The future of Medicare policy reform: Priorities for research and demonstrations

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The Medicare program, the largest health insurance program in the United States, is clearly at a crossroads as it enters its third decade. Historical increases in health care expenditures, plus a changing political and economic landscape, have set the groundwork for policy reform. Basic reform strategies, most notably reimbursement arrangements, are discussed. In 1983, Congress enacted the prospective payment system (PPS), which initiated a fundamental change in the way hospitals are paid for care delivered to Medicare beneficiaries. But PPS is only a steppingstone to broader reforms such as capitation and evolving organizational models in the delivery of care. Policymakers' considerations of coverage of services, such as long-term care and organ transplants, are also discussed. Within the context of these policy reforms, the authors shape an agenda for research and demonstrations—the blueprint for taking us from "here to there."

Overview

Introduction

Most western industrialized nations have reached a crossroads in the financing of health care. The United States is no exception. This is most evident with the Nation's largest single health insurance program, Medicare, which serves nearly 30 million elderly and disabled citizens. Last year this program, along with its sister program, Medicaid, marked the 20th anniversary of its original legislation. As a provider of payment for care to some of the Nation's most vulnerable and needy citizens, with an annual Federal budget exceeding $75 billion, the importance of Medicare and the magnitude of its impact are perhaps unparalleled in U.S. health care legislation.

Medicare was established as a federally administered program with uniform benefits for people 65 years of age or over, who were identified as having the greatest need for health care services, the least private health insurance coverage, and the least income to pay for services. Later, in 1972, Medicare was expanded to cover two additional high-risk groups: the disabled under Social Security and individuals with end stage renal disease (ESRD). There is no doubt that during the past two decades the Medicare program has done much to reduce financial barriers to access to state-of-the-art health care services for these population groups. By any measure, the millions of beneficiaries served by this program are better off today than they would have been without it. Not surprisingly, the program has received extraordinary and consistent public support, with more than 90 percent of those surveyed agreeing, time and again, with Medicare's purposes and policy goals.

But, along with the program's successes, a number of questions about its future have developed, given the changing economic, social, and political context in the United States during the last two decades.

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Although the Medicare program improved access to care for beneficiaries from the beginning, Medicare could not escape the criticisms of spiralling costs and the many perverse incentives created by its retrospective cost-based reimbursement mechanisms. By the late 1970's, the growing expenditure trends and the changing demographics (an increasing proportion of the U.S. population 65 years of age or over) combined to endanger the solvency of the Medicare Trust Fund. The rapid increases in expenditures for the Medicare program, as well as health care services in general, constrained the ability of the Federal Government to fund other health and social programs. To a certain extent, the growth in expenditures also endangered the Nation's overall economic productivity.

At the same time as health care expenditures were escalating, some say uncontrollably, the political landscape began to change dramatically. The national mood brought calls for fewer taxes, for reduction of budgets, and for deregulation of market sectors, such as transportation and health. This conviction of less general involvement by Government was reinforced by mounting public pressures surrounding growing budget deficits; Medicare, like other Federal programs, increasingly competed with more global policy objectives. In the space of a few years, the Nation moved from an era when health care was considered a right for all citizens to an era when cost considerations became the dominant issue.

A marketplace context

Health care cost containment is perhaps the most difficult of contemporary social issues. The health care system includes many individuals and organizations with competing goals and objectives. The interplay of public policies and this complex web of actors often produces unintended consequences. However, a number of principles or guidelines can usefully frame the policy options before us. First, Medicare will continue, as it has from the beginning, to "buy into," rather than displace, the existing health marketplace. In a culture that values

individualism, pluralism, and diversity, the flexibility of marketplace solutions will be pursued. This will assure the richness of diversity in health care institutions, comparable with that observed in housing, education, transportation, and other sectors. Second, Medicare will further promote the primacy of local decisionmaking and consumer choice over centralized regulatory approaches. Third, Medicare can be best understood in the context of the larger development and evolution of the private health care marketplace. If, for example, multihospital chains and prepaid health plans serve increasing numbers of health care consumers, Medicare can be expected to mirror this shift. Similarly, as clinical practice patterns shift to alternate settings (e.g., outpatient versus inpatient), Medicare can be expected to structure its payments accordingly.

