INTRODUCTION: PRINCIPLES AND SUMMARY

In July 2000 Medicare turned thirty-five. The significance of this birthday is open to multiple interpretations. Among experts and the general public, opinions vary about whether the nation's federal health insurance plan for older Americans and the disabled faces a full-blown midlife crisis, deserves thorough reexamination, or rates a mostly clean bill of health.

What is beyond dispute is the gravity of decisions to be made about the program's future. Medicare insures more Americans than any other government health care program, about 39 million people in 2000. It pays for one out of every five dollars spent on health care in the United States. It makes up more than 12 percent of the annual federal budget, and its spending will rise in the future as medical costs and program enrollment increase.

Medicare and Social Security (the federal program for retirement benefits) are far and away the most popular government programs. Ninety-five percent of all Americans believe that it is "very important" or "somewhat important" that Medicare be preserved.[1] Adults aged fifty to sixty-five, the next group that will enter the program, trust it to deliver better access to care, and a higher quality of care, than employer-sponsored group insurance or directly purchased private insurance.[2] Without Medicare, millions of older and disabled Americans would be unable to afford health insurance or to pay for medical care.

THE MISSION OF THE CENTURY FOUNDATION TASK FORCE

The debate over Medicare's future has evolved rapidly over the past several years. In 1997, passage of the Balanced Budget Act contributed greatly to ending federal budget deficits, principally by slowing the growth of Medicare payments to hospitals, home health agencies, health

care plans, and other medical providers.

This act also established a National Bipartisan Commission on the Future of Medicare to study and make recommendations on the program's long-run financing. When this commission convened, leading members argued that Medicare needed to be reformed swiftly and drastically because of the strain its future spending could place on the federal budget. Projections made by the program's trustees and by the Congressional Budget Office anticipate future shortfalls for Medicare's Hospital Insurance Trust Fund. This reflects the substantial growth in program enrollment that will occur after the baby-boom generation retires and higher medical costs that stem partly from the introduction and diffusion of costly new procedures and therapies. In the end, however, the commission was unable to issue formal recommendations owing to fundamental disagreements between those who wanted to encourage greater participation in Medicare by private health plans in order to reduce spending and those who doubted the potential savings from this approach and feared its impact on beneficiaries.

The Century Foundation's Task Force on Medicare Reform first convened in spring 1999, just before the national commission concluded its work. The members of the task force—policy analysts, physicians, hospital administrators, and representatives of consumer, business, labor, and health plan trade groups—are experts and pratitioners with diverse perspectives on the program.

The task force organized its work around the question, "What do we want Medicare to look like in the future?" To some degree, this effort paralleled that laid out by the cochair of the national Medicare commission, who described the commission's task as "looking at the fundamental question of what we want Medicare to do and what kind of health care system we want for the elderly in our country."[3]

While sharing the concern of the commission's leaders with the adequacy of the program's long-term financing, most members of The Century Foundation's task force did not view Medicare's potential financing difficulties as the primary reform imperative. Some task force members believed that incremental reforms more in keeping with the prior history of changes to Medicare would be prudent, while others favored more significant changes. All agreed, however, that major structural reforms to Medicare should not be made solely on the basis of prognostications of future fiscal doom. Looking beyond issues of Medicare financing, the task force members argued, could open the door to considering reform options—especially those that seem slightly beyond the reach of political

possibility—in a new light. This spirit animated the group's deliberations and informs the discussion that follows.

Over the course of five meetings of the full group and a number of discussions among smaller subcommittees of the group, the task force identified four major areas of agreement. The members agreed that:

- Medicare's character as a social insurance program should be preserved;
- the future cost of financing the program is not the only problem that reforms must address;
- the coverage provided by the current program is inadequate; and
- Congress and program administrators should explore ways to improve the quality and value of services that are paid for by Medicare and implement these approaches.

