and chief executive officer of Mount Sinai-NYU Medical Center and Health System.

For more information, call Richard Hebert, communications director, Center for the Advancement of Health, in Washington, D.C., at 202-387-2829.

Publications

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Beyond the Balanced Budget Act of 1997: Strengthening Federal GME Policy is an October 1998 report from the Pew Health Professions Commission, a program of the Pew Charitable Trusts. This report on graduate medical education (GME), by the commission's Federal Policy Task Force, chaired by Neal Vanselow, states that despite the "valuable role" of the federal government, "policy must be adapted to ensure that medical schools and clinical teaching sites have incentives to use federal subsidies in a manner consistent with workforce requirements." The commission advocates separate financing for the four products of teaching hospitals—education, uncompensated care, specialized clinical services, and research—which are now illogically "subsidized through current federal 'education' subsidies." That panel makes nine recommendations for reforming federal GME policy, including all-payer financing so that public and private payers "contribute to the subsidization of clinical education for physicians," advanced practice nurses, and physician assistants. The commission also recommends a way to set the number of all-payer

funded residency positions and establishment of a federal workforce policy commission, which "should be a public-private partnership." Orders must be prepaid. Send a check for \$20 to UCSF Center for the Health Professions, Suite 410, 3333 California Street, San Francisco, CA 94118.

From Generation to Generation: The Health and Well-Being of Children in Immigrant Families was released by the Institute of Medicine (IOM) in September 1998. "Because of the burgeoning importance of children and youth in immigrant families to the vitality of the nation," an IOM committee was appointed to do this study. The Carnegie Corporation of New York; the W.T. Grant, Rockefeller, and California Wellness Foundations; and the federal Departments of Health and Human Services and Education funded this report. *Health Affairs* readers will be particularly interested in the "Public Policies" chapter, which includes new data on immigrant families' use of benefits before welfare reform and discusses health insurance coverage patterns, access to and use of care, and barriers to care (for example, culture and language). Among six recommendations, one is for the federal government to conduct a longitudinal survey of immigrant children and youth. Another is that "both quantitative and qualitative research should be conducted on the effects of welfare and health care reform for children and youth in immigrant families, and on how access to and effectiveness of . . . services are affected by the provision of culturally competent care."

For a copy of the 314-page report, which costs (prepaid) \$52.95, plus \$4 shipping for the first copy, contact National Academy Press, 2101 Constitution Avenue NW, Washington, DC 20418, 800-624-6242. The report is available on the Internet at www.nap.edu.

Medical Coverage for Medicare Beneficiaries with HIV/AIDS: Issues and Implications is a June 1998 Academy for Educational Development (AED) report. Funded by the George Gund Foundation, the report by Helen Schietinger and Carol Schechter explains, "Little is known about the cost or quality of health care services provided to Medi-

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Generation: The Children in Immigrant Families by the Institute of Medicine, November 1998. "The importance of children and families to the future of the nation was the theme of the Carnegie Corporation's W.T. Grant, National Endowment of Health Education funded studies will be part of the "Public Policies" series on immigrants before welfare reform, insurance coverage, use of care, and culture and language. One is to conduct a longitudinal study of children and families, quantitative and qualitative, and be conducted on health care reform, migrant families, effectiveness of... provision of cul-

t, which costs (pre- the first copy, contact Constitution Ave- 800-624-6242. The at www.nap.edu.

Healthcare Beneficiaries and Implications for Educational Institutions. Funded by the National Endowment of Health Education, the report by David Schechter examines the cost or quality of care provided to Medi-

care beneficiaries... with HIV [human immunodeficiency virus] and AIDS [acquired immunodeficiency syndrome], or about their access to a range of service options available to other Medicare beneficiaries, such as managed care plans or Medigap coverage." The authors cite experts' estimates of the percentage of persons with HIV/AIDS who depend on Medicare—from 6 to 20 percent. The biggest problem for Medicare beneficiaries with HIV/AIDS is that the program "provides no outpatient prescription drug benefit," they maintain. The authors did a literature search followed by case studies in four diverse states. They suggest potential solutions to several important issues they identified. This report focuses attention on a challenging policy area and is useful to readers with various levels of Medicare expertise.

For a copy of the report, visit the AED's Web site at www.aed.org, or call Elisa Velasco at the AED, 202-884-8860 (limited supply available).

Public Values and Perspectives on Managed Care, which presents the views of health plan members and physicians, was released by the nonprofit group California Health Decisions (CHD) in October 1998. Lake Snell Perry and Associates, which prepared the report, first conducted focus groups or telephone surveys with some 1,000 plan members and 100 physicians in California over a four-year period. The executive summary explains that the report is based on information gathered by four subsequent CHD Consumer Feedback Loop projects, which have involved "patients, providers, purchasers, and health plans in a consumer-driven process of research, solutions, change, and evaluation." The Integrated Healthcare Association and Chevron Corporation funded the report; the St. Joseph Health System, California Wellness, and James Irvine Foundations were among several entities that funded specific projects. "The research findings show that the same issues cut across cultural, educational, age and other demographic boundaries, and they tend to relate more to the process of obtaining... care than to the quality of

care delivered," a CHD press release reported. For a copy of the executive summary (free) or of the full report (\$50), contact CHD, Publications-October 1998 Report, Suite 400, 505 South Main Street, Orange, CA 92868. The summary is also available on the Internet, www.cahd.org.

Announcements

The Robert Wood Johnson Foundation announced a new \$25 million initiative, the National Program for Improving Chronic Illness Care. "As the nation's population grows older, the number of Americans with chronic illnesses... will continue to rise," according to an RWJF press release. Large health care organizations across the nation are being forced "to reconsider the way in which they practice medicine." The five-year RWJF program, based at Group Health Cooperative of Puget Sound (a health maintenance organization), aims to help up to 120 organized health care systems to improve care for chronic illness. The program also will set up "a clearinghouse for information about effective approaches to treating chronic illness" and "establish a targeted research grants program."

For details, call the RWJF's Communications Office, 609-243-5937, or Ed Wagner at Group Health Cooperative, 206-287-2876.

The Rockefeller Foundation announced that it established a \$2.5 million Global Health Leadership Fund at the World Health Organization (WHO). New WHO Director General Gro Harlem Brundtland is using the nonrenewable fund "to recruit a cadre of experts from a variety of fields to serve during a two-year transition period," according to a press release. The fund will allow Brundtland "to infuse" WHO "with fresh approaches to global health challenges." Rockefeller's president, Gordon Conway, said in the release that the fund is an important component of the Rockefeller Health Sciences division's current "focus on global health [status] equity." For details, visit the Rockefeller Foundation's Web site, www.rockfound.org, or write to its Health Sciences division at 420 Fifth Avenue, New York, NY 10018.

INTERVIEW

Bringing Forth Medicare+Choice: HCFA's Robert A. Berenson

A practicing physician turned HCFA executive details his agency's plans to bring Medicare into the twenty-first century.

by John K. Iglehart

Q: The Health Care Financing Administration (HCFA) has had a long relationship with health maintenance organizations (HMOs), dating to the 1970s when the agency conducted experiments with how well health plans could serve Medicare beneficiaries under risk contracts.¹ In general, how well have HMOs, at financial risk for the obligations they must fulfill under Medicare risk contracts, performed over this extended period?

A: HMOs have had a solid track record in serving Medicare beneficiaries. In recent years Medicare beneficiaries have been enrolling in HMOs at a rate of almost 100,000 people a month. Now, about 17 percent of Medicare beneficiaries have selected HMOs as their preferred option. Many elderly people are smart shoppers. They recognize the value of the additional benefits HMOs are offering at little or no extra cost to them. What we know less about is the performance of HMOs in terms of the quality of care they offer and the satisfaction of their members.

Prescription Drug Coverage

Q: When you talk about HMOs as solid value for Medicare beneficiaries, what is the differential in dollars between what an average elderly person must pay to obtain those extra benefits—outpatient prescription drugs being the most valuable—if he or she paid for them by purchasing a Medi-

gap supplemental insurance policy? And until now, have all or only some HMOs that have Medicare risk contracts offered outpatient prescription drugs to beneficiaries for no additional premium?

A: The cost differential is quite substantial. Typical Medigap policies that include drug coverage cost about \$200 or more per month, whereas the typical Medicare risk plan offers drug coverage with no premium. Of perhaps even greater concern is that few of the Medigap policies available to Medicare beneficiaries offer outpatient prescription drugs. Second, there is no guaranteed issue for the three policies (out of ten standardized Medigap plans) that include a drug benefit, and applicants can be subject to preexisting condition exclusions. So beneficiaries who no longer can enroll in HMOs because plans have abandoned certain counties will be exposed to very high prices to obtain prescription drug coverage. This could add greatly to their out-of-pocket medical costs.

About two-thirds of plans offer a drug benefit today, and we expect that a large number will continue to do so next year. However, some plans will be reducing the scope of coverage, but we have not yet conducted a comprehensive analysis of changes in the benefits for next year.

Q: As more elderly people have enrolled in HMOs, a greater number of the program's

thirty-nine million beneficiaries have access to outpatient prescription drug benefit. It seems to me that politically sensitive issues are that beneficiaries have access to an affordable price, while others are not served by HMOs. Where does the Clinton administration stand on this issue? What is its thinking on including an outpatient prescription drug benefit to the for-service Medicare benefit package and thus eliminating this discrepancy?

A: There is a view that an outpatient prescription drug benefit should be a part of Medicare. The Competitive Pricing Advisory Committee set up under the Balanced Budget Act (BBA) of 1995 is to sign a demonstration project. Plans would bid to serve beneficiaries, recommends that the plans would bid on including a drug benefit. Other options for a drug benefit are under

HCFA's Payments

Q: I have heard a major leader—one, I might say—has not pursued the business aggressive payments to HMOs, a formula embedded in the scene profits. Has HCFA health plans?

A: Yes. That, of course, is correct. In 1999 payments were almost \$800 in states with about \$380 in many many counties—including states such as Maryland and Utah—we have seen we are witnessing is

Bob Berenson, a physician, is director, Center for Health Plans and Providers, Health Care Financing Administration. He is cofounder and former codirector of the National Capital Preferred Provider Organization, a PPO serving 130,000 patients in the Washington, D.C./Baltimore area.

thirty-nine million beneficiaries have had access to outpatient prescription drugs as a benefit. It seems to me that this sets up a politically sensitive issue—that is, some beneficiaries have access to drugs at an affordable price, while others, for no other reason than that they live in geographic areas not served by HMOs, must pay far more out of pocket to obtain these products. Where does the Clinton administration stand on this issue?

What is its thinking on adding an outpatient prescription drug benefit to the fee-for-service Medicare benefit package and thus eliminating this discrepancy?

A: There is a view that a basic outpatient prescription drug benefit should be a part of Medicare. The Competitive Pricing Advisory Commission, set up under the Balanced Budget Act (BBA) of 1997 to help HCFA design a demonstration under which health plans would bid to serve Medicare beneficiaries, recommends that the benefit package that plans would bid on include a modest drug benefit. Other options for broader provision of a drug benefit are under consideration.

HCFA's Payments To HMOs

Q: I have heard a managed care industry leader—one, I might add, whose company has not pursued the Medicare book of business aggressively—say that HCFA's payments to HMOs, which are based on a formula embedded in law, have led to obscene profits. Has HCFA been overpaying health plans?

A: Yes. That, of course, is speaking in the aggregate. In 1999 payment rates will vary from almost \$800 in Staten Island, New York, to about \$380 in many rural areas. Thus, for many counties—including even urban counties in states such as Minnesota, Washington, and Utah—we have not overpaid plans. What we are witnessing is that HMOs are eager to

enroll Medicare beneficiaries in high-payment areas, but they are dropping out of marginal-payment areas. The BBA will partly address this problem when HCFA has fully implemented the BBA's payment formula for managed care plans, but for now it places financial pressure on particular plans in certain areas.

Q: What is the basis of the overpayments? Is it strictly the payment formula, or is part of the equation the health status of Medicare beneficiaries who enroll in particular plans?

"HMOs are eager to enroll Medicare beneficiaries in high-payment areas, but they are dropping out of marginal-payment areas."

A: It involves both the payment formula and the favorable selection of members that some HMOs experienced and that the payment methodology simply did not capture. The risk-adjustment measures that the BBA requires—paying plans that enroll sicker pa-

tients more money than those that attract healthier people—are paid—should reduce the overpayment problem to some extent. Another factor was the way in which health plans were allowed to calculate their administrative overhead; it was too generous as well. HCFA permitted plans to take the same percentage of overhead and profit as they generated on the commercial side, and this led to an overpayment. This is being corrected. I should add that health plans were required by law to use most of these overpayments to provide additional benefits to enrolled Medicare beneficiaries. Again, that is what has made HMOs attractive to the elderly.

Medicare+Choice Implementation Issues

Q: Until last September (1998) we heard very little from HMOs about their concerns in enrolling Medicare beneficiaries based on the new regulatory requirements and payment constraints of the BBA. At that point, the American Association of Health Plans (AAHP) registered its concerns over

the approach HCFA was taking to implement the Medicare+Choice provisions of the BBA. Its most pressing concern involved the payments health plans would receive for each eligible beneficiary that they enrolled. The AAHP, acting on behalf of its member plans, sought approval from HCFA to change the benefits and the cost-sharing and premium requirements that were contained in the proposals they were required to submit to the agency last May. The association's rationale was that the payment methodology in the BBA, along with changes in market conditions and other requirements contained in HCFA's proposed implementation plan, combined to significantly change the operating environment for managed care companies. HCFA turned down the industry's request to allow plans to amend their offerings of last May because (as HCFA Administrator Nancy-Ann Min DeParle wrote to the AAHP's chief executive officer, Karen Ignagni, in a letter dated 1 October 1998) "many beneficiaries would receive fewer benefits while paying more for their health care." In HCFA's view, where is this dispute over the implementation of the Medicare+Choice provisions headed? Would it not have made sense in certain instances to allow plans to refile their plans? Or, in other words, would not higher costs and fewer benefits have been a better solution than no HMO at all?

A: Managed care companies submitted proposals to HCFA in May 1998 regarding their plans for enrolling Medicare beneficiaries. They were consistent with what we had seen in the past several years—stable benefits and stable cost-sharing requirements. We are still scratching our heads about what plans learned between May and September that compelled them to seek an opportunity to revise their proposals when, in fact, the 6 to 8 percent medical inflation that they reported had been a reality for some twelve to eighteen months. We have wanted to know why the health plans knew, for purposes of contract-

ing with the Federal Employees Health Benefits Program (FEHBP), that health care costs were rising so fast, but for purposes of submitting proposals to Medicare, they did not know until much later in the year. Nevertheless, we agree that the 1 May deadline that the BBA imposes on health plans for submitting their Medicare proposals should be pushed back until later in the year, as long as HCFA has the information it needs to conduct the information campaign for beneficiaries every November.

Physician And Hospital Payment Rates

Q: I am struck by the contrast between the reaction of health plans to the reduced payments levels they will receive from HCFA for enrolling Medicare beneficiaries and how physicians and hospitals have reacted to the tighter payment constraints that Congress has imposed on these providers repeatedly over the years. How do you account for this difference?

A: Physicians and hospitals had little choice in the matter. They were forced to carry on because if they turned away Medicare patients, they were essentially not in business—Medicare is such a large percentage of their financial base. Health plans, which, unfortunately, still too much resemble the traditional insurance company, often just have distant contractual relationships with providers. Many plans lack the infrastructure, the culture, the community roots, that would lead them to operate through leaner times, and they are able to just close down shop. I think that is different from the traditional staff- or group-model HMO that employed its own doctors or, in the case of Kaiser Permanente, signed exclusive contracts with full-time physicians dedicated to serving the enrolled population. Such plans often operated from their own facilities and, basically, like hospitals and private physicians, were seen as community institutions. So we have many large, usually for-profit, managed care companies that have stayed in some parts of the country and have dropped

out of other parts. They had a line analysis and decided to exit markets. Each decision to exit an area makes sense as a narrow business decision. But when you add up all the decisions, the HMO industry is facing a very unfortunate trend for the Medicare population. I have some doubt the hope that managed care might be a solution to Medicare's long-term financial problems.

Managed Care And Medicare Beneficiaries

Q: Let me ask you a hypothetical question, based on this new level of uncertainty regarding HMOs and the Medicare population, members of which are generally averse to taking any action when it comes to how to obtain health care. If you were to seek your counsel by asking a beneficiary to enroll in an HMO, how would you respond?

A: I worked in managed care as a physician, a medical director of a plan for ten years. I think, correctly, managed care has a level of quality and benefit that is at a lower cost than traditional medicine and indemnity. In fact, my mother might have been a good HMO. She had different physicians, coordinating her care with a good gatekeeper. I think the advantage of the fact that

But, unfortunately, consumer demand for managed care plans have stopped quality improvement. In some cases, health plans are holding them to a standard that I believe would help

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out of other parts. They have done a bottom-line analysis and decided to pull out of certain markets. Each decision to pull out of a service area makes sense as a narrow business decision. But when you add up all of these decisions, the HMO industry is losing a reputation for reliability and stability. And that is a very unfortunate trend for the industry and the Medicare population. Indeed, it casts in some doubt the hope that a competitive market might be a solution to Medicare's long-term financial problems.

Managed Care And Medicare Beneficiaries

Q: Let me ask you a hypothetical question, based on this new level of uncertainty regarding HMOs and the Medicare population, many members of which are quite averse to taking any risks when it comes to how they

obtain health care. If your mother were to seek your counsel by asking whether or not to enroll in an HMO, what would you tell her?

A: I worked in managed care as a practicing physician, a medical director, and a co-owner of a plan for ten years. I believe that, done correctly, managed care can deliver a higher level of quality and better patient satisfaction at a lower cost than traditional fee-for-service medicine and indemnity insurance can. In fact, my mother might well benefit from joining a good HMO. She now sees five or six different physicians, and no one seems to be coordinating her care. She might be better off with a good gatekeeper. Maybe she takes advantage of the fact that her son is a physician.

But, unfortunately, partly in response to consumer demand for provider choice, many plans have stopped innovating and have put quality improvement efforts on the shelf. In some cases, health plans are criticizing HCFA for holding them to quality standards that we believe would help to distinguish them from

fee-for-service plans. A lot of what we require, what beneficiaries want, is a higher standard of care, especially in an organization that is remunerated by a per capita, fixed payment in which the potential for underservice always exists. We won't retreat from our obligation as a purchaser of medical care for a vulnerable population to insure a basic level of quality and broad access for beneficiaries.

Q: What has the Clinton administration and HCFA itself heard from the Medicare population in response to the decisions of managed care companies to withdraw from certain areas? Most beneficiary groups have been relatively quiet in reacting to these actions, which certainly are of concern to many of their members.

A: At this time, an estimated 400,000 Medicare beneficiaries who are enrolled in HMOs

with risk contracts will have to switch plans or return to traditional fee-for-service coverage. I should emphasize that no beneficiary will be left without coverage. A large majority, perhaps 90 percent of elderly people who lose their HMO, will have an opportunity to simply switch plans because another plan operates in the same geographic area. Many will keep their same physicians because provider networks are so similar. Our greater concern is for some 50,000 beneficiaries who do not have the option of enrolling in another HMO because none exists, and they must return to fee-for-service medical care. Although all beneficiaries are guaranteed such coverage, they will need to purchase Medigap insurance to have access to the additional benefits that HMOs were providing under their risk contracts, such as annual physical examinations and outpatient prescription drugs. In this respect, there will be some dislocations because Medigap coverage is expensive, and not all beneficiaries can afford to pay for it.

"HCFA could spend a couple more decades trying to design the ideal risk-pull adjustment system, but I think that the time has arrived to get on with it."

Why The HMO Pullout?

Q: One of the vexing questions is why HMOs that have many years of experience in serving Medicare beneficiaries, such as Aetna/U.S. Healthcare, Humana, Kaiser Permanente, and United HealthCare, would withdraw from selected markets. Is this strictly a case of payments' being deemed too low? Will the administration hold fast to current payment levels?

A: There is a correlation between the areas from which these plans have withdrawn and the generosity of the payments. But it's important to underscore that these managed care companies are remaining in most of the markets where they enroll Medicare beneficiaries, even though some have absorbed losses on Medicare in the past fiscal year. We are certainly concerned about plans' withdrawing from Medicare in counties where payments are deemed too low, but the BBA payment formula should partly resolve this pressure over the next several years. HCFA does not have the discretion to take money from high-payment counties and reallocate it to low-payment counties.

Q: Do you anticipate that the Clinton administration will propose a legislative package to address those issues in the BBA that apply to Medicare+Choice that trouble the managed care industry?

A: President Clinton committed the department to put together a legislative package that will address the issues around health plans' pulling out of certain counties and, in the process, abandoning patients. We are concerned about plans' submitting their benefit packages to us too early in the year. We need to look at the timing of notice of withdrawal so that beneficiaries will be more aware of their plan choices. We are looking at other things, but at this point I really can't announce them.

Q: One issue is certainly payment levels. Will the Clinton administration seriously consider easing up on the strict payment constraints written into the BBA?

A: We think that there is enough money in the

system now to pay plans. There is no reason to reduce payments more than the phased-in reductions in the BBA. At this point, we are not looking at adding new funding overall. We are working with Congress and the industry to see if we can be smarter about distributing the available funds across geographic areas.

BBA Payment Methodology

Q: Almost from the first day that you began contracting with HMOs for Medicare elderly, policy analysts have criticized the payment methodology used by HCFA. Have you searched for new approaches? Does the BBA call on the agency to develop payments in its per capita payments for managed care plans based on the relative number of elderly beneficiaries who enroll? Is it at the difficult technical issues around calculating such adjustments that makes HCFA now believe that it will overcome these difficulties and meet congressional intent? Indeed, how do we know an adequate risk adjustment was one?

