Reengineering Medicare: From Bill-Paying Insurer to Accountable Purchaser

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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.1 Even with an FEHBP-type
arrangement and optimistic growth assump-
tions about private plan enrollments, many fac-
tors make it likely that most Medicare eligibles
in most states will still be in the program for the
rest of the decade and beyond.2 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 fun-
damental reform of the basic Medicare pro-
gram—"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 Medi-
care program? What would be in the best in-
terest of its 37 million elderly and disabled
enrollees?

This paper considers the question of wheth-
er Congress should give Medicare the same
types of authorities that are available to its
private-sector competitors—particularly au-
thorities 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 tax-
payers, 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 econ-
omy, quality, and services or in competing
private-sector health plans that are paid equiv-
alent (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.3

- The adoption of "report cards" that assess Med-
icare's performance on the basis of cost, quality,
  outcomes, and service so that it can be held ac-
countable by enrollees and policymakers. These
measures need to reflect a wide range of
criteria, including preventive care, quality of
care, consumer satisfaction, and health out-
comes, 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 refor-
mulated Medicare can be illustrated by com-
paring 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 Statisti-
cal Supplement published in February 1995.4 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. No-
where are there measures of quality of care
and improved health status or reports on en-
rollee 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 Pay-
ment 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 na-
tional 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.

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.6

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

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**TABLE 1**

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1992</th>
<th>1993</th>
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<tbody>
<tr>
<td><strong>Breast Cancer</strong></td>
<td></td>
<td></td>
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<tr>
<td>For patients with breast cancer,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>interval from biopsy to surgery less than 3</td>
<td>64%</td>
<td>61%</td>
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<tr>
<td>months</td>
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<tr>
<td>Mammography every year for patients with a</td>
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<tr>
<td>history of breast cancer</td>
<td>61%</td>
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<tr>
<td>Mammography every 2 years in female patients</td>
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<tr>
<td></td>
<td>39%</td>
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<tr>
<td><strong>Diabetes</strong></td>
<td></td>
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<tr>
<td>Eye exam every year for patients with diabetes</td>
<td>38%</td>
<td></td>
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<tr>
<td><strong>Heart Problems</strong></td>
<td></td>
<td></td>
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<tr>
<td>Visit within 4 weeks following discharge for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>patients hospitalized with MI</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>EKG during ER visit for unstable angina</td>
<td>81%</td>
<td></td>
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<tr>
<td><strong>Mental Diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit within 2 weeks following discharge of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>patients hospitalized for depression</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>

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.3
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.7 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. Today, 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).8

- 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.9

- 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).10

- 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.11

- 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.12

- 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 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.13

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%.14

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." 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. 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. 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.18

- 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-expense 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. 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 multiyear 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 whither away as beneficiaries choose better-managed private health plans? There will be those who believe that privately managed health care plans will outperform 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, 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
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. 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


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.


9. Ibid., pp. 208 (table 28).

10. Ibid., p. 232 (table 37).

11. Ibid., p. 252 (table 46).


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).