Much of the work of the task force was devoted to refining a set of general principles that would express these areas of agreement in more practical terms and thus bear upon both current and future debates over Medicare reform. These principles are listed below. Each principle refers to a critical element of program design, such as financing, the scope of the benefit package, and consumer choice. Taken together, the principles are intended to respond to the major issues that policymakers will need to consider when proposing comprehensive reforms to Medicare. While the details of proposals change, certain basic approaches to Medicare reform tend to persist. To be sure, there are other issues that large-scale reform would have to take into account, such as Medicare's role in funding medical education and its possible expansion as a payer for long-term care. But the task force felt that these other areas were either more technical in nature or removed from the current policy debate compared to the features of Medicare that are discussed in the principles and rationale.

The remainder of this introduction summarizes the essential points of the full report and relates the principles to these broad areas of agreement. The body of the report explains why these particular principles were chosen, defends their choice, and illustrates how they can be used to judge particular Medicare reform proposals.

Principles for Medicare Reform of The Century Foundation's Task Force

I. Medicare should remain a social insurance program that protects older and disabled Americans from the financial burden of health care, that shares the financial risk of serious illness and disability among the millions of Americans who are covered and who will be covered, and that requires contributions from workers and employers.

II. Medicare should continue to be financed in part through general revenues and in part by contributions from workers, employers, and the covered population, but as Medicare's financial needs grow, older and disabled Americans should not shoulder a significantly higher proportion of program expenditures or medical costs.

III. The scope of health care benefits covered under Medicare should be expanded to include elements that are critical to preventing or detecting disease and managing chronic conditions, as well as treating acute illness.

IV. Proposals to reform Medicare should reduce and eliminate, rather than maintain or exacerbate, the disadvantages faced by vulnerable populations within the program.

V. Medicare should be a responsible steward that works to promote and encourage high quality care and the efficient delivery of medical services.

VI. The process by which people with Medicare choose among alternative health insurance options and products should be made easier: it should clarify important distinctions among different types of health insurance and provide useful and unbiased education, information, and decision support to beneficiaries and those who help them make choices.

VII. Medicare's management and administrative capacities should be adequately funded so that the goals implied by these principles can be carried out effectively in the context of a growing Medicare population.

MEDICARE'S CHARACTER AS A SOCIAL INSURANCE PROGRAM MUST BE PRESERVED (PRINCIPLE I)

The members of the task force strongly felt that any reforms to Medicare should not jeopardize the program's social insurance character. Social insurance offers collective protection against a set of risks that private insurance markets are unlikely to insure against at an affordable cost.[4] In the United States, such programs characteristically involve the payment of a dedicated tax, administration by government or other public authority, and provision of benefits under uniform statutory rules. In Social Security, this benefit is a cash replacement for wage income. In Medicare, it constitutes payment for hospital stays, physicians' services, and other medical services.

All insurance plans pool risk, but social insurance programs like Medicare do so in distinctive ways. As one analyst puts it: "Health insurance, life insurance, disability insurance, and annuities—the principal components of Social Security and Medicare—can be found in the private market. But Social Security and Medicare insure against risks such as living longer than average; not earning a good living; and obtaining access to very specialized care generally or relatively routine care in both poor urban and poor rural areas"[5] Medicare helps protect against the large expenses that can—and do—occur as the prices of medical procedures and other services rise. Since the benefit package is uniform and the premiums for insurance do not rise with age, older, poorer, and sicker Americans get an especially good deal.[6] In addition, Medicare-eligible beneficiaries who are at or near the poverty line may have all or part of their premiums and copayments paid for by Medicaid, the federal/state health program for poor Americans who meet other criteria for eligibility.

Medicare modestly redistributes wealth from better-off to less well-off Americans. Unlike Social Security, there is no income ceiling on the payroll tax that funds the hospital insurance portion of Medicare. General revenues, which fund most of the payments for physicians' services, are more progressive than payroll taxes. Since Medicare relies in part on compulsory payments by current workers, it shares risk among different generations as well. Unlike workers in many other developed nations, American workers under the age of sixty-five contribute to a program for which they typically become eligible only when they reach retirement age. This magnifies the importance of retaining the social compact among different generations that has supported Medicare to date.