A: I am reminded that Medicare's payment methodology used to reimburse hospitals was a research tool when Congress decided to authorize its implementation. It was to dampen medical inflation and control soaring costs. HCFA could spend more decades trying to design the perfect adjustment system, but I think that time has arrived to get on with it. We know we're going to start with less-than-perfect methods by basing the risk adjustment on the prior hospitalization experience of beneficiaries. After that, we will move to a methodology that takes diagnoses from the ambulatory care sector as well. Risk adjustment is fundamental to giving the correct payments to plans that we need to move forward. It's imperfect. We would phase in the risk adjusters to cushion their impact, but Congress has directed us to implement those adjustments, and we will do so.

...the risk adjusters be... you anticipate that... HCFA money... of favorable... so, overall, we w... It is also important... plans will actually... risk adjustme... impact analysis... more detail. But... of risk adjustm... to avoid ext... plans and more...

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Q: Will the risk adjusters be budget-neutral, or do you anticipate that they will either save or cost HCFA money?

A: There is evidence of favorable selection into Medicare HMOs, so, overall, we would expect to see savings. It is also important to remember that some plans will actually have higher payments under risk adjustment. We have just started our impact analysis, so it's too early to talk in more detail. But we know that implementation of risk adjustment will need a transition period to avoid extreme financial impacts on plans and more dislocation for beneficiaries.

HCFA's Education Efforts

Q: What is the status of HCFA's efforts to educate Medicare's eligible population about the new world of Medicare+Choice? Does HCFA have the necessary resources (financial and human) to implement this congressional requirement, particularly as it applies to this vast population of thirty-nine million eligible people?

A: HCFA is using several vehicles to communicate with beneficiaries about Medicare+Choice. These include, for instance, print material, a toll-free telephone service, an Internet site, and outreach efforts in local communities conducted by our regional offices. Pilot testing of some of these vehicles in 1998 will allow us to assess and improve them in 1999. We also are trying to leverage our limited resources by establishing relations at the community level to get the greatest effect. This is an educational effort that will take some time to establish so that beneficiaries become more active participants in their health care decisions. What is clear is that the only way Medicare beneficiaries can make informed decisions is to be educated about their choices. For example, beneficiaries should be able to make choices not only by comparing benefit packages but by understanding and using relative quality measures and disenrollment rates.

Looking Ahead: HCFA's Dual Roles

Q: Looking ahead, should HCFA continue to be an agency that both regulates the

managed care industry and purchases its products?

A: Medicare is one of the largest health care purchasers in the world and by its market power can create winners and losers, even inadvertently. Therefore, by default, it is inevitable that the roles of purchaser and regulator are inextricably linked. Like other purchasers, HCFA is moving in the direction of being more beneficiary centered and focusing on value, not just cost control. At the same time, the private purchaser orientation to becoming more collaborative with plans through negotiations, selective contracting, and competitive bidding is much more difficult for such a large public purchaser. Because of specific procedural constraints, congressional oversight, and intense public scrutiny arising from being a public agency, HCFA must be scrupulously impartial in its treatment of actual and potential contractors and also must attempt to maintain a level playing field between managed care and traditional fee-for-service Medicare. A requirement for impartiality results in restricted purchaser flexibility and discretion. In short, HCFA should become a purchaser in some ways but will be viewed as a regulator in other ways.

NOTES

1. J.K. Iglehart, "Medicare Turns to HMOs," *New England Journal of Medicine* 312, no. 2 (1985): 132-136.
2. J.P. Newhouse, M.B. Buntin, and J.D. Chapman, "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs* (September/October 1997): 26-43.

PUBLICATIONS & REPORTS

Medicare

Employer Reaction to Medicare+Choice, 1998, a Hewitt Associates survey of 350 U.S. employers, found that 61 percent of them "haven't yet decided how the new [Medicare+Choice] options will fit into their retirement coverage or be communicated to retirees." Nevertheless, 33 percent of respondents plan to offer one or more of the new options to retirees in 1999, and 47 percent plan to offer the new options over the next three to five years. Health maintenance organizations (HMOs) are the most likely option that employers will offer (71 percent), followed by preferred provider organizations (PPOs) (55 percent). Employers are more divided over how they will handle requests to reenroll in an employer-sponsored plan from retirees who disenrolled to join one of the new options: 33 percent expect to allow reenrollment; 23 percent will not allow it; and 35 percent are undecided.

Free copies of the survey findings are available from the Hewitt publications desk, tel.: 847-295-5000.

A Families USA analysis found that sixty-one of the ninety HMOs that are pulling out of Medicare "because they can't make enough money" provided their top executives with an average of \$2.4 million in compensation (exclusive of stock options) in 1997. A few highlights: United HealthCare, which is pulling out of the Medicare market in parts of thirteen states, paid its top executives more than \$2.8 million each, on average, in 1997; Aetna, which is pulling out of Medicare in parts of eleven states and the District of Columbia, paid its top executives \$1.7 million; and Oxford Health Plans, which is pulling out of parts of four states, paid its top executives more than \$6.4 million and its former chief executive officer, Stephen Wiggins, more than \$30 million. The October 1998 analysis (in press release format) is based on Families USA's September 1998 report, *Premium Pay II: Corporate Compensation in America's HMOs*.

For further information, call Families USA at 202-628-3030.

"Medicare Beneficiaries with Dual Sources of Coverage," an October 1998 report by the Employee Benefit Research Institute (EBRI Notes no. 10), found that (1) the number of Medicare beneficiaries without a "supplemental source of coverage" increased from 6.9 million (22.9 percent) in 1994 to 7.6 million (24.9 percent) in 1996; (2) the percentage of females without an additional coverage source rose from 23.9 percent in 1994 to 26.4 percent in 1996, and for males, from 21.6 percent to 22.8 percent; and (3) lack of dual sources of coverage increased by age—from 23.8 percent of beneficiaries ages sixty-five to sixty-nine in 1996 to 32.8 percent of those age eighty-five and older.

Copies of the full report are available for \$25 each from EBRI publications, Suite 600, 2121 K Street, NW, Washington, DC 20037-1896, tel.: 410-516-6946.

Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services is a September 1998 report of the U.S. General Accounting Office (GAO). The study found that "neither agency closures nor the interim payment system" (which has been in effect for less than a year) "has significantly affected the capacity of the home health industry to provide services" to Medicare beneficiaries. However, the GAO's interviews with hospital discharge planners and representatives of organizations for the elderly "indicate that access to services may be more difficult for beneficiaries with particular needs" (higher-cost beneficiaries). The study also found that despite 760 agency closures nationwide between October 1997 and 30 June 1998, "there were still more agencies to treat Medicare beneficiaries in August 1998 than [there were] in October 1996."

Single copies are available free; additional copies are \$2 each (payable to Superintendent of Documents), from U.S. GAO, P.O. Box 37050, Washington, DC 20013, tel.: 202-512-6000.

"Medicare: New Choices, New Worries," a nineteen-city study published in the September 1998 issue of *Consumer Reports*, found that "seniors are facing higher out-of-pocket health care expenses, cutbacks in HMO benefits such as prescription drugs and vision care, and a burdensome array of Medicare choices." Key findings include the following: (1) Premiums for Medigap policies are up 35 percent, on average, since 1994; (2) premiums for Medigap Plan C (the most popular of the ten standardized supplemental plans) are up 41 percent since 1994; and (3) premiums for Medicare Part B will more than double over the next eight years—from \$526 in 1998 to \$1,172 in 2006. "Many seniors in this country are discovering that the health care system they were promised and depend on is becoming prohibitively expensive, restrictive, and unintelligible," said Trudy Lieberman, *Consumer Reports* health policy editor and director of the year-long investigation, in an August 1998 press release. "With more Medicare options coming in the Fall, this trend is going to get worse," she said.

For more information, contact Consumers Union at 914-378-2437.

Resecuring Social Security and Medicare: Understanding Privatization and Risk, released in October 1998, grew out of two symposia convened by the Gerontological Society of America in November 1996. Contributors include Robert Ball, Carroll Estes, Robert Hudson, Marilyn Moon, and Dallas Salisbury. The report was edited by Judith Gonyea and was funded by the Retirement Research Foundation.

Copies are available for \$10 each from the Gerontological Society, Suite 250, 1030 Fifteenth Street, NW, Washington, DC 20005-1503, tel.: 202-842-1275.

Restructuring Medicare for the Long Term, a National Academy of Social Insurance (NASI) project, has produced the following books and reports.

Securing Medicare's Future: What Are the Issues? (NASI, March 1997).

From a Generation Behind to a Generation Ahead:

Transforming Traditional Medicare (NASI, January 1998).

R.D. Reischauer, J. Lave, and S. Butler, eds., *Medicare: Preparing for the Challenges of the Twenty-first Century* (Brookings Institution, January 1998).

Structuring Medicare Choices (NASI, April 1998). (Summarized in *Health Affairs* GrantWatch section, September/October 1998, page 238.)

Medicare Choices in California, prepared for the California HealthCare Foundation (NASI, June 1998).

The project—which is funded by the Robert Wood Johnson Foundation, the Pew Charitable Trusts, the Henry J. Kaiser Family Foundation, and the California HealthCare Foundation—also has produced congressional testimony, a video, and twelve commissioned papers.

For further information, call NASI at 202-452-8097.

Systemic Problems with Medicare HMOs: Case Studies from the Medicare Rights Center HMO Hotline analyzes 179 cases that the Medicare Rights Center (MRC) handled during the hotline's first six months of operation, 28 August 1997–28 February 1998. Forty-nine percent of the cases involved HMOs' "noncompliance" with Medicare rules about appropriate care, coverage, or appeals rights; 40 percent involved callers' confusion about how Medicare HMOs work and what beneficiaries' rights and benefits are; and 11 percent involved "systemic problems" that "impeded access to care." The MRC recommends that Congress (1) require the Health Care Financing Administration (HCFA) or an independent enrollment broker to handle all Medicare enrollment functions; (2) provide HCFA with the resources to oversee Medicare HMOs and sanction those that "fail to comply" with Medicare rules; and (3) fund health insurance information, counseling, and assistance programs "to educate and assist Medicare consumers."

Copies of the September 1998 report are available from the MRC, tel.: 212-869-3850, ext. 19, or on the MRC Web site, www.medicarerights.org.

GRANTWATCH ESSAY

Medicare Reform: Foundations Respond To Federal Policy Changes

Private-sector efforts can supplement those of the federal government to inform Medicare beneficiaries about their expanded options.

by Lauren LeRoy and Anne Schwartz

AT ITS PASSAGE, the Balanced Budget Act (BBA) of 1997 was hailed as the most sweeping series of Medicare reforms since the program's creation in 1965. A year and a half later, as the Health Care Financing Administration (HCFA) is undertaking the enormous task of implementing the ambitious Medicare+Choice program, the jury is out on how the reforms will affect Medicare beneficiaries, program expenditures, and the health care system. Both government and private-sector organizations will be instrumental in shaping how these policies are carried out, monitoring their implementation, conducting research to improve their effectiveness, and translating lessons learned into better policy. At about the same time, the National Bipartisan Commission on the Future of Medicare will bring to the public's attention the options for program design and financing that policymakers must confront as they strive to keep the program solvent in the next century. This policy environment provides fertile ground for foundations, whether their interest is funding policy research, capacity building, advocacy, or direct services.

Roles For Foundations

Medicare is not a new item on the agendas of many health foundations. Foundation-supported research and analysis have informed policy development and reported the effects of policy change. Results from projects

on the specifics of hospital payment, risk adjustment, spending limits, quality assessment, practice guidelines, and graduate medical education (GME) financing, funded by grantmakers such as the Commonwealth Fund, the John A. Hartford Foundation, the Robert Wood Johnson Foundation (RWJF), and the W.K. Kellogg Foundation, influenced the shape of the BBA and previous reforms. Foundations also have been key sources of support for national and community-based organizations committed to informing and protecting the rights of Medicare beneficiaries, including the Medicare Rights Center in New York City and the Center for Health Care Rights in Los Angeles.

Foundation support for research, policy analysis, monitoring, and direct services related to Medicare becomes even more important with passage of the BBA, given the scope of the legislation and the changes it signals for how care will be delivered. Although it is HCFA's responsibility to implement and monitor the effects of the Medicare reforms, foundation-sponsored efforts can complement and reinforce the government's activities.

The projects that foundations choose to fund can focus on issues affecting the Medicare program and the health care system at the macro level or on the impact of Medicare reforms on individuals as they seek to gain access to health care services and navigate the health care system. These types of activities

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are not mutually exclusive, but foundations of differing sizes, scopes, and priorities may choose to concentrate more on one than the other and to approach the same issues with different types of strategies.

Local Foundations

Local or regional foundations that focus on the health of specific communities are most likely to fund efforts that respond to the particular needs of beneficiaries in their area. These foundations are particularly well suited to enrich our understanding of the effect of Medicare reform at the community level by documenting beneficiaries' experiences and bringing issues to the attention of those in a position to act: community organizations, health plans, state and federal policymakers, advocacy groups, and the media. Their initiatives also can enhance our understanding of what information has proven most meaningful to beneficiaries and has led to the best choices for them. These activities have the potential to inform policy development, but their initial priority is to help individuals.

For example, a long-established community foundation, the Cleveland Foundation, and a new conversion foundation, the Mt. Sinai Health Care Foundation, are supporting development of a consumer coalition to inform the elderly and the disabled about plan choices and track the performance of managed care plans in that community. The Coalition to Monitor Medicare Managed Care is a project of the local area Agency on Aging, which also secured Older Americans Act funding that accounts for about one-third of the project's revenues. The coalition consists of twenty-two local organizations, including the medical society, the American Association of Retired Persons, the bar association, social service agencies, and faith-based organizations. Its mission is to provide useful information about plan choices, one-on-one counseling for seniors seeking advice, and help with

grievances and appeals. The coalition also will work with health plans to correct systemic issues and will educate the community about the public policy issues arising from its work.

There are also several other strategies that community-based foundations might pursue that would complement HCFA's major educational campaign to inform Medicare beneficiaries about their new health plan options. One is to bridge the gap between consumer advocates and health plans serving the Medicare population. Plans are a principal source of information about their benefits and features, but their publications and telephone help lines are often viewed as marketing tools. Local foundations could act as neutral conveners, using community meetings, publications, and other strategies to open up lines of communication so that consumers can reap the advantages of detailed plan-level information. Another strategy is to develop

"Medicare reform provides a model for the complementary roles that government and grantmakers can play as they pursue a common goal."

partnerships with local print and broadcast media to get out the word to Medicare beneficiaries and their families (particularly adult children) about plan options and the implications of different choices.

Although implementation of Medicare+Choice has focused attention on the immediate issue of how beneficiaries select a health plan, beneficiaries are equally likely to need assistance in navigating the system that they have chosen. Again, there are many options for foundations to help. In northern Virginia, for example, the Arlington Health Foundation is funding its local area Agency on Aging to serve as a Medicare managed care ombudsman. Foundations also can assist beneficiaries by funding transportation, interpreter, or other services that increase access to care; supporting community organizations that increase beneficiaries' understanding of how to use their health plans; and fostering innovation in the care of the vulnerable elderly by health plans, providers, and community

groups. For California Health Care, a five-year, \$15 million grant for the program to improve the health of the elderly California population. The program includes projects that identify senior citizens' medical needs, expand the range of service professionals, and develop strategies to improve the health of the population. The program is being made to managed care, including a network of advocates with communities, develop for health services and creating a new system in

National Foundations

National foundations and counterparts are likely to understand the issues. They are in a position to both address and support locally based efforts. RWJF and the national foundations of Health Affairs at Mathematica, the University of Michigan, and the beneficiaries of the program need to be that information. The development of the program is located in New York and on strategies.

National foundations are more than local groups. They are subjects to monitor reform at the community level. The analytical basis for the changes. For the Fund and the program, both have

groups. For example, in October 1998 the California HealthCare Foundation launched a five-year, \$15 million initiative by awarding grants for thirteen projects designed to improve the health of chronically ill and frail elderly Californians enrolled in Medicare managed care. Three of these are demonstration projects that will develop new ways to identify senior citizens who need services, coordinate medical care and supportive services, and expand the roles of existing health and social service professionals to create comprehensive strategies to serve the multiple needs of this population. The remaining ten grants are being made to community organizations and managed care plans for such efforts as creating a network of community-based consumer advocates within San Diego's ethnic communities, developing a one-stop shopping system for health services for a Contra Costa County, and creating a coordinated health care delivery system in a rural area.

National Foundations

National foundations share with their local counterparts an interest in helping beneficiaries to understand the changes in Medicare. They are in a position to fund projects that both address programwide issues and support locally based efforts. For example, the RWJF and the Commonwealth Fund, large national foundations well known to the readers of *Health Affairs*, are supporting researchers at Mathematica Policy Research and Georgetown University to study what Medicare beneficiaries know about their options, what they need to know, and how best to provide that information. The RWJF also is funding the development of a national clearinghouse located in New York City, to gather and disseminate information on Medicare choices and on strategies to educate beneficiaries.

National foundations also are more likely than local grantmakers are to focus on projects to monitor implementation of Medicare reform at the system level and to develop the analytical base for the next set of policy changes. For example, the Commonwealth Fund and the Henry J. Kaiser Family Foundations both have funded efforts to consider

Medicare's future. Kaiser, in cooperation with the League of Women Voters Education Fund, recently launched an initiative, A Public Dialogue on Health Care: The Future of Medicare, to educate the public about the challenges that the Medicare program faces and the potential reforms that may be considered. Commonwealth's Program on Medicare's Future encompasses a number of health services research projects based at the Harvard School of Public Health and the University of California, Los Angeles, designed to promote better understanding of the Medicare market and its impact on beneficiaries. These include comparing accessibility and quality of care for Medicare beneficiaries in the managed care versus fee-for-service sector, monitoring implementation of Medicare+Choice both nationally and in several major metropolitan areas, and assessing options for changing Medicare's methods of paying managed care plans so that there are fewer incentives to avoid enrolling sicker patients.

Looking Ahead

The further restructuring of Medicare to ensure its availability when the baby-boom generation retires will remain one of the most pressing federal health policy issues. But the dialogue about future policy on health and aging in the next century must move beyond the current program's structure to focus on care for the chronically ill and encompass long-term care. The demands for both formal and informal caregiving will grow as the population ages, bringing to front and center the need to reexamine the interrelationships between Medicare and Medicaid policy. Foundations can take the lead in bringing these issues to public attention and supporting the development of innovative solutions.

Medicare reform illustrates how public policy shapes the context within which foundations work, as well as the opportunities for foundations to respond to the effects of policy and to influence its course. Medicare reform provides a model for the complementary roles that government and grantmakers can play as they pursue a common goal of improving health care for the elderly.

Impact Of The BBA On Medicare HMO Payments For Rural Areas

Will the Balanced Budget Act of 1997 increase availability of Medicare managed care in rural areas?

by Julie A. Schoenman

ABSTRACT: The balanced budget act (BBA) of 1997 radically changed the way Medicare risk plans are paid, replacing the adjusted average per capita cost (AAPCC) system with one in which county payment rates are set as the highest of (1) a local/national blended rate; (2) a national payment floor; or (3) a 2 percent minimum update from the prior year's rate. This DataWatch presents results of simulations of the likely impact of these changes throughout the BBA implementation period ending in 2003. The assessment considers urban/rural differences in payment levels, year-to-year rate volatility, the types of rates paid, and budget-neutrality issues.

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PRIOR TO THE BALANCED BUDGET ACT (BBA) of 1997, risk plans enrolling Medicare beneficiaries received a monthly capitation payment that was based on the adjusted average per capita cost (AAPCC). The AAPCC rates for each county were set annually by actuaries for the Health Care Financing Administration (HCFA), who used historical data to project what Medicare would expect to pay during the next year if the beneficiary remained in the traditional Medicare fee-for-service (FFS) system.¹ Plan payment rates were set at 95 percent of the AAPCC in an attempt to garner some of the expected efficiencies of capitated delivery systems. The resulting base payment rate for each market area was further adjusted for each plan enrollee to account for risk factors such as age, sex, institutional status, and so forth.

The problems resulting from this methodology have been widely described.² From a rural perspective, two issues were particularly relevant: lower payment rates for rural counties compared with urban counties, and higher volatility in rural rates over time.³ Among other factors, such as the supply of providers and the size and affluence of the population, the lower payments and higher rate volatility

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in rural areas have contributed to plans' reluctance to enter these markets, which in turn has contributed to much lower Medicare health maintenance organization (HMO) enrollment rates in rural areas.⁴ Since Medicare risk plans have traditionally offered enhanced benefits—such as prescription drug coverage and routine physicals—to their enrollees, the lower availability of managed care options in rural areas means that many rural beneficiaries do not have access to the same benefits as urban beneficiaries do.⁵

Overview Of The BBA Payment Methodology

Under the new BBA methodology each county's payment is determined as the higher of (1) a local/national blended rate, (2) a national floor, or (3) a minimum update rate set at 2 percent above the previous year's rate. The payment floor was set at \$367 in 1998 and will be updated each year by the national per capita growth rate for Medicare spending.⁶ The 1999 floor will be just under \$380.

The blended rates are computed as a weighted average of the county's own local rate from 1997, and a national rate that has been adjusted to reflect geographic differences in input costs. Medicare's expenditures for graduate medical education (GME) are removed from the local rate prior to blending. The local/national blending weights for 1998 were set at 90 percent and 10 percent, respectively, and will shift by eight percentage points annually until a fifty-fifty blend is reached in 2003.