At the same time, as the largest single payer of medical care services, constituting nearly 30 percent of the Nation's expenditures on health care, Medicare outlays affect the larger medical marketplace. For example, when Medicare coverage is extended to new technologies, the infusion of program dollars often propels the technology's further utilization and diffusion. Medicare's impact on the marketplace is unavoidable, and must be considered in the development of Medicare policy.

Medicare program objectives will be achieved, then, only through a subtle balancing act that includes changes within continuity. For example, program expenditures must be contained while maintaining responsiveness and access to needed medical care for beneficiaries. Correspondingly, broader social goals of greater efficiency and equity must be attained within the structure of the existing health care marketplace and local decisionmaking.

These objectives and goals are achievable through timely research and demonstrations that identify and refine the most promising of policy options, and through the structuring of four basic reform strategies:

- Reimbursement arrangements.
- The mix of program benefits.
- Eligibility requirements.
- Program-funding mechanisms.

The first approach has been utilized most during the last decade, and, correspondingly, it holds the greatest promise for future reform. Research and demonstration efforts continue to identify the relative strengths of this strategy in planning and developing the program's future. The following discussion emphasizes this approach.

Reimbursement arrangements

Historical perspective

When the Medicare program was created in 1965, it borrowed from models of existing health insurance practices of the day. Medicare adopted the practice of paying hospitals retrospectively, according to their costs, and of paying physicians according to a customary, prevailing, and reasonable charge method. To deal with the health care providers, fiscal agents were given the major responsibility for reimbursement and auditing services. This reliance on existing insurance models promoted rapid implementation of a program developed to reduce financial barriers, enabling and encouraging the Nation's elderly to gain access to mainstream high-quality care.

Program costs, however, began to spiral from the very first year of implementation, and continued unabated until only recently. Most observers agree that these dramatic changes in spending levels stemmed from several factors. One major factor was the substantial increase in demand for health care services, associated with Medicare, Medicaid, and other third-party payment. In addition, these third-party payment mechanisms insulated the individual from the direct consequences of the cost of services. Finally, the response of health care providers to these reimbursement methods was to provide nearly unlimited services. The net result was almost unbounded demand and supply of health care services in the United States.

As health care expenditures consistently increased, well ahead of the general rate of inflation, there was mounting pressure at the Federal level to develop policies to promote cost effectiveness and cost containment, while preserving access to care. In the search for solutions, every aspect of the health care system came under scrutiny, and a number of broad policy alternatives were advanced. For example, some minor tinkering with taxes, cutting eligibility and/or benefits, and increasing the direct costs to the beneficiary were among the options analyzed and debated. In the search for a "cure" to the underlying systemic problems, though, provider response to reimbursement methods has been most directly addressed in U.S. health care policy.

Initially, legislation was enacted that emphasized increased regulatory apparatus. The 1972 Amendments to the Social Security Act, for example, established the professional standards review organization (PSRO) program to review the care received by all federally funded patients. A major emphasis of the PSRO program was to eliminate unnecessary hospital days. Congress also established a network of health systems agencies (HSA's) with the responsibility of overseeing area-wide health planning and resource development. Certificate-of-need programs were implemented so that large capital expenditures could be reviewed.

In contrast to these regulatory programs, there were attempts to increase competition and general market efficiencies. The Federal Government encouraged the growth of health maintenance organizations (HMO's), which also promoted the use of preventive services and decreased the need for hospital care. New methods for paying hospitals were tested through demonstrations, with the primary goal of containing

hospital budgets and capital growth. The reimbursement methods tested included incentive reimbursement schemes (sharing the savings at reduced costs) and prospective reimbursement mechanisms.

Some of these approaches were judged to be generally ineffective or inconclusive. Others were terminated or altered. The results of some of these innovations were slow to take hold; the results of others were too new to measure. But none of these policy changes, except one, proved completely satisfactory in containing costs. By the early 1980's, 10 years of research, evaluation, and experimentation had clearly established the utility of prospective payment mechanisms. In 1982, Congress took an initial step in this direction with incentive reimbursements under the Tax Equity and Fiscal Responsibility Act (TEFRA). This legislation set limits on Medicare reimbursements for hospital costs at the per-case level, and also placed a limit on the annual rate of increase for Medicare's reasonable costs per discharge. One year later, in 1983, recognizing its potential as a pragmatic and immediate solution to spiralling costs, Congress enacted the prospective payment system (PPS) for most inpatient hospital services covered by Medicare.

