

THE WHITE HOUSE

WASHINGTON

July 28, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: Carol Rasco

SUBJECT: Kassebaum/Kennedy Bill and the Medicare Reforms Advocated by Etheredge

You asked how the Medicare reforms suggested by Lynn Etheredge squared with the recently introduced Kassebaum/Kennedy health bill. As you made clear you well understood in your comments on the Hill on Tuesday, the short answer is relatively little because the bill is dedicated primarily to insurance reforms.

**Background**

The Senate Labor and Human Resources Committee has no jurisdiction over Medicare. (Unlike the joint Commerce/Ways and Means in the House, the Senate Finance Committee has sole jurisdiction over Medicare.) Because of the jurisdiction issue, as well as its political sensitivity, Senators' Kassebaum and Kennedy chose not to deal with the Medicare reform issue. Instead, they chose to introduce a bill that had significant bipartisan support and, as a result, focused their efforts particularly around insurance reforms and purchasing cooperatives.

**Kassebaum/Kennedy Bill and Etheredge Medicare Reforms**

The provision of the bill that has the most similarity to the recommendations outlined by Lynn Etheredge is probably the one relating to the purchasing cooperatives. Lynn believes that the Medicare program should offer a range of options and information to purchasers that make the program more consumer-driven. Senator Kennedy hopes that his purchasing cooperatives provisions will assist toward that end for the employers and employees of small businesses. In addition, one could clearly argue that some of the insurance reform protections are consistent with the spirit of Lynn's strong belief that there should be strong consumer protection provisions to guard against discrimination of sicker, older beneficiaries. Attached for your information is a one-page summary of the bill.

The response to the Kassebaum/Kennedy modest, but positive step forward has been notable. The bill has already attracted virtually every member of the Committee as a cosponsor. And, in addition to the broad-ranging support of Committee members (Paul Wellstone through Judd Gregg), John Chafee signed up as an original cosponsor.

One last point worth noting, Senator Kennedy was extremely appreciative of your mentioning the Kassebaum/Kennedy bill during your remarks on Tuesday. On three separate occasions, he has mentioned to his staff that he felt you went over and beyond the call of duty to reference the bill (and how happy he was that you did.)

## Summary of Health Insurance Reform Act of 1995

1. Limit Exclusions for Pre-Existing Conditions. The bill would restrict pre-existing exclusions by prohibiting insurers and employees from limiting or denying coverage under group health plans for more than 12 months for a medical condition that was diagnosed or treated during the previous six months. Once the twelve month limit expired, no new pre-existing condition limit could ever be imposed on people maintaining their coverage, even if they changed jobs or insurance plans. The same protection would apply to individuals who transfer from group to individual coverage because they leave their job or go to work for an employer that does not provide group coverage.

Individuals receive credit for prior coverage against any pre-existing condition exclusion under a new health plan. For example, an individual who had coverage for six months when he or she changed jobs or changed health plans would have a maximum additional exclusion of six months, rather than the normal twelve months. The extension of this protection to the individual market is being strongly opposed by the insurance industry. They claim it will raise premiums by 10-15%. Most state insurance commissioners disagree.

2. Guarantee Availability. The bill prohibits health plans from denying coverage to any employer who wants to purchase a policy for his or her employees or from excluding any employee from coverage based on health status. Individuals who have had coverage under a group health plan for at least 12 months may not be denied coverage if they leave their job and are no longer eligible for COBRA continuation coverage.
3. Guarantee Renewability. Except in the case of fraud or misrepresentation by the policy holder, the bill requires insurers to renew coverage for groups and individuals as long as premiums are paid.
4. Portability. Because the bill limits pre-existing condition exclusions, allows credit for prior health coverage, and requires guaranteed availability for anyone who has employment-based coverage, workers would not be locked into a job or prevented from starting their own business because of the fear that health problems would prevent them from obtaining insurance.
5. Group Purchasing. Because small employers and individuals are at a real disadvantage in terms of access to affordable health insurance, the bill creates incentives for employers and individuals to form private, voluntary coalitions to purchase health insurance and negotiate with providers and health plans. It preempts some state laws that inhibit or prohibit the formation of these groups.
6. State Flexibility. The bill allows states to enact reforms providing additional consumer protection beyond the minimum requirements of the legislation. This is a key provision that many insurers will fight against.

@Chris Jenning: Pls. prepare brief  
memo to POTUS & submit to  
JB-A by COB 7/24.  
@Roy: tickler

THE WHITE HOUSE  
WASHINGTON

July 10, 1995

Mr. President:

This memo from Carol Rasco  
summarizes a report on  
modernizing Medicare by  
Lynn Etheredge. If you  
want to see the report itself,  
we'll send it up.

Rasco  
rodd Stern

How does this  
square w/ the  
Kassenbaum/Kennedy  
bill -  
THE PRESIDENT HAS SEEN  
7-17-95

How does  
this square w/ the  
Kassenbaum-Kennedy  
bill -

THE WHITE HOUSE  
WASHINGTON

July 7, 1995

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MEMORANDUM FOR THE PRESIDENT

FROM::

Carol H. Rasco 

SUBJECT:

Lynn Etheredge's Report on Medicare

Lynn Etheredge has just completed the attached report that provides solid recommendations about how the Medicare program can be modernized. It is a well-written and researched analysis that documents the current shortcomings of Medicare and provides specific suggestions about how we can move the program into the 21st century. In short, he advocates utilizing the best of private sector competition, quality and accountability innovations without undermining the program.

As you may recall, Lynn is a consultant who has worked closely with both Republicans (OMB career under Reagan) and Democrats (your health care transition team and as a consultant last year to Kennedy's Labor Committee.) Most recently, he has been associated with the Jackson Hole group. He is well respected by all sides and is shopping the concepts outlined in this paper to moderate Republicans and Democrats.

The good news is that much of what Lynn is advocating is consistent with the Medicare restructuring/managed care enhancement package you explicitly and/or implicitly included in your balanced budget alternative. His recommendations would empower beneficiaries and the Medicare program itself, without fundamentally destroying the current system that has gained the overwhelming support of the public. They would contribute to your goal of providing more efficient options without financially coercing beneficiaries into plans they otherwise would not choose. Most importantly, they represent an alternative to the status quo that can be used to counter Republican voucher proposals. In short, your proposal has choice with security, whereas the Republicans are financially coercing beneficiaries into capped managed care plans. The approach outlined by Lynn would likely have the added benefit of being well received by the business, the managed care, and the aging advocacy communities.

While we would probably have to push HHS on some of Lynn's recommendations -- particularly with regard to a timely implementation schedule -- we believe the current environment has made the Department much more receptive and encouraging of movement in this direction. Donna Shalala, in particular, would probably love to embrace them.

I wanted to share this with you now because I think it is particularly timely relative to the inevitable upcoming Medicare reform debate. I have asked Chris Jennings to stay in close touch with Lynn and to continue to have appropriate White House and Department representatives review our substantive and political positioning strategy vis a vis Medicare. Unfortunately, because of the perception that we (and HCFA in particular) are not sufficiently open to the types of suggestions Lynn has raised, we must be careful about how and when we move this type of agenda to ensure that the Administration gets its due credit. Attached is a one-page summary of Lynn's recommendations.

cc: Alice Rivlin  
Laura Tyson

## **HIGHLIGHTS OF ETHEREDGE'S MEDICARE REFORM RECOMMENDATIONS**

**Medicare's mission philosophy needs to be revised to emphasize Medicare as a health plan.** Most importantly, Medicare needs to become accountable, not just for insurance to pay bills and protect financial assets, but for improving the health of its enrollees, by providing preventive health measures and quality medical care.

**Medicare should have new authorities to purchase health care on the basis of explicit quality and other criteria and competitive performance.** To improve Medicare's performance, Congress needs to provide authority to move beyond the limits of regulatory rule-making and price-setting so that Medicare can adopt the same types of successful purchasing techniques pioneered by private-sector pay. (This is very similar to the Clinton Administration PPO and point of service options.)

**Report cards that assess Medicare's performance on the basis of cost, quality, outcomes, and service need to be utilized so that the program can be held accountable by enrollees and policymakers.** These measures need to reflect a wide range of criteria, including preventive care, quality of care, consumer satisfaction, and health outcomes, and should also apply to competing private health plans. Report cards should show national, state-level, and market-area performance.

**Medicare needs to adopt competitive purchasing of standardized services and supplies, including durable medical equipment, laboratory testing, radiology, and outpatient surgery.**

**Medicare needs to significantly expand its use of centers of excellence and specialized services contracting.** Medicare now uses such concepts in its coverage for transplant services; private-sector plans use selective contracting even more widely for many forms of surgery, cancer care, and mental health. Intelligent purchasing by Medicare would produce better quality, cost, and service competition among providers, to the benefit of Medicare beneficiaries and taxpayers.

**A national strategy for clinical effectiveness and outcomes studies for the Medicare population needs to be implemented by analyzing the Medicare data to identify procedures with wide variations that seem likely to reflect overuse and underuse.**

**Medicare needs to be better empowered to drop providers who are contributing to a significant fraud and abuse problem in the program.**

June 1995

# Reengineering Medicare: From Bill-Paying Insurer to Accountable Purchaser

*Prepared by*

**Lynn Etheredge**  
*Consultant*

Prepared for the Health Insurance Reform Project, George Washington University, with funding from the Robert Wood Johnson Foundation

*Reengineering... is the fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in critical contemporary measures of performance, such as cost, quality, [and] service.*

—Michael Hammer and James Champy,  
*Reengineering the Corporation*

At the time of its enactment 30 years ago, Medicare was patterned on the health insurance models widely used by private employers and insurers for the under-65 population. In this model, the primary administrative function of insurance companies and of the Medicare program was simply to pay bills. Today, Medicare remains essentially a bill-paying insurance program, with the addition of national formulas for hospital and physician payment rates.

In recent years, the private sector has moved beyond this traditional insurance model. Private-sector payers are no longer simply paying bills but are using a variety of evolving *purchasing* techniques, in a competitive marketplace, to restrain costs and improve quality and service. Among these purchasing strategies are many forms of selective, competitive contracting; capitation and risk-sharing arrangements; provider performance standards, with incentives, penalties, and continuous quality improvement goals; management of high-cost cases; centers of excellence for transplants, heart surgery, cancer care, and other treatment; prevention and chronic disease management initiatives; consumer information and incentives; specialized contracting for pharmaceutical benefits, substance abuse, mental health, and other services; and specialized claims-auditing firms to deal with fraud. Individuals with benefits offered by large employers—including, through the Federal Employees Health Benefits Program (FEHBP), the nation's political leaders and federal workers—are usually able to make choices among a number of health plans on the basis of provider networks, cost, quality, service performance, and other features.

In this new purchasing environment, private-sector employers and consumers are increasingly able to make informed choices—to hold providers (and the plans that contract with them) *accountable*—through the use of tools such as the National Committee on Quality Assurance's (NCQA's) "report cards," which are based on the Health Plan Employer Data and Information Set (HEDIS), and other quality measures, such as health outcomes. The HEDIS data set includes more than 60 quality, service access, patient satisfaction, outcomes, and other performance measures, including preventive care (such as immunizations, mammography screening, and eye exams for diabetics) and signal indicators for poor quality (such as inpatient admissions for asthma and treatment following heart attacks).

In the current political climate, there is great interest in the federal government's making available to the Medicare population a broader choice of competing private health plans that use such purchasing technologies. Today, health maintenance organizations (HMOs) and other private plans enroll only about 10% of the Medicare population. Among the many measures that could open up more plan options are an FEHBP-type "managed competition" approach that would allow Medicare beneficiaries to make informed choices among a wide range of HMO, preferred provider organization (PPO), Medicare Select, medigap, and other plans during an annual open season. Other options being discussed involve workers staying with employer/association plans after turning age 65 or some use of medical IRA accounts and catastrophic coverage. Much of the attention in Congress now centers on the policy questions involved in structuring new options for Medicare enrollees.

As a complete reform strategy, such options would fall short. They do not reform the basic Medicare program. Over 90% of Medicare's spending is through the fee-for-service model. As of January 1, 1995, 19 states had no Medicare HMO enrollees and 32 states had 1% or fewer of their Medicare-eligible populations

enrolled in HMOs. A handful of states—including California (42% of Medicare HMO enrollees) and Florida (17% of Medicare HMO enrollees)—accounted for most of the Medicare HMO membership.<sup>1</sup> Even with an FEHBP-type arrangement and optimistic growth assumptions about private plan enrollments, many factors make it likely that most Medicare eligibles in most states will still be in the program for the rest of the decade and beyond.<sup>2</sup> In its traditional bill-paying mode, the Medicare program has very few tools for dealing with the volume, intensity, and quality issues that are its major cost-drivers. Thus, devising a strategy for fundamental reform of the basic Medicare program—“reengineering” Medicare—is essential not only to deal with budget issues but also to achieve improvements for the 37 million people who depend on the program.

What should be done about the basic Medicare program? What would be in the best interest of its 37 million elderly and disabled enrollees?

This paper considers the question of whether Congress should give Medicare the same types of authorities that are available to its private-sector competitors—particularly authorities to use new purchasing techniques—and require performance accountabilities for their use through HEDIS-like quality and health outcomes measures. Should not the nation’s elderly and disabled, as well as taxpayers, ask for and expect a state-of-the-art Medicare program? If this approach were adopted, Medicare-eligible individuals would be able to enroll either in a Medicare program that is working hard to provide the best economy, quality, and services or in competing private-sector health plans that are paid equivalent (risk-adjusted) capitation amounts. One might expect that, over the long term, both taxpayers and Medicare-eligible persons would benefit by such competition.

At the most general level, reforming the Medicare program in this way would start with three fundamental changes:

- *A revised mission philosophy that emphasizes Medicare as a health plan.* Most importantly, Medicare would need to become accountable, not just for insurance to pay bills and protect financial assets, but for improving the health of its enrollees, by providing preventive health measures and quality medical care.<sup>3</sup>
- *The adoption of “report cards” that assess Medicare’s performance on the basis of cost, quality, outcomes, and service so that it can be held accountable by enrollees and policymakers.* These measures need to reflect a wide range of criteria, including preventive care, quality of care, consumer satisfaction, and health outcomes, and should also apply to competing private health plans. Report cards should show national, state-level, and market-area performance.

The measures that could be used by a reformulated Medicare can be illustrated by comparing current official data reports with new health-related data that could be a basis for the above-described report cards. The most extensive public accounting for Medicare’s operations is the *Medicare and Medicaid Statistical Supplement* published in February 1995.<sup>4</sup> Its more than 370 pages are filled with statistics that emphasize financial, workload, and claims-paid data, such as hospital days of care and expenditures, that are appropriate to a traditional health insurance program. Nowhere are there measures of quality of care and improved health status or reports on enrollee satisfaction.

Two recent studies highlight the kinds of health-related measures that might be used to assess Medicare’s future performance as an accountable health plan. The Physician Payment Review Commission (PPRC) and the RAND Corporation have recently developed a set of approximately 50 quality measures that can be implemented, using claims data, for the current Medicare program. Several measures, which have been run against Medicare’s national claims data, are shown below in Table 1. A number of them are similar to the

NCQA's HEDIS measures used for private-sector health plans. In the view of the physician consensus panels developing the measures, these are "necessary care" indicators; that is, professionally acceptable practice should be near 100% compliance.

**TABLE 1**

**Clinically Based Indicators of Quality of Care for the Elderly Medicare Claims Data, 1992 and 1993**

**Breast Cancer**

For patients with breast cancer, interval from biopsy to surgery less than 3 months 64%

Mammography every year for patients with a history of breast cancer 61%

Mammography every 2 years in female patients 39%

**Diabetes**

Eye exam every year for patients with diabetes 38%

**Heart Problems**

Visit within 4 weeks following discharge for patients hospitalized with MI 84%

EKG during ER visit for unstable angina 81%

**Mental Diagnosis**

Visit within 2 weeks following discharge of patients hospitalized for depression 95%

The PPRC-RAND study shows several quality indicators on which the care received by Medicare elderly patients merits an "A" (95%+) on a nationwide basis. But it also highlights a number of prevention indicators, such

as mammography and eye exams for diabetics, for which there should be failing grades, "D" or "F," as well as many indicators in the 60% to 85% range where care falls well below professional standards. The study also highlights particular problems for minority populations and for rural and underserved areas.<sup>5</sup>

Another recent study, by Lewin-VHI for the National Institute for Health Care Management, analyzed Medicare hospitalization rates for three diagnoses that are sensitive to good ambulatory care and preventive measures. For 1992, the study reported Medicare hospitalization rates for asthma to vary by more than 3:1 among states, hospitalization rates for diabetes by more than 5:1, and hospitalization rates for hypertension by more than 8:1. Even after statistical adjustments for demographic characteristics, several-fold variations still remained.<sup>6</sup>

Given such statistics, any presumption that Medicare has already become the "gold standard" of quality care and that it is up to its competitors to prove their superiority should be put aside. Medicare's performance needs to be measured and accountable on the same basis as its competitor plans, so its enrollees can make informed choices.