Each county's blended rate is compared with the floor and minimum update rates, and the county is provisionally assigned the highest of the three rates. Finally, a budget-neutrality adjustment is made to ensure that total payments under the new system are equal to the payments that would have been made if every county had been paid using local rates. Any reductions needed to achieve budget-neutrality are to be taken only from blended-rate counties.

The BBA also addresses the favorable selection into Medicare risk plans by requiring implementation of a new risk adjustment method beginning with year 2000 rates. Although the exact method is not yet finalized, early information indicates that it will be based on health status as indicated by the diagnosis assigned during an inpatient hospital stay.⁷

Data Sources and Simulation Methods

The database used for this study is a county-level file constructed by the Project HOPE Walsh Center for Rural Health Analysis using a variety of files obtained principally from HCFA. Each county record in the file contains AAPCC payment rates for 1990 through 1997; the BBA payment rates for 1998 and 1999; hospital wage indi-

ces and geographic adjustment factors (used for the input price adjustments to the national rate); GME spending percentages; and counts of the number of FFS and HMO Medicare beneficiaries, weighted by risk factors to reflect health status. The file also contains Urban Influence codes characterizing the county's urban/rural status, obtained from the U.S. Department of Agriculture.

These data were used to simulate the payment rates that would result under the BBA methodology for each county from 2000 to 2003, when the BBA will be fully implemented. Final rates for 1998 and 1999 have already been determined by HCFA and are not simulated. All calculations are based on the Medicare growth rates used by HCFA for 1998 and 1999 and on the January 1998 baseline projections of the Congressional Budget Office (CBO) for future years.

The simulation model is static in that it does not incorporate any future adjustments in Medicare HMO enrollment that may occur in response to payment rate changes. Rather, the model uses risk-standardized Medicare HMO enrollment figures from 1995 for all years of the projection period. To the extent that there is a large HMO enrollment increase in counties receiving large payment increases, the budget-neutrality adjustments would have to be more aggressive than the ones used in this model.

The model also does not incorporate the upcoming changes to the risk-adjustment methodology. Rate projections are presented in nominal dollars. To enhance the accuracy of budget-neutrality calculations, all computations were made including observations for the U.S. territories as well as countylike observations for Alaska. The results exclude these observations, however, because of the difficulty of accurately classifying these areas into urban/rural categories.

Results

Between 1997 and 1998 the average payment increase for rural counties was 8 percent, compared with 3 percent for urban counties (Exhibit 1). Movement up to the payment floor was primarily responsible for these substantial gains: 43 percent of rural counties received the floor rate compared with only 15 percent of urban counties. In 1999 the average increase in payment rates will be more similar for rural and urban counties, while the payment floor will remain much more important for rural counties. In both years the mean payment rate for urban areas is higher than in rural areas, with the differential narrowing only slightly over these years.

The payment floor also was critically important for increasing payments in the lowest-paid counties and in counties with the lowest Medicare HMO enrollment rates. All counties in the lowest quartile of AAPCC rates for 1997-92 percent of which were

EXHIBIT 1 Risk-Plan Payment Change

Type of county	Number of counties	Percent of rural counties
Urban	835	-
Rural	2,281	-
1997 AAPCC quartiles		
\$221-\$341	776	9
\$342-\$385	777	7
\$386-\$437	778	-
\$438-\$721	785	5
1995 HMO enrollment		
None	149	
<1 percent	2,014	
1-5 percent	520	
5-10 percent	184	
> 10 percent	249	
All counties	3,116	

SOURCE: Author's calculation.

NOTES: AAPCC is adjusted for

^a In 1998 and 1999 no county had a 10 percent minimum update rate.

^b Not applicable.

rural—were brought up to the age of nearly 21 percent, half of the 1997 AAPCC rate. The 2 percent minimum update rate would be urban. This pattern of counties with historical

Counties with 1 percent received large payment increases. Counties were overrepresented with high rates of increase. It is likely to be urban. Payment rates in 1998 were similar to the minimum update. In 1999, across counties, the payment floor was more important for rural counties.

Projected rate trends in mean payment rates over the period. Rural rates after the BBA is

EXHIBIT 1
Risk-Plan Payment Changes, By Type Of County, 1998 And 1999

Type of county	Number of counties	Percent rural	1998 rates			1999 rates		
			Mean rate	Mean percent change 97-98	Percent of counties at floor rate ^a	Mean rate	Mean percent change 98-99	Percent of counties at floor rate ^a
Urban	835	- ^b	\$451.53	3.2%	14.6%	\$461.42	2.2%	17.1%
Rural	2,281	- ^b	404.27	8.2	42.5	414.77	2.7	45.6
1997 AAPCC quartiles								
\$221-\$341	776	92.3%	367.00	20.5	100.0	379.84	3.5	100.0
\$342-\$385	777	77.7	374.64	3.1	40.7	384.66	2.7	52.3
\$386-\$437	778	71.6	418.66	2.0	0.0	427.03	2.0	0.0
\$438-\$721	785	51.5	506.45	2.0	0.0	516.58	2.0	0.0
1995 HMO enrollment								
None	149	99.3	403.39	11.6	47.7	414.16	2.7	50.3
<1 percent	2,014	79.3	408.31	7.2	37.9	418.64	2.6	40.9
1-5 percent	520	63.5	425.65	5.9	30.2	435.88	2.5	33.1
5-10 percent	184	53.3	447.51	4.4	20.1	457.68	2.3	23.9
> 10 percent	249	43.8	454.02	5.1	25.3	464.52	2.4	26.9
All counties	3,116	73.2	416.93	6.9	35.0	427.27	2.5	37.9

SOURCE: Author's calculations.

NOTES: AAPCC is adjusted average per capita cost. HMO is health maintenance organization.

^a In 1998 and 1999 no counties are assigned a blended rate. Thus, the percentage of counties receiving the 2 percent minimum update rate can be computed as 100—the percentage at the floor rate.

^b Not applicable.

rural—were brought up to the floor rate in 1998 (rates rose an average of nearly 21 percent for these counties). All counties in the top half of the 1997 AAPCC distribution saw their payments increase by the 2 percent minimum update. These counties were more likely to be urban. This pattern will hold in 1999, with even more of the counties with historically low payments moving to the floor rate.

Counties with little or no Medicare HMO enrollment in 1995 received large payment increases between 1997 and 1998. These counties were overwhelmingly rural, and the payment floor was disproportionately responsible for the large rate increases. Counties with high rates of Medicare HMO enrollment, which were more likely to be urban, saw smaller-than-average increases in their payment rates in 1998 and were more dependent on the 2 percent minimum update. In 1999 average rate increases will be more similar across counties, but the payment floor will continue to be relatively more important for the low-enrollment counties.

Projected rates: 2000-2003. Exhibit 2 shows the projected trends in mean payment rates throughout the BBA implementation period. Rural rates will remain consistently below urban rates even after the BBA is fully implemented. When examining for county

groupings based on 1997 AAPCC rates, we see a dramatic move toward convergence in the first year of the BBA—with counties in the lowest quartile receiving a significant boost because of the floor and counties in the highest quartile held to a 2 percent increase—but the difference does not narrow in later years.

It is clear that the BBA will cause the payment distributions for both urban and rural county groups to become much more concentrated around the national mean (Exhibit 3). Despite these gains, however, the rural distribution remains skewed toward the lower payment strata, while the urban distribution reflects a greater concentration of counties in the upper payment strata. By 2003 only about one-quarter of urban counties will have rates below the national mean, compared with more than two-thirds of rural counties.

Volatility in payment rates. With the exception of the 1997–1998 period, when some counties in rural and urban areas alike received significant increases in payment rates thanks to the new payment floor, the BBA will greatly decrease rate volatility (Exhibit 4). Because of the minimum update provision of the BBA, the smallest rate change that any county will ever see is always a 2 percent increase. The wide upward and downward swings in rates that previously plagued many rural counties will no longer occur.

EXHIBIT 3 Dispersion Of Local Rates Around By Type Of County, 1997–2003

Local rate as percent of national average	Percent of 1997
Urban counties	
Less than 80 percent	2.5%
80–89 percent	9.8
90–99 percent	18.7
100–109 percent	20.1
110–119 percent	19.3
120–129 percent	12.8
130–139 percent	8.1
140–149 percent	3.9
More than 150 percent	4.8
Rural counties	
Less than 80 percent	17.1
80–89 percent	21.0
90–99 percent	23.8
100–109 percent	18.3
110–119 percent	10.9
120–129 percent	4.4
130–139 percent	2.9
140–149 percent	1.1
More than 150 percent	0.5

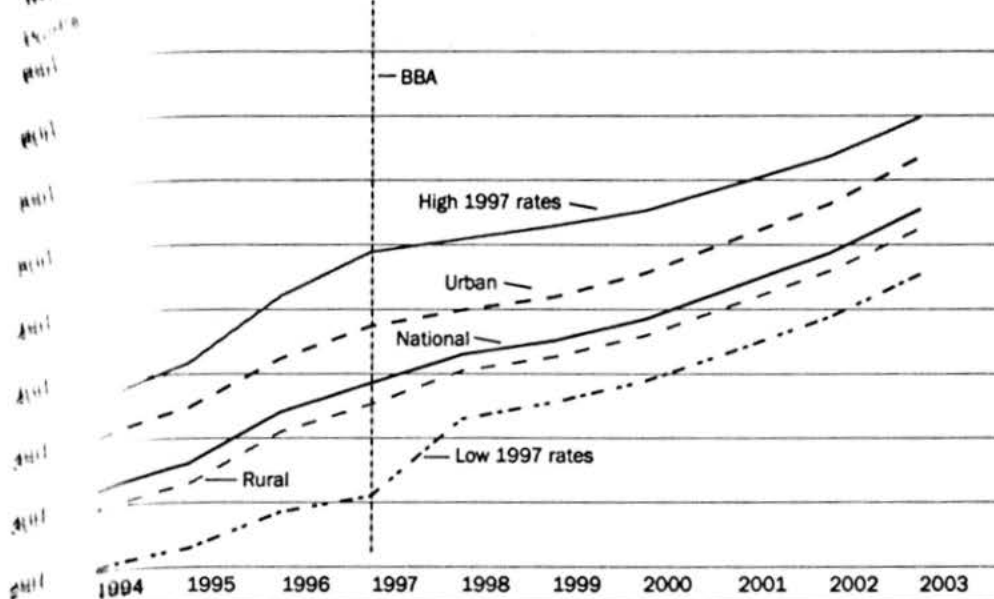
SOURCE: Author's calculations.
* No counties in the cell.

Relative importance switch from a single payment system under which the relative importance of alternative payment rates regarding the relative importance of the payment rate in 1998 or 1999 in the year 2000 and will remain consistently marginal areas. The payment floor will diminish over time.⁸

These projections are Medicare spending growth year will result in a large. Thus, if HCFA's actual the CBO projections urban counties will tend to be no blended-rate court

Budget-neutrality court receive a blended rate

EXHIBIT 2 Medicare Payment Rates, 1994–2003



NOTE: Author's calculations.
BBA is Balanced Budget Act.

EXHIBIT 3

Dispersion Of Local Rates Around National Mean Payment Rate, By Type Of County, 1997-2003

Local rate as percent of national average	Percent of counties						
	1997	1998	1999	2000	2001	2002	2003
Urban counties							
Less than 80 percent	2.5%	- ^a	- ^a	- ^a	- ^a	- ^a	- ^a
80-89 percent	9.8	17.5%	18.4%	10.3%	5.9%	- ^a	- ^a
90-99 percent	18.7	20.8	20.6	24.9	26.6	30.5%	25.9%
100-109 percent	20.1	20.9	21.2	27.8	29.5	31.4	36.7
110-119 percent	19.3	17.2	17.0	16.8	19.9	21.1	22.2
120-129 percent	12.8	11.3	10.7	10.3	10.7	10.7	10.2
130-139 percent	8.1	6.0	6.1	4.8	3.9	3.2	3.3
140-149 percent	3.9	3.1	2.9	2.2	1.7	1.9	0.7
More than 150 percent	4.8	3.2	3.1	2.9	1.8	1.2	1.0
Rural counties							
Less than 80 percent	17.1	- ^a	- ^a	- ^a	- ^a	- ^a	- ^a
80-89 percent	21.0	45.9	47.1	39.9	34.0	- ^a	- ^a
90-99 percent	23.8	23.8	23.4	30.9	35.0	68.5	67.7
100-109 percent	18.3	16.0	15.8	17.2	20.7	22.0	24.2
110-119 percent	10.9	7.3	7.1	6.7	6.7	6.8	6.5
120-129 percent	4.4	4.1	3.8	3.3	2.4	1.8	1.2
130-139 percent	2.9	1.9	1.9	1.3	0.8	0.6	0.3
140-149 percent	1.1	0.6	0.5	0.4	0.3	0.3	0.1
More than 150 percent	0.5	0.4	0.4	0.3	0.1	- ^a	- ^a

SOURCE: Author's calculations.

^a No counties in the cell.

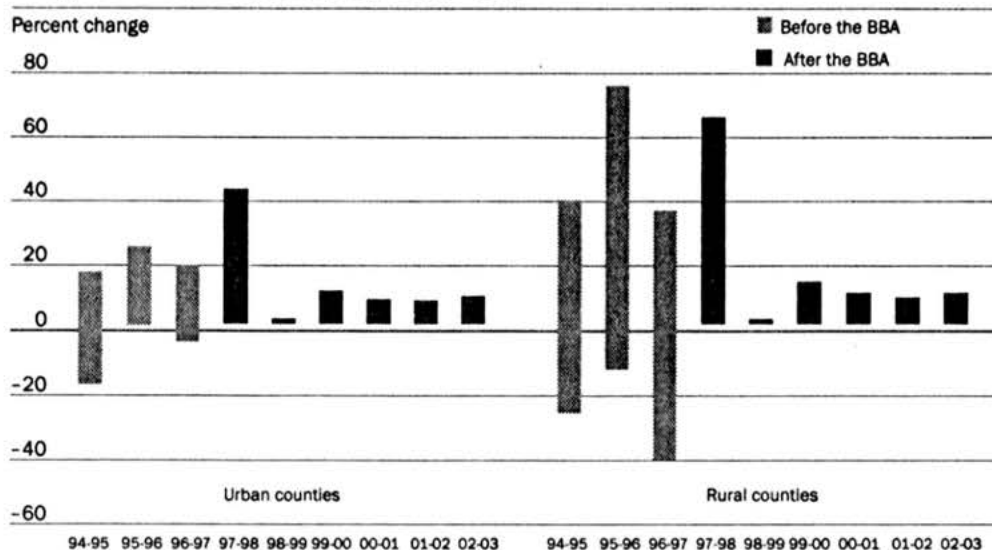
Relative importance of payment methods over time. The switch from a single payment method based on the AAPCC to a system under which the rate is determined as the highest of three alternative payment rates has generated considerable interest regarding the relative importance of the three payment methods (Exhibit 5). As noted in Exhibit 1, no county will receive a blended payment rate in 1998 or 1999. Blended rates should begin to appear in the year 2000 and will grow dramatically in importance over time, remaining consistently more important for urban areas than for rural areas. The payment floors will play an increasingly smaller role in the payments to urban areas but will remain very important for rural counties. Finally, the importance of the minimum update provision will diminish over time.⁸

These projections are quite sensitive to assumptions about future Medicare spending growth. In general, higher growth for a given year will result in a larger proportion of blended-rate counties.⁹ Thus, if HCFA's actual growth rates for future years are lower than the CBO projections used here, then the number of blended-rate counties will tend to be lower, and it is even possible that there will be no blended-rate counties in 2000 or later years.

Budget-neutrality considerations. The fact that no county will receive a blended rate in 1998 or 1999 indicates that it will not be

EXHIBIT 4

Range Of Annual Rate Changes, 1994-2003



SOURCE: Author's calculations.

NOTES: BBA is Balanced Budget Act.

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possible to implement the BBA payment changes in a budget-neutral fashion in these years. This situation arises because the BBA permits budget-neutrality reductions to be taken only from blended-rate counties. If the reductions push a county's blended rate below the floor of its minimum update rate, then the county is assigned the next-highest alternative rate and is removed from further calculations. Adjustments continue until budget-neutrality is achieved or until no blended-rate counties remain, preventing further reductions to achieve budget-neutrality.

Exhibit 6 illustrates this process for 1998. More than half of all urban counties were initially assigned a blended rate, compared

EXHIBIT 5

Relative Importance Of Payment Methods For Urban Versus Rural Counties, 1998-2003

	Percent of counties with the given rate					
	1998	1999	2000	2001	2002	2003
Urban counties						
Blended rate	0.0%	0.0%	58.3%	83.0%	88.0%	94.0%
Floor rate	14.6	17.1	9.8	5.6	3.8	1.8
Minimum update rate	85.4	82.9	31.9	11.4	8.1	4.2
Rural counties						
Blended rate	0.0	0.0	41.4	60.4	65.4	73.1
Floor rate	42.5	45.6	38.7	33.0	30.6	25.3
Minimum update rate	57.5	54.5	19.9	6.7	4.0	1.6

SOURCE: Author's calculations.

with a little more than the neutrality adjustment for rural counties. For the variance, the 2 percent finding was true for the importance of the mean differences between rate (that is, the maximum in pursuit of budget margins translated initial blended rates next-best rate and the

Discussion

The BBA is likely methodology to the particular, will help whereas the 2 percent that no county ever year to the next. Even payment rates will be

The higher and more counties more attractive wishing to serve Medicare Choice program. Of the decision to offer remains to be seen whether sufficient to increase rural areas. HCFA re

EXHIBIT 6

Impact Of 1998 Budget

Counties initially assigned a blended rate in 1998	Number of counties
Urban counties (n = 835)	426
Rural counties (n = 2,281)	813
All counties (n = 3,116)	1,239

SOURCE: Author's calculations.

NOTE: Budget-neutrality adjustment rates.

with a little more than a third of all rural counties. Thus, the budget-neutrality adjustments were taken disproportionately from urban counties. For the vast majority of counties initially given a blended rate, the 2 percent minimum update was the next-best rate; this finding was true for rural as well as for urban counties, despite the importance of the floor payments for rural areas in general. The mean differences between the initial blended rate and the next-best rate (that is, the maximum amount blended rates could be reduced in pursuit of budget-neutrality) averaged only \$4-\$5. These small margins translated into only about a 1 percent reduction from the initial blended rates before all blended counties converted to their next-best rate and the budget-neutrality calculations stopped.

Discussion

The BBA is likely to improve the Medicare risk plan payment methodology to the benefit of most rural areas. The payment floor, in particular, will help to boost payments for many rural counties, whereas the 2 percent minimum update provision will guarantee that no county ever receives a decrease in payment rates from one year to the next. Even with these improvements, however, rural payment rates will continue to lag behind urban rates.

The higher and more predictable payments should make rural counties more attractive to managed care plans and other providers wishing to serve Medicare beneficiaries under the new Medicare+Choice program. Of course, many other factors also may enter into the decision to offer a Medicare managed care product, and it remains to be seen whether the changes wrought by the BBA will be sufficient to increase the availability of Medicare+Choice options in rural areas. HCFA received only three applications for the coming

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EXHIBIT 6

Impact Of 1998 Budget-Neutrality Adjustments

Counties initially assigned a blended rate in 1998	Number of counties	Mean blended rate before budget-neutrality	Next best rate is	Number of counties	Mean difference between blend and next-best rate	Mean percent reduction from blend	Mean final rate	Mean percent increase over 1997 rate
Urban counties (n = 835)	426	\$420.91	Floor 2% update	30 396	\$5.21 4.60	-1.39% -1.12	\$367.00 420.00	3.31% 2.00
Rural counties (n = 2,281)	813	399.31	Floor 2% update	92 721	3.72 3.73	-1.00 -0.93	367.00 399.24	3.07 2.00
All counties (n = 3,116)	1,239	406.74	Floor 2% update	122 1,117	4.09 4.04	-1.09 -1.00	367.00 406.60	3.13 2.00

SOURCE: Author's calculations.

NOTE: Budget-neutrality adjustments in 1998 resulted in all blended-rate counties being converted to floor or minimum update rates.

year from providers wishing to form provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs)—the plan types expected to be more feasible and attractive in rural areas—and some existing Medicare HMOs have recently withdrawn from selected markets rather than expanding to rural areas.¹⁰

It also is as yet unknown whether any new managed care options that are offered in rural markets will be attractive to rural beneficiaries. Traditionally, beneficiaries have enrolled in managed care plans because of these plans' additional benefits. Anecdotal reports in the past year indicate that plans may have begun to scale back these added benefits in response to lower-than-expected payment increases. If plans entering rural markets do not offer the more generous benefits traditionally offered by their urban counterparts, then rural beneficiaries may be less likely to enroll.

Even with no positive enrollment response, the BBA payment changes will not be budget-neutral for the first two years. A large enrollment increase in counties whose rates have increased dramatically would require the budget-neutrality adjustment to be more aggressive than modeled here, further reducing blended rates and possibly even the number of blended-rate counties. If there are not enough blended-rate counties, or if their rates are not sufficiently above the floor and minimum update rates, the Medicare program will continue to be unable to finance the floor and minimum update payments in a budget-neutral fashion beyond 1999. An actual growth rate that is below the growth rates assumed for this Data-Watch could bring about a similar situation.

