The Future of Medicare
A Discussion Forum
About Medicare Reform and Growth

Based on a conference at the University of the Sciences in Philadelphia,
May 14, 2003

HIGHLIGHTS

• What Should Medicare Look Like in 2010?

• 4 Prescriptions for Medicare’s Future

• Medicare: An Evolution Nearing Revolution?

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INTRODUCTION

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What Should Medicare Look Like in 2010?

As the largest single payer for health care services, Medicare’s payment policies affect not only the health and lives of 41 million beneficiaries, but also the shape of the entire health care system. Medicare’s influence extends over everything—from the way hospitals are constructed, to the way physicians are trained, to the kinds of devices and procedures available at bedside.

Despite this prominence, the program faces critical challenges. In the coming decades, the number of elderly beneficiaries will rise while the proportion of wage-earning taxpayers shrinks. The array of expensive life-saving technologies will increase while pressures to control costs mount. How will the program remain effective and financially viable?

Three of the most knowledgeable Medicare experts in the United States—the immediate past three administrators of the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration)—met at the University of the Sciences in Philadelphia, in May, to debate its future. Gail R. Wilensky, PhD, Bruce C. Vladeck, PhD, and Nancy-Ann DeParle, JD, whose collective Medicare leadership spanned 12 years, reflect notably different political and professional orientations. Under the panel’s moderator, Samuel O. Thier, MD, of Harvard Medical School, they engaged in a lively, candid, productive interchange.

The panelists reached a consensus on several issues. They agreed that Medicare is here to stay; they saw incremental change, not wholesale revision, as the best path to reform; they concurred that the program should hold providers accountable for clinical outcomes. Where they disagreed, such as on the use of private plans to administer benefits, they sharpened the points of dispute.

It should be noted that since the time of this forum, legislative events have overtaken some of these conclusions. Many of the issues raised by the discussants are impossible to address until we know the fate of many of current congressional proposals.

These pages present a front-line look at issues that will shape the nation’s most influential health care program. Any reader concerned with Medicare on a professional or personal level will gain insights—and perhaps a preview of the program’s shape in 2010.
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ROBERT I. FIELD, JD, MPH, PhD

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Prescriptions for Medicare’s Future: 4 Panelists Address Social, Financial, Logistical Issues of Medicare Reform

Medicare has served the United States and its retired (and, to a much lesser extent, disabled) citizens for nearly four decades, but now its potential bankruptcy demands careful consideration of whether Americans and their government intend to maintain the program — and, if so, how to keep it viable. Without forethought, the inevitable money crunch will necessitate adjusting Medicare in haste or — at worst — abandoning federally subsidized geriatric health care insurance entirely.

In this section, four experts — including three past administrators of the Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services, or CMS) discuss the history, condition, and possible fate of Medicare.

Samuel O. Thier, MD, chairman of the Commonwealth Fund and professor of medicine and health care policy at Harvard Medical School, is a director of the Federal Reserve Bank of Boston and former CEO of Partners HealthCare System, Boston. Thier, a nationally recognized expert in health policy, is widely published. He has held positions with the Institute of Medicine of the National Academy of Sciences, Brandeis University, Yale University Medical School, and the University of Pennsylvania.

Gail R. Wilensky, PhD, was HCFA’s administrator during the presidency of George H.W. Bush, from 1989 to 1993. A John M. Olin senior fellow of Project HOPE, she co-chairs the President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans. An advisor to the Robert Wood Johnson Foundation and the Commonwealth Fund, Wilensky has chaired both the Physician Payment Review Commission and the Medicare Payment Advisory Commission.

Bruce C. Vladeck, PhD, was HCFA’s administrator under President Clinton from 1993 to 1997, overseeing the development of the Medicare and Medicaid provisions of the Balanced Budget Act of 1997. A long-time advocate of providing health care services to disadvantaged persons, particularly in urban settings, Vladeck has served as president of the United Hospital Fund of New York and as assistant commissioner for health planning and resources for the New Jersey State Department of Health.