The third fundamental change that would need to occur for Medicare to become more like a state-of-the-art accountable health plan is the following:

- Medicare should have new authorities to purchase health care on the basis of explicit quality and other criteria and competitive performance. Within the many statutory constraints Medicare has to operate under as a government program, it has generally been run effectively, efficiently, and with continuing improvement and innovation. Given its constraints, Medicare is now about as good a program as it can be. But, in nearly every area—such as three-year-long rule-making processes, volume increases and quality assurance issues, fraud and abuse, and rapidly rising budget costs—it is clear that Medicare cannot deal as effectively as it

needs to with the complexity and pace of change in today's health system, nor can it hold physicians, hospitals, and other providers accountable for improving their performance. To improve Medicare's performance, Congress needs to provide authority to move beyond the limits of regulatory rule-making and price-setting so that Medicare can adopt the same types of successful purchasing techniques pioneered by private-sector payers. Such evolution could build incrementally through many Health Care Financing Administration (HCFA) initiatives, but, if fully reengineered, the Medicare program would be quite different a decade hence. Such changes will require a new bipartisan political consensus.

The next section elaborates on management challenges for the Medicare program's future if it is to be an effective health care purchaser. Following that is a discussion of specific legislative changes needed to allow Medicare to be an effective purchaser and competitive health plan. A third section sketches a research agenda for developing a Medicare management strategy to use these new statutory authorities. A final section discusses issues related to competition between a reengineered Medicare program and competing private-sector health plans.

## THE CHALLENGE OF MEDICARE MANAGEMENT

For the federal government, serious efforts to manage Medicare as an accountable health plan would be among the most enormous and complex tasks it has ever undertaken. To put the task on the scale of private-sector enterprises, the Medicare program, with \$160 billion of spending in 1994, has passed General Motors—with \$154 billion in revenues, the nation's largest private company—to become the nation's largest business-type operation.<sup>7</sup> In 1994, only three privately managed U.S. corporations (General Motors, Ford, and Exxon) had more than \$100 billion in revenues, 11 had \$50 billion or more in revenues, and 110 had \$10 billion or more in revenues. To-

day, 37 million persons depend on the Medicare program. Within 30 years, as the baby boom generation retires, Medicare will be purchasing health care for about 70 million persons, and its annual spending will be many times greater than it is today.

An understanding of the challenges of charting Medicare's future begins with an understanding of the scale involved. Nevertheless, there is a widespread misperception about the Medicare program that must be dealt with to understand just how difficult it will be to manage the program. That is the myth of uniformity, predictability, and gradual change.

Medicare can seem to be a deceptively simple and easy-to-reform program. Its enrollments, financing, and benefits are defined in statute. It has a centralized administrative structure (DHHS/HCFA); a uniform set of regulations; payment rates for hospitals, physicians, and other services that are specified by national formulas; and a national quality assurance/peer review structure, the Professional Review Organization (PRO) system. Individuals who are not health services researchers also tend to presume that health care is enough of a science that area-to-area rates of service use will be roughly uniform and that clinical practices change gradually, primarily as a result of the steady accumulation of scientific data. A misperception that the health care system is evolving in gradual, uniform ways is also reinforced by national health expenditure and Medicare actuarial data that aggregate a vast number of complex changes and variations into single categories such as "intensity."

The following selection of data illustrates how far assumptions of uniformity and steady change are from the Medicare program's reality.

- *Hospital use.* Even on a regional basis, Medicare enrollees' use of hospital care varies by a ratio of 2:1—from 1,735 days/1,000 enrollees in the western states to 3,455 days/1,000 enrollees in the northeastern states in 1992. As they have for years, hospital

lengths of stay continue to average about 50% longer in the northeastern states (10.4 days) than for the western states (6.7 days).<sup>8</sup>

- *Rates of change in hospital use by diagnosis-related groupings (DRGs).* In the 1988-1992 period, hospital discharges for Medicare enrollees rose by 8.3%. Of the 65 leading DRGs, however, only 12 had increases between 0% and 20%. Seventeen DRGs had increases of 20% to 40%, 9 rose by 40% to 60%, and 5 increased by more than 60% in the four-year period. The most rapid increases were reported for DRG 88 (chronic obstructive pulmonary disease), 219%; DRG 462 (rehabilitation), 103%; and DRG 214 (back and neck procedures with complications and/or comorbidities), 75%. Discharges declined for 22 DRGs. Eleven DRGs had declines of between 0% and 20%; 8 declines were in the 20% to 40% range; 3 declined by over 40%. The DRGs that decreased most were DRG 90 (simple pneumonia and pleurisy) and DRG 96 (bronchitis and asthma with complications and/or comorbidities), which had declines of 52% and 58%, respectively.<sup>9</sup>
- *Nursing home use.* Rates of nursing home use varied by 6:1 across states. Minnesota residents used 1,364 days/1,000 enrollees, Connecticut residents 1,235 days/1,000 enrollees, and Indiana residents 1,067 days/1,000 enrollees in 1992. Among the low-use states were Maine (248 days/1,000 enrollees), Oklahoma (326 days/1,000 enrollees), and New Hampshire (327 days/1,000 enrollees).<sup>10</sup>
- *Home health use.* The rate of home health visits per 1,000 enrollees varied by more than 17:1 among states in 1992. The high-use states included Mississippi, with 11,786 visits/1,000 enrollees and Tennessee, with 11,717 visits/1,000 enrollees. At the other end of the range were Hawaii, with 668 visits/1,000 enrollees, and South Dakota, with 969 visits/1,000 enrollees.<sup>11</sup>
- *Growth rate in part B spending.* Over the 1986-1992 period, Medicare part B annual

expenditures rose at a national average of 8.8%. Here again, substantial national diversity, rather than uniformity, is the dominant pattern. The rate of increase varied more than 3:1 among states—from 4% to 5% annually in California and Hawaii to between 13% and 16% annually in South Carolina, Delaware, Kansas, Nevada, and North Carolina.<sup>12</sup>

- *Growth in physician procedures.* Over the 1991-1994 period, the growth rate of Part B services averaged 3.5% annually. Behind these averages, however, were quite different and rapidly changing patterns for different services. Echocardiograms increased at a 19.3% annual rate, angioplasty at 17.1% annually, MRIs at an 11.9% rate, arthroscopy at 9.1%, coronary artery bypass grafts at 8.8%, and joint prostheses at 7.3% per year. Among the declining procedures were transurethral prostate surgery, falling 9.9% annually, and cataract lens replacements, falling 2.3% annually.<sup>13</sup>

A common-sense view might be that high-use areas would probably also be areas of high overuse. This assumption was rigorously tested by RAND researchers using 1981 data for three procedures: carotid endarterectomy, coronary angiography, and upper gastrointestinal tract endoscopy. The rates per 10,000 elderly varied among three sites by 3.8 times for carotid endarterectomy, 2.3 times for angioplasty, and 1.5 times for upper gastrointestinal tract endoscopy. Their findings were that rates of inappropriate use were not much different between low-use and high-use areas. However, rates of inappropriate use for all three procedures were significant, ranging from 17% to 32%.<sup>14</sup>

One might be skeptical about some of the Medicare-reported trends. (Were there really major epidemics of chronic obstructive pulmonary disease and complicated back and neck problems requiring hospitalization of the elderly that escaped the national media attention in 1988-92?) But Medicare has spent a

great deal of effort and money to improve its data systems. To the extent that Medicare's payments do not accurately reflect the services being provided to its beneficiaries, then far more is wrong about provider billings (and Medicare administration) than data errors.

## REENGINEERING MEDICARE MANAGEMENT

*The only way we're going to deliver on the full promise of reengineering is to start reengineering management.*

—James Champy

If Medicare were to be operated in a more business-like way, what important changes should Congress consider making in the Medicare program's authorities? Many government-sponsored activities do have flexibility similar to that found in private-sector businesses; these activities include the Tennessee Valley Authority and other power marketing authorities, the Government National Mortgage Association, and the Federal Reserve Board. But granting Medicare, with \$175 billion in purchasing power and 37 million enrollees, a freer rein will need to be done carefully and watched vigilantly.

In general terms, *Medicare needs the authority to select providers based on quantifiable measures of quality, outcomes, and service and to use competitive purchasing.* The heart of a private-sector plan's ability to improve quality and assure accountability is its capacity to decline to do business with poor performers and to move business toward better performers. In contrast, Medicare is the prime remaining example of the traditional insurance "any willing provider" philosophy. To be certified as a Medicare provider usually requires little more than state licensure or accreditation by certifying organizations that are provider-dominated. Congress has created a virtual entitlement for health care providers to participate in Medicare. Competitive procurement is a standard business method for assuring good quality,

cost, and service, and it should also be available for Medicare administrators.

Among the areas for possible use of such authorities are:

- *Competitive purchasing of standardized services and supplies*, including durable medical equipment, laboratory testing, radiology, and outpatient surgery.
- *Establishment of explicit quality and service performance standards and refusal to do business with providers that do not measure up.* For the welfare of its beneficiaries, Medicare needs to move beyond the minimal participation requirements that are now set in legislation. New standards for providers should include the HEDIS-type "report card" and health outcomes measures for which the Medicare program will be accountable (for example, physicians who fell below certain standards in providing mammography screening for their patients would be dropped from the program).
- *Development and use of centers of excellence and specialized services contracting.* Medicare now uses such concepts in its coverage for transplant services; private-sector plans use selective contracting even more widely for many forms of surgery, cancer care, mental health, and so forth. Major expansions may be possible to develop disease management and preventive services for patients with chronic or high-expense illnesses and for disabled enrollees. Intelligent purchasing by Medicare could call forth better quality, cost, and service competition among providers, to the benefit of Medicare beneficiaries and taxpayers. To preserve Medicare's role in assuring a broad choice of providers, Medicare enrollees might still be able to go to non-preferred providers, but with higher co-payment rates.
- *Use of case management for high-cost patients.* Most private-sector health plans have the flexibility to work with high-cost patients to develop service packages, such as home

care, that can better meet their needs. The Medicare statute does not permit such flexibility, even when it would be in the best interests of the patient and the program. With so many frail elderly and disabled patients, Medicare might be able to make good use of such authorities.

- *Elimination of notice of proposed rule-making process for purchasing.* Like Gulliver tethered by many bonds, the Medicare program's effective use of its purchasing power is held back by numerous technical constraints, some of which are appropriate to a rule-making administrative style but not to a business-type operation. Most important of these is the Notice of Proposed Rule Making requirements that now involve at least a three-year process for major Medicare policy initiatives or changes. Such rule-making is frequently, in essence, simply a statement of contractual terms, that is, what Medicare will and will not pay for, under what terms, and in what circumstances. A private business that had to go through a three-year process any time it wanted to write or revise a contract with its suppliers would probably be in the same financial predicament as the Medicare program.
- *Authorization for Medicare simply to drop providers in the best interests of the program to deal with fraud and abuse.* In recent testimony, a Government Accounting Office (GAO) official noted that the Medicare program is "overwhelmed" by fraud and abuse and that it is a "particularly rich environment for profiteers."<sup>15</sup> Among Medicare's many problems are the difficulties of kicking providers out of the program and the limited resources made available by the Department of Justice. A recent GAO study based on studies of claims denial rates for 74 services across 6 carriers noted that one-half of denied claims were submitted by between 2% and 11% of providers.<sup>16</sup> Acting as a business-type purchaser, Medicare would have authority to simply stop doing business with any supplier, at its discretion. In areas of widespread fraud,

Medicare might also be allowed to engage private-sector law firms to recover on behalf of the government.

- *Authorization for Medicare to organize and contract for quality assurance at its discretion.* Since 1965, the major initiative to improve Medicare quality has been enactment of the PRO system. It is an expensive program (costing some \$325 million in 1994), deals almost exclusively with inpatient hospital care, and has been of questioned effectiveness. The 53 PROs are provider-dominated organizations. Most are physician-sponsored; for example, by local medical societies, and typically have a board of directors composed primarily of physicians and other provider representatives. Medicare Part B services are largely subject to quality review by the claims-paying carriers. As noted in an Institute of Medicine report on Medicare quality improvement, the implementation of a new health-oriented mission for the Medicare program will require far-reaching administrative, contractual, and other changes that include reconsideration of PRO, carrier, and HCFA roles.<sup>17</sup> Would a private-sector purchaser, intent on improving quality of care, want to be constrained to contracting with a medical society or provider-dominated organization?
- *Publicity about data on quality and service.* With the advent of HEDIS and buyers insisting on accountability, provider secrecy about quality problems is being replaced by publicized reporting in the private sector. Statutory change should also allow this approach to be adopted by the Medicare program. Such publicity about where physicians and hospitals stand compared to professional benchmarks and guidelines can be important acts in themselves to encourage better patterns of care and service.
- *Improvement of customer service.* The Medicare program has never had a strong customer orientation. As an adjunct to the Social Security Administration (SSA), it started with representatives in SSA's district offices, but

it lost these community-level staff when HCFA was established. Customer service is an area in which Medicare is at a competitive disadvantage vis-à-vis competing private health plans.

- *Enactment of special authorities for Medicare in the hiring, promotion, and compensation of employees.* There is no activity which is of larger budgetary consequence or greater management challenge for the federal government over the next half century than the Medicare program. Today, Medicare is bound by government-wide civil service procedures, promotion, firing, compensation levels, and personnel ceilings. In business-type operations, such as the Federal Reserve Board, Congress has been willing to make exceptions so that federal activities can be carried out with the required professional expertise. In particular, the Medicare program may need such flexibility if it is to compete with private-sector plans.

Certainly some health care providers—and competing health plans—will question the wisdom of such new Medicare authorities. But why would beneficiaries and taxpayers want to keep Medicare from being as good a program as it can be? If Medicare is expected to compete with private plans for enrollees, why should it not have comparable purchasing flexibility?

## A STRATEGIC PLAN FOR MEDICARE MANAGEMENT

If the Medicare program, as an accountable health care purchaser, is to begin to use these authorities to deal with quality, service, and cost issues, where should it start and what should it do? Given the program's scale and complexity, a great deal of work will need to be done to devise an intelligent purchasing strategy before that question can be answered in a way that has wide professional and political support. As a matter of law, Medicare cannot deal with such problems in an arbitrary or capricious manner. Beneficiaries have rights to

due process and to judicial review for claims denials. Much of the needed research will be useful for competing private-sector health plans, since these plans will face the same issues and few yet have much special expertise in managing care for the Medicare populations.

Research might help Congress, the executive branch, and other interested parties in the following five basic areas:

- *A national strategy for clinical effectiveness and outcomes studies for the Medicare populations.* This strategy could be built by analyzing the Medicare data to identify procedures with wide variations that seem likely to reflect overuse and underuse or excessive rates of increase and by prioritizing a research agenda by potential payoffs in enrollee health and program costs. It also needs to include recommendations concerning funding for the effort, the appropriate methodologies to assure usefulness, and an ongoing system to automatically evaluate new technologies and clinical practices. The serious shortcomings of much of the published literature on medical treatment, well-known to clinical effectiveness researchers, was highlighted in a recent *New York Times* story of a Canadian assessment of treatment for whiplash injury that found only 62 of 10,382 studies met the evaluators' criteria for solid scientific evidence.<sup>18</sup>
- *Development of HEDIS-type "report card" measures for quality/health outcomes, consumer satisfaction, and service.* These data need to be collected at the state and market-area level, so that HCFA can manage its carrier/PRO contractors accountably and so that enrollees have comparable data to private-sector plans for making their enrollment decisions. These report card measures need to be selected for their validity and reliability and should include information that is important to consumers for making choices among health plans.
- *Studies of "best practices" in all major areas of costs, quality, and service.* Medicare is a vast program that has not been very amenable to

centralized, command-and-control management. Political decision-makers and the Medicare program have rightfully been extremely wary about trying to use government coercion to change medical practices. Perhaps the best way to foster desirable change in a competitive-choice market system is to make sure that patients, providers, and competing health plans are well-informed about the best practices and performance benchmark standards that they should look for in making purchasing decisions or should offer to be successful in the marketplace. The private sector's new purchasing techniques, and their applicability to Medicare's populations, need to be carefully assessed.