In sum, although the BBA has accomplished the goal of increasing rates in low-payment areas, Medicare has been left to pay a larger bill than anticipated. As long as the minimum updates and floors are protected by statute, the BBA budget-neutrality provision cannot be a binding constraint. HCFA has recently signaled its interest in seeking a legislative change to correct this problem.¹¹

Ironically, even with these higher aggregate expenditures, the BBA payment rates may not be adequate to entice Medicare+Choice plans to enter rural markets and may even be causing plans to leave some urban markets. Thus, it appears likely that rural advocates and provider groups will seek higher payments in the next legislative session. This action will, of course, exacerbate budget-neutrality difficulties. In the end, policymakers may have to weigh the cost of increasing payments against the goal of ensuring equal access to the range of choices under Medicare+Choice.

Several aspects of the new payment methodology are not specified in detail in the BBA or are subject to change, and these features can be expected to change the rates simulated here. Chief among

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these factors is the risk-adjustment method that HCFA is to begin implementing in the year 2000. Future simulations should assess the redistributive impacts of changes related to risk adjustment. Another factor that could change is the way that input price adjustments are made. Although the BBA specified that existing hospital wage indices and geographic adjustment factors be used for 1998, the legislation granted the secretary of health and human services discretion to develop new price-adjustment mechanisms for later years. The Medicare Payment Advisory Commission (MedPAC) has recently recommended creating new price indices that would be more reflective of the costs faced by Medicare managed care plans.¹²

Finally, several other issues are likely to receive continued policy attention and may affect the determination of payment rates in the future. Removal of Medicare payments for disproportionate-share hospitals from the base rates was debated at the time the BBA was under consideration, and MedPAC has indicated that this issue is still worthy of attention. Increasing base rates to reflect payments for services Medicare beneficiaries received in military and Veterans Affairs (VA) facilities has garnered somewhat less attention but also is of continued interest. Although these two adjustments would approximately negate one another at the national level, they may have very different net impacts at the county level. Lastly, the finding that rural payment rates will continue to fall below urban rates even after the BBA is fully implemented may spark policy interest in moving to a more aggressive blending formula, or even to a fully national rate once improved risk adjusters are available.¹³

Elements of this paper were presented as a poster session at the May 1998 meetings of the National Rural Health Association in Orlando, Florida, and at the June 1998 meetings of the Association for Health Services Research in Washington, D.C. The author acknowledges the assistance of Michael Cheng with aspects of the budget-neutrality calculations and the substantive input of Curt Mueller during early phases of the simulations. This work was funded by the Office of Rural Health Policy (ORHP), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS). The views expressed are those of the author and do not necessarily reflect those of the ORHP or Project HOPE.

NOTES

1. See S. Palsbo, *The Demographic Factors Explained*, Research Brief no. 10 (Washington: Group Health Association of America, February 1990); S. Palsbo, *The AAPCC Explained*, Research Brief no. 8 (revised) (Washington: GHAA, October 1991); and S. Palsbo, *The USPPC Explained*, Research Brief no. 5 (revised) (Washington: GHAA, July 1992).
2. T. McBride, "Setting the Price for Medicare Risk Contracts in Rural Areas" (Presentation at the Robert Wood Johnson Foundation Invitational Policy Conference, Washington, D.C., 9 May 1997); Physician Payment Review Com-

- mission, *Annual Report to Congress* (Washington: PPRC, 1997), 59-62; and Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (Washington: ProPAC, June 1997), 35-45.
3. Although lower rates are not necessarily problematic if they accurately reflect lower costs of producing services or a lower need for services, they are problematic if they are depressed for reasons unrelated to these factors (for example, difficulties in accessing the health care system). If Medicare expenditures in rural areas historically have been lower than would have been expected given input prices and the health status of the population, then AAPCC rates based on these spending patterns are artificially low as well.
 4. ProPAC, *Medicare and the American Health Care System: Report to the Congress* (Washington: ProPAC, June 1997), 41-42, 52; M. Casey, "Serving Rural Medicare Risk Enrollees: HMO's Decisions, Experiences, and Future Plans," University of Minnesota Rural Health Research Center, Working Paper no. 19 (November 1997); and C. Serrato, R. Brown, and J. Bergeron, "Why Do So Few HMOs Offer Medicare Risk Plans in Rural Areas?" *Health Care Financing Review* (Fall 1995): 85-97.
 5. ProPAC, *Medicare and the American Health Care System*, 44; and PPRC, *Medicare Managed Care: Premiums and Benefits*, Basics no. 4 (Washington: PPRC, April 1997).
 6. This growth rate is to be projected by the HHS secretary by March of the year prior to the year for which rates are being determined. The BBA also specifies that these projected growth rates must be reduced by defined "offset percentages" through the year 2002 (for example, the rate projected for 1999 is to be reduced by 0.5 percentage points). There is also an adjustment mechanism that is to be used after the first year to correct retrospectively for under- or overprojections in prior growth rates.
 7. L. Greenwald et al., "Risk Adjustment for the Medicare Program: Lessons Learned from Research and Demonstrations" (Paper presented at the Robert Wood Johnson Foundation invitational meeting, "Health Based Payments: What Do We Know about Risk Adjustment?," 29 January 1998); and *Federal Register* 63, no. 173 (8 September 1998): 47506-47513.
 8. In its March 1998 report to Congress, the Medicare Payment Advisory Commission pointed out that those few counties still paid under the 2 percent minimum update in 2003 will eventually convert to the blended rate as long as the Medicare growth rate remains above 2 percent (p. 18). These conversions will leave only blended-rate and floor-rate counties. With both of these types of rates increasing annually by the same Medicare growth rate after 2003, there will be no further switching between the types of payment rates, and any remaining differences in payment levels between urban and rural counties will be perpetuated.
 9. J. Schoenman, "Impact of the Balanced Budget Act of 1997 on Medicare Risk Plan Payment Rates for Rural Areas," Final Report submitted to the Office of Rural Health Policy, Contract no. CSURC00005-01-2 (December 1997), 9-11.
 10. N. Jeffrey, "Medicare Gets Weak Reply to Request for New Types of Health Programs," *Wall Street Journal*, 8 September 1998, B8.
 11. *Federal Register* 63, no. 123 (26 June 1998): 35005.
 12. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy, Volume I* (Washington: MedPAC, March 1998), 23.
 13. *Ibid.*, 19, 21-23.

BOOK REVIEWS

An Unusual View Of Health Economics

BY BRYAN DOWD

The Economics of Health Reconsidered

by Thomas Rice

(Chicago: Health Administration Press, April 1998), 251 pp., \$50 (cloth), \$40 (paper)

In *The Economics of Health Reconsidered*, Tom Rice has provided a highly critical review of health economics and its application to health policy. The book builds on Rice's April 1997 article in the *Journal of Health Politics, Policy and Law*, which was named the 1998 Article of the Year by the Association for Health Services Research. Although I do not agree with all of Rice's analysis, I found it thought-provoking, and many of his points deserve more attention than they typically receive in a standard health economics course.

The organization of the book is unusual. Standard microeconomics texts usually present the theory of consumers, the theory of firms, the intersection of the two (general equilibrium theory), market pathologies, and welfare economics, in that order. Rice's book begins with general equilibrium theory, thus requiring discussion of consumer and firm behavior without any background in demand and supply. The reason for the odd ordering is that the purpose of the book is to undermine the reader's trust in the efficiency of perfectly competitive markets. Rice does not argue that the standard result is wrong but, rather, that the entire competitive model is inapplicable to the health care industry.

Rice points out several ways in which health care markets fail to meet the requirements of perfect competition. Some of these

ways are the usual suspects, such as poor information and distorted prices, while others (envy and altruism) may be less familiar. Rice also argues against using welfare analysis, in general, and consumer preferences in particular, as the basis for evaluating health policy proposals. I simultaneously suggest a different organization of the material and comment on Rice's analysis.

I would recommend starting the book with Rice's chapters 3 and 4 (demand and supply theory) but would limit the discussion to the standard results. Next I would cover the general equilibrium results in chapter 2, making sure that the standard results were fully appreciated. Following presentation of the standard theory, I would begin the discussion of market failure, starting with two most serious forms of "natural" market failure: decreasing marginal costs and pure public goods.

■ **Causes of market failure.** Rice's discussion of decreasing marginal costs (pp. 119-120) is incomplete, mixes results on quality with results on costs, deals only with hospitals, and unjustifiably generalizes results to the entire "health care area."

I found no reference to pure public goods per se. The omission may be due to the fact that neither health insurance nor health care services are pure public goods, but if we are to have a balanced analysis of the role of government based on a standard economic framework, it is necessary to discuss the findings that do not support our position, as well as those that do.

Even if we agree that health care markets pass the first hurdle of decreasing marginal costs and pure public goods, we still must ask how likely competitive markets are to produce efficient equilibria. Four possible problems stand in the way: poor information, restricted entry to and exit from the market, distorted prices, and externalities (spillover costs and benefits).

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s, such as poor incomes, while others are less familiar. Rice's welfare analysis, inferences in particular health policy suggest a differential and comment

ting the book with demand and supply discussion to the could cover the general chapter 2, making its were fully representation of the gain the discussion with two most serious failure: decreasing public goods.

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pure public goods be due to the fact of health care costs, but if we are to the role of government economic framework discuss the findings position, as well as

health care markets increasing marginal we still must ask markets are to provide possible problem information, reform from the market, externalities (spillover

Rice references the long-standing debate in the health economics literature over the degree of consumer information required to support a competitive market. He quotes Frank Sloan, Roger Feldman, and Mark Pauly's opinion that a few well-informed consumers may be able to discipline a market (p. 69) and then counters with a quote from Uwe Reinhardt, who argues that experts lack adequate information on consumers' specific needs, and vendors have ulterior motives. Ironically, Reinhardt (who wrote the book's foreword) identifies precisely the information flaw in full-blown national health insurance systems, since in those systems the government is both the expert that allocates resources and the vendor that supplies them.

Rice devotes very little discussion to restricted entry (for example, physician licensure). Restricted entry in health care markets is, for the most part, not a natural problem. It often is the result of government policy, used to counter the problem of poor consumer information. The proper question is whether government restrictions on market entry are efficiency-enhancing.

Rice appropriately devotes most of his discussion of distorted prices to the effect of moral hazard on the estimated welfare loss of "excess" health insurance. An analysis I did with Roger Feldman found that consumers purchased "excess" private insurance (beyond the point at which marginal benefits equal marginal cost), and the resultant welfare loss could be more than \$100 billion a year (in 1984 dollars).¹ Rice argues that our estimates are inflated because consumers are unable to judge the quality or effects of medical treatment. We believe that poor consumer information would make our estimates conservative.

Externalities are a crucial part of Rice's analysis. Rice argues that allocating resources on the basis of individual demand for health care services will lead to inefficiency because lavish consumption of health care services by the wealthy creates a negative externality in the form of envy on the part of lower-income people. Although no one can deny the existence of envy, I object to Rice's appeal to envy

as a justification for forced, uniform consumption of health care services, for several reasons. First, the welfare losses resulting from envy may be offset, or even more than offset, by welfare gains by pretentious consumers who enjoy maximizing the distance between their consumption and that of others. Second, in the absence of a clever mechanism designed to elicit honest appraisals of envy, self-reported levels would be a foolish and dangerous basis for public policy. Third, Rice's discussion contains no mention of moral justification, liberty, or rights, and envy in the form of "coveting" is expressly prohibited by the moral code to which most Americans at least nominally subscribe. Rice argues that moral distinctions have no place in economic assessments (p. 31). Even if I agreed, which I do not, I still would insist that seizure of property or property rights be justified on the grounds of economic efficiency as well as morality.

Altruism, on the other hand, not only is affirmed in the moral code, but its presence and extent are empirically verifiable: We observe people voluntarily transferring their income to others. Rice acknowledges the importance of "participation" altruism in explaining behavior such as voting and recycling (p. 156), but he fails to note that there is no market failure associated with participation altruism. He points out that altruism based on the income, welfare, consumption, or health status of others can suffer from collective-action and public-good problems. This is an important part of the book. However, Rice's position would be better served if the discussion were not scattered throughout the book (pp. 33-34, 79-81, and 155-163). Also, there is no discussion of private solutions to externalities; collective-action problems and public-good problems are discussed at length (pp. 78-79 and 155), but they never are referred to by those names; and there is no reference to the primary sources on this topic, including Mancur Olson's seminal analysis, *The Logic of Collective Action* (Harvard University Press, 1965). My own opinion is that neither consumption externalities nor the collective-action or pure public-good problems associated

with charity provide a compelling case for either public financing or public provision of health care services to the general population purely on efficiency grounds.

Rice also objects to using consumer preferences, as embedded in standard welfare analysis, as a foundation for judging the efficiency of alternative health care reform proposals. It is important for advocates of national health insurance to discredit consumer preferences because, as Rice reports, only 23 percent of the U.S. population agrees with the statement: "It is the responsibility of the government to take care of the very poor people who can't take care of themselves" (p. 163). Taken at face value (albeit a dangerous exercise with surveys), that means that 77 percent of the U.S. population doesn't even support the current Medicaid program, much less further government-based redistribution.

■ **Fairness.** The discussion of fairness brings us to what I think is the main point of the book. In standard economic theory there is no necessary relationship between competitive markets and the fairness of the distribution of resources. In contrast, Rice thinks that competition has contributed to unfairness by increasing the financial pressure on providers so that they no longer can afford to provide charity care. This topic needs additional empirical work. I could agree that increased competition might necessitate more explicit mechanisms for charity. But reduced prices resulting from competition also may reduce the need for charity.

Market failure, as found throughout the health care industry, results in competitive equilibria that are inefficient, but society nonetheless may judge those inefficient equilibria to be fair. Thus, imperfect competition does not preclude attainment of a fair final distribution.

Fairness has a value to consumers, just as efficiency does. In some cases, correcting intrinsic sources of market failure, such as poor

consumer information, may cost more than the improvement in efficiency is worth to consumers. The same is true of fairness. "Fairness at all cost" may be seductive rhetoric, but from a purely economic viewpoint, it is as nonsensical as "efficiency at all cost."

Rice believes that both the current method of distributing health care resources and the distribution itself are unfair. Many health economists would agree. He argues for an allocation system based on determination of need and a distribution of health care services that is equal across all members of society, after adjusting for "need" (pp. 160-162). Contrasting this system with one that provides a minimal floor of services to those who otherwise could not afford it reveals the crucial role of envy in Rice's analysis. A

minimal floor might satisfy the altruistic desires of consumers, but only equality of consumption can eliminate envy. Rice makes a plea for putting fairness issues first, followed by efficiency concerns, but I am left with the feeling that I am being asked to put envy first, followed by efficiency. I also am concerned that while Rice is quick to question the reliability of consumers' preferences over their own consumption, he seems quite sanguine about converting consumers' preferences regarding the consumption of others directly into public policy.

Rice also favors national health insurance proposals that address fairness through the use of in-kind transfers (in the form of health care services) rather than cash transfers, because donors prefer them to cash transfers (pp. 157-158). Donors' preferences are defensible criteria, but I wonder if Rice would be equally enthusiastic about donors' preferences if they included conditions on recipients' behavior, such as refraining from having children out of wedlock.

Rice favors comprehensive coverage in NHI systems, rather than point-of-purchase cost sharing (pp. 81-101 and 129-135). The

"The U.S. health care system is by no means ideal, but neither is it adrift. Rather, it is the aggregate of hundreds of tradeoffs."

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fairness argument against point-of-purchase
 cost sharing is that poor people can't afford it.
 The standard reply is that there is no reason to
 impose the inefficiency of first-dollar coverage
 on the whole health care system to address
 the fairness concerns of poor people. Means-
 tested waivers of coinsurance, deductibles,
 and out-of-pocket premiums, like those al-
 ready in place in the Medicare program, pro-
 vide a solution. Of course, Rice does not be-
 lieve that zero cost sharing increases
 inefficiency, but he and I disagree about that.

■ **Summary.** The central question, as
 Pauly notes, is not whether our current sys-
 tem is optimally efficient or fair.² The central
 question is whether the efficiency and fair-
 ness problems that exist are addressed best by
 imperfect government or by imperfect mar-
 kets.

Rice's objective is to have national health
 insurance proposals begin on an equal footing
 with market-based proposals for health care
 reform (p. 168). Before I could agree to that,
 someone would have to go further than point-
 ing out market imperfections that are, for the
 most part, well recognized by health econo-
 mists and common to many sectors of the
 economy that seem to function well enough. I
 would have to be shown that the problems of
 regulatory capture, self-serving and self-per-
 petuating bureaucracies, homogeneity res-
 trictions (imposed on government charity
 but not private charity), and a host of other
 sources of "government failure" are less prob-
 lematic than market failure is. I also would
 have to understand why the outcome of a na-
 tional health insurance proposal would differ
 from Medicare—the best example we have of
 our government's inability to run a national-
 ized health insurance system. Medicare ap-
 pears to have taken up permanent residency
 on the brink of fiscal insolvency; has been
 blocked politically from implementing even
 the simplest efficiency-improving competi-
 tive-bidding arrangements; would not be able
 to provide its beneficiaries with anything ap-
 proaching the benefits enjoyed by the pri-
 vately insured population were it not for an
 irrational HMO payment system and con-

tracts with private-sector health plans; and
 transfers income from the poor to the
 wealthy.

The U.S. health care system is by no means
 ideal, but neither is it adrift. Rather, it is the
 aggregate of hundreds of tradeoffs. Restricted
 market entry counters poor information. Risk
 protection is traded against moral hazard.
 Moral hazard also is countered by the restric-
 tions of managed care. The awkwardness of
 employment-based health insurance counters
 adverse selection. Any of these decisions
 could be wrong. All constantly are being
 called into question, mostly by U.S. health
 economists. The same is true of our decisions
 regarding fairness. The working poor pay
 taxes to subsidize the health insurance premi-
 ums of aged multimillionaires. Our Medicare
 HMO payment policy allocates the most gen-
 erous benefits to the healthiest beneficiaries,
 while the old and poor remain in a bare-bones
 fee-for-service system. These decisions pro-
 vide the best evidence of our government's in-
 ability to allocate health care resources fairly
 and efficiently, and I do not find in them any
 encouragement for the national health insur-
 ance position.

As Pauly noted in 1997, "[Economic] theory
 tells us that, at best, the ideal market can tie an
 ideal government, not that it can do better."³
 The reverse also is true. But the ideal govern-
 ment can tie the ideal market only if consum-
 ers are indifferent between bundles of goods
 that they are assigned and bundles of goods
 that they freely choose. As Rice reminds us
 twice (pp. 81 and 155), "It does not take much
 introspection to realize that the latter may in-
 deed result in higher utility." We need more
 such introspection, and if Tom Rice's work
 can inspire it, his work will deserve even more
 awards than it has already received.

NOTES

1. R. Feldman and B.E. Dowd, "A New Estimate of the Welfare Loss of Excess Health Insurance," *American Economic Review* (March 1991): 297-301.
2. M.V. Pauly, "Who Was That Straw Man Anyway? A Comment on Evans and Rice," *Journal of Health Politics, Policy and Law* (April 1997): 467-473.
3. Ibid.

Bloody Business

BY ROBERT M. GOLDBERG

Bleeding Edge: The Business of Health Care in the New Century

by J.D. Kleinke

(Gaithersburg, Md.: Aspen Publishers, September 1998), 362 pp., \$30

Bleeding Edge is a readable and original contribution to our understanding of the chaos and discontent spreading throughout the U.S. health care system. J.D. Kleinke argues that integration of health care—the reorganization of services into a one-stop array of provider groups that people can choose from—is changing forever the way medicine is practiced and care is delivered. Second, providers and producers of health care services can no longer depend on a guaranteed profit based on their “cut” of the health care dollar. To survive, let alone prosper, providers at all levels must assume the financial risk of care.

Although many other observers claim that health care is rapidly becoming market driven, Kleinke correctly notes that the change is slow (thanks to government regulation) and long overdue. The fact is that while almost every other industry is racing to become more responsive, innovative, productive, and profitable en route to the twenty-first century, most of health care (except when it comes to sending out bills or collection notices) operates according to preindustrial principles of organization and enterprise.

In a market economy, Joseph Schumpeter wrote, “the impact of new things . . . on the existing structure of an industry considerably reduces the long-run scope and importance of practices that aim, through restricting output, at conserving established positions and at maximizing the profits accruing from them.”¹ In health care such barriers are still the path

to profitability. Utilization review, gatekeepers, prior authorization for the use of new drugs and devices, and the effort to slash costs without regard to outcomes or quality are the tools that insurers and health plans use to reduce the availability of novel goods and services. Moreover, the ability of health maintenance organizations (HMOs) and insurers to ward off new forms of health care delivery has been critical to earnings growth over the past decade. Indeed, no other industry over the past thirty years has undergone fewer changes or new challenges to the existing order than health care has.

Throughout this century, hospitals and doctors have never reorganized in ways to compete for the increasing amount of cash people have been willing to spend on medical care. In fact, physician-led programs did seek to go directly after consumers by offering integrated acute health care systems. (The most famous was the partnership of the Mayo brothers and five Catholic sisters to create the Mayo Clinic.) But, as Kleinke notes, opposition by medical associations, particularly the American Medical Association (AMA), to such arrangements made it difficult for more doctors to follow suit. The AMA did not want individual doctors to have to compete with organized care systems. Doctors and hospitals reached an uneasy accommodation to avoid forms of care and insurance that would have easily led to a stronger entrepreneurial role for hospitals and insurers. Both doctors and hospitals aggressively sought to enforce these agreements through legislation if possible and by illegal boycotts when necessary.

For the most part, the financing of health care and insurance coverage was limited to services provided in the hospital, even though the Mayo model showed that they could have been offered in a doctor's office. And since patients wanted services to be covered by insurance, doctors practiced medicine in hospitals. As Kleinke concludes, the treatment of employer-based health insurance as a tax-free benefit only accelerated a monopolistic ar-

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rangement that discouraged competition and entrepreneurial activity.