PPS, which established a national payment rate for hospitals based on diagnosis-related groups (DRG's), has been under way since October 1983, and is scheduled to be phased in during a 4-year period. PPS holds the promise of being a major structural change. Indeed, this aspect of "prospectivity" in payment (and the corresponding movement away from cost-based reimbursement mechanisms) is probably best viewed as a first step in a series of policy decisions intended to move Medicare from its position as a financer of health care to that of prudent purchaser of efficient, yet high quality care. Concurrently, PPS has dovetailed with private sector health care financing initiatives to increase overall market efficiency.

The effects of these public and private sector changes have already been striking. During the first year of PPS, for example, although the average length of stay was expected to fall, the actual decrease experienced was more pronounced than would have been projected, based on Medicare historical trend lines. Contrary to nearly universal expectations, admission rates under PPS have also fallen. Supply capacity has been affected; the number of short-stay hospital beds has fallen, and occupancy rates are the lowest since data have been available on this measure. Still, hospital profits increased during the first year of the new system, primarily because of the reduced lengths of stay and associated cost reductions (Guterman and Dobson, 1986).

From a program standpoint, the new system has not only stabilized outlays, but has enabled Medicare to predict annual increases in hospital expenditures. It has also pushed back, by at least a decade, concerns about Medicare Trust Fund solvency.

PPS in transition

Overall, the new system has demonstrated itself to be a driving force in an era of veritable revolution surrounding the delivery and financing of health care. That is not to say the new system is perfect, or even permanent. The implementation of a per-case payment system using DRG's was a bold step in providing an economic incentive to restrain resource use and maximize efficiency, without adversely affecting access or quality of care. However, making the system function smoothly now encompasses more than principles of insurance; it necessitates careful attention to details of the payment mechanism that influence the wider policy parameters. Although PPS has achieved initial success, it also requires important policy choices as the system evolves. For example, by how much should payment rates increase year by year to assure continued access to care? To what degree should wide geographic variations in prices paid across areas (e.g., urban versus rural) and within regions be reflected in future payment levels?

The new system also introduced a new set of immediate concerns, including finding methods for refining the system to take account of severity of illness as well as intensity of services rendered. Perhaps the most important concern relates to assuring access and quality of care. As continued fiscal pressures constrain payment levels, program efficiencies may no longer be possible. Because the instruments to measure production efficiencies are still blunt, though, the signposts marking unwanted program cuts and implicit rationing may not clearly appear. As a result, policymakers may need to arrive at more precise mechanisms and standards for quality assurance.

Medicare's research and demonstration initiatives have reflected this concern since the advent of the new system. Federal policymakers carefully monitor levels of quality and access to care through a series of internal studies that assess patterns of national utilization and expenditure data. In addition, Medicare's grant and cooperative agreement mechanisms have extended these analytic activities and fostered the development of more precise and sensitive indicators of high-quality care.

Other issues include finding payment methods for supporting portions of medical education, continued clinical research and technological innovation, and care for the medically indigent. As Rashi Fein (1985) has noted, the new competitive marketplace has made the "implicit explicit." That is, the cross-subsidies and cost-shifting policies of the past, phenomena uniquely rooted in the American health care system, are disappearing. This has led to a dilemma about how to handle these and other nonmarket items that are not clearly under reimbursement formulas for patient care, but nonetheless are greatly influenced by them. The situation of uncompensated care, for example, is instructive. Depending on the particular estimate, somewhere between 20 and 40 million

citizens in the United States have either no health insurance or inadequate insurance to cover their individual medical care costs. In the past, providers, such as hospitals, have been willing to absorb a great percentage of the unpaid bills. The more competitive markets appear to reduce the amount of the uncompensated care institutions can provide without additional sources of revenue. This issue, along with others perhaps, will need to be addressed during the next decade.