- *Effective communication strategies.* The development of a national research effort for effectiveness and outcomes studies, report card data, and identification of best practices need to be matched by strategies to be sure the information is effectively communicated and that it takes into account the range of sociological and other factors that need to be addressed for effective change. Good clinical research data on outcomes and effective communication seem to have been an effective strategy in the recent declines in prostate operations and cataract surgery, two procedures that had been increasing rapidly until better information was made available to clinicians and patients.
- *Assessment of where both Medicare and competing private health plans do and do not work well, and why.* One of the important open issues for health policy is to identify market conditions where health plan competition can improve health care and where such competition does not work well. In today's market, for example, while the Twin Cities area has one of the highest national rates of HMO enrollment for the under-65 population, only 9% of Medicare eligibles are enrolled. A possible reason is that HMOs cannot make much money or provide many additional benefits for 95% of the Medicare expenditures in this area. Some analysts

have also argued that managed competition will not work well in rural areas. If Medicare competition is opened up to a wide variety of options more attractive than HMOs—for example, PPOs, point-of-service (POS) plans, Medicare Select options, and other arrangements—market research on their comparative success can yield insights about how the Medicare program may need to be changed to better meet the needs and preferences of its enrollees.

In addition to these areas, there are a number of special study topics that could prove useful for devising a strategy for Medicare to operate as an accountable health plan.

- *Special studies of needs and service for Medicare's disabled populations.* Medicare's 4 million disabled enrollees have been badly neglected by health policy analysts and in Medicare policy discussions. Medicare publishes very little data on their characteristics, needs, and service use. Nevertheless, this is an important group for analysis, as its rate of growth (4.0% annually in the period 1982-1992) is more than twice that of the elderly population (a 1.9% annual increase during the same period); the under-45 disability group has been growing even faster, almost 11% annually over this period. With a benefit package focused on acute medical care, the Medicare program is not well-designed for totally and permanently disabled persons. Since this group is unlikely to be attractive to private health insurance plans, it is particularly important that the Medicare program, as an accountable health plan, make special efforts to be sure that they are being well served. Separate HEDIS-type measures may be needed for disabled subpopulations.
- *Special studies of high-use elderly populations.* As is the case with the under-65 population, Medicare's spending for the aged is highly skewed, with about 5% of enrollees accounting for about 50% of expenditures on care, 10% for about 70% of expenditures on care, and about 20% accounting for about 80% of

expenditures on care. Among the high-expenditure populations are important subpopulations with chronic illness. Trying to identify these groups and analyze potential improvements in their care will be of particular importance for dealing with Medicare spending issues. To the extent that such high-use groups remain with the Medicare program, it will be even more important for Medicare to have a scientifically strong clinical basis for assessing their needs and care.

- *Special studies of disease management and prevention initiatives.* It may seem unusual to think about prevention and long-term disease management for Medicare enrollees, but its elderly enrollees are in the program, on average, for over a decade, with some enrolled for up to 40 years; its disabled enrollees receive benefits for even longer.

Among prevention initiatives reported by HMOs for the over-65 are activities to reduce falls, a leading cause of hospitalization in the elderly, and to identify inappropriate prescribing and potential drug-drug interactions. As an increasing number of pharmacy benefit management and other firms develop disease management expertise, it will be important to assess the potential of these developments for the Medicare population, particularly in light of the many studies that show misprescribing for the elderly.

- *Policy development for post-acute hospital care.* A particularly rapid part of Medicare's recent growth has been in post-acute hospital care. Between 1992 and 1993, Medicare spending for home health and skilled nursing care each grew by about 40%, to a total of nearly \$17 billion. Rehabilitation therapy claims are growing about 30% a year.<sup>19</sup> This entire policy area needs careful review, in conjunction with the Medicaid program, which is the nation's largest financier of long-term care, to rationalize the service efforts. Standards of appropriateness of care are more difficult to come by in this area than for clinical effectiveness and outcomes studies of acute care.

- *Better risk-adjustment mechanisms and procedures.* It is predictable that the basic Medicare program will continue to have a less healthy population than competing private health plans, at least for the foreseeable future. This will be an ongoing area of research and policy analysis. Perhaps an independent or quasi-independent organization should manage the annual "open season" competition between Medicare and private health plans to help assure fair, well-informed choice by eligible individuals.

This is an outline for a very broad and multi-year research agenda. But such an effort is needed, by both public and private sectors. Over the past 10 years the primary focus of Medicare policy has been to design, implement, and refine its price controls—using DRGs and a resource-based relative value scale (RBRVS). Today, there is very little that is "on the shelf" that can be implemented in the short run.

#### CAN MEDICARE COMPETE SUCCESSFULLY?

Given new accountabilities, new management authority to purchase health care, and a strategic plan for its future, can Medicare compete successfully with private health plans for the benefit of the elderly and disabled? Why not just leave Medicare alone as a traditional bill-payer and hope that it will wither away as beneficiaries choose better-managed private health plans? There will be those who believe that privately managed health care plans will out-perform any new-model, government-run Medicare program in head-to-head competition and that trying to manage Medicare as a competitive health program is hopeless or unwise.

Nevertheless, the Medicare program is still the choice of over 90% of its eligible population (and, in a majority of states, of 99% or more of eligibles), and it seems premature to predict Medicare's demise or to make an unchallengeable case about private health plans' interest and ability to compete, on a nationwide basis, for the Medicare population,

particularly its high-expense frail elderly, chronically ill, and disabled populations. Given the current situation, it would be a high-stakes risk to ignore upgrading Medicare and place all of the nation's Medicare budgetary bets on presumptions about the success of private-sector plans that may prove to be wishful thinking. In addition, the federal government has a number of strengths to build on in trying to make Medicare a better program.

Among these strengths are:

- *Good track record.* It is fashionable to disparage government competence, but, compared to much of the private insurance industry, the Medicare program has an excellent track record for innovation and efficiency, within its statutory constraints. Through the use of DRGs and RBRVS, Medicare has led private payers in reducing payments for overpriced procedures and using purchasing power to restrain inflation and rationalize payment rates. Medicare has also led in investing in medical efficacy studies and protocol development to improve clinical practices reflecting outcomes research (through the Agency for Health Care Policy and Research [AHCPR]); publicizing information on comparative provider quality, for example, hospital mortality rates and nursing home reviews; setting up standardized data systems; establishing electronic submission of claims; and overall administrative efficiency. In all of these areas, Medicare still betters the private insurance norms. Among recent innovative steps are beneficiary surveys, a consumer information strategy (immunizations, mammography), a coronary artery bypass surgery demonstration with bundled payment rates, Medicare Select demonstrations, and performance contracts with PROs. With a new statutory mandate and authorities, Medicare may also excel in new competition vis-à-vis private health insurance plans.
- *Flexible administrative structure.* Medicare is normally thought of as a government-run program, but, in fact, no federal employees

actually pay claims. Federal employees oversee a system of some 74 private contractors (called intermediaries and carriers—mostly Blue Cross/Blue Shield plans or commercial insurers) that actually run the program on a day-to-day basis. These private-sector insurers—themselves now involved in developing and managing private health plans—bring administrative flexibility, staffing and subcontracting capabilities, and expertise in local markets. When Medicare was first established, its contractor system offered administrative capabilities the government did not possess and could not develop on the scale and in the time frame that was needed. A well-managed Medicare program might be able to take advantage of this flexibility, in new relations with its contractors. As discussed in a recent companion piece,<sup>20</sup> the Blue Cross Blue Shield Federal Employees Plan managed pharmacy benefits program offers a model for how state-of-the-art managed care programs can be developed and offered in a government-financed framework for public beneficiaries. Medicare might be able to cross-fertilize between HCFA's rule-making and bill-paying culture and the private payers' purchasing culture to produce hybrid plans through joint efforts with its primary contractors.

- *Public trust and freedom of choice.* While government, in general, may be viewed with distrust and suspicion by many voters, the Medicare and Social Security programs retain strong senior citizen support. Medicare remains the program of choice of the elderly. In the Medicare program, enrollees have much broader freedom to choose a provider than in private managed care plans. They also have legal rights and due processes that help to guarantee their benefits—and an ability to appeal to their members of Congress for assistance.
- *Enormous purchasing power.* Medicare is the nation's largest health care purchaser, with an estimated \$175 billion of spending in

1995. In 1993, it accounted for 19% of personal health care expenditures, including 28% of hospital care expenditures, 20% of physician care expenditures, and 39% of home health expenditures. The price discounts Medicare has been able to achieve through DRGs and RBRVS alone—although now undercut by HMOs in some markets—and its high assignment rate (over 96%) suggest a reasonable amount of optimism should be in order about the success of future purchasing strategies. If managed purposefully, Medicare should be able to strike economic terms that are at least as favorable as its competing health insurance plans, as well as use its purchasing discretion for upgrading quality and service standards.

- *Data and research capacity.* Finally, Medicare has an unsurpassed data system, including claims records on medical services use by some 37 million enrollees and a potential for service-profiling and quality-auditing most of the nation's health care providers. This is a unique resource for developing national management strategies and for rapid learning about the effectiveness of these providers. Medicare and AHCPR also have a strong tradition of health services research and can work with many professional groups in developing clinical quality indicators and improvement strategies.

How best to manage competition between competitive Medicare and private-sector plans, all trying their best to enroll Medicare eligibles with the most attractive benefits, costs, quality, and service, is a complicated topic in its own right. If reengineering Medicare, as described in this paper, is a primary challenge, another ongoing challenge of daunting complexity will be to assure that competition among Medicare and competing health plans works well. Congress is now in the midst of debating many major policy questions, including enrollee financial incentives and the potential for budget savings, and there are numerous questions which will require long-term learning agendas.

Thirty years after Medicare's enactment, a much-needed debate about Medicare's future is taking place; its focus is whether (and how) the Medicare program should be rethought in light of the private sector's transition from bill-paying insurance to accountable health care purchasing. Whether one favors Medicare reforms alone, more private plan options alone, or a "two-track" strategy that includes both approaches (the possibility raised in this paper), there are good reasons to proceed with caution in use of either Medicare's new business-type authorities or new competitive arrangements. The welfare of 37 million elderly and disabled individuals is at stake. While it is attractive to envision improving the Medicare program, it is also important to realize that discretionary authority can also be misused, and competitive forces can go awry. The Medicare program could be made worse if it is subjected to unrealistic budget pressures and its new authorities are used to ration services, or if competing plans "skim" the Medicare enrollment. As well, the American tradition of public management—based on the view that government officials should not be allowed to act in ways that are arbitrary, capricious, and unfair—has usually insisted on "a government of laws and not of men." But protection of Medicare enrollees in private plans from poor HMO practices should be no less an issue.<sup>21</sup> With broader administrative discretion for political appointees also comes increased possibility for the application of political pressures, from Congress and other sources, and the pursuance of personal agendas. Perhaps the Medicare program is unmanageable or will prove to be so; perhaps private plan enthusiasm about the profit potential of Medicare enrollees will abate. For many such reasons, there will need to be a great deal of oversight and vigilance about Medicare and its competitors. Just as Congress established the Prospective Payment Assessment Commission and PPRC to advise on development of Medicare price regulation, it may also wish to establish a similar advisory commission for an implementation period of market-oriented Medicare reforms.

## ENDNOTES

1. *Medicare: Opportunities Are Available to Apply Managed Care Strategies*, statement of Janet Shikles, GAO/T-HEH-95-81, February 10, 1995 (Appendix I).
2. About 77% of Medicare eligibles already have medigap, Medicaid, or other supplemental coverage, so switching enrollment to an HMO may provide them few additional benefits. Individuals may also be deterred from enrolling in an HMO because they would have less freedom of choice of physicians and other providers and would not be able to re-enroll in their current plans if the HMO were not satisfactory. Insurers' ability to compete with Medicare is also lessened because Medicare pays providers well below average private market rates.
3. An Institute of Medicine committee has also recommended that Congress make quality assurance, including improved patient health outcomes, a fundamental program goal. See Kathleen Lohr (ed.), *Medicare: A Strategy for Quality Assurance*, National Academy Press, 1990. The study, chaired by Steven Schroeder, M.D., was requested by Congress in OBRA 1986.
4. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, HCFA Pub. No. 03348, February 1995.
5. Physician Payment Review Commission, *Monitoring Access of Medicare Beneficiaries*, Report No. 95-1 (forthcoming); S. Asch, et al., *Access to Care for the Elderly Project*, Final Report, RAND Corporation, April 13, 1995 (photocopy).
6. National Institute for Health Care Management, *Health Care Problems: Variation across States*, December 1994, pp. 34-36 (exhibits 4.4, 4.5, 4.6).
7. "The Fortune 500 Largest U.S. Corporations," *Fortune*, May 15, 1995, p. F-1.
8. *Medicare and Medicaid Statistical Supplement*, p. 199 (table 25).
9. *Ibid.*, pp. 208 (table 28).
10. *Ibid.*, p. 232 (table 37).
11. *Ibid.*, p. 252 (table 46).
12. Physician Payment Review Commission, *Expenditure Limits*, July 1993 (staff paper), p. 62.
13. Physician Payment Review Commission, *Annual Report to Congress: 1995*, p. 20 (table 1-1).
14. M. Chassin, et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?" *J.A.M.A.*, November 13, 1987. Jack Wennberg has been among the pioneers in Medicare area variation studies.
15. Statement of Sarah Jagger, March 22, 1995 (cited in *BNA Health Care Policy Report*, March 27, 1995, p. 479).
16. *Medicare Part B Factors That Contribute to Variations in Denial Rates for Medical Necessity across Six Carriers*, GAO/T-PEMD-95-11.
17. Lohr, *Medicare: A Strategy for Quality Assurance*.
18. "Study Finds Most Treatments for Whiplash Are Ineffective," *New York Times*, May 2, 1995.
19. *Medicare: High Spending Growth Calls for Aggressive Action*, Statement of William Scanlon, February 6, 1995, GAO/T-HEHS-95-75.
20. Lynn Etheredge, *Pharmacy Benefit Management: The Right Rx?* Research Agenda Brief, Health Insurance Reform Project, George Washington University, April 1995.
21. Complaint rates vary by more than 25:1, from 1.8/10,000 enrollees for Group Health of Puget Sound to 45.8/10,000 enrollees at Humana (Florida).

Etheredge ALG

## REENGINEERING MEDICARE

### ETHEREDGE'S CHALLENGE

In "Reengineering Medicare: From Bill-Paying Insurer to Accountable Purchaser," Lynn Etheredge argue that Medicare should emulate private health care plans in using the competitive marketplace to contain costs and improve quality and service. This reengineering would rest primarily on the adoption of report cards that assess Medicare's performance and new authorities--of the sort available to private sector health plans--to purchase health care on the basis of explicit quality and other criteria and competitive performance. With these new authorities, Etheredge argues, Medicare could do everything from establishing explicit quality and service performance standards to publicizing data on quality and service. "There are," Etheredge notes, "good reasons to proceed with caution in use of either Medicare's new business-type authorities or new competitive arrangements. The welfare of 37 million elderly and disabled individuals is at stake."

### REENGINEERING MEDICARE MANAGEMENT

Etheredge cited several areas where Medicare could select providers based on quantifiable measures and could use competitive purchasing. They are listed below, followed by Medicare's current efforts:

- ◆ **Competitive purchasing of standardized services and supplies, including durable medical equipment. (p. 7)**
  - Authority to purchase medical equipment and supplies and other Part B services on a competitive basis is proposed as part of the President's budget package.
  - HCFA is currently considering a demonstration for competitive pricing of durable medical equipment that could begin in FY 1996.
  