If this still is the case, why aren't managed care organizations and provider groups becoming more profitable instead of less? Because, according to Kleinke, even the slightest amount of competition for market share is forcing health care companies to behave differently. Once insurers and HMOs scooped up all of the healthy people, they had to take on chronically ill consumers to expand. The prepayment of services combined with low copayments has led to significant overuse and misuse of medical resources by persons who are healthy and for whom a day in bed (at home) would be the best course of treatment. Meanwhile, restrictions on access to specialists often compounds the cost and morbidity associated with the most costly illnesses. It is easy to see why health care companies cannot stop their financial hemorrhaging in their present form.

The fight for financial survival has led most companies to try to capitate the cost of care and leave others to assume the risk of treatment. Most of *Bleeding Edge* describes how competition for survival will lead to the integration of health care services—a process Kleinke calls *industrialization*. It is not pretty, more like the beaches of Normandy than the Microsoft campus. The hopes, expectations, and profits of every provider, from the sole practitioner to the largest HMO, are being crushed by the spread of capitation and the ceaseless demand for efficiency, quality, and accountability.

In this phase of integration, managed care and insurance giants seem to rule the land, but they are regarded by Kleinke as emergent life forms at the bottom of the evolutionary ladder. What happened to GM and IBM under the lash of competition will happen to Oxford and Aetna. Indeed, HMOs and large insurers are crumbling and retreating, trying to hand over the responsibility of making medical decisions—and the financial risk that goes along with them—to (surprise!) the doctors and institutions that managed care claimed were the problem in the first place.

In response to this shift, doctors and hospitals are consolidating, creating physician practice management companies and a vast collection of hospitals and related services under the ownership of a single corporate entity. These new forms of organization also are finding it hard to make a buck. They are not nearly as integrated or as efficient in reducing the cost of care in ways that keep consumers happy as they will have to be to stay alive.

Kleinke predicts that ultimately the innovations that will replace both forms of health care delivery not only will provide people with medical care but also will manage their own financial risk without the help of HMOs or large insurance companies. Hence, what Kleinke calls the "emerging health organization" (EHO) seems to be more like a mutual fund than any other type of business. One classic example of an EHO is the Choice Plus program organized by the Buyers' Health Care Action Group (BHCAG), an employers' health care purchasing group in Minnesota. Choice Plus provides consumers with the money to choose among integrated health groups that use a large clinic and teaching hospital as the hub for coordinating care. Consumers select groups based on cost and quality. Choice Plus does its own risk pooling and risk adjustment, cutting out traditional insurers and HMOs altogether. In recent years, competition has led to a shift in market share toward groups offering the best value and an overall reduction in what employers spend on each employee.

But BHCAG reveals a fundamental truth overlooked by Kleinke and others who have offered insights into the value of market competition for health care: Market forces do not emerge without conscious effort. If we want a health care market, we will have to build one in the same way that democratic nations have helped Communist countries in a similar transition. And, as Kleinke's book shows, this will be a beneficial but bloody process.

NOTE

1. J. Schumpeter, *Capitalism, Socialism, and Democracy* (New York: Harper Collins, 1962), 107.

LETTERS

We welcome your responses to papers that appear in *Health Affairs*. Please keep your comments brief (500-750 words) and sharply focused. *Health Affairs* reserves the right to edit all letters for clarity and length. Letters can now be submitted via e-mail (healthaffairs@projopec.org) or the *Health Affairs* Web site (www.projopec.org/HA).

Health Spending: Questioning The Assumptions

To the Editor:

The Health Care Financing Administration's (HCFA's) projections of national health spending ("The Next Ten Years of Health Spending: What Does the Future Hold?" *Health Affairs*, September/October 1998) offer new insights into future trends in health spending. Although the HCFA projections of total health spending are only about 10 percent higher than those of the Congressional Budget Office (CBO), they embody a substantially different assumption about the relative growth rates of Medicare and private health insurance spending. That assumption is embedded deeply in the projection model chosen and reflects sharp differences in the interpretation of changes in the health sector over the past several years and likely future trends.

The HCFA team projects that the growth of Medicare spending will lag behind that of private insurance premiums, even after the savings provisions of the Balanced Budget Act (BBA) of 1997 have expired.¹ In effect, the HCFA model implies that the growth of costs for Medicare's unlimited fee-for-service (FFS) insurance will be slower than that of private plans, most of which now manage costs or care. That result is not plausible as the basis for a long-run projection.

HCFA chose a projection model explicitly based on extrapolation of long-run trends—specifically, the rate of growth of health spending in relation to disposable income. It assumed that slow premium growth in recent years is largely due to the shift from FFS to managed care. In effect, the authors argued

that movement from high-cost (FFS) plans to lower-cost (managed care) plans has caused most of the slowdown in the growth in premiums and benefits overall. Now that most privately insured persons are in managed care, they reason, growth of aggregate premiums will not slow much more and will nearly return to its historical trend.

The preceding summary is highly simplified. For one thing, the HCFA analysts introduced what they termed a "small reduction" in the projected growth of spending as a result of the continuing impact of managed care. Also, this summary does not do justice to the highly detailed actuarial factors, involving trends in use, prices, and residual growth of each type of service, that HCFA's analysts used. Nevertheless, I believe that it is a fair representation of their theory and its result.

Although the techniques that HCFA used are sophisticated, the result boils down to one key assumption. That is, that these developments during the 1990s—changes in purchasers' behavior, the spread of managed care, and increased competitiveness—will have only one-time effects. I believe that each of these developments will have significant long-term effects on both the rate of spending growth and its level. Although private insurance benefits over the next ten years will likely grow more rapidly than during the mid-1990s, I expect that the average rate will be much lower than it was over the twenty years prior.

The HCFA analysts characterized the mid-1990s as a period in which people switched from high- to lower-cost plans. In my view, recent changes in the health sector are much more complex. The striking thing about the experience of the mid-1990s is how the rate of growth of premiums in all types of plans slowed dramatically, as exemplified by trends in health care premiums for the companies surveyed by the Hay Group, primarily large and medium-size firms.² In recent years the Hay report has separated trends into two concepts: (1) the weighted average of same-

LETTERS

company and aggregate of all data. The firm the impact of low-cost plans the impact of trends are the same-plan trends employees are in lower-cost plans same-company shows that story.

I believe that the increase in health care is a progressive behavior. This, another trend of the past has reached the markets. Workers and physicians down and to productivity series of "one" contain cost

EXHIBIT 1 Excess Of P 1990-2007

Percentage point

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SOURCES: Congressional Budget Office
NOTES: GDP is gross domestic product

company and same-plan data, and (2) the aggregate of all companies and prevalent plan data. The first concept attempts to exclude the impact of switching from high-cost to low-cost plans; the second, in effect, includes the impact of that switching. Prevalent plan trends are lower than the same-company/same-plan trends, which indicates that employees are indeed switching from higher- to lower-cost plans. However, the fact that the same-company/same-plan trends remain low shows that switching plans is only part of the story.

I believe that a key factor behind the slowing of premium growth in the mid-1990s was the increased degree of competitiveness in health care markets. Although purchasers' aggressive behavior might account for some of this, another cause could be that the proportion of the population in managed care plans has reached a critical mass in many important markets. When the latter occurs, hospitals and physicians feel pressure to keep prices down and to cut costs. As in other industries, productivity improvements often come from a series of "one-time changes," and pressure to contain costs leads to a process in which a

new crop of "one-time changes" is developed and implemented each year. For health care establishments, these changes have taken the form of slow growth in unit costs and wage growth that more closely matches that of the rest of the economy.³ If health care providers feel pressure to continually cut costs and perceive real competition from other providers, the result can be a permanent effect on the rate of growth the prices they receive.

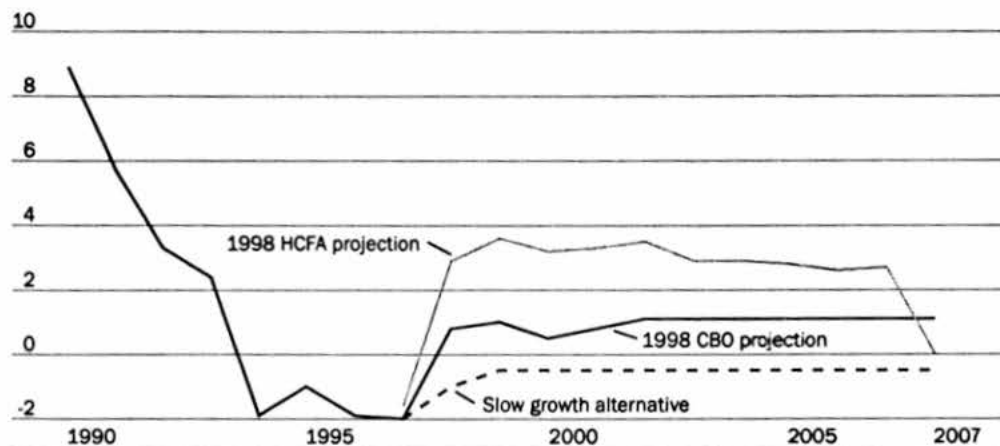
I have modeled the effect of HCFA's projections based on the assumption that managed care would have primarily a one-time effect, a hypothetical alternative assumption in which managed care would have primarily a permanent effect, and the CBO's assumption, which represents a middle approach (Exhibit 1).⁴ Although some of the contribution of managed care to the slowing of growth in premiums is likely to be a one-time effect, the competitiveness of markets is forcing managed care plans to manage care more effectively and providers to continually seek to lower their costs. On balance, I am more comfortable with the CBO's assumption.

Nevertheless, I expect rates of increase of private health insurance premiums to start

EXHIBIT 1

Excess Of Private Premium Growth Over GDP Growth, Based On Three Assumptions, 1990-2007

Percentage points



SOURCES: Congressional Budget Office (CBO), Health Care Financing Administration (HCFA), and the author.

NOTES: GDP is gross domestic product. Excess premium growth averaged four percentage points during 1961-1997.

spiking up sometime, at least temporarily. Premium increases have been less than underlying cost increases for some time now, and signs that the underwriting cycle is turning—the exit of insurers from markets in which they are doing poorly and little entry into new markets—suggest that premium increases will soon exceed cost increases. But there are few early indications that the underlying benefit costs for private plans (which determine premiums in the long run) are soon headed back toward the 8 percent growth rate implied by HCFA's projections.

PAUL B. GINSBURG

CENTER FOR STUDYING HEALTH SYSTEM
CHANGE
WASHINGTON, D.C.

NOTES

1. The author projects that the growth rate of both aggregate Medicare spending and private insurance premiums will be about 8 percent per year. Assuming that Medicare enrollment will grow faster than the number of persons covered by private insurance in the projection period, HCFA's projections imply that Medicare spending per enrollee will grow more slowly than private insurance spending.
2. *Hay Benefits Report, 1993-1997*. The Hay survey is not drawn from a random sample, and its findings may not be definitive. Nevertheless, results are generally consistent with other surveys of employers on the levels and trends of health costs or premiums by type of plan. Data for 1998 are courtesy of Edwin Hustead and Michael Carter of the Hay Group.
3. National Hospital Panel Survey data from the Trend Analysis Group, American Hospital Association.
4. Congressional Budget Office, "Projections of National Health Expenditures: 1997-2008," in *Economic and Budget Outlook* (Washington: CBO, January 1998).

Functioning In A Different Health Economy

To the Editor:

Because "The Next Ten Years of Health Spending" was a front-page story in the nation's newspapers, we must critically review the assumptions behind the projections, so as not to mislead opinion- and policymakers.

Sheila Smith and her colleagues forecast

that national health care spending will rise from 13.6 percent to 16.6 percent of gross domestic product (GDP). They note:

In a reversal of recent trends, the higher anticipated growth in real per capita national health spending will be driven almost entirely by rising expenditures in the private rather than the public sector (p. 128).

They see growth in private, third-party spending accelerating from 2.9 percent a year in 1996 (the last year for which HCFA has data) to 7.4 percent a year in 2007. Underlying this projection is the belief that managed care is largely a one-time savings. With only 14 percent of workers still in indemnity coverage, the authors foresee an end to the slowdown in health care spending that has occurred throughout the 1990s, because we have virtually exhausted our supply of indemnity enrollees to convert to managed care.¹

I believe that these authors have inadequately credited and understood how managed care has altered the expectations and ethos of employers and providers. After a decade of actively restructuring their health care plans to reduce medical expenses, employers will not simply roll over and pay the bill for inflationary rates of this magnitude. Since 1993 the annual rate of increase in premiums among firms with 200 or more workers has averaged just 2.6 percent a year. Employers don't expect and will not pay for 1980s-like premium increases. Both employers and employees will vote with their feet for less expensive health plans.

The major savings come from how providers' behavior changes when large numbers of consumers enroll in managed care. The dominance of managed care has imposed a cost-consciousness on providers that most analysts failed to predict a decade ago. The rate of increase in prices, use of services, and adoption of cost-increasing technologies will be far slower in a system in which providers must live within budgets that simply did not exist when indemnity insurance was dominant and when providers essentially could charge as they wished.²

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There remain many cost-saving measures that employers have not adopted. For example, generic drugs constitute the same percentage of prescriptions in health maintenance organizations (HMOs) as they do for health care overall.¹ Among firms offering multiple health plans, only 12 percent do not subsidize more-expensive health plans through higher premium contributions.⁴ HMOs have barely tapped their potential for using information systems to identify patients who fail to comply with their physicians' recommendations and physicians who fail to comply with clinical guidelines.

Statistics in my paper with Paul Ginsburg in the same issue of *Health Affairs* are at odds with these authors' gloomy view of the future.⁵ It is not just premium inflation that has fallen. The underlying rate of medical inflation, which will drive long-run rates of inflation, also has fallen to roughly 3.5 percent per year. Perhaps the most compelling indication of a new health care economy is the fact that wages have risen more rapidly in the overall economy than in health care.⁶

Americans live in a different health economy than the one we grew up in. We are not returning to the pass-through system of third-party payment, and the long-run increase in private health care spending will reflect this.

JON R. GABEL
KPMG PEAT MARWICK
ARLINGTON, VIRGINIA

NOTES

1. KPMG Peat Marwick, *Health Benefits in 1998* (Monvale, N.J.: KPMG, June 1998), 40.
2. In fairness, Smith and colleagues award modest savings to managed care for slowing down the rate of technological diffusion.
3. D. Epstein, "Utilization of Generics: A Managed Care Failure," *Managed Care* (May 1997).
4. K. Hunt et al., "Paying More Twice: When Employers Subsidize Higher-Cost Plans," *Health Affairs* (November/December 1997): 6.
5. P.B. Ginsburg and J.R. Gabel, "Tracking Health Care Costs: What's New in 1998?" *Health Affairs* (September/October 1998): 141-146.
6. Ibid.

Cost Control: Don't Count Employers Out

To the Editor:

Sheila Smith and her colleagues seem to have assumed that after nearly a decade of successfully combating the growth in health care costs, employers will haplessly accept the increases in health spending that the authors estimate will occur over the next decade. The authors assume that managed care will be only minimally effective in controlling costs, based on the assertion that employers have already enrolled as many workers as they can in HMOs. In fact, they estimate that most of the cost growth in the next decade will be concentrated in the private sector.

These assumptions are difficult to understand, in light of the powerful role that employers played in controlling costs during the past several years. These efforts helped to slow the rate of growth in benefits costs per worker to 0.5 percent by 1996 (2.1 percent in 1997 and 3.3 percent in 1998).¹ Most importantly, these data report that the rates of growth in spending were reduced by approximately the same proportion for all types of health plans, including indemnity plans.

Moreover, the notion that employers have realized all of the savings that they can get from managed care is plainly wrong. It is widely recognized in the industry that health plans could greatly reduce costs through aggressive utilization controls, if the market would permit it. However, employers have not wanted to alienate their workers with significant utilization restrictions, particularly in a tight labor market.

Although some employers are likely to respond to rising premiums by increasing employee premium contributions or cutting benefits, the experience of the past decade strongly suggests that employers will take measures to improve the efficiency of their health plans as well—such as eliminating the point-of-service (POS) options, moving people back to HMOs, limiting alternatives to HMOs, and seeking out lower-price plans. This will be particularly likely if the economy

slows down enough to soften the demand for labor.

There is already evidence that employers are fighting some plans' widely publicized premium increases. A recent series of insurer interviews conducted by the Lewin Group indicates that many employers are telling insurers that these proposed premium increases are unacceptable and have sought bids from other insurers. Also, many insurers are accompanying their requests for premium increases with information on more-restrictive coverage alternatives in anticipation of employers' demand for less costly options. In fact, after a year of highly publicized reports of double-digit premium growth in some plans, employer survey data report that the average per capita premium increase among employer plans was only 3.3 percent in 1998 (both employee and employer share).²

The authors also discount the possibility that employers will develop new approaches to further reduce spending growth. Some employers are starting to negotiate networks directly with providers. Others have implemented programs to measure and reduce geographic practice-pattern variations. Employers also could strengthen their bargaining leverage via purchasing coalitions. These and other innovations will continue to strengthen employers' bargaining leverage in a system flooded with excess capacity.

Employers are now accustomed to success in controlling health costs and are not likely to accept large premium increases without a fight. As long as there is excess capacity in the health care system, employers will find effective ways of slowing the growth in health spending.

JOHN F. SHEILS
LEWIN GROUP
FAIRFAX, VIRGINIA

NOTES

1. Includes employee and employer share of premiums. KPMG Peat Marwick, *Health Benefits in 1998* (Montvale, N.J.: KPMG, June 1998).
2. P.B. Ginsburg and J.R. Gabel, "Tracking Health Care Costs: What's New in 1998?" *Health Affairs* (September/October 1998): 141-146.

The HCFA Authors Respond

To the Editor:

Paul Ginsburg, Jon Gabel, and John Sheils suggest that HCFA's projection of health care spending growth is higher than can be justified. Our projection calls for slower growth in real per capita spending relative to the pace of the two decades preceding the recent slowdown, partially due to the dominance of managed care in the private sector (we expect growth of 3.3 percent for 1998-2007 versus 4.8 percent for 1973-1992). Our projections do not imply higher long-term growth for private spending relative to Medicare per enrollee. Rather, a sharp demographic shift into the cohort ages fifty-five to sixty-four (where costs are high relative to other private enrollees) temporarily inflates growth in private spending near 2007. Excluding this factor, growth in private spending per enrollee is expected to be below that for Medicare.

Is this projection unreasonably high? The real question is one of magnitude and timing. How will recent systemic changes affect future spending growth? Over the past several years of double-digit growth in private managed care enrollment, most of the privately insured population has moved from a system that exercises little restraint on access to one that imposes a range of restrictions on choice of providers and covered services. Health plans, under enormous pressure to hold down premiums, have done so through utilization constraints, selective contracting, and price negotiation. In turn, health plans have pressured providers to improve efficiency. In the process, growth in private health spending has been pushed to new lows. Based on both reason and empirical evidence, we expect future cost savings per enrollee to be smaller.

In the short term, higher growth in health costs is almost certain. Recent data show an acceleration in real health sector payrolls and medical inflation through mid-1998, confirming our projection of a rebound in real health spending for 1998. Absent major changes in benefit packages, it is a matter of time before the upturn is reflected in premiums.

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This raises the second major contention: employers' ability to restrain growth in health costs over the next ten years. The commenters express confidence that some combination of altered incentives attributable to managed care and the determined and creative efforts of employers will succeed in restraining growth to a pace near the recent lows. Ginsburg anticipates cost reductions on a scale sufficient to hold long-term growth in private premiums to within a percentage point of growth in GDP, relative to a historical gap of over four percentage points. This seems a fairly bold conclusion.

All three point to increased competition in markets for insurance and health services as a key factor behind the slowing of premium growth in the mid-1990s. We agree. Indeed, we expect that further efficiencies can be found and that the continued presence of excess capacity in the health care system will continue to dampen medical inflation. However, we disagree with the conclusions drawn on the nature and magnitude of this effect.

First, in identifying the impact of managed care on long-term growth in health spending, Gabel and Sheils include not only efficiency gains but also the potential for cutting demand for medical services outright through tighter utilization controls. Sheils notes that employers have the ability to impose such controls and will eventually do so, when employees are willing to accept them. But this implies an anticipated slowdown in employee demand for medical care, which is not an intrinsic effect of the management of care. In contrast, our model controls separately for the effect of slowing demand as the economy falls from its cyclical peak.

Confining the analysis to options that reduce inefficiency, we conclude that further nonrecurring cost savings are likely to decline in magnitude. Easy cuts will be made first. Research has shown that much of the cost reduction associated with managed care stems from cutbacks in inpatient hospital services. Other options, such as the use of generic drugs or elimination of unnecessary tests, also reduce costs. However, all such op-

tions are eventually subject to diminishing returns. Further changes that offer similar reductions in costs without unacceptable restrictions on consumer choice and access will be increasingly difficult to find. The case for a permanent reduction in cost growth therefore rests on the potential for managed care to restrain the diffusion of new cost-increasing medical technology.