Lastly, payment reform must be extended beyond hospital services if Medicare is to contain costs over the long term. Payment for post-acute services, such as care in skilled nursing facilities (SNF's) and home health agencies (HHA's), will need to be modified. In addition, although services by physicians are only 20 percent of all health spending, physicians account for more than 70 percent of expenditures. Physicians' decisions on use of hospital services, diagnostic testing, and so forth, are critical determinants of overall health expenditures (Davis and Schieber, 1984). Because the rate of growth of overall Medicare reimbursements during the last two decades has proven to be as inflationary as inpatient hospital care, general agreement has emerged that physician payment under Medicare must be changed. Possible reform alternatives under consideration have been the development of fee schedules and relative value scales for physician services, as well as more general prospective payment mechanisms.

However, many have argued that these physician and other provider reform approaches are, perhaps, more appropriately viewed as impediments to the overall objective of Medicare payment reform. Although PPS has redirected the hospital industry, it may be most effective as an intermediate step to a more permanent solution that would extend across all providers and settings. Continued cost pressures from an aging population have further demanded timely consideration and development of a more long-term approach. Such reform is likely to be based on more competitive strategies that use capitation as the basic payment mechanism. Under this reform, the objective is to have a single capitated arrangement encompassing physician, hospital, and other Medicare-covered services.

Beyond PPS: Moving to capitation

Enrollment by Medicare beneficiaries in capitated payment systems and prepaid health plans, such as HMO's, has occurred for several years, but until recently the numbers were very small. In 1981, about 595,000 Medicare beneficiaries (a little more than 2 percent) were enrolled in such plans. In addition, services for these beneficiaries were paid on a retrospective, cost-reimbursement basis. The 1982 TEFRA legislation, though, included prepayment and other provisions to encourage enrollment in HMO's and other competitive medical plans (CMP's). By 1985, the number of Medicare beneficiaries enrolled in risk-based HMO's and CMP's had effectively gone from zero to more than one-half million.

The appeal of capitated payment systems stems from the incentives for efficiency (and the assumed cost savings that result) when the health care provider receives the following:

- A single price.
- In a defined period of time (e.g., 1 year).
- For one person (or each person enrolled).
- With a known set of benefits.

Furthermore, capitated systems hold the promise of injecting greater competition into the health care sector, which in turn could constrain health care costs. If individuals are offered incentives to choose efficient, less costly health delivery plans, then providers will compete for enrollees. Competitive capitation approaches are seen as "all-win" situations; that is, they hold potential advantages for all of the actors: the beneficiary, the provider, and the payer. For example, the beneficiary is typically offered a broad choice of plans and lower copayment provisions than under fee-for-service, and can receive superior management and continuity of care. Providers, on the other hand, are less restrained concerning the organization and delivery of care, and have generally greater freedom in determining the appropriate mix of technologies, the balance of preventive and curative services, and the service-delivery mix. In addition, capitated payment systems allow the provider to retain any surplus of revenues over cost. Lastly, purchasers of care benefit from capitation in that expenditures not only are reduced because of fewer hospitalizations, but expenditures become fully predictable, allowing better management of program resources.

In an effort to promote competition in Medicare and within the health care system, demonstrations of various capitated approaches are projects currently under development. These approaches include systems for capitating retirees by employers, unions, and pension fund managers; participation by non-TEFRA prepayment plans; and testing of organizational models that assume partial risk for benefits on a capitated basis. A model of particular interest is one in which an employer, union, or health and welfare fund manager would contract with the Federal Government and underwrite the costs of medical care for all of its Medicare-eligible retirees for a fixed dollar amount per person. These organizations would negotiate and/or bid with the Government to establish the fixed price and contract terms (e.g., time period, risk). General guidelines for demonstrations of these organizational models would allow beneficiaries to continue to obtain benefits through the traditional Medicare delivery system or to elect to enroll in alternative arrangements, such as HMO's or preferred provider organizations (PPO's). These organizations at risk may operate more efficiently, not only in relation to the alternative delivery systems within their project, but also in the administration of the fee-for-service part of their system.

Another important demonstration priority involves the State Medicaid programs. Capitated arrangements are becoming more prevalent as a mechanism for States to purchase and/or finance health care under the Medicaid program. Such arrangements can include counties, health-insuring organizations, or other prepaid organizations. A critical issue here will be the extent to which particular payment models are successful (and why), particularly as a richer diversity of capitation arrangements are established across populations and regions.