- ◆ **Establishment of explicit quality and service performance standards and refuse to do business with providers that do not measure up. (p. 7)**
  - HCFA is developing supplier standards for durable medical equipment and services to incorporate quality standards, for example, as they relate to the demonstration and use of medical equipment.
  - As part of the revised conditions of participation for home health agencies, HCFA is developing a standard assessment tool to measure the quality of care provided to beneficiaries. Ultimately this assessment

tool will provide both providers and regulators the data they need to improve quality in this setting.

- HCFA is also rewriting the ESRD conditions of participation to focus more on outcome measures.

- Medicare-contracting HMOs are required to have internal quality assurance systems that include stressing health outcomes; provide for peer review by physicians and other practitioners; use systematic data collection of performance and patient results, and institute needed changes.

◆ **Development and use of centers of excellence and specialized services contracting.**

- HCFA uses the centers of excellence approach in selecting heart and liver transplant centers. We also use specialized contracting for CABG and cataract services and are expanding these in FY 96.
- The President's budget package proposes a significant expansion of this strategy to other services.
- Risk HMOs use selective contracting to arrange for the provision of certain specialized services.

◆ **Use of case management for high-cost patients. (p.7)**

- HCFA currently pays for three types of case management services under the physician fee schedule:
  - i) the monthly capitated payment for End Stage Renal Disease (ESRD) patients;
  - ii) the weekly capitated payment for radiation therapy management; and
  - iii) the payment for care plan oversight by physicians who provide these services to patients in hospices or those receiving home health benefits.

- Risk HMOs may contract for case management of high cost patients. HCFA intends to study how this concept might be developed and offered to beneficiaries who are not members of such health plans.

- In its proposed physician fee schedule for CY 1996, HCFA is soliciting information, recommendations from the public on how primary care case management can be made available as part of the Medicare fee-for-service system.

- HCFA is testing the use of case management for high cost Medicare beneficiaries in three sites and the evaluation report is expected in FY 96. Expanded demonstrations are planned for FY 96-97.

- ◆ **Elimination of notice of proposed rule-making process for purchasing.** (p.8)

As Etheredge notes, HCFA does not have the authority to eliminate the rule-making process. However, HHS has streamlined the regulations process in a number of ways. We are also exploring other means of increasing purchasing flexibility, including the use of contractor manuals and other tools.

- ◆ **Authorization for Medicare simply to drop providers in the best interests of the program to deal with fraud and abuse.** (p. 8)

- HCFA and the Office of the Inspector General are co-sponsoring Operation Restore Trust. It is to target fraud and abuse in the DME, home health, and nursing home industries. We expect that the effort will lead to the exclusion of some suppliers and providers.

- Fraud identification will be greatly improved with the implementation of the Medicare Transaction System (MTS). The integrated data provided by MTS will greatly assist HCFA in detecting fraud before inappropriate payment is made.

- The consolidation of DME claims processing into four sites has resulted in quicker identification of suspect suppliers.

- ◆ **Authorization for Medicare to organize and contract for quality assurance at its discretion.** (p. 8)

To ensure that HCFA gets the best value from its PRO and ESRD contracts, HCFA is implementing a performance-based evaluation approach based on quality improvement measures. These measures will allow HCFA to target contractors' work in areas that the contractors are most successful, and in the worst case to terminate contractors based on failure to perform.

◆ **Publicity about data on quality and service. (p. 8)**

- As part of its Medicare Choices initiative, HCFA is sponsoring a study to determine the types of information beneficiaries want and need to make informed choices about health plans.
- HCFA is awarding a contract for beneficiary information, education and marketing in FY 95 that will include some type of report card information that can be used to compare quality and service across managed care plans.

◆ **Improvement of customer service. (p.8)**

HCFA has made a major commitment to improving customer service in the last two years. It has published a customer service plan outlining specific standards for customer service and a promise of continuous improvement. By September of this year it will have established, in cooperation with DHHS, standards that will guide its performance with respect to its grantees (States and research institutions). Among the more notable of its customer service initiatives are:

- HCFA On-Line, a comprehensive communications strategy designed to coordinate activities of the Agency and its partners to respond to beneficiary information needs with flexibility, accuracy and speed. The President's budget proposal includes HCFA On-Line.
- a demonstration project to examine the feasibility of establishing a national 1-800-MEDICARE telephone line to provide a response to any Medicare problem.
- the development of customer service plans by all contractors (intermediaries and carriers).
- evaluation of all beneficiary focused publications to assure that they are readable and informative.
- creation of beneficiary focus groups on fraud and abuse, Medicare coverage policy, and managed care.
- redesign of the Explanation of Medicare Benefits so that beneficiaries will have little or no trouble understanding their benefits.
- the funding of grants to organizations in every State which provide information, counseling and assistance to Medicare beneficiaries.

- the collection and analysis of information concerning beneficiary satisfaction through the Medicare Current Beneficiary Survey.

◆ **Special authorities for Medicare in the hiring, promotion, and compensation of employees. (p. 9)**

- HCFA is pursuing a number of improvements in its hiring system.

- i) HCFA no longer requires the lengthy and cumbersome SF 171, the standard government application form. Like private sector employers, HCFA assesses a candidate's qualifications based on a traditional resume.
- ii) In addition to being an active participant in the Presidential Management Intern program, HCFA has also developed several programs including the Outstanding Scholar and Scholar Intern programs to encourage particularly gifted young talent to enter federal service with HCFA.
- iii) Through the programs mentioned above and other recruitment efforts, HCFA is working to increase the diversity of its workforce to more accurately reflect the diversity of the people it serves.
- iv) HCFA also takes advantage of recruitment and retention bonuses to attract and retain certain specialists.

**STRATEGIC PLAN FOR MEDICARE MANAGEMENT**

Etheredge calls for research in several broad areas, as well as in special study areas, to help Medicare become a more accountable health care purchaser. Again, HCFA has extensive research activities under way, as the following bullets show:

◆ **A national strategy for clinical effectiveness and outcomes studies for the Medicare populations. (p. 9)**

- HCFA, together with the Department of Defense and the Federal Employees Health Benefits Plan, has joined private sector purchasers to form the Foundation for Accountability (FACct), a new organization for quality improvement and managed care accountability. The intent of FACct is to leverage the collective buying power of the participating organizations to ensure our beneficiaries' needs are met and to eliminate unnecessary duplication of individual quality improvement and HMO accountability efforts.

- HCFA has joined the ESRD networks and the renal community to develop the ESRD Core Indicators Project, HCFA's first nationwide, population-based study assessing opportunities to improve the care of adult ESRD patients. The project will be extended to other ESRD treatment groups over the next few years.
- HCFA is developing the Medicare Quality Indicator System (MQIS) to measure access, appropriateness, outcomes, and patient satisfaction for preventive, acute, and chronic care services in both fee-for-service and managed care settings. MQIS will use practice guidelines sponsored by medical societies and AHCPR to profile patterns of care.

◆ **Development of HEDIS-type "report card" measures for quality/health outcomes, consumer satisfaction, and service. (p. 9)**

- HCFA is partnering with the Kaiser Family Foundation and the National Committee on Quality Assurance to develop a HEDIS-like set of performance measures to support the evaluation of managed care organizations that contract with Medicare.
- In 1993, HCFA launched the Cooperative Cardiovascular Project, a four State pilot project aimed at measuring and improving the quality of care given to Medicare beneficiaries hospitalized for acute myocardial infarctions (AMIs). HCFA is now implementing a national program to improve AMI care based on the results of the pilot project.
- HCFA is developing surveillance reports to be used by PROs to monitor the care provided to Medicare beneficiaries in their States. PROs will be expected to use their surveillance data to conduct pattern analyses both by geographic area within the State and in State-to-nation comparisons.

◆ **Studies of "best practices" in all major areas of costs, quality, and service. (p. 9)**

- HCFA is convening a series of exploratory meetings with employers, purchasers, and providers to identify areas where Medicare can collaborate with the private sector to improve beneficiary understanding and satisfaction with different types managed care options.
- As part of its outcomes based survey process, HCFA is working with the health care community to develop best practices standards of care. Examples of such standards include reducing the rate of use of restraints in nursing homes and improving the adequacy of dialysis in

hemodialysis facilities.

- HCFA is working with clinical specialty societies and patient advocacy groups to develop performance measures of consumer information and treatment for several clinical conditions affecting the Medicare population.

- HCFA encourages the PROs to use AHCPR guidelines as standards in their quality improvement projects.

◆ **Effective communication strategies. (p. 10)**

HCFA has undertaken the Consumer Information Strategy, a national and local public health campaign to encourage beneficiaries to use preventive health care services while providing them with current, data-driven information so that they can make informed decisions about their health care.

◆ **Special studies of needs and service for Medicare's disabled populations. (p. 10)**

- All HCFA Regional Offices have started outreach activities to advocacy groups for the disabled to better understand their needs.

- HCFA is assessing the impact of Medicare coverage policies on the disabled population with a view toward making changes.

- HCFA is sponsoring several demonstrations to look at models of care for disabled beneficiaries, including long term care and beneficiary-centered care.

◆ **Special studies of high-use elderly populations. (p. 10)**

- HCFA has focused many research resources over the years on issues pertaining to elderly beneficiaries with high service use including high cost hospice, access to physician and hospital services, use of nursing facilities, home health, DME, and other Medicare benefits.

- Demonstrations such as the Nursing Home Case Mix and Quality, On Lok/PACE and many others investigate methods by which providers are adequately paid for services for extremely frail beneficiaries.

◆ **Special studies of disease management and prevention initiatives. (p.11)**

- HCFA has sponsored several recent major prevention initiatives

including mammography and flu vaccine, focused on getting utilization data out to communities and identifying areas where there are disparities in utilization by race/ethnicity.

- HCFA has sponsored demonstrations to identify the most promising preventive services for Medicare coverage.
- S/HMO plans are selected to develop geriatric services within an integrated service delivery network.
- S/HMO ESRD site is being developed to test capitated approaches for beneficiaries with ESRD.
- HCFA's Alzheimer's disease demonstration, which recently concluded with evaluation results pending, tested the impact of a limited community services benefit package.

◆ **Policy development for post-acute hospital care (p.11).**

- HCFA has been looking extensively at policy for post-acute hospital care.
  - i) The Medicare Home Health Initiative has undertaken an effort to identify, develop, and implement improvements for the entire home health benefit.
  - ii) In order to control costs of non-inpatient therapy services, HCFA is developing salary equivalency guidelines for contracted physical therapy, respiratory therapy, occupational therapy and speech language pathology.
- HCFA recognizes the significant growth in the costs and utilization of post-acute care services under Medicare and has directed significant policy development efforts to that area. The following are examples of these efforts:
  - i) HCFA has developed legislative proposals that would give HCFA authority to implement a first-stage prospective payment system for SNFs. The PPS would initially target routine costs and later incorporate ancillary costs.
  - ii) Development of prospective payment demonstrations for SNFs and home health agencies. The SNF PPS demonstrations will test a case-mix system of PPS in six States and goes beyond the

more cost-based legislative proposal.

- iii) HCFA is developing a rule that will require SNFs to electronically submit the nursing home minimum data set resident assessment instrument. This will create a valuable data resource for studying care patterns, resident conditions and outcomes.
- iv) HCFA published detailed hospital discharge planning requirements to assure that hospitals initiate post-discharge planning early in the hospitalizations of patients who are likely to require it. These regulations mandate that the families of the patients be involved and that the hospital continue to assess the effectiveness of the process.
- v) HCFA has developed a uniform needs assessment instrument (UNAI) to anticipate which services or types of care will be needed at the time of discharge. The goals of the UNAI are two fold: 1) to improve the quality by creating a clinical standard for assessing care needs/discharge planning; and 2) to improve consistency of decisions made by fiscal intermediaries for post-acute care services.

◆ **Better risk-adjustment mechanisms and procedures. (p. 11)**

- HCFA has underway several million dollars of research and development efforts to develop more effective risk adjustment methods.
- Research efforts are underway to test diagnostic cost groups and ambulatory care groups and will conclude this calendar year.
- HCFA will include several risk-adjustment mechanisms in demonstrations such as those under the Choice initiative.

All these efforts reflect HCFA's interest in proceeding vigorously, but with caution, in considering new business-like authorities and new competitive arrangements.



# HEALTH CARE FINANCING ADMINISTRATION



*Duplicate*

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**REMARKS:**

*This is our response to the Etheredge paper.*

## REENGINEERING MEDICARE

### ETHEREDGE'S CHALLENGE

In "Reengineering Medicare: From Bill-Paying Insurer to Accountable Purchaser," Lynn Etheredge argue that Medicare should emulate private health care plans in using the competitive marketplace to contain costs and improve quality and service. This reengineering would rest primarily on the adoption of report cards that assess Medicare's performance and new authorities--of the sort available to private sector health plans--to purchase health care on the basis of explicit quality and other criteria and competitive performance. With these new authorities, Etheredge argues, Medicare could do everything from establishing explicit quality and service performance standards to publicizing data on quality and service. "There are," Etheredge notes, "good reasons to proceed with caution in use of either Medicare's new business-type authorities or new competitive arrangements. The welfare of 37 million elderly and disabled individuals is at stake."

### REENGINEERING MEDICARE MANAGEMENT

Etheredge cited several areas where Medicare could select providers based on quantifiable measures and could use competitive purchasing. They are listed below, followed by Medicare's current efforts:

- ◆ **Competitive purchasing of standardized services and supplies, including durable medical equipment. (p. 7)**
  - Authority to purchase medical equipment and supplies and other Part B services on a competitive basis is proposed as part of the President's budget package.
  - HCFA is currently considering a demonstration for competitive pricing of durable medical equipment that could begin in FY 1996.
- ◆ **Establishment of explicit quality and service performance standards and refuse to do business with providers that do not measure up. (p. 7)**
  - HCFA is developing supplier standards for durable medical equipment and services to incorporate quality standards, for example, as they relate to the demonstration and use of medical equipment.
  - As part of the revised conditions of participation for home health agencies, HCFA is developing a standard assessment tool to measure the quality of care provided to beneficiaries. Ultimately this assessment

tool will provide both providers and regulators the data they need to improve quality in this setting.

- HCFA is also rewriting the ESRD conditions of participation to focus more on outcome measures.
- Medicare-contracting HMOs are required to have internal quality assurance systems that include stressing health outcomes; provide for peer review by physicians and other practitioners; use systematic data collection of performance and patient results, and institute needed changes.

◆ **Development and use of centers of excellence and specialized services contracting.**

- HCFA uses the centers of excellence approach in selecting heart and liver transplant centers. We also use specialized contracting for CABG and cataract services and are expanding these in FY 96.
- The President's budget package proposes a significant expansion of this strategy to other services.
- Risk HMOs use selective contracting to arrange for the provision of certain specialized services.

◆ **Use of case management for high-cost patients. (p.7)**

- HCFA currently pays for three types of case management services under the physician fee schedule:
  - i) the monthly capitated payment for End Stage Renal Disease (ESRD) patients;
  - ii) the weekly capitated payment for radiation therapy management; and
  - iii) the payment for care plan oversight by physicians who provide these services to patients in hospices or those receiving home health benefits.
- Risk HMOs may contract for case management of high cost patients. HCFA intends to study how this concept might be developed and offered to beneficiaries who are not members of such health plans.

- In its proposed physician fee schedule for CY 1996, HCFA is soliciting information, recommendations from the public on how primary care case management can be made available as part of the Medicare fee-for-service system.

- HCFA is testing the use of case management for high cost Medicare beneficiaries in three sites and the evaluation report is expected in FY 96. Expanded demonstrations are planned for FY 96-97.

- ◆ **Elimination of notice of proposed rule-making process for purchasing.**  
(p.8)

As Etheredge notes, HCFA does not have the authority to eliminate the rule-making process. However, HHS has streamlined the regulations process in a number of ways. We are also exploring other means of increasing purchasing flexibility, including the use of contractor manuals and other tools.