Empirical work addressing managed care's ability to reduce long-term cost growth for existing members supports our assessment. A recent extensive literature review on the subject concludes that growth in health spending in areas with high managed care penetration (while below that for low-penetration areas) continues to exceed the pace of GDP by about 1.5-5.0 percent.¹ This overstates the probable effectiveness in reducing long-term growth since it includes "savings from reductions in inefficiencies and movements toward competitive pricing that may be hard to replicate in the future."² Studies analyzing the rate of growth of premiums (thus excluding one-time effects from switching plans) conclude that growth in HMOs was 80-99 percent of that seen in fee-for-service plans.³

The speed of the recent transformation leaves room for a range of opinions, but the balance of evidence indicates that managed care and related developments will have a declining impact. A return to a path of growth above recent lows but below earlier experience appears the most likely outcome. As analysis illuminates the effects of recent systemic change, uncertainty regarding these critical issues will approach resolution. We look forward to continuing the dialogue.

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HEALTH CARE FINANCING
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BALTIMORE, MARYLAND

NOTES

1. M.E. Chernew et al., "Managed Care, Medical Technology, and Health Care Cost Growth: A Review of the Evidence," *Medical Care Research and Review* (September 1998): 259-288.
2. *Ibid.*, 270-271.
3. *Ibid.*, 267.

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1. T. Rice, K. Desmond, and J. Gabel, "The Medicare Catastrophic Coverage Act: A Post-Mortem," *Health Affairs* (Fall 1990): 75-87.
2. P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 5-20.

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Health Care For The Elderly: How Much? Who Will Pay For It?

Medicare reform may be too little, too late if we do not address policy issues raised by the rapid growth in use of health care by the elderly.

by Victor R. Fuchs

ABSTRACT: Health care expenditures on the elderly tend to grow about 4 percent per year more rapidly than the gross domestic product (GDP). This could plunge the nation into a severe economic and social crisis within two decades. This paper describes recent growth in age/sex-specific health care utilization by the elderly and discusses the important role of technology in that growth. It also explores the potential for the elderly to pay for additional care through increases in work and savings. Efforts to "save Medicare" will prove to be "too little, too late" unless they are embedded in broader policy initiatives that slow the rate of growth of health care spending and/or increase the income of the elderly.

MEDICARE &
PUBLIC POLICY

11

HEALTH CARE EXPENDITURES on the elderly have outpaced the gross domestic product (GDP) by 3.5 to 4.0 percent per year in recent decades.¹ This differential is partly attributable to demographic change, with the number of elderly growing about 1.0 percent per year faster than the rest of the population. By far the more important factor, however, is the rapid growth of age/sex-specific consumption of health care by the elderly.² If the trends of the past decade or two continue until 2020, the elderly's health care consumption in that year will be approximately \$25,000 per person (in 1995 dollars), compared with \$9,200 in 1995.³ If the current public/private shares remain unchanged (a bit less than two-thirds public, a bit more than one-third private), an enormous increase in taxes will be necessary, and the elderly still will be left with less income for other goods and services than they had in 1995.

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Without a dramatic change in health care costs, income, or both, health spending on the elderly in 2020 is likely to be two to three times the income available for all other goods and services.⁴

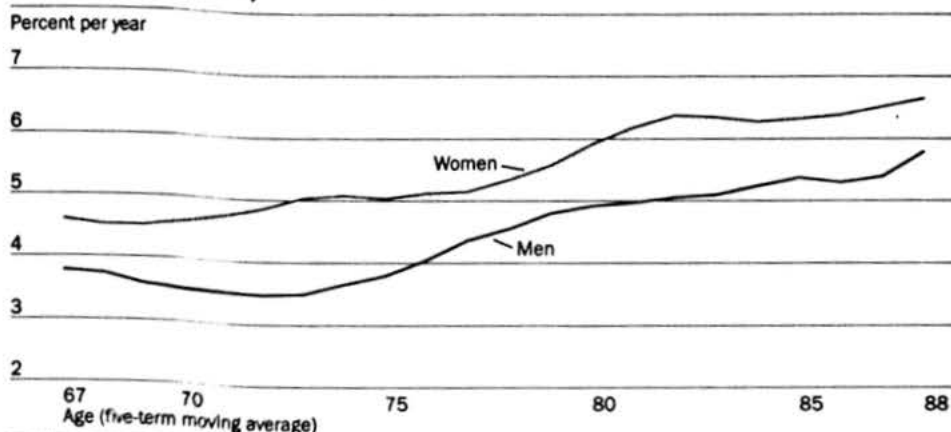
■ **Age/sex-specific expenditures.** A more detailed picture of the rate of growth of age/sex-specific expenditures (Exhibit 1) shows the average annual percentage rate of change between 1987 and 1995 of Medicare payments in constant dollars. The calculations were made by single years of age from a 5 percent sample of Medicare patients and then smoothed with a five-term moving average to reduce the effects of sampling variability.⁵ The rate of change tended to be greater at older ages and somewhat greater for women than for men. On average, the rate of increase was between 4 percent and 5 percent per year in constant dollars. During that same period real GDP per capita grew at only 1.2 percent per year. It is this gap that is at the heart of the "Medicare problem." And because the private share of health care expenditures looms so large in the total financial needs of the elderly, it has major implications for the earnings-replacement problem as well.

Why did age/sex-specific expenditures increase so rapidly during a period when reimbursement rates for physicians and hospitals were being held under tight rein? It was not because physician fees for specific interventions were growing rapidly; they were not. It was not because hospital admission rates were increasing or patients were staying in the hospital longer; they were not. Moreover, the growth of utilization over time cannot be attributed to declining health of the elderly. On the contrary, age-specific health status

HEALTH
SPENDING

EXHIBIT 1

Annual Rate Of Change In Medicare Payments Per Person, By Age, 1987-1995
(Adjusted For Inflation)



SOURCE: V.R. Fuchs and M. McClellan, "Medical Technology and Mortality in an Aging Society" (National Bureau of Economic Research paper in progress, 1998).

probably has been improving.

Most experts believe that the long-term rise of health care health economists in 1995, "The primary reason for the GDP over the past 30 years. Expenditures grew primarily delivering more and better services resonance imaging (MRI), many other costly interventions have made it feasible and desirable to intervene with more patients.

■ **The Impact of technological advances on expenditures** is raising a blockbuster "breakthrough Viagra, the new male impotence boost annual health care spending within a year or two of its technological advance such as a diagnostic technique has only initially. Over time, however, the diffusion of the technology res process of progressive diffusion shows levels of utilization of 1987 and 1995 and rates of change are age/sex-specific, thereby explaining graphic variables on changes showed substantial increases for both sexes at all ages. Even which was expected to obviate graft (CABG) for many patients of the latter procedure. The mean procedure/age groups was 11.1 percent per year for women. The rapid at older ages.

One lesson from these data is expenditures to "technological broad sense. None of the severe 1987. Instead, as physicians develop ity to perform the procedures on patients, utilization steadily increases care use probably follows this appearance of a new intervention.

Increases in rates of procedure

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Most experts believe that "technology" is the driving force behind the long-term rise of health care spending. In a survey of fifty leading health economists in 1995, 81 percent agreed with the statement, "The primary reason for the increase in the health sector's share of GDP over the past 30 years is technological change in medicine."⁶ Expenditures grew primarily because the medical care system was delivering more and better services to patients: new drugs, magnetic resonance imaging (MRI), angioplasties, hip replacements, and many other costly interventions. Advances in medical technology have made it feasible and desirable to do more for each patient and to intervene with more patients.

■ **The impact of technology.** The effect of technological advances on expenditures is rarely simple or immediate. Occasionally a blockbuster "breakthrough" has a rapid impact on expenditures; Viagra, the new male impotence drug, for example, is expected to boost annual health care spending by more than a billion dollars within a year or two of its introduction.⁷ More often, however, a technological advance such as a new drug, surgical procedure, or diagnostic technique has only a modest effect on expenditures initially. Over time, however, further development, refinement, and diffusion of the technology result in large increases in spending. This process of progressive diffusion can be seen in Exhibit 2, which shows levels of utilization of seven frequently used procedures in 1987 and 1995 and rates of change between those years. The changes are age/sex-specific, thereby eliminating the effects of these demographic variables on changes in utilization. All seven procedures showed substantial increases in utilization between 1987 and 1995 for both sexes at all ages. Even the rapid diffusion of angioplasty, which was expected to obviate the need for coronary artery bypass graft (CABG) for many patients, did not result in lower utilization of the latter procedure. The median rate of change for the thirty-five procedure/age groups was 11.1 percent per year for men and 10.7 percent per year for women. The rate of increase tended to be more rapid at older ages.

One lesson from these data is that the attribution of increases in expenditures to "technological change" must be understood in a broad sense. None of the seven procedures was a breakthrough in 1987. Instead, as physicians developed greater confidence and capacity to perform the procedures on more patients, especially on older patients, utilization steadily increased. Most of the growth in health care use probably follows this pattern, rather than the sudden appearance of a new intervention that is widely used from the start.

Increases in rates of procedures and other interventions most

EXHIBIT 2

Use And Rates Of Change In Use Of Seven Procedures, By Age And Sex, 1987-1995

	Men					Women				
	65-69	70-74	75-79	80-84	85+	65-69	70-74	75-79	80-84	85+
Procedures per 100,000										
Angioplasty										
1987	249	215	122	75	22	124	111	82	56	15
1995	712	756	589	411	131	339	367	322	245	74
CABG										
1987	560	545	357	179	33	187	179	138	59	12
1995	750	849	706	436	106	266	322	324	171	29
Cardiac catheterization										
1987	1,146	1,135	740	379	111	708	709	483	182	52
1995	1,624	1,863	1,652	1,109	399	1,086	1,254	1,064	706	183
Carotid endarterectomy										
1987	182	287	246	174	65	111	132	132	95	30
1995	321	460	553	433	152	221	229	273	217	77
Hip replacement										
1987	76	90	113	122	92	78	133	175	174	143
1995	250	331	467	609	724	338	519	782	965	1,444
Knee replacement										
1987	160	182	205	200	70	218	278	322	242	82
1995	403	478	529	385	164	523	657	667	475	193
Laminectomy										
1987	208	215	169	97	54	188	186	153	103	32
1995	285	322	320	218	106	278	316	258	143	57
Average rate of change (percent per year from 1987 to 1995)										
Angioplasty	13%	16%	20%	21%	22%	13%	15%	17%	18%	20%
CABG	4	6	9	11	15	4	7	11	13	11
Cardiac catheterization	4	6	10	13	16	5	7	10	17	16
Carotid endarterectomy	7	6	10	11	11	9	7	9	10	12
Hip replacement	15	16	18	20	26	18	7	19	21	29
Knee replacement	12	12	12	8	11	11	11	9	8	11
Laminectomy	4	5	8	10	8	5	7	7	4	7

SOURCE: V.R. Fuchs and M. McClellan, "Medical Technology and Mortality in an Aging Society" (National Bureau of Economic Research paper in progress, 1998).

NOTE: CABG is coronary artery bypass graft.

likely have contributed to longer and better-quality lives for many elderly persons. From 1987 to 1995 their age/sex-specific mortality rates declined at a brisk pace (about 1 percent per year). It is possible that the additional expenditures, on average, met reasonable cost-effectiveness standards. If so, the key question is not, "Shall we do it?" but rather, "Who will pay?" If expenditures continue to grow at the same rate as they have in the past, health care for the elderly in 2020 will require 10 percent of GDP, compared with 4.3 percent in 1995. Will it be possible to raise tax rates enough to maintain the

"Over the long haul, spending growth: slow"

government's current share have enough income to seriously jeopardizing the Nothing in current income greater Social Security re that they will.

What Can Be Done?

There are only two possible crises foreshadowed in the rate of growth of health to pay for the additional

■ **Slow the growth of** exist to slowing the growth rate of growth of the price example, squeeze physicians more services with fewer tory tests); or (3) slow the

The first route may be confined to physicians a much over an extended period scored some quick gains possibility of further squeezing has become much smaller trying to pay lower prices est impact on the rate of must approximately keep attract resources to the efficiency, faces problems A few quick gains can be cies, but there is little reason can continue to achieve a decade without undermining

Over the long haul, the ing growth: slow the growth quality of care? Almost care are delivered in every system impossible to cut back on delivery of other services

"Over the long haul, there is only one reliable way to slow spending growth: slow the growth of services to patients."

government's current share? That seems unlikely. Will the elderly have enough income to pay their current share, or more, without seriously jeopardizing their ability to buy other goods and services? Nothing in current income trends of the elderly or in prospects for greater Social Security retirement payments in the future suggests that they will.

What Can Be Done?

There are only two possibilities to avoid the economic and social crises foreshadowed in current trends. The nation must either slow the rate of growth of health care spending on the elderly or find ways to pay for the additional care.

■ **Slow the growth of health care spending.** Only three routes exist to slowing the growth of health care spending: (1) reduce the rate of growth of the prices of the resources used in health care (for example, squeeze physicians' incomes); (2) produce the same or more services with fewer resources (for example, automate laboratory tests); or (3) slow the rate of growth of real services to patients.

The first route may be politically popular as long as the bashing is confined to physicians and drug companies, but it will not yield much over an extended period of time. Managed care organizations scored some quick gains this way in the mid-1990s, but by 1998 the possibility of further squeezing without jeopardizing quality of care has become much smaller. Over a period of twenty years or more, trying to pay lower prices for health resources can have only a modest impact on the rate of growth of expenditures because prices must approximately keep pace with the rest of the economy, to attract resources to the health sector. The second route, greater efficiency, faces problems similar to lowering the prices of resources. A few quick gains can be scored by eliminating obvious inefficiencies, but there is little reason to expect that the health care system can continue to achieve ever greater gains in efficiency decade after decade without undermining quality of care.

Over the long haul, there is only one reliable way to slow spending growth: slow the growth of services to patients. Will this affect quality of care? Almost certainly. Although some ineffective services are delivered in every system and at every point in time, it is virtually impossible to cut back only on those services without affecting the delivery of other services that do extend lives, improve functioning,

or provide assistance with activities of daily living. Furthermore, because technology is the principal force behind the growth in use of services, the most important strategy for slowing that growth must be to slow the development and diffusion of new technology. One way that public policy affects technology is through Medicare, Medicaid, and other publicly funded health insurance programs. Government's willingness to pay for particular services influences the adoption and diffusion of technologies, and the pace of adoption influences private investment in research and development. Government also influences the development and diffusion of technology by subsidizing medical research and the training of specialists and subspecialists.

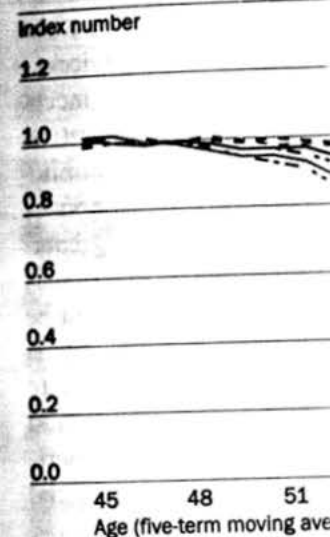
If the rate of growth of age-specific expenditures could be reduced by one percentage point per year, health care spending per older person in 2020 would be less than \$20,000 (1995 dollars); if it could be reduced by two percentage points per year, spending would average about \$15,000 per person, a figure that probably would be manageable with modest tax increases and some realignment of the elderly's priorities regarding work, savings, and consumption. But most present thinking in Washington is to accelerate the rate of growth of medical technology. Proponents of this strategy usually assert that new technology will reduce spending. On balance, it has not worked out that way in the past, and there is no particular reason to think that it will in the future. A technological advance may cut the cost of performing a particular intervention, or of treating a particular patient, but expenditures depend on the number of units of service as well as on the price per unit. For example, technological advances in the computer industry have led to spectacular decreases in price per unit of service; nevertheless, spending on computers has soared. Much the same happens with most technological advances in medicine.

■ **Find ways to pay for the additional care.** Most people want to live longer, better-quality lives; therefore, some policy advisers prefer to focus on finding ways to pay for more health care rather than on slowing spending growth. After all, there is no physical law or economic principle that says a nation cannot spend 10 percent of its GDP on health care for the elderly if it chooses to do so. But how can this be accomplished? An increase in government's share of the bill seems very unlikely. Indeed, even to maintain its current share, government will have to hike tax rates appreciably and make major cuts in other programs. If the growth of services were to continue as before, with many new and improved interventions available to patients, the elderly would have to be willing to forgo other goods and services, work more than they have in the past, and greatly increase

their savings prior to retirement. Consider cutting back on bill were \$25,000 per person would have to adjust to a cut and services relative to 1995 the same.* An increase of five of health care spending would than 10 percent in income. There probably are limits to to sacrifice an adequate diet leak for more medical care.

Given better health and work may be one feasible. Many policy analysts look retirement age as a way of increasing ages. Such an increase surely that many men and women well before age sixty-two, ment benefits first become mean annual hours of all and mean hours of those from forty-five to seventy and 1995.⁹ The values for age

EXHIBIT 3
Indexes Of Mean Annual Health Care Spending
Average Of 1993, 1994, And 1995



SOURCE: CPS Utilities, March CPS Utilization Survey, Santa Monica, California 90401.

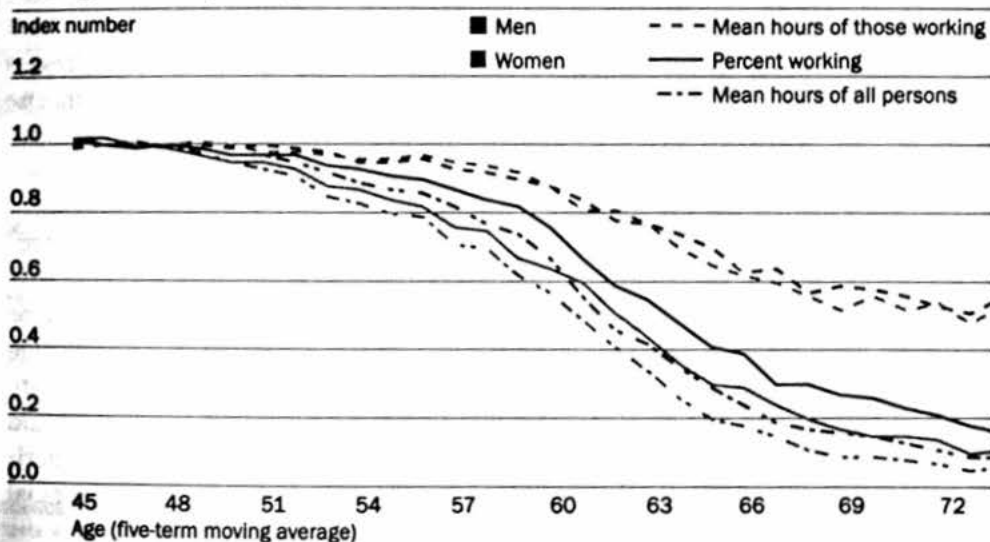
Furthermore, growth in use of that growth in new technology through Medicare, insurance programs, influences the rate of adoption of technology by specialists and

their savings prior to retirement. These are not easy options. Consider cutting back on other goods and services. If the health bill were \$25,000 per person (1995 dollars) in 2020, the elderly would have to adjust to a cut of more than 20 percent in other goods and services relative to 1995, even if their share of the bill remained the same.⁸ An increase of five percentage points in the elderly's share of health care spending would result in a further decrease of more than 10 percent in income available for other goods and services. There probably are limits to how much the elderly would be willing to sacrifice an adequate diet, a car that runs, or a roof that doesn't leak for more medical care.

Given better health and longer life expectancy, an increase in work may be one feasible approach to curbing spending growth. Many policy analysts look to an increase in the Social Security retirement age as a way of increasing labor-force participation at older ages. Such an increase surely would help, but it is important to note that many men and women substantially decrease their paid work well before age sixty-two, the age at which Social Security retirement benefits first become available. Exhibit 3 shows indexes of mean annual hours of all persons, percentage of persons working, and mean hours of those who were working by single years of age from forty-five to seventy-five, averaged over the years 1993, 1994, and 1995.⁹ The values for ages forty-five to forty-nine were set equal

EXHIBIT 3

**Indexes Of Mean Annual Hours Of Work And Percentage Working, By Age And Sex
Average Of 1993, 1994, And 1995**



SOURCE: CPS Utilities, March CPS Utilities, 1964-1996, Release 96.1 (1997) (Unicorn Research Corporation, 1640 Fifth Santa Monica, California 90401).

"Differences in willingness to save provide a major explanation for the huge inequality in accumulated savings at retirement."

to 100.¹⁰ By age sixty, men's hours are only 67 percent of the average of ages forty-five to forty-nine; for women, only 57 percent. The decrease in mean hours arises for two reasons: (1) a decline in the percentage of persons who have any paid work during the year, and (2) a decline in average annual hours for those who are working. Exhibit 3 shows that the former is by far the more important reason. At age sixty the percentage of men who have any hours of work during the year is only 76 percent of the average at ages forty-five to forty-nine; the comparable figure for women is 64 percent. Some decline in average annual hours of those who are working does occur, but the change is much smaller than the percentage dropping out of the workforce entirely. Moreover, only 3 percent of the sixty-year-olds who had no paid work during the year spent any time looking for work.¹¹ A critical examination of the public and private policies that discourage older workers from seeking work and inhibit firms from employing them is badly needed.

The most important potential source of increased income for the elderly is greater saving prior to retirement. The reason is in the numbers: After age sixty-five, income from savings (interest, dividends, and private pensions) is now four times larger than income from work.¹² Thus, only a 25 percent increase in the savings rate prior to age sixty-five would add as much to income as a doubling of work. Furthermore, the nonannuitized portion of the increased savings could be "spent down" in later years, thus adding to the elderly's capacity to pay for health care and other goods and services.