Medicare's Costs Are Hard to Predict, and Their Burden Should Be Shared Fairly (Principle II)

What Medicare costs—rather than what the program accomplishes for seniors, the disabled, and their families—has been the principal focus of Congress during much of the program's lifetime. This is not surprising. The steady rise of Medicare expenditures in the 1970s and 1980s exceeded the rate of inflation and contributed to the growth of federal deficits.[7] Demographic and economic projections show a growing population of older, longer-lived Americans and rising medical costs, especially prescription drug costs.

However, placing such a strong emphasis on Medicare's financing and on its expected long-run impact on the federal budget tends to obscure the reality of Medicare's current fiscal situation and the importance of the program's basic aims. For example:

The Fiscal Situation Has Improved. Medicare's financing looks more sturdy than experts predicted several years ago. As recently as 1997, the trustees of the Hospital Insurance Trust Fund warned that this fund could be depleted by 2001. Though projections of near-term trust fund insolvency had not been uncommon, the new numbers helped focus additional attention on the program's financing. The Balanced Budget Act of 1997 has had a more potent effect in reducing Medicare's expenditures than expected, while a strong economy has boosted revenues. In 1999, for the first time, Medicare spending actually decreased by 1.5 percent, compared to a growth rate of slightly more than 4 percent for private health insurance. Thanks to this favorable trend, the Part A Trust Fund is now expected to be in the black through 2029.[8] These developments do not counsel complacency, but they certainly appear to be grounds for deliberate rather than hasty action.

Projections Are Uncertain. The rapid changes from shortfalls (or anticipated shortfalls) to surpluses, in both the federal budget and in the Medicare Trust Fund, point out the uncertainty of projections, especially long-run projections, and the dangers to policymakers of relying too heavily on these estimates. The budget deficit for the 1998 fiscal year, for example, was estimated in 1993 at $357 billion, while the actual figure turned out to be a $69 billion surplus.[9] The 1999 Congressional Budget Office forecast of Medicare spending for the 2000–2007 period was more than $530 billion less than the office had predicted in 1997.[10] To be sure, projections have been known to understate as well as overstate future

obligations. But these trends offer a fundamental caution against basing policy changes largely on estimates of future costs.

Changes in various social and economic trends could ease the effect of the baby-boom generation's retirement on taxpayers. Some of these changes are incorporated in official projections, while others are not. The size of the labor force and of the elderly population itself may vary. Reduced disability among the elderly—perhaps accelerated by behavioral changes and new medical treatments at the genetic level—could conceivably lower Medicare and Medicaid costs. And it is worth keeping in mind that the size of the U.S. elderly population relative to most other industrialized nations is still quite small. Because the percentage of Americans over the age of sixty-five will approach the current levels of Germany or Japan only by 2020, the United States will have the advantage of observing how other countries deal with this demographic transition.

The most important—and uncertain—determinant of the sustainability of government programs is the rate of economic growth. Citizens of a nation that grows steadily wealthier can afford to pay higher taxes for social welfare programs while still raising their living standards. One 1999 study, for example, estimated that if U.S. economic growth averages 2.8 percent over the next thirty years (slightly less than the 2.9 percent it has averaged over the past thirty-two years), government spending as a share of GNP will remain constant despite the anticipated demographic changes.[11]