Nancy-Ann DeParle, JD, was HCFA’s administrator during the second Clinton administration, from 1997 to 2001. A joint fellow of Harvard University’s Institute of Politics at the Kennedy School of Government and the Interfaculty Health Policy Forum, she is an adjunct professor at the Wharton School of the University of Pennsylvania. DeParle was assistant director for health and personnel in the White House Office of Management and Budget and served as the Tennessee Commissioner of Human Services.
A Case for Comprehensive Support For the Elderly

Samuel O. Thier, MD

For decades, Medicare critics have been concerned that the program is too expensive and that costs are spiraling out of control. Medicare patients, meanwhile, have feared that financial support for the program is under attack, their coverage is shrinking, and their ability to afford parts of the program is dwindling.

Unless Medicare is revised comprehensively and effectively, the program will be in serious trouble. This will have profound consequences.

Written by opponents

After several failed attempts — the first was in 1935 — to produce a federally supported health insurance program, Congress finally passed the Social Security Amendments of 1965 (Social 2003a). This made Medicare a reality (Social 2003b).

Medicare is described by some observers as the only American legislation ever written entirely by its opponents. These were people who had lived through the Great Depression and who opposed the creation of another welfare program. Because retirement at age 65 was mandatory, the elderly could not be expected to pay for health insurance, so Medicare’s authors wrote a social insurance program; its philosophical underpinning is that the people who receive Medicare benefits deserve them.

In the beginning, funding Medicare was a relatively reasonable proposition, as the pool of eligible recipients was small, patients’ needs were typically for acute care, and the number of medical care options was limited and — relative to today’s choices — inexpensive. For example, in 1965, diagnostic imaging almost always meant X-ray. Now, computerized tomography, magnetic resonance imaging, and positron emission tomography are common — and are much more expensive than an X-ray. The array of covered services that patients and their families need is far more complex now than in 1965.

Originally, the system was simple and economical. One part of Medicare covered hospital and acute care at federal expense; the other part provided some funding for physician services to those who purchased it. No incentives were built into the program to integrate care, control costs, or provide preventive services; these complications were unforeseen.

Cost control fails

In the 1930 census, only 5 percent of the United States population was 65 or older; by 1960, this segment had expanded to almost 13

How we got what we got

Medicare’s development

• Legislation written by policy makers who were sensitive about welfare
• Social insurance entitlement program emerged
• In 1965, age 65 meant mandatory retirement
• Acute care granted to relatively small and needy population

Medicare’s implementation

• Providers were paid generously
• Care was more expensive and more complex than predicted
• Program characterized by lax enforcement of quality
• Cost-containment efforts were largely unsuccessful

Medicare’s evolution

• Longer life span increased chronic-illness burden
• Preventive strategies proved effective
• Treating aging as a medical problem taxed the system
• Managed care involvement burgeoned, then backfired
percent. Meanwhile, no one foresaw the baby boom and what it would mean to Medicare. It is expected that, between 1990 and 2020, the segment of Americans between the ages of 65 and 74 will expand by 74 percent (National 2003).

The growth of an aging population over the years brought an accumulation of illnesses. The nature of Medicare patients’ ailments shifted from acute to chronic, necessitating new therapeutic modalities — some of which would be administered indefinitely. The expanding burden of chronic illness raised the demand for coverage well beyond Medicare’s original parameters, at a substantially higher cost.

That Medicare expenditures escalated faster than expected cannot be completely tied to demographics and the health consequences of living longer, however.

When Medicare was launched, there was concern that the elderly would not participate and that providers would subsequently drop out of the program. To ease implementation, Congress made patient access easy, paid participating doctors and hospitals generously, and largely refrained from establishing quality-control standards. This combination made the program more expensive than had been predicted. In addition, the framers of the enabling legislation had little idea of the complexity of providing care for the elderly. Therefore, cost-containment efforts by the agencies administering the program — first, the Social Security Administration and, later, HCFA (now CMS) — have largely failed.

**New approach to aging**

The elder segment of the American population is growing, life expectancy is increasing, and the scope of the challenges associated with aging is expanding. It is no longer adequate to provide only medical care; a comprehensive approach to aging is necessary to keep people healthy, functional, and independent as long as possible.