- ◆ **Authorization for Medicare simply to drop providers in the best interests of the program to deal with fraud and abuse.** (p. 8)

- HCFA and the Office of the Inspector General are co-sponsoring Operation Restore Trust. It is to target fraud and abuse in the DME, home health, and nursing home industries. We expect that the effort will lead to the exclusion of some suppliers and providers.

- Fraud identification will be greatly improved with the implementation of the Medicare Transaction System (MTS). The integrated data provided by MTS will greatly assist HCFA in detecting fraud before inappropriate payment is made.

- The consolidation of DME claims processing into four sites has resulted in quicker identification of suspect suppliers.

- ◆ **Authorization for Medicare to organize and contract for quality assurance at its discretion.** (p. 8)

To ensure that HCFA gets the best value from its PRO and ESRD contracts, HCFA is implementing a performance-based evaluation approach based on quality improvement measures. These measures will allow HCFA to target contractors' work in areas that the contractors are most successful, and in the worst case to terminate contractors based on failure to perform.

◆ **Publicity about data on quality and service. (p. 8)**

- As part of its Medicare Choices initiative, HCFA is sponsoring a study to determine the types of information beneficiaries want and need to make informed choices about health plans.
- HCFA is awarding a contract for beneficiary information, education and marketing in FY 95 that will include some type of report card information that can be used to compare quality and service across managed care plans.

◆ **Improvement of customer service. (p.8)**

HCFA has made a major commitment to improving customer service in the last two years. It has published a customer service plan outlining specific standards for customer service and a promise of continuous improvement. By September of this year it will have established, in cooperation with DHHS, standards that will guide its performance with respect to its grantees (States and research institutions). Among the more notable of its customer service initiatives are:

- HCFA On-Line, a comprehensive communications strategy designed to coordinate activities of the Agency and its partners to respond to beneficiary information needs with flexibility, accuracy and speed. The President's budget proposal includes HCFA On-Line.
- a demonstration project to examine the feasibility of establishing a national 1-800-MEDICARE telephone line to provide a response to any Medicare problem.
- the development of customer service plans by all contractors (intermediaries and carriers).
- evaluation of all beneficiary focused publications to assure that they are readable and informative.
- creation of beneficiary focus groups on fraud and abuse, Medicare coverage policy, and managed care.
- redesign of the Explanation of Medicare Benefits so that beneficiaries will have little or no trouble understanding their benefits.
- the funding of grants to organizations in every State which provide information, counseling and assistance to Medicare beneficiaries.

- the collection and analysis of information concerning beneficiary satisfaction through the Medicare Current Beneficiary Survey.

◆ **Special authorities for Medicare in the hiring, promotion, and compensation of employees. (p. 9)**

- HCFA is pursuing a number of improvements in its hiring system.
  - i) HCFA no longer requires the lengthy and cumbersome SF 171, the standard government application form. Like private sector employers, HCFA assesses a candidate's qualifications based on a traditional resume.
  - ii) In addition to being an active participant in the Presidential Management Intern program, HCFA has also developed several programs including the Outstanding Scholar and Scholar Intern programs to encourage particularly gifted young talent to enter federal service with HCFA.
  - iii) Through the programs mentioned above and other recruitment efforts, HCFA is working to increase the diversity of its workforce to more accurately reflect the diversity of the people it serves.
  - iv) HCFA also takes advantage of recruitment and retention bonuses to attract and retain certain specialists.

#### STRATEGIC PLAN FOR MEDICARE MANAGEMENT

Etheredge calls for research in several broad areas, as well as in special study areas, to help Medicare become a more accountable health care purchaser. Again, HCFA has extensive research activities under way, as the following bullets show:

◆ **A national strategy for clinical effectiveness and outcomes studies for the Medicare populations. (p. 9)**

- HCFA, together with the Department of Defense and the Federal Employees Health Benefits Plan, has joined private sector purchasers to form the Foundation for Accountability (FAcct), a new organization for quality improvement and managed care accountability. The intent of FAcct is to leverage the collective buying power of the participating organizations to ensure our beneficiaries' needs are met and to eliminate unnecessary duplication of individual quality improvement and HMO accountability efforts.

- HCFA has joined the ESRD networks and the renal community to develop the ESRD Core Indicators Project, HCFA's first nationwide, population-based study assessing opportunities to improve the care of adult ESRD patients. The project will be extended to other ESRD treatment groups over the next few years.
- HCFA is developing the Medicare Quality Indicator System (MQIS) to measure access, appropriateness, outcomes, and patient satisfaction for preventive, acute, and chronic care services in both fee-for-service and managed care settings. MQIS will use practice guidelines sponsored by medical societies and AHCPR to profile patterns of care.

◆ **Development of HEDIS-type "report card" measures for quality/health outcomes, consumer satisfaction, and service. (p. 9)**

- HCFA is partnering with the Kaiser Family Foundation and the National Committee on Quality Assurance to develop a HEDIS-like set of performance measures to support the evaluation of managed care organizations that contract with Medicare.
- In 1993, HCFA launched the Cooperative Cardiovascular Project, a four State pilot project aimed at measuring and improving the quality of care given to Medicare beneficiaries hospitalized for acute myocardial infarctions (AMIs). HCFA is now implementing a national program to improve AMI care based on the results of the pilot project.
- HCFA is developing surveillance reports to be used by PROs to monitor the care provided to Medicare beneficiaries in their States. PROs will be expected to use their surveillance data to conduct pattern analyses both by geographic area within the State and in State-to-nation comparisons.

◆ **Studies of "best practices" in all major areas of costs, quality, and service. (p. 9)**

- HCFA is convening a series of exploratory meetings with employers, purchasers, and providers to identify areas where Medicare can collaborate with the private sector to improve beneficiary understanding and satisfaction with different types managed care options.
- As part of its outcomes based survey process, HCFA is working with the health care community to develop best practices standards of care. Examples of such standards include reducing the rate of use of restraints in nursing homes and improving the adequacy of dialysis in

hemodialysis facilities.

- HCFA is working with clinical specialty societies and patient advocacy groups to develop performance measures of consumer information and treatment for several clinical conditions affecting the Medicare population.
- HCFA encourages the PROs to use AHCPR guidelines as standards in their quality improvement projects.

◆ **Effective communication strategies.** (p. 10)

HCFA has undertaken the Consumer Information Strategy, a national and local public health campaign to encourage beneficiaries to use preventive health care services while providing them with current, data-driven information so that they can make informed decisions about their health care.

◆ **Special studies of needs and service for Medicare's disabled populations.** (p. 10)

- All HCFA Regional Offices have started outreach activities to advocacy groups for the disabled to better understand their needs.
- HCFA is assessing the impact of Medicare coverage policies on the disabled population with a view toward making changes.
- HCFA is sponsoring several demonstrations to look at models of care for disabled beneficiaries, including long term care and beneficiary-centered care.

◆ **Special studies of high-use elderly populations.** (p. 10)

- HCFA has focused many research resources over the years on issues pertaining to elderly beneficiaries with high service use including high cost hospice, access to physician and hospital services, use of nursing facilities, home health, DME, and other Medicare benefits.
- Demonstrations such as the Nursing Home Case Mix and Quality, On Lok/PACE and many others investigate methods by which providers are adequately paid for services for extremely frail beneficiaries.

◆ **Special studies of disease management and prevention initiatives.** (p.11)

- HCFA has sponsored several recent major prevention initiatives

including mammography and flu vaccine, focused on getting utilization data out to communities and identifying areas where there are disparities in utilization by race/ethnicity.

- HCFA has sponsored demonstrations to identify the most promising preventive services for Medicare coverage.
- S/HMO plans are selected to develop geriatric services within an integrated service delivery network.
- S/HMO ESRD site is being developed to test capitated approaches for beneficiaries with ESRD.
- HCFA's Alzheimer's disease demonstration, which recently concluded with evaluation results pending, tested the impact of a limited community services benefit package.

◆ **Policy development for post-acute hospital care (p.11).**

- HCFA has been looking extensively at policy for post-acute hospital care.
  - i) The Medicare Home Health Initiative has undertaken an effort to identify, develop, and implement improvements for the entire home health benefit.
  - ii) In order to control costs of non-inpatient therapy services, HCFA is developing salary equivalency guidelines for contracted physical therapy, respiratory therapy, occupational therapy and speech language pathology.
- HCFA recognizes the significant growth in the costs and utilization of post-acute care services under Medicare and has directed significant policy development efforts to that area. The following are examples of these efforts:
  - i) HCFA has developed legislative proposals that would give HCFA authority to implement a first-stage prospective payment system for SNFs. The PPS would initially target routine costs and later incorporate ancillary costs.
  - ii) Development of prospective payment demonstrations for SNFs and home health agencies. The SNF PPS demonstrations will test a case-mix system of PPS in six States and goes beyond the

more cost-based legislative proposal.

- ii) HCFA is developing a rule that will require SNFs to electronically submit the nursing home minimum data set resident assessment instrument. This will create a valuable data resource for studying care patterns, resident conditions and outcomes.
- iv) HCFA published detailed hospital discharge planning requirements to assure that hospitals initiate post-discharge planning early in the hospitalizations of patients who are likely to require it. These regulations mandate that the families of the patients be involved and that the hospital continue to assess the effectiveness of the process.
- v) HCFA has developed a uniform needs assessment instrument (UNAI) to anticipate which services or types of care will be needed at the time of discharge. The goals of the UNAI are two fold: 1) to improve the quality by creating a clinical standard for assessing care needs/discharge planning; and 2) to improve consistency of decisions made by fiscal intermediaries for post-acute care services.

◆ **Better risk-adjustment mechanisms and procedures. (p. 11)**

- HCFA has underway several million dollars of research and development efforts to develop more effective risk adjustment methods.
- Research efforts are underway to test diagnostic cost groups and ambulatory care groups and will conclude this calendar year.
- HCFA will include several risk-adjustment mechanisms in demonstrations such as those under the Choice initiative.

All these efforts reflect HCFA's interest in proceeding vigorously, but with caution, in considering new business-like authorities and new competitive arrangements.

THE WHITE HOUSE

WASHINGTON

July 7, 1995

MEMORANDUM FOR THE PRESIDENT

FROM::

Carol H. Rasco 

SUBJECT:

Lynn Etheredge's Report on Medicare

Lynn Etheredge has just completed the attached report that provides solid recommendations about how the Medicare program can be modernized. It is a well-written and researched analysis that documents the current shortcomings of Medicare and provides specific suggestions about how we can move the program into the 21st century. In short, he advocates utilizing the best of private sector competition, quality and accountability innovations without undermining the program.

As you may recall, Lynn is a consultant who has worked closely with both Republicans (OMB career under Reagan) and Democrats (your health care transition team and as a consultant last year to Kennedy's Labor Committee.) Most recently, he has been associated with the Jackson Hole group. He is well respected by all sides and is shopping the concepts outlined in this paper to moderate Republicans and Democrats.

The good news is that much of what Lynn is advocating is consistent with the Medicare restructuring/managed care enhancement package you explicitly and/or implicitly included in your balanced budget alternative. His recommendations would empower beneficiaries and the Medicare program itself, without fundamentally destroying the current system that has gained the overwhelming support of the public. They would contribute to your goal of providing more efficient options without financially coercing beneficiaries into plans they otherwise would not choose. Most importantly, they represent an alternative to the status quo that can be used to counter Republican voucher proposals. In short, your proposal has choice with security, whereas the Republicans are financially coercing beneficiaries into capped managed care plans. The approach outlined by Lynn would likely have the added benefit of being well received by the business, the managed care, and the aging advocacy communities.

While we would probably have to push HHS on some of Lynn's recommendations -- particularly with regard to a timely implementation schedule -- we believe the current environment has made the Department much more receptive and encouraging of movement in this direction. Donna Shalala, in particular, would probably love to embrace them.

I wanted to share this with you now because I think it is particularly timely relative to the inevitable upcoming Medicare reform debate. I have asked Chris Jennings to stay in close touch with Lynn and to continue to have appropriate White House and Department representatives review our substantive and political positioning strategy vis a vis Medicare. Unfortunately, because of the perception that we (and HCFA in particular) are not sufficiently open to the types of suggestions Lynn has raised, we must be careful about how and when we move this type of agenda to ensure that the Administration gets its due credit. Attached is a one-page summary of Lynn's recommendations.

cc: Alice Rivlin  
Laura Tyson

## HIGHLIGHTS OF ETHEREDGE'S MEDICARE REFORM RECOMMENDATIONS

**Medicare's mission philosophy needs to be revised to emphasize Medicare as a health plan.** Most importantly, Medicare needs to become accountable, not just for insurance to pay bills and protect financial assets, but for improving the health of its enrollees, by providing preventive health measures and quality medical care.

**Medicare should have new authorities to purchase health care on the basis of explicit quality and other criteria and competitive performance.** To improve Medicare's performance, Congress needs to provide authority to move beyond the limits of regulatory rule-making and price-setting so that Medicare can adopt the same types of successful purchasing techniques pioneered by private-sector pay. (This is very similar to the Clinton Administration PPO and point of service options.)

**Report cards that assess Medicare's performance on the basis of cost, quality, outcomes, and service need to be utilized so that the program can be held accountable by enrollees and policymakers.** These measures need to reflect a wide range of criteria, including preventive care, quality of care, consumer satisfaction, and health outcomes, and should also apply to competing private health plans. Report cards should show national, state-level, and market-area performance.

**Medicare needs to adopt competitive purchasing of standardized services and supplies, including durable medical equipment, laboratory testing, radiology, and outpatient surgery.**

**Medicare needs to significantly expand its use of centers of excellence and specialized services contracting.** Medicare now uses such concepts in its coverage for transplant services; private-sector plans use selective contracting even more widely for many forms of surgery, cancer care, and mental health. Intelligent purchasing by Medicare would produce better quality, cost, and service competition among providers, to the benefit of Medicare beneficiaries and taxpayers.

**A national strategy for clinical effectiveness and outcomes studies for the Medicare population needs to be implemented by analyzing the Medicare data to identify procedures with wide variations that seem likely to reflect overuse and underuse.**

**Medicare needs to be better empowered to drop providers who are contributing to a significant fraud and abuse problem in the program.**

June 1995

## Reengineering Medicare: From Bill-Paying Insurer to Accountable Purchaser

*Prepared by*

**Lynn Etheredge**  
*Consultant*

Prepared for the Health Insurance Reform Project, George Washington University, with funding from the Robert Wood Johnson Foundation

*Reengineering... is the fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in critical contemporary measures of performance, such as cost, quality, [and] service.*

—Michael Hammer and James Champy,  
*Reengineering the Corporation*

At the time of its enactment 30 years ago, Medicare was patterned on the health insurance models widely used by private employers and insurers for the under-65 population. In this model, the primary administrative function of insurance companies and of the Medicare program was simply to pay bills. Today, Medicare remains essentially a bill-paying insurance program, with the addition of national formulas for hospital and physician payment rates.

In recent years, the private sector has moved beyond this traditional insurance model. Private-sector payers are no longer simply paying bills but are using a variety of evolving *purchasing* techniques, in a competitive marketplace, to restrain costs and improve quality and service. Among these purchasing strategies are many forms of selective, competitive contracting; capitation and risk-sharing arrangements; provider performance standards, with incentives, penalties, and continuous quality improvement goals; management of high-cost cases; centers of excellence for transplants, heart surgery, cancer care, and other treatment; prevention and chronic disease management initiatives; consumer information and incentives; specialized contracting for pharmaceutical benefits, substance abuse, mental health, and other services; and specialized claims-auditing firms to deal with fraud. Individuals with benefits offered by large employers—including, through the Federal Employees Health Benefits Program (FEHBP), the nation's political leaders and federal workers—are usually able to make choices among a number of health plans on the basis of provider networks, cost, quality, service performance, and other features.

In this new purchasing environment, private-sector employers and consumers are increasingly able to make informed choices—to hold providers (and the plans that contract with them) *accountable*—through the use of tools such as the National Committee on Quality Assurance's (NCQA's) "report cards," which are based on the Health Plan Employer Data and Information Set (HEDIS), and other quality measures, such as health outcomes. The HEDIS data set includes more than 60 quality, service access, patient satisfaction, outcomes, and other performance measures, including preventive care (such as immunizations, mammography screening, and eye exams for diabetics) and signal indicators for poor quality (such as inpatient admissions for asthma and treatment following heart attacks).