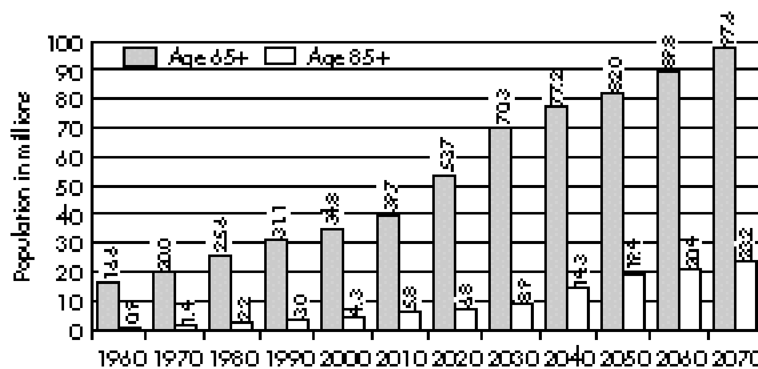
Increased Medicare Spending May Be Worth the Cost. Several recent studies argue that there is a strong connection between the availability of Medicare and the overall improvement in the health of seniors and the disabled over time. In particular, reductions in mortality have been concentrated among the elderly since 1966, in large part thanks to better prevention and treatment of cardiovascular disease.[12] Functional disabilities also have declined among seniors, and new technologies such as artificial joints have improved their quality of life.[13] Depending on how much advances in medicine reduce morbidity and disability for older Americans and how highly society weighs the value of these improvements, higher Medicare spending may in fact be worth the cost.

Trends in public spending on health care also should be gauged by the number of beneficiaries served. Since the number of Medicare beneficiaries is expected to rise substantially after the baby-boom generation (those born between 1946 and 1964) retires, the proportion of overall spending on Medicare is likely to rise in tandem (see Figure 1). If

Americans continue to place a high priority on the program's aims, and assuming per capita increases are kept to a reasonable rate of growth, this spending is likely to gain public support.

The Future of Private Plans in Medicare Is Uncertain. The 1997 Balanced Budget Act aimed to increase the number and variety of private health plans, mostly managed care plans, that could contract with Medicare. The establishment of the Medicare+Choice program under the BBA was the most important provision of this kind (see Box 1, page 12). Many supporters of the bill regarded the implementation of Medicare+Choice as the first step toward introducing a much broader element of competition in Medicare. Alarmed at the prospects of escalating Medicare expenditures and of new deficits that might crimp investment and stifle future economic growth, these proponents argued that competition among plans would yield quality health care, dismantle an inefficient government bureaucracy, and eventually reduce government spending. A "premium support" proposal under which Medicare beneficiaries would apply an annual government contribution toward the premium of a plan they select is the legislative centerpiece of this competition-based approach to Medicare reform (see Box 2, page 15).

FIGURE 1. GROWTH IN THE U.S. ELDERLY POPULATION, HISTORIC DATA AND PROJECTIONS



Source: "Growth in the U.S Elderly Population, Historic Data and Projections," U.S. Department of Commerce, Bureau of the Census, available at http://www.census.gov/ipc/prod/97agewcl.pdf, p. 6.

The background paper by Lisa Potetz, a health policy consultant, offers an in-depth analysis of the extent to which the Medicare program should rely on competition among private plans to provide benefits to enrollees. Potetz discusses both the theory and practice behind this managed competition approach. Her paper illustrates the difficulties of using Medicare+Choice as a platform on which to build a superstructure of greater plan competition. Though expected to enroll a rapidly increasing number of beneficiaries, growth in the program has leveled off, and the number of enrolled beneficiaries actually shrank in 2000. Medicare HMO withdrawals from the Medicare+Choice program—either from the program altogether or in certain areas—affected more than 2 million beneficiaries in the three-year period from 1998 to 2000, and many of the newer plan options have not been offered at all. Health plans that dropped Medicare coverage cited too-low payment rates and burdensome regulations, while beneficiaries who had been attracted by the more generous benefit packages saw those benefits shrink. Replacing the current system of payments to plans, which is linked to fee-for-service rates, with one based on competitive pricing, under which a plan's premiums would reflect its bid to cover a basic Medicare benefit package, might result in fairer payments. However, demonstration projects designed to study the feasibility of this approach have been beset by difficulties.[14]