These demonstrations will rigorously examine quality, beneficiary access, and out-of-pocket liability, as well as cost effectiveness of service provision. Currently, ongoing evaluations of both the existing Medicare and State Medicaid capitation demonstrations, as well as the HMO's and CMP's operating under TEFRA, have received careful attention. In the move toward capitated systems, these evaluations are helping, in specific ways, to guide the special needs of evolving organizational models. For example, a crucial concern is beneficiary impact. Thus far, it would appear that beneficiaries who have enrolled in HMO's or other types of alternative health plans have been satisfied with their selection. Assessments of beneficiary satisfaction will remain an integral part of testing and monitoring other capitation models.

In moving toward fully capitated systems under Medicare, though, at least three major issues must be confronted. The first is to adequately develop the technology to determine capitated payments, reflecting differences in health status and potential use of resources. This allows for control of favorable or unfavorable selection practices on the part of both providers and beneficiaries; thus, the competition is on the basis of efficiency rather than unfair market advantages (Eggers, 1980).

Presently, Medicare's price for risk-based TEFRA HMO's and CMP's is based on the adjusted average per capita cost (AAPCC). This measure has undergone much scrutiny, and undoubtedly will undergo further examination. We need to be assured that the established payment is accurate, reliable, and equitable for both the Government and the providers. Several research and demonstration projects are testing various health status refinements and modifications to the AAPCC. These projects will determine the extent (if any) of selection bias in the enrollment process and whether the AAPCC can or does adjust for it. A continued challenge in using the AAPCC to set capitated rates is that over time it will be increasingly difficult to establish payment rates based on fee-for-service market prices. As the percentage of beneficiaries receiving services in a fee-for-service setting continues to decrease, the utility of those data to set prices will also decrease.

The second major issue is the delineation of the extent of the Government's responsibility for quality assurance in a system, which may have incentives for underprovision of care, especially for high-risk beneficiaries. The third relates to the previously discussed geographic variations in Medicare reimbursements across areas and within regions, and the extent to which these differences should be taken into account in future payment formulas.

Related to these last two issues are newly emerging areas for research and development; these areas will focus on the type of data collection efforts that should be initiated to examine and monitor a new system and its evolving organizational models. This is true both from the perspective of the individual beneficiary and the payer. The ultimate objectives of Medicare's competition strategy cannot be met without appropriate and accessible information for the consumer of care. To select alternatives best suited along individual needs, beneficiaries must understand available options, the specific benefits offered by each alternative, the price and out-of-pocket liabilities, and the comparability of these features across plans.

Likewise, the Medicare program as payer must identify those data elements necessary to assure appropriate oversight responsibilities. Federal data requirements will be largely defined by the pricing strategy and quality measurements implemented by the public sector. The ability to effectively establish prices and monitor quality will directly flow from the quality and type of data collected. In the ongoing redesign of Medicare, however, maximum provider participation must be encouraged, and data collection efforts should not impose unnecessary reporting burdens on any participants.

Finally, there is an emergent consensus about what can be expected or predicted under capitation in the short term. In general, greater competition, less hospitalization, and lower costs for beneficiaries and purchasers should be the norm in the early years. Observers disagree, though, as to whether pressures for cost containment will continue indefinitely or whether the new system will produce a "one-shot" reduction. One side of the argument is that the push of new and costly technologies will overshadow long-run gains in efficiency. Historically, this often has been the outcome with new programs undertaken for cost-containment purposes. As with PPS, though, the incentives underlying capitation may redirect drug and device industries to develop more cost-reducing technologies. In addition, the more intensified levels of competition in the marketplace, coupled with policy initiatives to make available information for consumer comparison shopping, could produce cost reductions indefinitely. A number of new and existing research and demonstration projects will attempt to isolate and measure individual facets of market behavior in each system.

Alternative strategies for reform

The success and promise of reimbursement mechanisms as a strategy for reform need not preclude alternative strategies. Other broad strategies, especially as they pertain to containing program costs, are to change benefits or alter program-funding sources. These strategies can apply to both public and

private programs, and can complement reforms pertaining to payment approaches. For example, we have witnessed significant HMO innovations, reflecting their private enrollment experience, in benefit package design. By offering an appealing mixture of benefits and cost sharing, significant numbers of beneficiaries have left fee-for-service to enroll in HMO's and CMP's where there is less flexibility in provider choice. To date, HMO's and CMP's have also tinkered with the redesign of cost sharing under Medicare. Though remaining actuarially equivalent to costs under the traditional Medicare provisions, beneficiaries have reacted favorably to the new cost sharing.