This holistic view involves adjusting the nation’s social structure, creating employment opportunities, and establishing preventive health strategies. It may be costly initially, but it will reduce the frequency and intensity of medical services consumed.

Given the changing health care needs of the elderly, dramatic technological advancements, and current funding levels and mechanisms, it is clear that a new approach to Medicare is vital based on certain realities:

- Older Americans, who want and need a comprehensive support program, represent a growing segment of the population who pay taxes and vote.
- Retirees are more satisfied with their Medicare coverage than younger persons are with their health insurance coverage (Davis 2002).
- Medicare expenses are increasing at a slower rate than private-sector health insurance costs.

**Conclusion**

Most debates about the future of Medicare focus on costs, financing, and the pros and cons of privatization. The ideological divide is related to where benefits should be added to the present Medicare program and to whether incremental change is the best approach. Medicare was started by people who believed that it would be the first step to developing broader health care coverage for the population as a whole. The incremental system never really came to be; incremental change in policy is useful only if you know where you’re headed.

To achieve optimal benefit, it will be necessary to consider the program’s organization, the value of its services, and the benefits that will accrue by implementing changes incrementally within the framework of a comprehensive support program.
Time To Bring Medicare Into the 21st Century

Gail R. Wilensky, PhD

Since its inception, the Medicare program has performed — for the most part — as expected, providing beneficiaries with access to good-quality care. Now, America needs a contemporary health insurance plan for its elderly residents. Medicare is modeled on the traditional indemnity plan of the 1960s, and it still looks like a typical Blue Cross/Blue Shield plan in terms of benefits and payment structures. Medicare shows its age because it lacks catastrophic coverage and an outpatient pharmacy benefit, which have been commercial-plan staples for at least 15 years.

Change drivers

Between 2010 and 2030, about 78 million Americans will retire, nearly doubling the number of people who receive Medicare benefits (Smith 1998). This will create a situation that demands action. Although Medicare has problems beyond funding, solvency is the most visible of several issues and may well drive any change.

Solvency. Continuing to fund the Medicare program is by no means impossible. The federal government has increased health care spending in the past, and it will spend more on Medicare in the future — despite any shifts in the nation’s economy that this continued support might cause.

For the next decade, Medicare is expected to grow at an annual rate of about 7 percent, approximately 2 percentage points more than the annual growth of the gross domestic product. Federal general revenue accounts for about 75 percent of the funding for Medicare Part B. The latest projections indicate that Medicare will begin running a cash deficit in 2012 and will be insolvent in 2026.

Medicare’s financial pressures will increase over time, perceived not as a sudden impact but as a gradual constriction. This will become seriously uncomfortable around 2014 or 2015, when enough baby boomers will have retired such that the pressure will require relief if no action has been taken to provide it before then.

Administrative woes. Participating physicians’ complaints about payment rates are legendary, and they perceive the relative value scale to be bizarre. They bemoan the complex and arcane manner in which they interact within the system — or do not interact, considering their complaints of receiving inadequate information from contractors. Another issue is whether to continue to put the majority of administrative pressure on the providers, or to transfer some of it to beneficiaries, as patients and consumers.

Spending variations. The amount of spending on segments of Medicare fluctuates enormously, leading to perceptions of inequity. Most visibly, the Medicare HMO raises concerns because its structure eases the ability to see just how much money the government pays on the recipient’s behalf.

Payment fluctuations derive from tremendous spending variations among geographic areas. These peculiar cross-subsidies generally relate to lower costs and more

“When changes are made to Medicare, we must anticipate who is coming in while protecting those who are already there.”

— Gail R. Wilensky, PhD

Is it better to influence medical practice in lower-cost/more conservative areas by raising the financial bar, or to try to influence practitioners in higher-cost/more aggressive areas by lowering it?
conservative practice styles in some locations, compared with higher costs and more aggressive practice styles in others. Congress has had difficulty dealing with these inherent disparities. The quandary is simple: Is it better to influence medical practice in lower-cost/more conservative areas by raising the financial bar, or to try to influence practitioners in higher-cost/more aggressive areas by lowering it? Either way, Congress is uneasy, particularly with the latter option.