In the early 1990s, large employers enjoyed considerable success paring their expenditures on health care by turning to managed care plans to enroll their employees. Many legislators and policymakers were eager to see if Medicare could do likewise. Recent trends suggest, however, that the dissatisfaction of some consumers with managed care is leading insurers to retreat from many of the techniques, such as restricted provider networks, that may have been central to managed care's ability to control costs.[15] The jury is still out on whether managed care can be effective in the long run in keeping down overall health care costs.[16]

Medicare's Coverage Is Inadequate (Principles III and IV)

The task force believes that Medicare, while highly successful in achieving its primary goals of improving the economic security of the elderly and disabled and their access to care, requires reforms that would make its benefits more comparable to those routinely available in private health insurance plans while encouraging care that reflects new innova-

Box 1. Medicare Fee-for-Service, Managed Care, and Medicare+Choice

At its inception, Medicare was set up as a "fee-for-service" program. For most beneficiaries, it remains a fee-for-service arrangement to this day. Beneficiaries choose from any provider who accepts Medicare patients. Medicare reimburses hospitals with a set price for an episode of care determined by a patient's diagnosis, while paying physicians based on a fee schedule.[a] Most physicians "accept assignment," meaning that Medicare's fee is accepted as payment in full for covered procedures and treatments. Some doctors choose to bill patients an additional amount that is limited by law ("balance billing").

Since the early 1970s, and especially after new laws took effect in 1985, Medicare beneficiaries have been permitted to enroll in Medicare managed care plans. In contrast to fee-for-service arrangements, managed care is understood as a system in which health plans construct a network of providers and adopt particular payment and coverage rules. Individuals who join managed care plans typically accept some restrictions on their choice of provider in return for lower premium costs or more health benefits, or both.

Until the mid-1990s, Medicare beneficiaries who chose managed care plans were enrolled almost exclusively in health maintenance organizations (HMOs), the best-known form of managed care. Under this arrangement, plans agree to offer the services covered by the Medicare benefit package in return for a fixed amount per enrollee ("capitation") from the government. If Medicare's payments exceed a plan's profit in its private commercial business, the plan is required to provide additional benefits to enrollees, lower its cost sharing, or return the excess money to the government.

Attracted in large part by the possibility of receiving extra benefits, especially prescription drugs with little or no increase in their premiums, the proportion of Medicare beneficiaries enrolled in managed care grew to 16 percent by 1998. Access to these plans, however, varied considerably for a number of reasons, including Medicare's method of paying them. Medicare pegged the capitation rate for plans at 95 percent of the average cost for a fee-for-service beneficiary in a given county, with some adjustments for the demographics and other characteristics of the payment area. Plans clustered in metropolitan areas where fee-for-service reimbursements were high and physicians were plentiful. At least until the early 1990s, and possibly up to the present, plans attracted beneficiaries who were healthier than the Medicare average, meaning that the government overpaid because of this favorable selection.[b]

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BOX 1. MEDICARE FEE-FOR-SERVICE, MANAGED CARE, AND MEDICARE+CHOICE (CONT.)

The Balanced Budget Act of 1997 (BBA) tried to remedy these flaws by partially uncoupling the managed care payments from local fee-for-service rates, requiring the creation and implementation of a new "risk adjustment" method for paying plans, and establishing a demonstration project for competitive pricing approaches. However, for a variety of reasons, including the effects of reductions in Medicare payments to providers and plans that also were included in the BBA, these policies have not yet begun to achieve their intended results.[c]

The 1997 BBA established the Medicare+Choice program with the intent of expanding the options available to beneficiaries for enrolling in private health plans. The Medicare+Choice program incorporated the existing Medicare managed care plans and allowed new types of managed care plans, such as provider-sponsored plans, to contract with Medicare. It also permitted plans other than the managed care kind to accept Medicare patients, some of which (like private fee-for-service plans) were exempt from regular Medicare payment and coverage rules.