In the current political climate, there is great interest in the federal government's making available to the Medicare population a broader choice of competing private health plans that use such purchasing technologies. Today, health maintenance organizations (HMOs) and other private plans enroll only about 10% of the Medicare population. Among the many measures that could open up more plan options are an FEHBP-type "managed competition" approach that would allow Medicare beneficiaries to make informed choices among a wide range of HMO, preferred provider organization (PPO), Medicare Select, medigap, and other plans during an annual open season. Other options being discussed involve workers staying with employer/association plans after turning age 65 or some use of medical IRA accounts and catastrophic coverage. Much of the attention in Congress now centers on the policy questions involved in structuring new options for Medicare enrollees.

As a complete reform strategy, such options would fall short. They do not reform the basic Medicare program. Over 90% of Medicare's spending is through the fee-for-service model. As of January 1, 1995, 19 states had no Medicare HMO enrollees and 32 states had 1% or fewer of their Medicare-eligible populations

enrolled in HMOs. A handful of states—including California (42% of Medicare HMO enrollees) and Florida (17% of Medicare HMO enrollees)—accounted for most of the Medicare HMO membership.<sup>1</sup> Even with an FEHBP-type arrangement and optimistic growth assumptions about private plan enrollments, many factors make it likely that most Medicare eligibles in most states will still be in the program for the rest of the decade and beyond.<sup>2</sup> In its traditional bill-paying mode, the Medicare program has very few tools for dealing with the volume, intensity, and quality issues that are its major cost-drivers. Thus, devising a strategy for fundamental reform of the basic Medicare program—"reengineering" Medicare—is essential not only to deal with budget issues but also to achieve improvements for the 37 million people who depend on the program.

What should be done about the basic Medicare program? What would be in the best interest of its 37 million elderly and disabled enrollees?

This paper considers the question of whether Congress should give Medicare the same types of authorities that are available to its private-sector competitors—particularly authorities to use new purchasing techniques—and require performance accountabilities for their use through HEDIS-like quality and health outcomes measures. Should not the nation's elderly and disabled, as well as taxpayers, ask for and expect a state-of-the-art Medicare program? If this approach were adopted, Medicare-eligible individuals would be able to enroll either in a Medicare program that is working hard to provide the best economy, quality, and services or in competing private-sector health plans that are paid equivalent (risk-adjusted) capitation amounts. One might expect that, over the long term, both taxpayers and Medicare-eligible persons would benefit by such competition.

At the most general level, reforming the Medicare program in this way would start with three fundamental changes:

- *A revised mission philosophy that emphasizes Medicare as a health plan.* Most importantly, Medicare would need to become accountable, not just for insurance to pay bills and protect financial assets, but for improving the health of its enrollees, by providing preventive health measures and quality medical care.<sup>3</sup>
- *The adoption of "report cards" that assess Medicare's performance on the basis of cost, quality, outcomes, and service so that it can be held accountable by enrollees and policymakers.* These measures need to reflect a wide range of criteria, including preventive care, quality of care, consumer satisfaction, and health outcomes, and should also apply to competing private health plans. Report cards should show national, state-level, and market-area performance.

The measures that could be used by a reformulated Medicare can be illustrated by comparing current official data reports with new health-related data that could be a basis for the above-described report cards. The most extensive public accounting for Medicare's operations is the *Medicare and Medicaid Statistical Supplement* published in February 1995.<sup>4</sup> Its more than 370 pages are filled with statistics that emphasize financial, workload, and claims-paid data, such as hospital days of care and expenditures, that are appropriate to a traditional health insurance program. Nowhere are there measures of quality of care and improved health status or reports on enrollee satisfaction.

Two recent studies highlight the kinds of health-related measures that might be used to assess Medicare's future performance as an accountable health plan. The Physician Payment Review Commission (PPRC) and the RAND Corporation have recently developed a set of approximately 50 quality measures that can be implemented, using claims data, for the current Medicare program. Several measures, which have been run against Medicare's national claims data, are shown below in Table 1. A number of them are similar to the

NCQA's HEDIS measures used for private-sector health plans. In the view of the physician consensus panels developing the measures, these are "necessary care" indicators; that is, professionally acceptable practice should be near 100% compliance.

TABLE 1

Clinically Based Indicators of Quality of Care for the Elderly Medicare Claims Data, 1992 and 1993

**Breast Cancer**

For patients with breast cancer, interval from biopsy to surgery less than 3 months 64%

Mammography every year for patients with a history of breast cancer 61%

Mammography every 2 years in female patients 39%

**Diabetes**

Eye exam every year for patients with diabetes 38%

**Heart Problems**

Visit within 4 weeks following discharge for patients hospitalized with MI 84%

EKG during ER visit for unstable angina 81%

**Mental Diagnosis**

Visit within 2 weeks following discharge of patients hospitalized for depression 95%

The PPRC-RAND study shows several quality indicators on which the care received by Medicare elderly patients merits an "A" (95%+) on a nationwide basis. But it also highlights a number of prevention indicators, such

as mammography and eye exams for diabetics, for which there should be failing grades, "D" or "F," as well as many indicators in the 60% to 85% range where care falls well below professional standards. The study also highlights particular problems for minority populations and for rural and underserved areas.<sup>5</sup>

Another recent study, by Lewin-VHI for the National Institute for Health Care Management, analyzed Medicare hospitalization rates for three diagnoses that are sensitive to good ambulatory care and preventive measures. For 1992, the study reported Medicare hospitalization rates for asthma to vary by more than 3:1 among states, hospitalization rates for diabetes by more than 5:1, and hospitalization rates for hypertension by more than 8:1. Even after statistical adjustments for demographic characteristics, several-fold variations still remained.<sup>6</sup>

Given such statistics, any presumption that Medicare has already become the "gold standard" of quality care and that it is up to its competitors to prove their superiority should be put aside. Medicare's performance needs to be measured and accountable on the same basis as its competitor plans, so its enrollees can make informed choices.

The third fundamental change that would need to occur for Medicare to become more like a state-of-the-art accountable health plan is the following:

- Medicare should have new authorities to purchase health care on the basis of explicit quality and other criteria and competitive performance.

Within the many statutory constraints Medicare has to operate under as a government program, it has generally been run effectively, efficiently, and with continuing improvement and innovation. Given its constraints, Medicare is now about as good a program as it can be. But, in nearly every area—such as three-year-long rule-making processes, volume increases and quality assurance issues, fraud and abuse, and rapidly rising budget costs—it is clear that Medicare cannot deal as effectively as it

needs to with the complexity and pace of change in today's health system, nor can it hold physicians, hospitals, and other providers accountable for improving their performance. To improve Medicare's performance,

Congress needs to provide authority to move beyond the limits of regulatory rule-making and price-setting so that Medicare can adopt the same types of successful purchasing techniques pioneered by private-sector payers. Such evolution could build incrementally through many Health Care Financing Administration (HCFA) initiatives, but, if fully reengineered, the Medicare program would be quite different a decade hence. Such changes will require a new bipartisan political consensus.

The next section elaborates on management challenges for the Medicare program's future if it is to be an effective health care purchaser. Following that is a discussion of specific legislative changes needed to allow Medicare to be an effective purchaser and competitive health plan. A third section sketches a research agenda for developing a Medicare management strategy to use these new statutory authorities. A final section discusses issues related to competition between a reengineered Medicare program and competing private-sector health plans.

## THE CHALLENGE OF MEDICARE MANAGEMENT

For the federal government, serious efforts to manage Medicare as an accountable health plan would be among the most enormous and complex tasks it has ever undertaken. To put the task on the scale of private-sector enterprises, the Medicare program, with \$160 billion of spending in 1994, has passed General Motors—with \$154 billion in revenues, the nation's largest private company—to become the nation's largest business-type operation.<sup>7</sup> In 1994, only three privately managed U.S. corporations (General Motors, Ford, and Exxon) had more than \$100 billion in revenues, 11 had \$50 billion or more in revenues, and 110 had \$10 billion or more in revenues. To-

day, 37 million persons depend on the Medicare program. Within 30 years, as the baby boom generation retires, Medicare will be purchasing health care for about 70 million persons, and its annual spending will be many times greater than it is today.

An understanding of the challenges of charting Medicare's future begins with an understanding of the scale involved. Nevertheless, there is a widespread misperception about the Medicare program that must be dealt with to understand just how difficult it will be to manage the program. That is the myth of uniformity, predictability, and gradual change.

Medicare can seem to be a deceptively simple and easy-to-reform program. Its enrollments, financing, and benefits are defined in statute. It has a centralized administrative structure (DHHS/HCFA); a uniform set of regulations; payment rates for hospitals, physicians, and other services that are specified by national formulas; and a national quality assurance/peer review structure, the Professional Review Organization (PRO) system. Individuals who are not health services researchers also tend to presume that health care is enough of a science that area-to-area rates of service use will be roughly uniform and that clinical practices change gradually, primarily as a result of the steady accumulation of scientific data. A misperception that the health care system is evolving in gradual, uniform ways is also reinforced by national health expenditure and Medicare actuarial data that aggregate a vast number of complex changes and variations into single categories such as "intensity."

The following selection of data illustrates how far assumptions of uniformity and steady change are from the Medicare program's reality.

■ *Hospital use.* Even on a regional basis, Medicare enrollees' use of hospital care varies by a ratio of 2:1—from 1,735 days/1,000 enrollees in the western states to 3,455 days/1,000 enrollees in the northeastern states in 1992. As they have for years, hospital

lengths of stay continue to average about 50% longer in the northeastern states (10.4 days) than for the western states (6.7 days).<sup>8</sup>

- *Rates of change in hospital use by diagnosis-related groupings (DRGs).* In the 1988-1992 period, hospital discharges for Medicare enrollees rose by 8.3%. Of the 65 leading DRGs, however, only 12 had increases between 0% and 20%. Seventeen DRGs had increases of 20% to 40%, 9 rose by 40% to 60%, and 5 increased by more than 60% in the four-year period. The most rapid increases were reported for DRG 88 (chronic obstructive pulmonary disease), 219%; DRG 462 (rehabilitation), 103%; and DRG 214 (back and neck procedures with complications and/or comorbidities), 75%. Discharges declined for 22 DRGs. Eleven DRGs had declines of between 0% and 20%; 8 declines were in the 20% to 40% range; 3 declined by over 40%. The DRGs that decreased most were DRG 90 (simple pneumonia and pleurisy) and DRG 96 (bronchitis and asthma with complications and/or comorbidities), which had declines of 52% and 58%, respectively.<sup>9</sup>
- *Nursing home use.* Rates of nursing home use varied by 6:1 across states. Minnesota residents used 1,364 days/1,000 enrollees, Connecticut residents 1,235 days/1,000 enrollees, and Indiana residents 1,067 days/1,000 enrollees in 1992. Among the low-use states were Maine (248 days/1,000 enrollees), Oklahoma (326 days/1,000 enrollees), and New Hampshire (327 days/1,000 enrollees).<sup>10</sup>
- *Home health use.* The rate of home health visits per 1,000 enrollees varied by more than 17:1 among states in 1992. The high-use states included Mississippi, with 11,786 visits/1,000 enrollees and Tennessee, with 11,717 visits/1,000 enrollees. At the other end of the range were Hawaii, with 668 visits/1,000 enrollees, and South Dakota, with 969 visits/1,000 enrollees.<sup>11</sup>
- *Growth rate in part B spending.* Over the 1986-1992 period, Medicare part B annual

expenditures rose at a national average of 8.8%. Here again, substantial national diversity, rather than uniformity, is the dominant pattern. The rate of increase varied more than 3:1 among states—from 4% to 5% annually in California and Hawaii to between 13% and 16% annually in South Carolina, Delaware, Kansas, Nevada, and North Carolina.<sup>12</sup>

- *Growth in physician procedures.* Over the 1991-1994 period, the growth rate of Part B services averaged 3.5% annually. Behind these averages, however, were quite different and rapidly changing patterns for different services. Echocardiograms increased at a 19.3% annual rate, angioplasty at 17.1% annually, MRIs at an 11.9% rate, arthroscopy at 9.1%, coronary artery bypass grafts at 8.8%, and joint prostheses at 7.3% per year. Among the declining procedures were transurethral prostate surgery, falling 9.9% annually, and cataract lens replacements, falling 2.3% annually.<sup>13</sup>

A common-sense view might be that high-use areas would probably also be areas of high overuse. This assumption was rigorously tested by RAND researchers using 1981 data for three procedures: carotid endarterectomy, coronary angiography, and upper gastrointestinal tract endoscopy. The rates per 10,000 elderly varied among three sites by 3.8 times for carotid endarterectomy, 2.3 times for angioplasty, and 1.5 times for upper gastrointestinal tract endoscopy. Their findings were that rates of inappropriate use were not much different between low-use and high-use areas. However, rates of inappropriate use for all three procedures were significant, ranging from 17% to 32%.<sup>14</sup>

One might be skeptical about some of the Medicare-reported trends. (Were there really major epidemics of chronic obstructive pulmonary disease and complicated back and neck problems requiring hospitalization of the elderly that escaped the national media attention in 1988-92?) But Medicare has spent a

great deal of effort and money to improve its data systems. To the extent that Medicare's payments do not accurately reflect the services being provided to its beneficiaries, then far more is wrong about provider billings (and Medicare administration) than data errors.

## REENGINEERING MEDICARE MANAGEMENT

*The only way we're going to deliver on the full promise of reengineering is to start reengineering management.*

—James Champy

If Medicare were to be operated in a more business-like way, what important changes should Congress consider making in the Medicare program's authorities? Many government-sponsored activities do have flexibility similar to that found in private-sector businesses; these activities include the Tennessee Valley Authority and other power marketing authorities, the Government National Mortgage Association, and the Federal Reserve Board. But granting Medicare, with \$175 billion in purchasing power and 37 million enrollees, a freer rein will need to be done carefully and watched vigilantly.

In general terms, *Medicare needs the authority to select providers based on quantifiable measures of quality, outcomes, and service and to use competitive purchasing.* The heart of a private-sector plan's ability to improve quality and assure accountability is its capacity to decline to do business with poor performers and to move business toward better performers. In contrast, Medicare is the prime remaining example of the traditional insurance "any willing provider" philosophy. To be certified as a Medicare provider usually requires little more than state licensure or accreditation by certifying organizations that are provider-dominated. Congress has created a virtual entitlement for health care providers to participate in Medicare. Competitive procurement is a standard business method for assuring good quality,

cost, and service, and it should also be available for Medicare administrators.

Among the areas for possible use of such authorities are:

- *Competitive purchasing of standardized services and supplies*, including durable medical equipment, laboratory testing, radiology, and outpatient surgery

- *Establishment of explicit quality and service performance standards and refusal to do business with providers that do not measure up.* For the welfare of its beneficiaries, Medicare needs to move beyond the minimal participation requirements that are now set in legislation. New standards for providers should include the HEDIS-type "report card" and health outcomes measures for which the Medicare program will be accountable (for example, physicians who fell below certain standards in providing mammography screening for their patients would be dropped from the program).

- *Development and use of centers of excellence and specialized services contracting.* Medicare now uses such concepts in its coverage for transplant services; private-sector plans use selective contracting even more widely for many forms of surgery, cancer care, mental health, and so forth. Major expansions may be possible to develop disease management and preventive services for patients with chronic or high-expense illnesses and for disabled enrollees. Intelligent purchasing by Medicare could call forth better quality, cost, and service competition among providers, to the benefit of Medicare beneficiaries and taxpayers. To preserve Medicare's role in assuring a broad choice of providers, Medicare enrollees might still be able to go to non-preferred providers, but with higher co-payment rates.

- *Use of case management for high-cost patients.* Most private-sector health plans have the flexibility to work with high-cost patients to develop service packages, such as home

care, that can better meet their needs. The Medicare statute does not permit such flexibility, even when it would be in the best interests of the patient and the program. With so many frail elderly and disabled patients, Medicare might be able to make good use of such authorities.