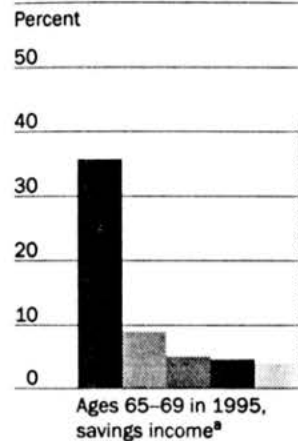
How can current workers be induced to save more? Tax incentives almost surely would help, as evidenced by the individual retirement account (IRA) program during 1981-1986. When public-finance economists at the forty leading U.S. university economics departments were asked what percentage of inflows to IRAs represented net additions to national savings, the median estimate was 20 percent.¹³ Tax incentives alone, however, probably would not be enough. Many workers with average, or even above average, income did not participate in the IRA program and do not now participate in employer-sponsored 401-K plans, even when the employer would provide a matching contribution. In recent years millions of Americans have reached age sixty-five without any significant financial assets.

Not only is the average level of savings very low, but inequality in

income from savings of inequality in employment were younger (Exhibit 4 reported in the Current equally among family income to the median was in 1995, less than 10 percent 1.4 times the median of \$100,000, as compared with \$70,000 at the extremes of 0.2 of the median, and \$140,000. The inequality in income in the cohort when they were forty-five to forty-nine (1970) was many factors that influence employment income surely. Exhibit 4 suggest that differences in accumulated savings at retirement

This view receives support from David Wise based on the Retirement Survey. The survey shows that retirement is not primarily a function of retirement: Households with retirement with vastly different

EXHIBIT 4
Ratio Of Per Person Income To Median Income For Cohort



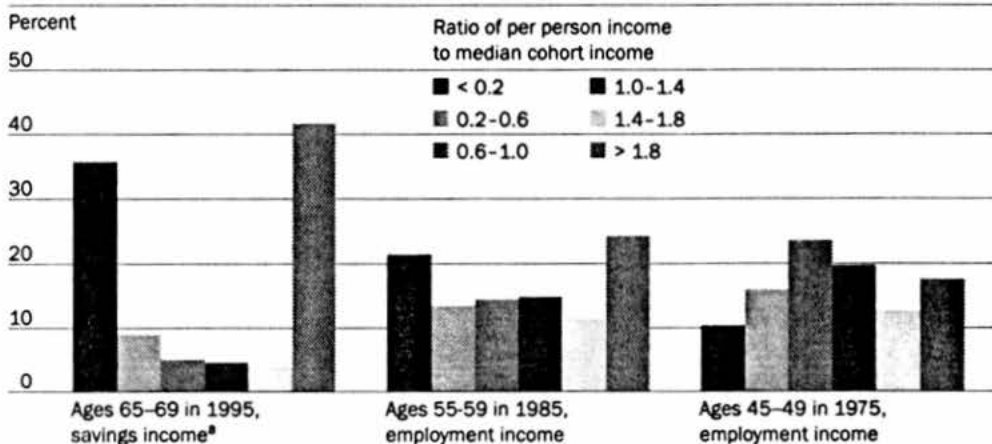
SOURCE: CPS Utilities, March CPS Utilization Study, Santa Monica, California 90401.
* Includes interest, dividends, rents, and other income.

income from savings of retirees is extraordinarily large relative to inequality in employment income of the same cohort when they were younger (Exhibit 4).¹⁴ To measure inequality, family income reported in the Current Population Survey (CPS) was divided equally among family members, and the ratio of each person's income to the median was calculated. At ages sixty-five to sixty-nine in 1995, less than 10 percent of persons had income between 0.6 and 1.4 times the median of \$1,800. Most of this age group were concentrated at the extremes of the distribution: 36 percent had less than 0.2 of the median, and 42 percent had more than 1.8 times the median. The inequality in employment income experienced by this cohort when they were ages fifty-five to fifty-nine (in 1985) or ages forty-five to forty-nine (in 1975) was much less. Although there are many factors that influence the ability to save for retirement, employment income surely is the dominant one. Thus, the data in Exhibit 4 suggest that differences in the willingness to save probably provide a major explanation for the huge inequality in accumulated savings at retirement.

This view receives substantial support in a study by Steven Venti and David Wise based on longitudinal data from the Health and Retirement Survey. They show that inequality in savings for retirement is not primarily the result of inequality in earnings prior to retirement: Households with the same lifetime earnings approach retirement with vastly different levels of accumulated wealth.¹⁵ Even

EXHIBIT 4

Ratio Of Per Person Income From Savings (1995) Or Employment (1985 And 1975) To Median Income For Cohort Born In 1926 To 1930



SOURCE: CPS Utilities, March CPS Utilities, 1964-1996, Release 96.1 (1997) (Unicorn Research Corporation, 1640 Fifth Street, Santa Monica, California 90401).

* Includes interest, dividends, rents, and private pensions.

after adjustments for special factors that affect the ability to save and for differences in investment returns, the authors conclude, "The primary determinant of the dispersion of wealth at retirement is evidently the choice to save or spend while young."¹⁶

If public policy aims at greatly increasing the elderly's income from savings while avoiding huge increases in income inequality after age sixty-five, it seems that part of the program would have to be compulsory. Even then, if the elderly became more dependent on their own income from work and savings, there probably would be greater income inequality among the elderly than there is now. Such a possibility should be evaluated in context. Once Social Security retirement is added to income from savings and employment, there is less total income inequality at older ages than at any other age.¹⁷ An inalterable commitment to an egalitarian policy after age sixty-five probably would inhibit the changes in work and savings that will be required to pay for future increases in health care.

HEALTH
SPENDING

LONG-TERM REFORM OF MEDICARE (and Social Security) must face three harsh but inescapable facts. First, total expenditures for health care of the elderly are rising much faster than GDP, tax revenues, or the personal income of the elderly. Second, the number of years that the elderly are financially dependent on savings and government transfer payments continues to increase because rising life expectancy at age sixty-five has not been matched by rising labor-force participation after that age. Third, on average, Medicare pays for less than half of the health care of the elderly, and Social Security retirement benefits provide less than half of total personal income after age sixty-five. Thus, efforts to "save Medicare" or "save Social Security" miss the main point: Even when these efforts move policy in the right direction, they will prove to be "too little, too late" unless they are embedded in broader policy initiatives that slow the rate of increase in health care spending and/or increase the income of the elderly.

The author gratefully acknowledges financial support to the National Bureau of Economic Research from the Robert Wood Johnson and Andrew W. Mellon Foundations, and the research assistance of Deborah Kerwin-Peck.

NOTES

1. V.R. Fuchs, "Provide, Provide: Issues and Answers," ed. T.R. Savit, Chicago Press, forthcoming), Economic Research (NBER) Working Paper No. 1975, 1 of total personal health care to Medicare, et al., "Health Expenditures by Age and Sex," *Review* (Summer 1989): 116-120. The data were calculated by the author.
2. For 1975-1995 and 1985-1995 the change in the aged was decomposed into: (1) change in the number of persons; (2) change in the age distribution of the elderly; (3) change in age-specific expenditures was calculated. Fuchs, "Provide, Provide."
3. Ibid. Projections were based on constant dollars combined with the 1975-1995 series).
4. Ibid. Income available for other uses = personal income minus personal taxes.
5. V.R. Fuchs and M. McClellan, "The Economics of Medicare" (NBER paper in progress).
6. V.R. Fuchs, "Economics, Values, and Policies," *Review* (March 1996): 1-24, Table 1.
7. D.J. Morrow, "The Elixirs of Life," *Review* (March 1996): 25-36.
8. Fuchs, "Provide, Provide."
9. CPS Utilities, March CPS Utilities, Research Corporation, 1640 Fifth Avenue, New York, NY 10019 (310-393-4636).
10. The actual values at ages forty-four to forty-five are 2,024 for men and 1,817 for women; at ages forty-six to forty-seven are 2,024 for men and 1,817 for women.
11. CPS Utilities.
12. Fuchs, "Provide, Provide."
13. V.R. Fuchs, A.B. Krueger, and J.M. Poterba, "Values, and Policies: Survey Evidence," *Journal of Economic Literature* (September 1996): 1169-1191.
14. CPS Utilities.
15. S.F. Venti and D.A. Wise, "The Choice or Chance?" *American Economic Review* (September 1996): 1169-1191.
16. Ibid., 191.
17. Fuchs, "Provide, Provide."

NOTES

1. V.R. Fuchs, "Provide, Provide: The Economics of Aging," in *Medicare Reform: Issues and Answers*, ed. T.R. Saving and A. Rattenmaier (Chicago: University of Chicago Press, forthcoming), currently available as National Bureau of Economic Research (NBER) Working Paper no. 6642 (1998). Total health care spending on the aged for 1975, 1985, and 1995 was estimated by applying ratios of total personal health care to Medicare payments as presented in D.R. Waldo et al., "Health Expenditures by Age Group, 1977 and 1987," *Health Care Financing Review* (Summer 1989): 116-120. Rates of change for 1975-1995 and 1985-1995 were calculated by the author.
2. For 1975-1995 and 1985-1995 the rate of change of health care expenditures on the aged was decomposed into (1) change in the age/sex-specific expenditures per person; (2) change in the number of elderly persons; and (3) change in the age distribution of the elderly. For both time periods the rate of change of age-specific expenditures was more than double the sum of the demographic effects. Fuchs, "Provide, Provide."
3. Ibid. Projections were based on past trends in age/sex-specific expenditures in constant dollars combined with Census Bureau population projections (middle series).
4. Ibid. Income available for other goods and services was defined as total personal income minus personal taxes and personal health care expenditures.
5. V.R. Fuchs and M. McClellan, "Medical Technology and Mortality in an Aging Society" (NBER paper in progress, 1998).
6. V.R. Fuchs, "Economics, Values, and Health Care Reform," *American Economic Review* (March 1996): 1-24, Table 1.
7. D.J. Morrow, "The Elixirs of Life Style," *New York Times*, 11 November 1998, C1.
8. Fuchs, "Provide, Provide."
9. CPS Utilities, March CPS Utilities, 1964-1996, Release 96.1 (1997) (Unicon Research Corporation, 1640 Fifth Street, Santa Monica, California 90401; tel.: 310-393-4636).
10. The actual values at ages forty-five to forty-nine are as follows: average annual hours for all persons, 2,024 for men and 1,439 for women; percentage working, 91 for men and 79 for women; average annual hours for those working, 2,217 for men and 1,817 for women.
11. CPS Utilities.
12. Fuchs, "Provide, Provide."
13. V.R. Fuchs, A.B. Krueger, and J.M. Poterba, "Economists' Views about Parameters, Values, and Policies: Survey Results in Labor and Public Economics," *Journal of Economic Literature* (September 1998): 1387-1425, Table 2.
14. CPS Utilities.
15. S.F. Venti and D.A. Wise, "The Cause of Wealth Dispersion at Retirement: Choice or Chance?" *American Economic Review* (May 1998): 185-191.
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17. Fuchs, "Provide, Provide."

The Political Economy Of Medicare

Medicare reform requires political reform.

by Bruce C. Vladeck

ABSTRACT: Medicare spends more than \$200 billion a year; the politics surrounding the Medicare program cannot be fully understood without an adequate appreciation of that fact. An understanding of the political economy of Medicare is perhaps best achieved by thinking along three dimensions: (1) Medicare as redistributive politics; (2) Medicare as special-interest politics; and (3) Medicare as distributive politics. Seeing the extent to which Medicare policies flow from these political processes makes clear that Medicare reform and broader political reform are, at some level, inseparable and indistinguishable.

MY EPIPHANY, MY FLASH OF INSIGHT: An evening in August 1996, riding from the airport into Pittsburgh, prior to a seminar at the University of Pittsburgh the following morning. Few cities have so theatrical an entrance: If you're coming in from the airport, through the Fort Pitt tunnel, you emerge from the tunnel with all of downtown, across the river, laid out before you. At night especially, the taillights from the elevated expressway on the bluff above the river's north bank add motion to the more vertical tableau of the skyscrapers behind.

In the past, when the steel mills were operating, the view was even more spectacular. Lining both banks of the Monongahela, beginning just east of the Golden Triangle at the confluence with the Allegheny and extending miles upstream, stood the great industry that provided Pittsburgh its identity. During World War II, it is said, the mills on the Monongahela produced more steel than all of Germany's; Hitler and Tojo were defeated by western Pennsylvania. If you've never seen an operating open-hearth mill at night, it's difficult to imagine the orange-red brightness of the flames or the volume of smoke or the simple inhuman size of everything, with hard-hatted workers dwarfed by their tools.

By the mid-1980s the mills were all shut, made obsolete by mini-

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Y mills in Alabama and megamills in Korea and fuel-economy standards for cars. It must say something important about modern capitalist economies that the photographic images of closed factories rest more prominently in our memories than do the images of working mills.

But the scene as I emerged from the Fort Pitt tunnel that night more than two years ago was more dramatic still, for someone who remembered older times, because now the mills were gone altogether, torn down in the hope of urban regeneration from the brown fields cleared of rust and slag. My mind's eye played tricks, calling up the sight of enormous structures that were no longer there. In the Middle East, when one civilization succeeds another, it builds on top of the ruins of the old one. Here, we just leave the ghosts behind.

So we drove into town past the unmarked graves of the great steel plants, through the Medical Center, which was bustling on a summer night in the way that most American downtowns don't. Medical students carrying textbooks, stethoscopes proudly dangling from the pockets of their lab coats; housestaff and nurses grabbing a quick bite or just some fresh air, walking past brightly lit storefronts; cars double-parked on crowded streets. My hosts, two considerate health policy wonks, reminded me of what I already knew: that health care has replaced steel as Pittsburgh's largest industry, its major source of good jobs and economic growth.

Then I remembered something else. Western Pennsylvania has an especially high proportion of elderly citizens, second only to that of south Florida; as the mills dried up, young people left Homestead and Braddock and Carnegie and all of the other towns in the valley, while the old stayed. It's not just health care that is now the largest industry in Pittsburgh. The largest industry in Pittsburgh is Medicare.

For a Health Care Financing Administration (HCFA) administrator and lifelong city boy and amateur urbanologist, that was a sobering and disconcerting thought; there is only so much responsibility one can take. It also clarified for me a whole gamut of perceptions and experiences from my four years on the job. It provided a framework and a perspective for much of what I had known and thought I had understood all along.

Every reader of *Health Affairs* knows that Medicare spends more than \$200 billion a year. As they say, that's a lot of money, even by Washington standards, and although the political and ideological conflicts generated by that much money are familiar to most observers of the policy process, there are at least three other dimensions to that volume of expenditure that engender political processes of their own. To use some rather shopworn but still evocative

terminology from political science, those dimensions are as follows: (1) Medicare as redistributive politics, in the sense of Medicare as a massive transfer program; (2) Medicare as special-interest politics, in the workings of what I call the "Medicare-industrial complex"; and (3) Medicare as distributive politics, in the allocation of financial benefits across regions and communities.

Medicare As Redistributive Politics

Medicare provides, through an insurance mechanism, a set of service benefits to many persons who otherwise would be unable to afford or obtain adequate access to health services. It has revolutionized access to health care for the elderly and disabled and thus has contributed to the demonstrable improvements in health status and life expectancy experienced by older Americans over the past thirty years. Not incidentally, Medicare also has been an extremely powerful weapon for reducing poverty for the elderly and disabled.

Medicare does so, however, at least in part by transferring income from working-age persons to retired or disabled former workers. On average, each working-age person contributes something over \$1,250 a year to provide about \$5,000 in benefits to each Medicare beneficiary. (The astute observer may interject at this point that Medicare funds are not in fact actually transferred to Medicare beneficiaries but rather to the providers that give them services—or, as the more cynically astute observers might argue, in the case of some managed care plans and some beneficiaries, providers that do not give them services. Certainly, unlike other Social Security programs, Medicare rarely puts cash into the hands of those who are described as its beneficiaries. But they benefit nonetheless. The politics of those who do cash the checks are the subject of the next section of this paper.) Although hardly anyone will say it out loud, the dynamics of this transfer—indeed, its very existence—lie not far below the surface of many of the most bitter and contentious political fights about Medicare that have erupted throughout its history, especially in the past five years.

Just under 60 percent of Medicare revenues—essentially all of the financing of Part A (hospital insurance)—comes from payroll taxes, which are mildly regressive since they apply uniformly to earned income at all levels and exclude all nonwage income. Since 1993, however, the payroll tax contribution to Medicare has been less regressive than Social Security's, since it now applies to all wage income, regardless of amount. Thirty percent of Medicare funds come from general federal revenues and are as progressive or regressive as those revenues are these days—which is to say, a lot less progressive than they used to be. The most regressive part of Medi-

care's income is the 10 percent of beneficiaries who pay the same premium but while the political number of beneficiaries (fewer than 6 percent) comes greater than \$50,000 premium structure arises from the level of eligibility.

Medicare benefits, of course, are progressively distributed (as long as we attribute benefits to the recipients of the checks rather than to those who are sicker, just under 10 percent of expenditures are on behalf of the income distribution by generating average beneficiaries, partially offset by times, however, this is more-affluent beneficiaries.

As income-transfer programs go, Medicare is bad, in the sense that it is one of the total spectrum of programs that provide benefits, in any given year, to the society as a whole. It provides a greater share of the financing of the general revenue (as was the case in the Budget Act, or BBA, of 1993) than any other program's premiums were reduced for prescription drugs and long-term care, and the regressivity of benefit distribution is high.

But the very fact that Medicare is a transfer program under debate, even if that dimeric form the program for contributions, to encourage the share of program costs to be borne by the broader political community, to redistribute income or wealth (policies that redistribute income are much less controversial than Medicare and Social Security). Medicare and Social Security are the baby boomers' policy in all of its forms, and one allows into the di-

care's income is the 10 percent derived from beneficiary premiums, but while the political debate has focused on the relatively small number of beneficiaries at the upper ends of the income distribution (fewer than 6 percent of beneficiaries live in households with incomes greater than \$50,000 a year), the real regressivity in the flat premium structure arises from the millions with incomes just above the level of eligibility for additional subsidies through Medicaid who pay the same premiums that average beneficiaries pay.¹

Medicare benefits, on the other hand, are distributed more progressively (as long as we continue, for purposes of this section, to attribute benefits to the recipients of the service, rather than to the recipients of the checks). Because lower-income beneficiaries tend to be sicker, just under three-quarters of all Medicare fee-for-service expenditures are on behalf of beneficiaries in the bottom two-thirds of the income distribution.² (The growth of Medicare managed care, by generating average expenditures for healthier-than-average beneficiaries, partially reverses this effect.) Over beneficiaries' lifetimes, however, this effect is greatly attenuated by the fact that more-affluent beneficiaries live longer.

As income-transfer programs go, in other words, Medicare isn't bad, in the sense that its revenue sources fall roughly in the middle of the total spectrum from progressivity to regressivity, and its benefits, in any given year, are highly progressive when viewed across society as a whole. It could be made much more progressive if a greater share of the financing were transferred from payroll taxes to general revenue (as was done to a small degree in the Balanced Budget Act, or BBA, of 1997) and a little more progressive if beneficiaries' premiums were related to income. Extending coverage to prescription drugs and long-term care would greatly increase the progressivity of benefit distribution.

But the very fact that Medicare is a mildly progressive income-transfer program underlies much of the contemporary political debate, even if that dimension is rarely acknowledged. Efforts to transform the program from one of defined benefits to defined contributions, to encourage medical savings accounts (MSAs), or to raise the share of program costs paid by beneficiaries are all part of the broader political and ideological attack on all policies that redistribute income or wealth from the more affluent to the less affluent (policies that redistribute income in the other direction remain much less controversial). Indeed, even much of the insistence that Medicare and Social Security face a "crisis" because of the aging of the baby boomers is rooted in visceral hostility to redistributive policy in all of its forms; the baby-boomer crisis simply goes away if one allows into the discussion the possibility of increased taxes on

the more affluent.

There is no question, from an economic point of view, that this society could "afford" to support indefinitely a more generous Medicare program than the one we now have. The question is whether, politically, we want to do so. That question really comes down to the extent of our willingness to require the better-off to subsidize the less well off—a willingness that seems to be shrinking.

Nowhere is the redistributive dimension of Medicare politics more apparent than in the argument made by some proponents of radical change that it is imperative to do something soon, before a much larger share of the electorate is made up of Medicare beneficiaries or persons close to eligibility age, at which point the politics of the issue presumably would change. In fact, the views of Medicare beneficiaries, in responding to public opinion polls or in their voting behavior, do not differ substantially from those of forty- or fifty-year-olds regarding Medicare policies. This argument thus is less a reflection of reality and more of an anxiety that has persisted in American politics since the days of the Founding Fathers. The authors of *The Federalist*, after all, insisted that the separation of powers within a federal system was necessary to prevent the more numerous lower classes from abusing direct democracy to confiscate the wealth of the upper classes.¹

The political behavior of lower-income Americans ever since has run largely counter to the Federalists' expectations: Most working Americans not only have identified themselves as "middle class" but generally have held "middle-class" views about taxation, inflation, and workers' solidarity, even when such views have run directly counter to their "objective" economic interests. That cultural reality has never sufficiently assuaged the paranoia of the more affluent, nor has it discouraged them from seeking to further tilt the political and economic systems in their own direction, as they continue to do in the Medicare debate. The image of hordes of voracious Medicare beneficiaries feasting on the hard-gotten gains of struggling, virtuous investment bankers has an almost Hogarthian tone to it, but such eighteenth-century imagery continues to dominate the conceptual map of much of the policy elite.

Medicare As Interest-Group Politics: The Medicare-Industrial Complex

Of course, James Madison's system works, most of the time, the way it was designed to, so American politics, most of the time, revolves not around the great redistributive issues but around narrower ones of primary concern to more focused interests. In that world of "normal" politics, Medicare's annual \$200 billion is a major prize or,

more precisely, an end in itself. It is here that the politics of services, not distribution, of Medicare is the large issue: hospitals, physicians, health maintenance organizations, medical equipment manufacturers, among others, all seek to protect and advance their interests.