Contrary to expectations, growth in Medicare+Choice has thus far failed to materialize. Few new private plans have decided to contract with Medicare. In fact, faced with rising costs for prescription drugs and other health costs, a number of insurers have withdrawn either completely from the program or from some areas; those that remain have tended to raise their premiums and cost sharing for beneficiaries. At least 934,000 beneficiaries will be affected by Medicare+Choice withdrawals and service reductions in 2001, following 407,000 in 1999 and 327,000 in 2000 who were similarly affected. A majority of these beneficiaries were able to join other HMOs, but others (about 17 percent of those affected in 2001) will have to return to traditional fee-for-service Medicare or to join a Medigap plan, in most cases facing a reduction of benefits and higher out-of-pocket costs.[d]

[a] David G. Smith, *Paying for Medicare: The Politics of Reform* (Hawthorne, N.Y.: Aldine de Gruyter, 1992), is an excellent and detailed study of the origins and nature of Medicare provider payment methods and reforms.

[b] To what extent, if any, this favorable selection into Medicare+Choice plans persists is a subject of considerable debate among health services researchers. Most of the data for studies that have found this effect come from the early 1990s or before; a few studies use sources that date from the mid-1990s. For a summary of the debate and a complete bibliography of the recent literature, see Herbert S. Wong and Fred J. Hellinger, "Conducting Research on the Medicare Market: The Need for Better Data and Methods," *Health Services Research* 36, Part II (April 2001): 291–308. For an argument about the probable convergence of the characteristics of fee-for-service and managed care populations over time, see Mark Pauly and Sean

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Box 1. Medicare Fee-for-Service, Managed Care, and Medicare+Choice (cont.)

Nicholson, "Adverse Consequences of Adverse Selection," *Journal of Health Politics, Policy and Law* 24, no. 5 (October 1999): 921–29. For earlier findings of favorable selection into Medicare managed care, see R. S. Brown et al., "The Medicare Risk Program for HMOs: Final Summary on Findings from the Evaluation," report submitted to the U.S. Department of Health and Human Services, Mathematica Policy Research, Princeton, N.J., February 1993.
[c] On risk adjustment, see Richard Kronick and Joy de Beyer, *Medicare HMOs: Making Them Work for the Chronically Ill* (Chicago: Health Administration Press, 1998); and Kronick and De Beyer "Risk Adjustment Is Not Enough," Commonwealth Fund, New York, 1997. On competitive pricing, see Len M. Nichols and Robert D. Reischauer, "Who Really Wants Price Competition in Medicare Managed Care?" *Health Affairs* 19, no. 5 (September/October 2000): 30–43.
[d] Marsha Gold, "Trends Reflect Fewer Choices," *Monitoring Medicare+Choice: Fast Facts*, no.

tions in medicine that can improve the health and quality of life of older Americans.

Medicare's most glaring weakness is its absence of coverage for almost all outpatient prescription drugs. As more medical procedures are performed on an outpatient basis, and as an aging population develops more chronic illnesses, this absence has become more significant. Unlike most private insurance plans, Medicare also lacks "stop-loss" protection that pays for very high medical expenses above a cap. Since Medicare covers only a set number of hospital days per benefit period and over a lifetime, expenses can mount rapidly for the very few beneficiaries who exceed this limit. Likewise, the cost sharing for physician services and other Part B procedures, generally set at 20 percent of the allowable cost of care, can be a hurdle for lower-income beneficiaries whose income just exceeds the limit under which they can seek assistance from Medicaid.