It is possible to limit Medicare spending by initiating administered-pricing and quality-control programs, and by exercising political will. The Balanced Budget Act of 1997 tied overall spending to growth in the economy. Because these financial restraints and incentives relate to providers, it is necessary to persuade beneficiaries to become active cost controllers by choosing high-quality, cost-effective care.

**New and improved Medicare**

If revising Medicare is necessary — and this appears to be the case — what form should the revised program take? To answer that, it is necessary to understand:

- The nature of beneficiaries already in the system
- The nature of participants who are about to enter the system
- The options that make sense for participants, providers, and taxpayers
- What the new and improved Medicare should look like

Compared with most Americans who are 65 or older, the baby boomers tend to be more advantaged. Compared with women in the current pool of elders, baby boomer women have spent more time in the labor market. Generally, a higher percentage of boomers are or have been higher-income earners. And boomers tend to have stronger retirement assets, including 401(k) plans, than the previous generation.

The point is, when changes are made to Medicare, we must anticipate who is coming in while protecting those who are already there — particularly, the frail elderly.

Investigators have compared Medicare and private insurance plans on the basis of spending rates; this lacks practical validity, however. Over the past 30 years, private insurance plans have seen dramatic increases in the number of services they typically provide. Adjusting the parameters so that one can compare Medicare with similar services through private insurers results in a much less significant difference in spending. Even so, the investigator is comparing organizations that operate differently.

It is more valid, therefore, to compare Medicare with an insurance provider that uses a public sector group-purchasing arrangement, such as the Federal Employees Health Benefits Plan (FEHBP). When comparing Medicare with this type of entity, spending rates appear to be quite similar over a sustained period.

FEHBP may serve as a good model for future iterations of Medicare. Here, the government is neutral about which plan the enrollee chooses, and makes the same basic financial contribution (apart from minor adjustments related to benefits and risk) on behalf of enrollees toward each plan. Several plans exist, each with its own rules, benefit structure, cost-constraint mechanisms, and quality-of-care approaches.

**Conclusion**

All things considered, the key to improving Medicare is to determine the best possible direction change should take. That process is only beginning, and ultimately getting from here to there is going to be tough with a closely divided Congress. It is going to require time to get from here to there — once we decide what “there” is.
If We Keep Medicare, Who Pays the Bills?

Bruce C. Vladeck, PhD

In considering Medicare reform, perhaps the most difficult prediction to make will relate to the most basic of issues: How should medical care for the elderly be defined? Even if medical science has cured Alzheimer’s disease, cancer, and heart disease by 2030 — when about 78 million Americans will be at least age 65 — the elderly still will need some kind of health care. Medicare itself, however, may be less significant than many observers now believe it to be. At some point, we need to ask how medical care will be organized by that time.

Within this framework, two questions are at the root of all debate about Medicare reform and the future of Medicare:
1. Will this society continue to support health care for its elderly citizens?
2. Who will pay the bills?

Collective responsibility

Once a consensus is reached about the health care needs of this population, the question becomes: Are we, as a nation, going to continue to pay for meeting those needs? This is a basic exercise in which every society engages — constantly evaluating and reevaluating central societal values. In our society, decisions about those issues are made primarily in the polling places and only secondarily in our government.

To what extent should society define the provision of health care to older persons as a social responsibility? In 2020, will working Americans be as generous in supporting the medical care that baby boomers will need by then as boomers have been in supporting the medical care that the current generation of elders receives now? It is a good working assumption that they will, because the alternative is difficult to contemplate.

Most of the political fight about Medicare reform is about who will pay for the program. Over the life of Medicare, allocation of financial responsibility has shifted, substantially, from taxpayers to beneficiaries. In fact, the growth rate of out-of-pocket expenses has, in many instances, exceeded the growth rate of covered expenditures (see “Who’s Footing the Bill: An Analysis,” page 8). Periodic spasms of cost cutting reduce federal support for the program while the costs of some therapies that Medicare does not pay for, such as prescription drugs, increase steadily and rapidly.