Almost all HMO's and CMP's have offered catastrophic coverage for hospital care. As additional research and demonstration projects are initiated, testing the effects of changes in the Medicare benefit package will need to be considered. The flexibility available through capitated Medicare may prove more optimal than that under fee-for-service Medicare.

Similarly, program-funding methods could be especially important if the future heralds an extension and expansion of Medicare coverage. Given the general concern in the Nation about the aging of the population, one considered option has been the development of policies that will provide mechanisms for the financing and delivery of long-term care services. Medicare is an acute-care program, and the burden for providing payment for long-term care has traditionally fallen on Medicaid. Whether the program can carry this burden indefinitely, though, is far from clear. Currently, few of the aged have private insurance for nursing home care or for long-term care services in the home. Consequently, a majority of the aged face the risk of financial ruin and dependency from an extended long-term illness or disability that requires personal and nursing care services. The current financing dilemma is likely to worsen in the next three decades as the proportion of the population 65 years of age or over rises, although the extent to which the private long-term care insurance market could develop remains unclear.

Related to the funding issue is the lack of availability of appropriate and less costly community-based, long-term care services. The impaired elderly are likely to require personal care and support services as much as medical care services. Except in an institutional setting, the combination of such services often is difficult to obtain by those with long-term care needs. Most aged people with functional limitations prefer to remain in the community and to maintain their independence as long as possible. As a consequence, a major concern is that new approaches be found for caring for the needs of the elderly in the community (Gornick, et al., 1985).

A final area of coverage extension is new technology. As previously noted, PPS offers an opportunity to moderate the flow of new technology into the health sector. In the future, the Medicare program, nevertheless, can be expected to face some tough decisions relating to coverage of quality-enhancing, yet highly technological and costly, services. Only after several years of research, debate, and deliberation did Medicare approve coverage of heart transplants. Organ transplants generally provide the latest of examples of hard choices about who will pay and (possibly) who will receive.

Summary and conclusions

As the Medicare program enters the third decade, it is clearly in a state of transition. When Medicare was initiated in 1965, the health care marketplace rapidly changed from one of little, or no, cost concern to one where the escalation in expenditures forced cost and budget issues to dominate. By the early 1980's, though, there were indications that the spiral in health care outlays was beginning to end. The Medicare hospital prospective payment system is generally perceived to have contributed substantially to this event.

PPS has set into motion a set of payment reforms that have drastically altered the underlying behavioral incentives in the management and delivery of care. A seller's market has been transformed into a buyer's market. The Federal Government, along with other major private and public purchasers of care, has seized the initiative in deciding on the volume and mix of health care services and how much they will cost. This decade has witnessed less and less reliance upon traditional fee-for-service medicine and retrospective cost-based reimbursement principles. Instead, prospectivity is rapidly becoming the norm.

Changes in Medicare policy cannot stop here, though. As cost concerns diminish, efforts have redoubled, in this new environment, to assure access and quality of care for the Nation. Similarly, other lessons of the new PPS must help guide and structure the creation of more complete systems of prospectivity, such as capitation. Perfecting the set of payment incentives is also not only important for covering current benefits, but almost a prerequisite as new applications for care, as well as different types of care, are explored.

Within this environment, Medicare's research and demonstration agenda must focus on competitive health care delivery systems in general, with particular emphasis on those which would be paid on a capitated basis. The agenda also must be constructed in a manner that would complement and promote the continued growth of TEFRA risk contracts. Indeed, the previous discussion has delineated Medicare's research and demonstration program along the lines of several principal issues. These include the following:

- Quality and access.
- Pricing.
- Organization models.
- Beneficiary impact.
- Market behavior.
- Information needs.

In another 20 years, research and demonstration efforts in these areas will no doubt contribute, perhaps even lead, to a different health care system and a different Medicare program. The challenge will be to build not only a different program, but a better program.

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