The health care industry is so complicated, that it is difficult to see the politics of the process in Medicare—and the public policy concerns that it raises.

Medicare accounts for about one-third of the average U.S. hospital's operating budget. It is a heterogeneous and important source of money on hospitals' balance sheets. Hospital-delivered services are a major source of aggregation, hospital macrobudgetary policy. But most hospitals' Medicare income is far lower than that of other sources. For example, contains at individual hospitals. HCFA's administration on behalf of particular interests advanced by individual hospitals. In 1980, the prospective payment system, some of its initiator's policy, looks less like more like the Internal Revenue Service.

A little more broadly, the classes of hospitals, communities. Teaching hospitals, medical technology and medical science communities and are their total revenues, presentation in the U.S.

Interest-group politics, interests seeking special interests, also a matter of organization, representatives themselves clearly in the relationship.

(AMA). Although it occupies a central place in the literature on the politics of Medicare, largely because of its central role in delaying Medicare's enactment in the 1960s, the AMA, despite the size of its membership, the magnitude of its political contributions, and the number of lobbyists it employs, is much less influential on global issues of Medicare policy than is often believed. That is in part because of how closely the AMA has identified itself with the Republican party—a greater disadvantage, to be sure, when Democrats controlled the committees of jurisdiction, but a tactical disadvantage even today—and in part because, within the Republican party, the AMA continues to be outmuscled by the business and insurance interests with which it is so frequently in conflict.

The AMA's role in Medicare politics also must be understood as a manifestation of the dynamics of organizational maintenance. The AMA is implicated in Medicare's system of paying physicians because it helped to develop that system, but also because it holds the extremely lucrative copyright on the basic coding terminology, and because HCFA has largely delegated to it responsibility for maintaining many of the system's technical aspects. This requires the increasingly disputatious specialty societies to go through an AMA process to achieve some of their objectives. As HCFA administrator, I received hundreds of letters from the executive vice-president of the AMA, but the strongest and most urgent were always those that involved protection of the AMA's ministerial role.

In the U.S. political system, and especially in the current political climate, executive-branch agencies achieve what legitimacy they can by relying on private representatives for as many tasks as possible. The relationship between HCFA and the AMA is thus functional for both parties, although the extent to which it protects the interests of practicing physicians, even that fraction who belong to the AMA, is subject to increasing question.

Far more effective is the health maintenance organization (HMO) industry. Medicare beneficiaries still make up just a fraction of total HMO enrollment, but they represent the fastest-growing market and until recently accounted for a disproportionate share of all HMO profits, especially among the largest, publicly traded firms. Of all of the major types of Medicare providers, only HMOs incurred substantially smaller payment reductions in the BBA than were proposed by the Clinton administration, and they continue to enjoy a degree of support among the congressional leadership that is significantly at variance from the broader public perception.

Perhaps the most effective interest in the interest-group politics of Medicare is one that is rarely discussed or noticed—the *sine qua non* of effective interest-group politics—Medicare contractors. Con-

"Large, national, public soldiers in the Medicare

tractors, of course, are the private contractors who perform the basic administrative task of the program: communicating with beneficiaries, processing bills, and auditing cost reports. Its member plans, and its member plans still in the game operate under rules that differ in a number of ways from those that apply to almost all other government programs. By only a very small number of members of Congress,

Public concern about the eagerness of Medicare contractors to enter the HMO program as part of the program's expansion. Several contractors were caught in this special arrangement. Health Insurance Portability and Accountability Act (HIPAA) was authorized to contract with contractors, and other program in the community has continued to expand, as well as more far-reaching for contracting. If long-term expansion of the fee-for-service program certainly must, then moderately is a necessary precondition, however, according to the issue of contractor relations into part of a much larger issue.

Hospitals, doctors, HMOs, and other major stakeholders in Medicare politics. Yet there are other Medicare customers, such as durable medical equipment, for therapy services, as the Medicare program does business with Medicare entrepreneurs account for a large, national, publicly traded stock market. These firms are really the

"Large, national, publicly traded firms are really the foot soldiers in the Medicare-industrial complex.."

tractors, of course, are the private insurance companies that perform the basic administrative tasks of the Medicare fee-for-service program: communicating with providers, reviewing claims, paying bills, and auditing cost reports. The Blue Cross/Blue Shield Association, its member plans, and the few commercial insurance companies still in the game operate under a set of contracting and procurement rules that differ in a number of critical respects from those that apply to almost all other government contractors. They have their own piece of statute, which is understood (let alone known about) by only a very small number of bureaucrats, congressional staff, and a few members of Congress, as well as the contractors themselves.

Public concern about health care fraud and abuse, the increasing eagerness of Medicare contractors to participate in the Medicare HMO program as part of their "private" businesses, and the fact that several contractors were caught in illegal activity, permitted a partial breach in this special arrangement in 1996 when, as part of the Health Insurance Portability and Accountability Act (HIPAA), HCFA was authorized to contract separately for audits, investigations, and other program integrity activities. However, the contractor community has continued to resist implementation of those provisions, as well as more far-reaching changes in the legal framework for contracting. If long-term reform of Medicare is to include modernization of the fee-for-service part of the program, as it almost certainly must, then modernization of the contractor process probably is a necessary precondition. For that precondition to be met, however, according to the general laws of interest-group politics, the issue of contractor reform probably will have to be redefined into part of a much larger issue.

Hospitals, doctors, HMOs, and Medicare contractors all have a major stake in Medicare policy and act as expected in the political system. Yet there are other service providers that essentially serve only Medicare customers. Literally thousands of home health agencies, durable medical equipment suppliers, and firms that contract for therapy services, as the most notable examples, have been formed to do business with Medicare. In most of these industries, individual entrepreneurs account for the large majority of suppliers, although large, national, publicly traded firms have become more important as a buoyant stock market has made equity capital easy to raise. These firms are really the foot soldiers in the Medicare-industrial

complex.

Nothing is more frustrating to Medicare administrators, nor more puzzling to outside observers, than the fact that the payment methods—and even levels of payment—for so many things Medicare purchases are written into law, often at prices higher than a big buyer such as Medicare could obtain in the marketplace. Efforts to make Medicare a more “prudent purchaser” have been supported by administrators of both political parties for more than a decade. But Medicare suppliers occupy a political territory of classic dimensions in American political science: narrowly focused interest groups with an enormous specific stake in issues about which the rest of the body politic could really care less, seeking benefits of enormous importance to themselves, but almost invisible in the total aggregate of the federal budget. They thus have succeeded in resisting almost every effort to improve Medicare’s purchasing by enlisting key members of Congress to defend their constituents from the depredations of the “big bad federal bureaucracy.”

Medicare suppliers thus have built on the earlier successes of the more visible providers, such as hospitals and doctors, in turning the program from one that provides a legal entitlement to beneficiaries to one that provides a de facto political entitlement to providers. Part of that transformation dates to the attitudes of program administrators from the early days of Medicare, when officials were concerned (astonishingly enough, in retrospect) that not enough providers would be willing to participate in the program; part of it stems from some truly misguided decisions by the federal judiciary over the years. But the conversion of Medicare into an entitlement for thousands of smaller providers is also closely tied to the continued romancing of the small-business community by political leaders of both parties. Even though they exist for no purpose other than to sell services to a government program, and even though the government and its beneficiaries might be better off if there were fewer, larger, more efficient, and cheaper suppliers, these providers have acquired a kind of legitimacy in the political process that turns our conventional notions of the boundary between the public and private sectors upside down. Thus, we find the astonishing spectacle in which a presidential appointee in the Small Business Administration recently denounced, as inimical to small firms, the implementation of restrictions on home care agencies that had been announced as a presidential initiative barely a year earlier.⁶

The analogy to defense contractors is not totally far-fetched. There are plenty of \$400 toilet seats in the Medicare program, because Medicare cannot deliver services to its beneficiaries without providers and because providers are major sources of employment,

political activity, an electoral district in the United States is very much smaller than either one produces the

Medicare As Dis

The analogy between down Medicare provisions between Medicare as city politics—the dis economy. Medicare spending and in every congressional federal government spending, the geographic come a matter of increasing

The very wide variety to another has services research. Some differences in demographic communities; some to different and some—although precisely and that may practice patterns among health services from the and since the prices in the program moves to variation is reflected in noted above, the revenue in general, varies income and payroll from Patrick Moynihan (Director recent years, the federal tributive, spending on military installations (higher-cost-of-living)

Examination of Medicare comparing the state's share of Medicare revenues relative standing (Exhibit both pay a dollar in federal care spends, but Michigan 40 percent higher. California same Medicare balance each of its proportion.

political activity, and campaign contributions in every congressional district in the nation. Although the average home care agency is very much smaller than the average military base, efforts to close either one produce the same kinds of congressional responses.

Medicare As Distributive Politics

The analogy between shutting down military bases and closing down Medicare providers also stands precisely at the boundary between Medicare as interest-group politics and Medicare as locality politics—the distributive dimension of Medicare's political economy. Medicare spends money in just about every city and town, and in every congressional district, in the United States. With the federal government reducing almost every other form of domestic spending, the geographic distribution of Medicare dollars has become a matter of increasing attention.

The very wide variation in health care spending from one community to another has long been accepted as a basic fact in health services research. Some of that variation is attributable to differences in demographic characteristics and health status across communities; some to differences in input prices and other price factors; and some—although an amount that is, in fact, hard to determine precisely and that may be less than often asserted—to differences in practice patterns among health professionals. Since Medicare buys health services from the existing system in every U.S. community, and since the prices it pays remain tied in some way to cost, even as the program moves to capitated or prospective payment, all of that variation is reflected in patterns of Medicare spending. Further, as noted above, the revenue that supports Medicare, as does federal revenue in general, varies with the differences in both total taxable income and payroll from one community to the next. As Sen. Daniel Patrick Moynihan (D-NY), among others, has noted repeatedly in recent years, the federal budget as a whole is significantly redistributive, spending money in poorer states and those with large military installations that is derived, net, from higher-income (but higher-cost-of-living) states in the Northeast and Midwest.

Examination of Medicare's "balance of payments" by state—comparing the state's share of Medicare expenditures to the state's share of Medicare revenues—produces no easy explanation for states' relative standing (Exhibit 1).⁷ Michigan and Montana, for example, both pay a dollar in federal taxes for every ninety-two cents Medicare spends, but Michigan's per beneficiary expenditures are almost 40 percent higher. California, Kansas, and Georgia all have about the same Medicare balance of payments, but California spends a lot on each of its proportionately few beneficiaries; Kansas has more eld-

EXHIBIT 1

Medicare Balance Of Payments And Payments Per Enrollee, By State, 1996 (cont.)

State	Medicare balance of payments (millions of dollars) ^a	Medicare balance- of-payments ratio ^b	Medicare payments per enrollee	
			Amount	Rank
WA	\$-1,343	0.68	\$3,401	39
WY	-107	0.65	3,537	34
AK	-318	0.33	3,687	33

SOURCES: Health Care Financing Administration, "Estimated Benefit Payments for Fiscal Year 1996," unpublished data (Baltimore: HCFA, March 1998); Board of Trustees, Federal Hospital Insurance Trust Fund, 1997 *Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (Washington: U.S. Government Printing Office, April 1997), 30-31; Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, 1997 *Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Washington: U.S. GPO, April 1997), 26; Tax Foundation, unpublished data (Washington: Tax Foundation, March 1998); J.H. Walder and H.B. Leonard, *The Federal Budget and the States: Fiscal Year 1996, 21st Edition* (Washington: U.S. Senate, September 1997), 85; and *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1996 (1996): 211-213.*

^a The Medicare balance of payments for any state is calculated as follows: Medicare benefit payments in that state minus Medicare revenues contributed by state residents. Thus, a positive figure indicates that Medicare's spending in that state exceeded what its taxpayers paid in taxes toward Medicare. The contributions for the program were \$188 billion.

^b The Medicare balance-of-payments ratio is calculated as the ratio of Medicare benefit payments in the state to the tax contributions that the state's residents pay toward the Medicare program. Thus, a ratio of greater than one indicates that a state's residents receive more in benefits than the state's taxpayers paid in taxes toward Medicare.

erly people than Georgia, but Georgia has a higher proportion of Medicare disabled beneficiaries. In general, western states have younger populations and relatively low per beneficiary costs, while the Southeast has lower per capita incomes and relatively higher health care spending, but there are exceptions all over the lot.

Whatever the actual results, however, issues of regional allocation increasingly affect Medicare policy. The most dramatic recent example is the treatment of payment rates for capitated plans in the BBA. Congress sought to respond to the complaints of rural representatives that the adjusted average per capita cost (AAPCC) formula, based as it was on actual Medicare costs in specific counties, penalized lower-cost (and therefore presumably more virtuous) rural counties, as well as such low-cost metropolitan areas as the Twin Cities and Portland, Oregon. At the same time, however, Congress responded to the concerns of teaching hospitals by carving out costs associated with Medicare's teaching hospital payments from capitated rates, to pay the money directly to the hospitals. Doing so by itself, however, would have produced significant rate reductions in major urban communities on both coasts, so Congress also established a hold-harmless provision in which each county was guaranteed a rate increase of at least 2 percent per year. The result was, in essence, a series of simultaneous equations that could not be solved. The BBA has produced the sought-after effect of substantial rate increases in rural counties, which has not yet been accompanied by

EXHIBIT 1

Medicare Balance Of Payments And Payments Per Enrollee, By State, 1996 (Ranked In Descending Order By Balance-Of-Payments Ratio)

State	Medicare balance of payments (millions of dollars) ^a	Medicare balance-of-payments ratio ^b	Medicare payments per enrollee	
			Amount	Rank
DC	\$ 638	2.12	\$5,655	1
FL	6,822	1.74	5,027	6
LA	1,544	1.64	5,468	2
MS	588	1.41	4,189	21
WV	374	1.37	3,798	29
TN	1,139	1.34	4,441	14
OK	615	1.33	4,098	23
AL	803	1.32	4,454	12
PA	2,408	1.27	5,212	4
AR	352	1.25	3,719	32
MO	626	1.18	4,191	20
KY	347	1.15	3,862	27
ND	54	1.14	3,218	43
AZ	351	1.14	4,442	13
MA	611	1.12	5,147	5
RI	71	1.09	4,148	22
TX	831	1.07	4,703	10
SD	15	1.04	2,952	50
ME	20	1.03	3,464	36
OH	124	1.02	3,982	24
NC	-67	0.99	3,465	35
IN	-57	0.99	3,945	25
NY	-281	0.98	4,855	8
SC	-62	0.97	3,777	30
GA	-349	0.93	4,402	16
KS	-131	0.93	3,847	28
MT	-41	0.92	3,114	45
MI	-568	0.92	4,307	18
CA	-2,107	0.91	5,219	3
NV	-98	0.91	4,306	19
CT	-333	0.89	4,426	15
IA	-227	0.88	3,080	47
NE	-154	0.86	2,926	51
DE	-81	0.85	4,712	9
IL	-1,508	0.84	4,324	17
WI	-569	0.84	3,246	42
NM	-159	0.83	3,110	46
OR	-385	0.82	3,285	41
NJ	-1,355	0.81	4,531	11
VT	-78	0.80	3,182	44
ID	-166	0.76	3,045	49
CO	-716	0.74	3,935	26
MN	-946	0.73	3,394	40
UT	-304	0.73	3,443	37
MD	-1,161	0.72	4,997	7
NH	-255	0.72	3,414	38
HI	-266	0.70	3,069	48
VA	-1,522	0.68	3,748	31

EXHIBIT 1

Medicare Balance Of

State	Medicare balance (millions)
WA	\$-1,343
WY	-107
AK	-318

SOURCES: Health Care Finance (Baltimore: HCFA, March 1998); Trustees of the Federal Hospital of Trustees, Federal Supplemental Medical Insurance (Washington: Tax Foundation, 21st Edition (Washington: U.S. Statistical Supplement, 1996).

^a The Medicare balance of payments is the difference between Medicare revenues contributed by the state and Medicare revenues received by the state.

^b The Medicare balance-of-payments ratio is the Medicare balance of payments divided by the state's total Medicare contributions that the state's residents receive more

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"The health policy debate consists of high-sounding arguments cloaking relatively narrow, traditional regional and local issues."

any increase in the availability of capitated plans in most of those communities, and has produced modest rate increases in high-cost urban areas, but at the same time the Twin Cities and Portland have received almost no benefit.

There is no platonically "right" formula for allocating capitated payments across communities, especially since the dynamics of individual markets vary on a number of dimensions, only one of which is price. In fact, a strong case can be made that formula-driven administered prices are a fundamentally unsound way of setting capitated rates to begin with, a position that HCFA has long advanced in the face of considerable resistance from the HMO industry and Congress. But the health policy debate increasingly consists of high-sounding arguments cloaking relatively narrow, traditional regional and local issues.

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**MEDICARE
POLITICS**

The Political Economy Of Public Action

The three dimensions of Medicare's political economy—redistributive, interest-group, and distributive—come together in a particularly insidious set of arguments that are made with increasing frequency in the contemporary debate about the future of Medicare. The tendency of politicians and the interests to which they respond to behave as politicians and interest groups generally do is advanced as a rationale for moving responsibility for management of Medicare out of the public sector altogether, through some form of greater privatization such as a defined-contribution plan. The politics of Medicare, it is argued, makes more rational or more effective administration virtually impossible unless some mechanism is found to delink Medicare policy from the political process.

This argument, of course, is most frequently made by those parties who, the rest of the time, are most busily engaged in interest-group and distributive politics. As such, the argument is the moral equivalent of a junkie's seeking to be thrown in jail because it is the only way he or she knows to keep away from temptation. "Stop me before I sin again" might be the practical translation of this position. Apart from its dubious moral basis, this argument has two basic flaws.

First, the solution it proposes probably would not work. As the process of modifying capitation rates in the BBA demonstrates so well, when regional or local interests conflict with broader policy

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principles, the former often prevail, and those interests can be advanced or protected in a defined-contribution or voucher scheme almost as easily as in the current program. Those who think that it would be more difficult to promote interest-group or distributive politics under such an arrangement simply are not giving Congress enough credit; one has only to think for a moment about the Internal Revenue Code to realize that. Of course, Congress, executive-branch officials, and interest groups probably would have to think of new ways in which to bend a new system to their interests, and that might slow down the process for a year or two—but just think of the bonanza for new generations of consultants!

More basically, the argument that Medicare must somehow be insulated from the day-to-day workings of the political system is, at root, an argument that in some basic sense we have lost the capacity as a nation to govern ourselves. The flaws in our current political system are real and profound, and there is a long-standing tradition in American politics in which academic and social elites have sought to insulate one public function or another from "politics." That tradition has given us civil service; the Interstate Commerce Commission; and independent, ineffectual boards of public health. But that tradition is, at root, fundamentally antidemocratic.⁸

Inside the psychic Beltway occupied by the policy elites, there is broad consensus that "we" could run Medicare, or other parts of the health care system, much better if only the ugly exigencies of the political process could be pushed aside. But if we take that approach to Medicare—which affects almost every American family, reflects a profound and long-standing intergenerational compact, and often literally involves matters of life and death—then we are saying either that the American people cannot be trusted with something so large and so important or that we cannot trust our political processes to adequately protect the American people. Either conclusion would suggest that our problems are far worse than the pending insolvency of the Hospital Insurance trust fund or the economic impact of the retirement of the baby boomers.

Conversely, this means that the task of reforming Medicare in a way that serves all Americans, present and future, may be inseparable from the task of broader political reform. The corrosive influences of campaign contributions, media both bought and unbought, and widespread public disillusionment and apathy are generic political problems that are also specific to Medicare. Politics does matter.

As Medicare has gotten bigger, more expensive, and more important with each passing year, it has become more and more subject to the broader workings of the U.S. political system. That is something,

I believe, that we cannot escape. More importantly, it is something, I also profoundly believe, that we should not try to escape. Doing so would break a bond far more basic than Medicare itself.

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NOTES

1. U.S. Department of Health and Human Services, Health Care Financing Administration, *A Profile of Medicare* (Washington: HCFA, May 1998), 16.
2. *Ibid.*, 18.
3. Compare *The Federalist*, no. 10 (New York: Mentor Books, 1961), 77-83.
4. K.R. Levit et al., "National Health Spending Trends in 1996," *Health Affairs* (January/February 1998): 35-51.
5. *Ibid.*
6. *BNA's Medicare Report*, 1 May 1998, 447.
7. The data that make up these "balance-of-payments" tables are too extensive to be presented comprehensively in this paper. For more concisely prepared tables, contact the author at Institute for Medicare Practice, Mt. Sinai Medical Center, One Gustave Levy Place, Box 1077, New York, NY 10029, or via e-mail at Bruce_Vladeck@smtplink.mssm.edu.
8. The historical ties between academe and the Progressive tradition pose what should be a worrisome parallel for this generation of health services researchers. Just as an earlier generation of social "scientists" provided much of the intellectual rationale through which dominant Protestant elites maintained sovereignty at the expense of newly emergent immigrant populations a century ago, so the increasing influence of health services research may serve, if health services researchers are not careful, to advance the interests of particular contemporary elites. In today's social sciences this danger is primarily the result of the simple fact that nothing ever works as well in practice as it does in theory, so no real program can ever compete with abstract micro-economic hypotheticals. The greater power that markets give to those with more wealth thus is reinforced in the political arena by analyses that confuse market models with reality.

Budget Medicare The I

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