Medicare's lack of comprehensive coverage means that most beneficiaries either purchase supplemental insurance (Medigap), receive coverage through a previous employer (or a spouse's employer), or obtain additional benefits through HMOs. Just 9 percent of beneficiaries had only Medicare coverage in 1998. But, as Thomas Rice of the UCLA School of Public Health shows in his background paper on supplemental insurance, the availability of these sources of insurance is decreasing, and their cost is increasing rapidly. As these sources of coverage dwindle, the number of Americans favoring a more comprehensive benefit package is likely to rise.

Box 2. Premium Support

Premium support, a term given to a comprehensive restructuring proposal for Medicare, would involve the payment of a fixed government contribution on behalf of a beneficiary toward the premium of a health plan that contracts with Medicare. A beneficiary would pay the difference between this amount and the cost of the premium of the plan he or she selected.

Modeled on the Federal Employees Health Benefits Program (FEHBP), premium support would replace the traditional fee-for-service Medicare program with a system based on beneficiary choice among competing health plans.[a] The traditional program offers a standard benefit package and identical premiums and establishes prices for thousands of medical procedures. Under a premium support model, the federal sponsor would negotiate with health plans rather than set fees for providers. These plans would construct provider networks and offer different benefit packages with varying premiums (though a minimum benefit package probably would be specified in law). The traditional fee-for-service program would become one of the competing plans and adopt its own premium. Medicare's payment to health plans would be based on the cost of an average premium and adjusted for the characteristics of a plan's enrolled population. The underlying expectation for premium support is that informed Medicare beneficiaries will choose plans that offer the most value, thereby saving money for themselves and for the program as a whole.

A premium support proposal was at the heart of a bill first introduced by Senators John Breaux (D.-La.) and Bill Frist (R.-Tenn) during the 106th Congress [S.1895] and reintroduced in similar form in the 107th Congress [S.357]. (For a fuller description and critique of this proposed reform, see the background paper by Lisa Potetz, "Competition-based Approaches to Medicare Reform," in this volume.)

In his 1999 plan for Medicare reform, President Clinton proposed a "competitive defined benefit" idea.[b] Private health plans would be reimbursed based on the price of their bid on a standard Medicare benefit package including a drug benefit.[c] If beneficiaries selected lower-cost plans, they would pay lower premiums. The government would realize savings as well. The logic of this proposal resembles that of premium support in its intent to stimulate competition among health plans and choice among beneficiaries. It would replace the existing system that links payments to plans to fee-for-service costs in a given area. However, the competitive defined benefit idea, unlike premium support proposals, would not restructure Medicare.

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Box 2. Premium Support (cont.)

It would apply only to existing health plans that contract with Medicare, leaving the traditional fee-for-service program intact. Beneficiaries who chose to remain in this program would pay no more than the Part B premium as specified in statute. Under premium support, on the other hand, they might pay considerably more than this amount depending on how the cost of a fee-for-service arrangement compared over time with that of other competing health plans.

[a] For a full description of the ways in which the idea of premium support evolves from the existing program of health benefits for federal employees, see Mark Merlis, *Medicare Restructuring: The FEHBP Model*, Henry J. Kaiser Family Foundation, Washington, D.C., February 1999. An early statement of the premium support idea may be found in Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs* 14, no. 4 (Winter 1995): 8–30.
[b] See "The President's Plan to Modernize and Strengthen Medicare for the 21st Century," National Economic Council and Domestic Policy Council, July 2, 1999, pp. 8–13.
[c] Initially, this payment would not exceed 96 percent of the cost of Medicare's original fee-for-service payments for the average beneficiary, though plans also would be explicitly subsidized

Medicare Should Actively Seek Ways to Improve the Value of the Services It Pays For (Principles V, VI, and VII)

Members of the task force felt that the value of the medical services that Medicare pays for should be and could be improved. Concerns about medical errors, worries about the high cost of care, better evidence about the effectiveness of treatments in yielding desired outcomes, and greater awareness of how financial incentives affect the delivery of health care have combined to bring this issue to the fore. For example, a recent Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, criticized the "highly fragmented delivery system" that "does not, as a whole, make the best use of its resources" and expressed regret at "the absence of real progress toward restructuring health care systems to address both quality and cost concerns."[17]