- *Elimination of notice of proposed rule-making process for purchasing.* Like Gulliver tethered by many bonds, the Medicare program's effective use of its purchasing power is held back by numerous technical constraints, some of which are appropriate to a rule-making administrative style but not to a business-type operation. Most important of these is the Notice of Proposed Rule Making requirements that now involve at least a three-year process for major Medicare policy initiatives or changes. Such rule-making is frequently, in essence, simply a statement of contractual terms, that is, what Medicare will and will not pay for, under what terms, and in what circumstances. A private business that had to go through a three-year process any time it wanted to write or revise a contract with its suppliers would probably be in the same financial predicament as the Medicare program.

- *Authorization for Medicare simply to drop providers in the best interests of the program to deal with fraud and abuse.* In recent testimony, a Government Accounting Office (GAO) official noted that the Medicare program is "overwhelmed" by fraud and abuse and that it is a "particularly rich environment for profiteers."<sup>15</sup> Among Medicare's many problems are the difficulties of kicking providers out of the program and the limited resources made available by the Department of Justice. A recent GAO study based on studies of claims denial rates for 74 services across 6 carriers noted that one-half of denied claims were submitted by between 2% and 11% of providers.<sup>16</sup> Acting as a business-type purchaser, Medicare would have authority to simply stop doing business with any supplier, at its discretion. In areas of widespread fraud,

Medicare might also be allowed to engage private-sector law firms to recover on behalf of the government.

- *Authorization for Medicare to organize and contract for quality assurance at its discretion.* Since 1965, the major initiative to improve Medicare quality has been enactment of the PRO system. It is an expensive program (costing some \$325 million in 1994), deals almost exclusively with inpatient hospital care, and has been of questioned effectiveness. The 53 PROs are provider-dominated organizations. Most are physician-sponsored, for example, by local medical societies, and typically have a board of directors composed primarily of physicians and other provider representatives. Medicare Part B services are largely subject to quality review by the claims-paying carriers. As noted in an Institute of Medicine report on Medicare quality improvement, the implementation of a new health-oriented mission for the Medicare program will require far-reaching administrative, contractual, and other changes that include reconsideration of PRO, carrier, and HCFA roles.<sup>17</sup> Would a private-sector purchaser, intent on improving quality of care, want to be constrained to contracting with a medical society or provider-dominated organization?
- *Publicity about data on quality and service.* With the advent of HEDIS and buyers insisting on accountability, provider secrecy about quality problems is being replaced by publicized reporting in the private sector. Statutory change should also allow this approach to be adopted by the Medicare program. Such publicity about where physicians and hospitals stand compared to professional benchmarks and guidelines can be important acts in themselves to encourage better patterns of care and service.
- *Improvement of customer service.* The Medicare program has never had a strong customer orientation. As an adjunct to the Social Security Administration (SSA), it started with representatives in SSA's district offices, but

it lost these community-level staff when HCFA was established. Customer service is an area in which Medicare is at a competitive disadvantage vis-à-vis competing private health plans.

■ *Enactment of special authorities for Medicare in the hiring, promotion, and compensation of employees.* There is no activity which is of larger-budgetary consequence or greater management challenge for the federal government over the next half century than the Medicare program. Today, Medicare is bound by government-wide civil service procedures, promotion, firing, compensation levels, and personnel ceilings. In business-type operations, such as the Federal Reserve Board, Congress has been willing to make exceptions so that federal activities can be carried out with the required professional expertise. In particular, the Medicare program may need such flexibility if it is to compete with private-sector plans.

Certainly some health care providers—and competing health plans—will question the wisdom of such new Medicare authorities. But why would beneficiaries and taxpayers want to keep Medicare from being as good a program as it can be? If Medicare is expected to compete with private plans for enrollees, why should it not have comparable purchasing flexibility?

## A STRATEGIC PLAN FOR MEDICARE MANAGEMENT

If the Medicare program, as an accountable health care purchaser, is to begin to use these authorities to deal with quality, service, and cost issues, where should it start and what should it do? Given the program's scale and complexity, a great deal of work will need to be done to devise an intelligent purchasing strategy before that question can be answered in a way that has wide professional and political support. As a matter of law, Medicare cannot deal with such problems in an arbitrary or capricious manner. Beneficiaries have rights to

due process and to judicial review for claims denials. Much of the needed research will be useful for competing private-sector health plans, since these plans will face the same issues and few yet have much special expertise in managing care for the Medicare populations.

Research might help Congress, the executive branch, and other interested parties in the following five basic areas:

■ *A national strategy for clinical effectiveness and outcomes studies for the Medicare populations.* This strategy could be built by analyzing the Medicare data to identify procedures with wide variations that seem likely to reflect overuse and underuse or excessive rates of increase and by prioritizing a research agenda by potential payoffs in enrollee health-and-program costs. It also needs to include recommendations concerning funding for the effort, the appropriate methodologies to assure usefulness, and an ongoing system to automatically evaluate new technologies and clinical practices. The serious shortcomings of much of the published literature on medical treatment, well-known to clinical effectiveness researchers, was highlighted in a recent *New York Times* story of a Canadian assessment of treatment for whiplash injury that found only 62 of 10,382 studies met the evaluators' criteria for solid scientific evidence.<sup>18</sup>

■ *Development of HEDIS-type "report card" measures for quality/health outcomes, consumer satisfaction, and service.* These data need to be collected at the state and market-area level, so that HCFA can manage its carrier/PRO contractors accountably and so that enrollees have comparable data to private-sector plans for making their enrollment decisions. These report card measures need to be selected for their validity and reliability and should include information that is important to consumers for making choices among health plans.

■ *Studies of "best practices" in all major areas of costs, quality, and service.* Medicare is a vast program that has not been very amenable to

centralized, command-and-control management. Political decision-makers and the Medicare program have rightfully been extremely wary about trying to use government coercion to change medical practices. Perhaps the best way to foster desirable change in a competitive-choice market system is to make sure that patients, providers, and competing health plans are well-informed about the best practices and performance benchmark standards that they should look for in making purchasing decisions or should offer to be successful in the marketplace. The private sector's new purchasing techniques, and their applicability to Medicare's populations, need to be carefully assessed.

- *Effective communication strategies.* The development of a national research effort for effectiveness and outcomes studies, report card data, and identification of best practices need to be matched by strategies to be sure the information is effectively communicated and that it takes into account the range of sociological and other factors that need to be addressed for effective change. Good clinical research data on outcomes and effective communication seem to have been an effective strategy in the recent declines in prostate operations and cataract surgery, two procedures that had been increasing rapidly until better information was made available to clinicians and patients.
- *Assessment of where both Medicare and competing private health plans do and do not work well, and why.* One of the important open issues for health policy is to identify market conditions where health plan competition can improve health care and where such competition does not work well. In today's market, for example, while the Twin Cities area has one of the highest national rates of HMO enrollment for the under-65 population, only 9% of Medicare eligibles are enrolled. A possible reason is that HMOs cannot make much money or provide many additional benefits for 95% of the Medicare expenditures in this area. Some analysts

have also argued that managed competition will not work well in rural areas. If Medicare competition is opened up to a wide variety of options more attractive than HMOs—for example, PPOs, point-of-service (POS) plans, Medicare Select options, and other arrangements—market research on their comparative success can yield insights about how the Medicare program may need to be changed to better meet the needs and preferences of its enrollees.

In addition to these areas, there are a number of special study topics that could prove useful for devising a strategy for Medicare to operate as an accountable health plan.

- *Special studies of needs and service for Medicare's disabled populations.* Medicare's 4 million disabled enrollees have been badly neglected by health policy analysts and in Medicare policy discussions. Medicare publishes very little data on their characteristics, needs, and service use. Nevertheless, this is an important group for analysis, as its rate of growth (4.0% annually in the period 1982-1992) is more than twice that of the elderly population (a 1.9% annual increase during the same period); the under-45 disability group has been growing even faster, almost 11% annually over this period. With a benefit package focused on acute medical care, the Medicare program is not well-designed for totally and permanently disabled persons. Since this group is unlikely to be attractive to private health insurance plans, it is particularly important that the Medicare program, as an accountable health plan, make special efforts to be sure that they are being well served. Separate HEDIS-type measures may be needed for disabled subpopulations.
- *Special studies of high-use elderly populations.* As is the case with the under-65 population, Medicare's spending for the aged is highly skewed, with about 5% of enrollees accounting for about 50% of expenditures on care, 10% for about 70% of expenditures on care, and about 20% accounting for about 80% of

expenditures on care. Among the high-expenditure populations are important subpopulations with chronic illness. Trying to identify these groups and analyze potential improvements in their care will be of particular importance for dealing with Medicare spending issues. To the extent that such high-use groups remain with the Medicare program, it will be even more important for Medicare to have a scientifically strong clinical basis for assessing their needs and care.

- *Special studies of disease management and prevention initiatives.* It may seem unusual to think about prevention and long-term disease management for Medicare enrollees, but its elderly enrollees are in the program, on average, for over a decade, with some enrolled for up to 40 years; its disabled enrollees receive benefits for even longer. Among prevention initiatives reported by HMOs for the over-65 are activities to reduce falls, a leading cause of hospitalization in the elderly, and to identify inappropriate prescribing and potential drug-drug interactions. As an increasing number of pharmacy benefit management and other firms develop disease management expertise, it will be important to assess the potential of these developments for the Medicare population, particularly in light of the many studies that show misprescribing for the elderly.
- *Policy development for post-acute hospital care.* A particularly rapid part of Medicare's recent growth has been in post-acute hospital care. Between 1992 and 1993, Medicare spending for home health and skilled nursing care each grew by about 40%, to a total of nearly \$17 billion. Rehabilitation therapy claims are growing about 30% a year.<sup>19</sup> This entire policy area needs careful review, in conjunction with the Medicaid program, which is the nation's largest financier of long-term care, to rationalize the service efforts. Standards of appropriateness of care are more difficult to come by in this area than for clinical effectiveness and outcomes studies of acute care.

- *Better risk-adjustment mechanisms and procedures.* It is predictable that the basic Medicare program will continue to have a less healthy population than competing private health plans, at least for the foreseeable future. This will be an ongoing area of research and policy analysis. Perhaps an independent or quasi-independent organization should manage the annual "open season" competition between Medicare and private health plans to help assure fair, well-informed choice by eligible individuals.

This is an outline for a very broad and multi-year research agenda. But such an effort is needed, by both public and private sectors. Over the past 10 years the primary focus of Medicare policy has been to design, implement, and refine its price controls—using DRGs and a resource-based relative value scale (RBRVS). Today, there is very little that is "on the shelf" that can be implemented in the short run.

#### CAN MEDICARE COMPETE SUCCESSFULLY?

Given new accountabilities, new management authority to purchase health care, and a strategic plan for its future, can Medicare compete successfully with private health plans for the benefit of the elderly and disabled? Why not just leave Medicare alone as a traditional bill-payer and hope that it will wither away as beneficiaries choose better-managed private health plans? There will be those who believe that privately managed health care plans will out-perform any new-model, government-run Medicare program in head-to-head competition and that trying to manage Medicare as a competitive health program is hopeless or unwise.

Nevertheless, the Medicare program is still the choice of over 90% of its eligible population (and, in a majority of states, of 99% or more of eligibles), and it seems premature to predict Medicare's demise or to make an unchallengeable case about private health plans' interest and ability to compete, on a nationwide basis, for the Medicare population,

particularly its high-expense frail elderly, chronically ill, and disabled populations. Given the current situation, it would be a high-stakes risk to ignore upgrading Medicare and place all of the nation's Medicare budgetary bets on presumptions about the success of private-sector plans that may prove to be wishful thinking. In addition, the federal government has a number of strengths to build on in trying to make Medicare a better program.

Among these strengths are:

- *Good track record.* It is fashionable to disparage government competence, but, compared to much of the private insurance industry, the Medicare program has an excellent track record for innovation and efficiency, within its statutory constraints. Through the use of DRGs and RBRVS, Medicare has led private payers in reducing payments for overpriced procedures and using purchasing power to restrain inflation and rationalize payment rates. Medicare has also led in investing in medical efficacy studies and protocol development to improve clinical practices reflecting outcomes research (through the Agency for Health Care Policy and Research [AHCPR]); publicizing information on comparative provider quality, for example, hospital mortality rates and nursing home reviews; setting up standardized data systems; establishing electronic submission of claims; and overall administrative efficiency. In all of these areas, Medicare still betters the private insurance norms. Among recent innovative steps are beneficiary surveys, a consumer information strategy (immunizations, mammography), a coronary artery bypass surgery demonstration with bundled payment rates, Medicare Select demonstrations, and performance contracts with PROs. With a new statutory mandate and authorities, Medicare may also excel in new competition vis-à-vis private health insurance plans.

- *Flexible administrative structure.* Medicare is normally thought of as a government-run program, but, in fact, no federal employees

actually pay claims. Federal employees oversee a system of some 74 private contractors (called intermediaries and carriers—mostly Blue Cross/Blue Shield plans or commercial insurers) that actually run the program on a day-to-day basis. These private-sector insurers—themselves now involved in developing and managing private health plans—bring administrative flexibility, staffing and subcontracting capabilities, and expertise in local markets. When Medicare was first established, its contractor system offered administrative capabilities the government did not possess and could not develop on the scale and in the time frame that was needed. A well-managed Medicare program might be able to take advantage of this flexibility, in new relations with its contractors. As discussed in a recent companion piece,<sup>20</sup> the Blue Cross Blue Shield Federal Employees Plan managed pharmacy benefits program offers a model for how state-of-the-art managed care programs can be developed and offered in a government-financed framework for public beneficiaries. Medicare might be able to cross-fertilize between HCFA's rule-making and bill-paying culture and the private payers' purchasing culture to produce hybrid plans through joint efforts with its primary contractors.

- *Public trust and freedom of choice.* While government, in general, may be viewed with distrust and suspicion by many voters, the Medicare and Social Security programs retain strong senior citizen support. Medicare remains the program of choice of the elderly. In the Medicare program, enrollees have much broader freedom to choose a provider than in private managed care plans. They also have legal rights and due processes that help to guarantee their benefits—and an ability to appeal to their members of Congress for assistance.

- *Enormous purchasing power.* Medicare is the nation's largest health care purchaser, with an estimated \$175 billion of spending in

1995. In 1993, it accounted for 19% of personal health care expenditures, including 28% of hospital care expenditures, 20% of physician care expenditures, and 39% of home health expenditures. The price discounts Medicare has been able to achieve through DRGs and RBRVS alone—although now undercut by HMOs in some markets—and its high assignment rate (over 96%) suggest a reasonable amount of optimism should be in order about the success of future purchasing strategies. If managed purposefully, Medicare should be able to strike economic terms that are at least as favorable as its competing health insurance plans, as well as use its purchasing discretion for upgrading quality and service standards.

- *Data and research capacity.* Finally, Medicare has an unsurpassed data system, including claims records on medical services use by some 37 million enrollees and a potential for service-profiling and quality-auditing most of the nation's health care providers. This is a unique resource for developing national management strategies and for rapid learning about the effectiveness of these providers. Medicare and AHCPR also have a strong tradition of health services research and can work with many professional groups in developing clinical quality indicators and improvement strategies.

How best to manage competition between competitive Medicare and private-sector plans, all trying their best to enroll Medicare eligibles with the most attractive benefits, costs, quality, and service, is a complicated topic in its own right. If reengineering Medicare, as described in this paper, is a primary challenge, another ongoing challenge of daunting complexity will be to assure that competition among Medicare and competing health plans works well. Congress is now in the midst of debating many major policy questions, including enrollee financial incentives and the potential for budget savings, and there are numerous questions which will require long-term learning agendas.

Thirty years after Medicare's enactment, a much-needed debate about Medicare's future is taking place; its focus is whether (and how) the Medicare program should be rethought in light of the private sector's transition from bill-paying insurance to accountable health care purchasing. Whether one favors Medicare reforms alone, more private plan options alone, or a "two-track" strategy that includes both approaches (the possibility raised in this paper), there are good reasons to proceed with caution in use of either Medicare's new business-type authorities or new competitive arrangements. The welfare of 37 million elderly and disabled individuals is at stake. While it is attractive to envision improving the Medicare program, it is also important to realize that discretionary authority can also be misused, and competitive forces can go awry. The Medicare program could be made worse if it is subjected to unrealistic budget pressures and its new authorities are used to ration services, or if competing plans "skim" the Medicare enrollment. As well, the American tradition of public management—based on the view that government officials should not be allowed to act in ways that are arbitrary, capricious, and unfair—has usually insisted on "a government of laws and not of men." But protection of Medicare enrollees in private plans from poor HMO practices should be no less an issue.<sup>21</sup> With broader administrative discretion for political appointees also comes increased possibility for the application of political pressures, from Congress and other sources, and the pursuance of personal agendas. Perhaps the Medicare program is unmanageable or will prove to be so; perhaps private plan enthusiasm about the profit potential of Medicare enrollees will abate. For many such reasons, there will need to be a great deal of oversight and vigilance about Medicare and its competitors. Just as Congress established the Prospective Payment Assessment Commission and PPRC to advise on development of Medicare price regulation, it may also wish to establish a similar advisory commission for an implementation period of market-oriented Medicare reforms.