The share of financial support from taxpayers for the health care services provided to Medicare beneficiaries is declining. Including taxpayer-supported Medicare expenses that are paid by Medicaid, working Americans shoulder about 60 percent of the program’s medical costs. But from whose pockets are those dollars coming? Half of Medicare beneficiaries pay income taxes, and all beneficiaries are former taxpayers. Further, Medicare beneficiaries directly pay for about 40 percent of the benefits they receive — too much, some observers argue, considering that in 1968, the balance was closer to 70/30. How will Medicare reform affect that 60/40 balance?

Financial responsibility for health care should be allocated as broadly as possible, across all age groups, according to ability to pay. Accumulated wealth should be con-
Who’s footing the bill? An analysis

Lack of comparable data prevents direct comparisons of the rates of growth of federal support for Medicare-covered services and out-of-pocket spending among beneficiaries for personal health expenditures. Nevertheless, a MANAGED CARE analysis of various reports offers insight into Vladeck’s assertion that in some segments of Medicare, out-of-pocket costs are rising faster than federally covered expenses.

Medicare spending, 1993–2001
Total national expenditures, billions (Percent growth from previous year)

Out-of-pocket spending, Medicare beneficiaries, 1997–1999*
Average total personal health spending (Average annual increase)

Average annual spending for specific goods/services (Average annual increase)

Takeaway: Federal spending on Medicare rose nearly 6.4 percent annually from 1998 to 2001. Over a similar period, beneficiaries’ out-of-pocket expenses rose 5.8 percent annually, though this increase was much higher within certain therapeutic areas. Greater out-of-pocket costs have been particularly acute for M+C enrollees.

Out-of-pocket spending, Medicare+Choice enrollees
Average total personal health spending (Percent growth from previous year)

Distribution of out-of-pocket expenses, 2003

* Excludes beneficiaries under age 65.
† AARP cautions that direct comparisons of year-to-year data may not be accurate due to changes in methodology.

SOURCES: AARP 1997, 1999

SOURCE: LEVIT 2003

SOURCE: GOLD 2003
sidered when determining how to allocate responsibility. The alternative is to de-
mand that the elderly or their families bear that burden, regardless of their ability
to afford it.

Any modification of the Medicare program must respect the responsibility that
society bears to support its elders. Some reform proposals, such as the FEHBP, pro-
vide the purchaser (in this case, the federal government) an opportunity to freeze
its financial contribution at any point.

Public policy that would allow the government to abdicate its responsibility for
older Americans, and incorporate such policy into the basic structure of Medicare,
could result in the systematic evisceration of the program. Freezing federal contrib-
utions to the program may eliminate vital benefits for people who have the least
available disposable income while simultaneously transferring financial risk to them.

Medicare as delivery vehicle

Medicare has proven to be a sound program, providing more than adequate medi-
cal care as medical practice and technology have evolved to meet the challenges of
providing care to the geriatric population. Frustration with the program has more
to do with the inadequacies of delivering care than it does with understanding the
health care needs of the elderly or developing the ability to treat them.

We are learning on the fly how to provide health care to the elderly. Medicare is
the wrong tool for this. It is wielded by the wrong people, operating under the wrong
set of rules and the wrong set of constraints.

Born of political compromise, Medicare was designed to provide health care with-
out interfering with the practice of medicine. Yet, governmental control of how
medicine is practiced, particularly for government-sponsored beneficiaries, is higher
in the United States than it is in most countries with so-called socialized medicine.
This results from our unwillingness to address health care financing and responsi-
bility issues directly. In our antibureaucratic society, we prefer to control costs and
access circuitously.

The democratic process is particularly inappropriate for determining how to or-
ganize medical care, and the members of a democratic government are generally
ill equipped to perform the task. Expecting CMS and the U.S. Department of Health
and Human Services to sit down at a committee meeting to determine the optimal
size of a group practice makes no sense. But, because Medicare payment is a pow-
erful political tool, these are the people who make such decisions.