The task force felt that Medicare could play a major role in this potential revamping of the U.S. health system while noting that it needs to move cautiously because of its special responsibilities as a publicly accountable program and for other reasons of custom and statute.[18] Some ways the program might encourage greater value in the delivery of care could involve:

- taking steps toward improving the quality of care delivered by

providers and plans that contract with Medicare and toward better care in the medical system as a whole (Principle V);

- adopting methods for developing and disseminating information about providers and plans so that Medicare beneficiaries can make informed and meaningful choices about their coverage (Principle VI); and

- dedicating more resources to the program's management (Principle VII).

Much effort in quality improvement revolves around applying clinical evidence to everyday medical procedures with the aim of reducing unneeded or potentially harmful care and steering resources toward necessary care. (The wide difference in per capita spending on Medicare patients in different parts of the United States, even after attempts to adjust for the characteristics of the populations served, is one piece of evidence that leads researchers to believe that spending on health care does not necessarily correlate with health gains.[19]) The Health Care Financing Administration (HCFA), the federal agency that runs Medicare,[20] has expanded its existing quality assurance programs to monitor how well health plans and some providers adhere to "process" measures of quality—carrying out clinical interventions that research shows will produce better health outcomes, such as administering beta blockers to heart attack victims. More aggressive ways of using Medicare's market power to improve quality might involve contracting selectively with providers who met or exceeded various predetermined performance measures. Assuming these measures accurately reflect the underlying data and that this type of contracting does not unduly affect access to care, they are worth considering.

Measures to enhance quality in Medicare or to introduce more choice for beneficiaries depend fundamentally on enrollees becoming more knowledgeable about the real distinctions between different kinds of health insurance products, such as original Medicare, health maintenance organizations, and Medigap, as well as on the development of "user-friendly" data. This is challenging in part because Medicare beneficiaries are a diverse group. In particular, those with cognitive and physical impairments, or whose first language is not English, vary in their capacity for understanding the program. Studies also show that beneficiaries as a group have a sketchy understanding not only of new and potential options under Medicare but of traditional Medicare as well. HCFA, which

formerly dealt almost exclusively with providers, has been expanding its efforts both to develop and to disseminate useful comparative data for beneficiaries. For this effort to be successful, "information intermediaries," especially those based in organizations that assist seniors and people with disablities, will need to evolve.

Compared to private insurers, Medicare features low administrative costs as a percentage of benefits paid (around 1–2 percent annually), as opposed to a much higher percentage (9.5 percent per year according to one estimate[21]) in the private sector. To the extent that this reflects maintaining a lower disenrollment rate among the covered population and not having to incur marketing costs, it is advantageous. However, the amount spent on administration may not be optimal given the rise in program spending, complexity, and enrollment. HCFA has been charged with implementing and overseeing a large number of new regulations, especially those included in the Balanced Budget Act of 1997 and in subsequent bills that amended it. Dedicating more resources to program management is essential to expanding the capacity of administrators both to streamline and to carry out the regulations that are on the books—both in terms of enforcement and in terms of offering adequate support to providers, plans, and beneficiaries.

Medicare is obligated to those it covers to ensure that treatments are safe and of high quality. It also is accountable to the taxpayers and beneficiaries who pay the program's bills. Focusing on value raises hopes for a modus vivendi between the two imperatives that generally drive reform proposals: the need for fiscal restraint and the need for a more comprehensive benefit package and a more rational payment system.

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A wealth of excellent books and reports explains how to navigate Medicare, laying out its basic rules and coverage policies. First-rate histories of the program exist. Policy analyses (and policy nostrums) are legion. With few exceptions, however, the debate lacks an accessible guide that develops a set of principles through which a variety of reform proposals can be evaluated while identifying the context for both principles and policies. This task force report strives to fill that gap.