## ENDNOTES

1. *Medicare: Opportunities Are Available to Apply Managed Care Strategies*, statement of Janet Shikles, GAO/T-HEH-95-81, February 10, 1995 (Appendix I).
2. About 77% of Medicare eligibles already have medigap, Medicaid, or other supplemental coverage, so switching enrollment to an HMO may provide them few additional benefits. Individuals may also be deterred from enrolling in an HMO because they would have less freedom of choice of physicians and other providers and would not be able to re-enroll in their current plans if the HMO were not satisfactory. Insurers' ability to compete with Medicare is also lessened because Medicare pays providers well below average private market rates.
3. An Institute of Medicine committee has also recommended that Congress make quality assurance, including improved patient health outcomes, a fundamental program goal. See Kathleen Lohr (ed.), *Medicare: A Strategy for Quality Assurance*, National Academy Press, 1990. The study, chaired by Steven Schroeder, M.D., was requested by Congress in OBRA 1986.
4. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, HCFA Pub. No. 03348, February 1995.
5. Physician Payment Review Commission, *Monitoring Access of Medicare Beneficiaries*, Report No. 95-1 (forthcoming); S. Asch, et al., *Access to Care for the Elderly Project*, Final Report, RAND Corporation, April 13, 1995 (photocopy).
6. National Institute for Health Care Management, *Health Care Problems: Variation across States*, December 1994, pp. 34-36 (exhibits 4.4, 4.5, 4.6).
7. "The Fortune 500 Largest U.S. Corporations," *Fortune*, May 15, 1995, p. F-1.
8. *Medicare and Medicaid Statistical Supplement*, p. 199 (table 25).
9. *Ibid.*, pp. 208 (table 28).
10. *Ibid.*, p. 232 (table 37).
11. *Ibid.*, p. 252 (table 46).
12. Physician Payment Review Commission, *Expenditure Limits*, July 1993 (staff paper), p. 62.
13. Physician Payment Review Commission, *Annual Report to Congress: 1995*, p. 20 (table 1-1).
14. M. Chassin, et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?" *J.A.M.A.*, November 13, 1987. Jack Wennberg has been among the pioneers in Medicare area variation studies.
15. Statement of Sarah Jagger, March 22, 1995 (cited in *BNA Health Care Policy Report*, March 27, 1995, p. 479).
16. *Medicare Part B Factors That Contribute to Variations in Denial Rates for Medical Necessity across Six Carriers*, GAO/T-PEMD-95-11.
17. Lohr, *Medicare: A Strategy for Quality Assurance*.
18. "Study Finds Most Treatments for Whiplash Are Ineffective," *New York Times*, May 2, 1995.
19. *Medicare: High Spending Growth Calls for Aggressive Action*, Statement of William Scanlon, February 6, 1995, GAO/T-HEHS-95-75.
20. Lynn Etheredge, *Pharmacy Benefit Management: The Right Rx?* Research Agenda Brief, Health Insurance Reform Project, George Washington University, April 1995.
21. Complaint rates vary by more than 25:1, from 1.8/10,000 enrollees for Group Health of Puget Sound to 45.8/10,000 enrollees at Humana (Florida).

[INTRODUCTIONS BY MR. BILL GORHAM AND MARILYN MOON TO FOLLOW. JOINED WITH SECRETARY SUMMERS' COMMENTS.]

SEC. SUMMERS: (Applause.) Thank you very much. Thank you very much, Marilyn, and I'm very glad to be here. Before I say anything else, I want to echo what Bill Gorham said about Herb Stein. Probably more than any other individual I can think of, Herb Stein graced fora like this for many, many years in this city. Whatever the issue was, whatever the challenge was, Herb Stein was a voice of conspicuous clarity, constant good humor, and frequent -- almost always spoke the real truth. He was for many, many of us -- and I remember the first few times that I had the chance to come to Washington as a young academic; he was a tremendous example of what it meant to be a policy economist in the best sense of that term. He always spoke the truth, even when the truth was inconvenient to the position that he was advocating. He always, to use a phrase that the president uses often in a different context, put progress ahead of partisanship, and he did an enormous amount to advance our understanding of the many public policy challenges that are ahead of us.

It is satisfying to me that he did live to see the United States budget go into surplus, he did live to see us in a position to start to think rationally about what our national priorities were as we allocated our budget. And he does live on in the influence that he has had on so many of us who attempt to imitate the clarity which he brought to public policy discussions.

Marilyn, I appreciate your organizing this event, and I appreciate all of the Urban Institute and the other organizations' work in this area.

The remarkable advances in science, in techniques of health care delivery, have given us a health care system today at the end of this century that is dramatically different from the one that existed in 1965, when Medicare was introduced. Clearly, a health care system -- a health care program that was right for beneficiaries 34 years ago is unlikely to be right for Americans today, but I think we can all agree that having the right Medicare system, one that guarantees America's senior and disabled citizens high-quality health care, is today more important than ever.

I want in that regard to commend Representative Thomas, who will be here in a few moments, and Senator Breaux, for their leadership in the bipartisan Medicare commission. That group has advanced the debate over how to improve the health care and social safety net for older and disabled Americans. Their efforts and those of others, including Senate Finance Committee Chairman Roth and Ranking Member Moynihan and many others, have given rise to an atmosphere where meaningful bipartisan reform seems possible.

Yesterday in New York, I had an opportunity to reflect on what seemed to me the crucial factors behind our economic strength in this country and to reflect on the priorities that seemed most important going forward. Broadly, I highlighted two things. I highlighted the absolute centrality of fiscal responsibility to the strength of our economy, and the importance of addressing problems by harnessing market forces in order to address them, what one might call a helping-hand approach that replaced what has too often been a traditional heavy-handed approach to public policy in the past. At the same time, I noted that public actions to support the market system are essential if we are to maximize the results that market competition delivers for the American people.

I believe that it is these themes -- fiscal responsibility, competition, proper management of that competition to assure that it actually works for people -- that need to guide us as we debate how best to modernize Medicare. Indeed, the administration's approach to Medicare reform has stressed two crucial principles, that we must protect the elderly and disabled Americans who rely on Medicare for their health coverage and that by enhancing the level of competition within Medicare we can improve the quality and efficiency of the program without higher premiums for these beneficiaries.

I'd like to focus my remarks on these two points before briefly discussing the fiscal virtues of our proposal and the importance of adding a Medicare prescription drug benefit. Let me say that I am here to make the case that Medicare reform that is good health and social policy can also be good and right economic policy, and it is because the use of the right economic tools can make such a contribution to policy in this area that the Treasury Department has been a very active participant in the design of the administration's Medicare proposal.

The administration firmly believes that adequate protections must be afforded to beneficiaries as we move into a more competitive environment. Traditional Medicare now provides the central care for 84 percent of all beneficiaries and it should not become less affordable for our most vulnerable citizens, even as we do make changes in the program. Perhaps a third or more of elderly and disabled citizens have serious, chronic illnesses and impairments, and their very survival may depend on continuing access to specialized care.

That is why we consider it critical that any reform allow beneficiaries to stay in traditional Medicare for the same monthly premium as under current law, now about \$45 a month. While this would protect the elderly and the disabled, in no way would it exempt Medicare from competition. Let me be clear. It is not necessary, in our judgment, to raise premiums in traditional Medicare in order to have real competition.

The collective efforts of the president, the Medicare Commission and others have given rise to an emerging bipartisan consensus -- bipartisan consensus on the need to act to strengthen and modernize Medicare and that now is the right time. At the same time, one of the greatest concerns that the administration has about the Breaux-Thomas plan and some of the other Medicare reform proposals that have been put forth is that the

benefits of competition might be obtained at too high a cost, in terms of exposure of beneficiaries to increased risk. Monthly Medicare premiums are already expected to increase substantially over the next decade, simply because growth in forecast health-care costs will continue.

Against this backdrop, it is especially important that we prevent an extra premium increase from accompanying the transition to a more competitive system, because it wouldn't be right as social policy and frankly because of the damage that it could do to the case and acceptability of more competitive and market-oriented approaches. We believe that it's crucial to select an approach that encourages robust competition among health care providers in Medicare, while preserving the vitality of the social safety net that is so important to many of our citizens.

And I might just note that it was the case, at least as of several years ago -- and, I imagine, the case today -- that while American life expectancy did not stand out in international comparison, American life expectancy, starting at the age of 65, did stand out in the international comparison, and that that is much more prominently the case today than it was in the mid-1960s, before Medicare had taken effect. And that just illustrates that these protections are not just abstractions, and they are not just something financial, but they are something very real for our aged citizens, for many of our parents, for many of our children's grandparents.

The administration believes that the proper approach to Medicare reform would have all plans in the program and traditional Medicare engage in head-to-head competition, while at the same time protecting beneficiaries' premiums.

To be sure, there is a kind of competitive element in Medicare right now. Under the current program, payments to private plans are determined by regulated prices, rather than competitive bidding. And since each beneficiary pays the same basic premium, regardless of plan choice, plans compete primarily by offering extra benefits, rather than on price. These additional benefits vary widely in content and perceived value, so it is difficult for seniors to make apples-to-apples comparisons based on plan costs and quality.

In many ways it's analogous to the situation before airline deregulation where airlines could compete, they could compete vigorously with each other, it's just one thing they couldn't do in an effort to attract customers -- reduce their prices. That led to quite inefficient service mix, it reduced the pressure for efficiency. And that is the difficulty with the kind of competition that we have in Medicare today.

There is yet another problem. If one has competition that can only take place on dimensions of service provided rather than on price, one maximizes the potential for cherry picking, for designing the mix of services so as to compete by selecting the right patients rather than by providing the most important care.

Under the president's approach, private health plans participating in Medicare would submit a competitive bid at the price at which they're willing to cover an average senior citizen. These bids would then be compared to the costs in traditional Medicare to determine the price for a beneficiary of enrolling in that plan.

As under current law, a participant choosing a private plan which costs about the same as traditional Medicare would pay the same premium. But under our proposal -- and this is the crucial point -- someone who opts for a plan that is less expensive would pocket three-quarters of the savings, with the remainder accruing to the Medicare trust fund. As a result, all beneficiaries would have strong new incentives to choose efficient plans, and plans would have strong incentives to deliver the most value for money because if they let their costs grow excessively or their quality slip, enrollment would fall.

The introduction of competition in this way is expected to result in \$9 billion in savings for the government over the next 10 years, and \$22 billion in savings to beneficiaries. At the same time, it will enhance the range of options available to participants, leaving them free to select a plan that could reduce or possibly eliminate their monthly premium.

Let me just say that in health care perhaps more than any other area, I'm sure if Herb Stein were here he would counsel a certain humility in projecting the way in which the system will evolve, in judging the consequences of interventions.

The approach that we have laid out seems to me to be a prudent start down the competitive road. Coupled with the introduction of risk adjustment, it offers the prospect of making competition more vigorous and starting to give people something back when they successfully economize. I don't think any of us can know what the full benefits will be down the road. My judgment, all things considered and given the tremendous costs that our country has paid for fiscal lack of discipline, the scorekeepers in this area are probably correct to be very careful about scoring speculative -- possibly speculative -- benefits from the introduction of greater degrees of competition. I think that is the right, conservative way for us to make policy.

On the other hand, I would just advise that everything that I know as an economist and almost every experience that we have looked at suggests that greater competition brings about more efficiencies, brings about more changes, brings about changes along dimensions that would not have been forecast at the time the competition was introduced, and so I suspect that over time, those estimates might well prove to be underestimates of the benefits that result from introducing a more competitive element.

Some would respond to that by saying, Why not introduce a more forceful, vigorous competition that goes directly at challenging the core Medicare benefit? That, in our judgment, is just too great a risk at this point and it is, therefore, one that we cannot support.

The president's approach recognizes that, as important as they are, these structural reforms and the cost savings that we can bring back, after making appropriate adjustments where problems have shown up, are not likely to generate enough savings to meet the costs of caring for the baby boom generation when it retires. This group knows the facts of that situation better than most.

With an elderly population set to double from 40 million to 80 million over the next three decades, it is clear that additional financing will be necessary to maintain basic health care services and quality for any length of time.

Now, in a real sense, there is only one way in which an economy can provide for its future. Accounting alone does not achieve that objective. The only way an economy can provide for its future is by saving more, and it is clear from our recent experience that the most potent and reliable way to increase our national savings is to raise the amount that we save, raise public savings in our country.

And that is why we believe that it is important to use this moment of budget surplus, this moment of unique economic strength, to take a portion of that surplus, assure that it is not dissipated through new spending -- through new spending programs or through tax cuts, but instead contributes to extra national saving that can be used to reduce future interest costs, raise the size of our national economy in the future, with the benefits earmarked for what are our rising commitments. And that is the essence of the administration's proposal to dedicate more than \$300 billion in on-budget surpluses over the next 10 years to extend the Medicare trust fund solvency beyond 2025.

Let me emphasize what is crucial about this proposal is not accounting. What is crucial is that we take steps today that make room in the federal budget in the future by reducing interest costs, that make room for our economy by increasing national savings and that we do not commit those resources to new uses until we have assured that our existing obligation to pay for our own retirement health care costs is met.

Let me highlight one final aspect of the president's program that I also believe is good economics. As the president has said, nobody would devise a Medicare program today, if we were starting all over, without including a prescription drug benefit. A drug benefit is not just good health policy, it's good economics. The investment in improved and lengthened lives yields benefits that easily justify its costs. And while no economist has yet figured out how to put a price on peace of mind, all current and future seniors will gain peace of mind, knowing that they have a reliable source of meaningful insurance.

Drug therapies have become an ever-larger and more important part of the arsenal of modern medicine, providing more effective and lower-cost treatments for many illnesses that used to result in disability, hospitalization, and death.

But prescription drugs are only effective when they're utilized. Of the estimated 20 million women in this country who could benefit from treatments for osteoporosis, I am told that only about 3 million are treated, even though replacement therapies and other drugs maintain bones that -- help bones maintain their strength are currently widely available. There are many reasons for that gap -- many, many reasons for that gap. But there is no question that one of those reasons is cost and that that is a very shortsighted economy when one considers the costs of treating broken hips down the road.

The president's plan makes needed drugs more accessible to the three-quarters of seniors and the disabled who do not have dependable and affordable drug coverage today. When fully implemented, the drug benefit would cover half a beneficiary's drug expenses, up to \$5,000 a year, at a cost to them that is one-half to one-third as much as a typical Medigap drug plan.

The president's plan does so without price controls. We do adopt best private-sector purchasing practices. But I assure you that we are very mindful of the need to purchase drugs in a reasonable and fair way, that preserves what is absolutely crucial to the future of our health economy, the ability to innovate going forward.

The president's program also provides new subsidies to encourage employers to provide or retain high-quality coverage for their retirees. And let me stress -- because I did not emphasize it, and it's really a crucial part of why this plan is fiscally responsible -- that most of the drug benefit's costs to the government will be offset by sensible reforms, including the proposal to create true price competition that I have spoken about.

In the time ahead, we have a historic opportunity to reform Medicare in a way that will strengthen our economy and our health system and our future. We look forward to working with Representative Thomas and other members of Congress to enact Medicare reform that we can all support. None of us, I think, have all the answers, but I think we are making progress in coming to a shared recognition of the absolute importance of protections that Medicare provides and the appropriateness of assuring that they are provided in as modern, competitive, and fiscally prudent a way as we possibly can. With this moment, we have a rare opportunity and I hope and trust that we can seize it.

Thank you very much. (Applause.)