The organization of medical care ought to be figured out not by government
bureaucrats, but by doctors, nurses, patients, and administrators who:

• Work and make decisions in an open public process
• Consider experimentation to be expensive and risky
• Must publish all their ideas in the Federal Register every 30 days
• Watch the results of every pertinent federal election to predict which individ-
  uals and what political agendas are going to gain control

Conclusion

We should first determine what the system is and then decide how to pay for it,
rather than letting payment issues drive the system configuration. We should let the
health care system evolve, then honestly address issues of financing and delivery,
asking the real experts to recommend what the system ought to look like.
Concerns about adequate financing and the solvency of Medicare are valid. There is a sense that society will always struggle with this problem, but the future may not be as bleak as it appears now. Taking the right approach to reform, it will be possible to revitalize the Medicare program by 2010 by strengthening its benefits, solvency, and financing.

Occasionally, the positive aspects of Medicare are overshadowed, in the media and elsewhere, by focusing on policy disputes, arguments about the scope of a prescription drug benefit, administrative shortcomings, or insufficient resources.

The agency must be accountable to its beneficiaries, providers, and the public, but the program’s administration has become inflexible because of far too much congressional and executive branch micromanagement. Personnel cutbacks have compounded the problem. For example, the Balanced Budget Act of 1997 demanded implementation of about 350 changes in the law. HCFA had to make those adjustments, then deal with more than 1 million providers and millions of beneficiaries, all of whom needed to understand the changes. At the time, HCFA had 1,000 fewer full-time employees than it did in 1980, the year it became a freestanding agency.

For almost 40 years, Medicare has guaranteed older Americans affordable health insurance that is universal, equitable, and often of high quality, offering reliable coverage with a choice of providers. Even some of Medicare’s problems are caused by positive factors, such as increased life expectancy and emerging medical technology.

Nature and timing of reform

The shape that Medicare will take in 2010 depends on the baby boomers. According to Ken Dychtwald, PhD, an astute observer of demographic trends, boomers have an insatiable demand for service, are probably at least marginally inclined to pay for things themselves, and resist aging. They will transform Medicare, just as they have transformed every other industry, from banking to fast food (Dychtwald 1999).

Medicare can no longer afford to look like a 1965 insurance plan. To survive and thrive, Medicare must be revised to improve its competitiveness, efficiency, and financing. Congress is considering a number of different reform plans. For the sake of consensus development, reform probably will feature, for example, a more generous prescription drug benefit than most of the Republican plans envision and a slightly more privatized system than the Democrats propose — the former to improve competitiveness, the latter to improve efficiency.

Optimally, improvements would begin to emerge from the Capitol within the next year or two, but Medicare reform is unlikely in the near future. Big things rarely happen in Washington unless they are top-priority items backed by the full support of the president, and the fact is that Medicare is not high on the Bush agenda.

Further impediments to quick action:

• According to the Congressional Research Service, a branch of the Library of Congress that provides nonpartisan research reports to members of the House
and Senate, the federal budget surplus for fiscal year 2000 was $236 billion (Winters 2001). That surplus is gone.

• The federal government enacted a $1.7 trillion tax cut in 2001, which was expanded this year.
• The 2004 election cycle is in full swing, with several members of Congress running for president.

The DeParle plan

Because the matter of Medicare reform remains open, it is appropriate to review an alternative to the Breaux-Frist plans (1 and 2), the Graham-Snowe plan, and the Tripartisan plan: the DeParle plan (see box).

Favoring a stepwise approach to Medicare reform is based on two things: a major accomplishment and a valuable lesson. By extending the Medicare Trust Fund (MTF) to 2026, there is adequate time to plan well-thought-out changes that can improve Medicare. In implementing 350 changes to Medicare during the late 1990s, we discovered that some new policies negatively affected beneficiaries, providers, and Medicare. This argues powerfully against trying to do too much at one time.

Phase 1

Repealing the Bush tax cut and using the money to provide Medicare beneficiaries with a strong prescription drug benefit would be an excellent way to initiate phase 1. As an alternative, a realistic first step would be to provide CMS with more resources, improve its administrative flexibility, and require more accountability from the agency, perhaps by establishing an advisory panel or a board of directors.

Currently, Medicare’s administrative costs represent 1 percent of federal program dollars. More funding for the agency could be accomplished by gently tapping the MTF. Disseminating quality-improvement measures and educating beneficiaries and providers will improve understanding of the program. Competitive, market-based pricing, rather than administered pricing, of selected fee-for-service functions and

### DeParle’s Medicare reform proposal

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<td>• Require more accountability from CMS</td>
<td>• Launch prescription drug benefit</td>
<td>• Address the idea of charging something to current group of beneficiaries</td>
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<td>• Tap the Medicare Trust Fund to fund administration of the program</td>
<td>• Move forward on modernization: offer preventive benefits, etc.</td>
<td>• Incorporate ideas from demonstration programs to strengthen Medicare financing</td>
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<td>• Move forward on quality improvement</td>
<td>• Offer large demonstration programs for premium support, defined benefit, and an FEHBP model, to make beneficiaries more cost-conscious</td>
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<td>• Engage in beneficiary and provider education</td>
<td>• Allow providers to make benefit determinations; not all Medicare preventive benefits are based on what clinicians say patients need</td>
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<td>• Competitively price selected Medicare services and products</td>
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<td>• Require implementation of computerized physician-order entry and other high-tech communications systems</td>
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some durable medical equipment products in some markets will improve competitiveness. Requiring and funding clinical information systems, electronic medical records, and computerized physician-order entry systems for providers would improve efficiency by reducing errors and their consequences.

Phase 2

Between 2005 and 2008, the focus would be on modernizing cost sharing — for example, by adding a prescription drug benefit and establishing a cap for beneficiaries on out-of-pocket expense for catastrophic illness.

Initiating rigorous demonstration projects, such as premium support, competitive defined benefit, and the FEHBP model, would establish whether these concepts are useful in Medicare, make beneficiaries cost conscious, and enhance cost-effectiveness.

Asking clinicians and medical researchers to recommend which services to offer to beneficiaries will eliminate waste and improve benefit. Currently, politicians and administrators recommend changes, which are often costly but generate no benefit.

Phase 3

By 2008, the changes needed to reinvigorate Medicare should be apparent, and baby boomers should be in a position to ensure that Medicare becomes the program that they want and need it to be. If all else fails, the boomers will still have a few years to generate new ideas before bankruptcy dooms Medicare. This provides an opportunity to address the idea of whether to charge some or all beneficiaries for selected services; this idea, however, strikes me as unrealistic and, perhaps, unfair.

Conclusion

Reforming Medicare without destroying it requires a scalpel guided by a surgeon, rather than a cleaver wielded by a butcher. By starting the reform process now, planning the optimal procedures, and applying them incrementally, Operation Medicare should save the patient’s life — in fact, giving it greater strength than ever before.

References


After concluding their opening remarks about the nature of current and future difficulties that Medicare faces, the panelists discussed and debated methods of improving the system. Gail R. Wilensky, PhD, Bruce C. Vladeck, PhD, and Nancy-Ann DeParle, JD — the three immediate past administrators of the Health Care Financing Administration (HCFA) — engaged in a lively discussion moderated by Samuel O. Thier, MD (see biographies on page 2). The direction of the debate was dictated in part by questions from a live audience of managed care and health care clinicians and decision makers. The panelists’ divergent ideologies with respect to the direction of reform, while clear, were nonetheless offset by several areas of consensus.

SAMUEL O. THIER, MD: We agree that affordable health care should be made accessible, but we have not defined affordable or health care, nor have we elaborated on expanded benefits or quality-improvement measures that might be included in comprehensive Medicare reform. We also agree on the necessity of a properly supported administrative structure. I don’t think the Balanced Budget Act of 1997 tried to do too much. The problem was that most of its actions were directed — almost independently of each other — at controlling costs, and some of them reinforced each other. There was no global view of the intended result, and without that, there’s no way to manage a set of independent or interacting decisions effectively.
GAIL R. WILENSKY, PhD: I disagree, because the unexpected impact of the Balanced Budget Act was largely due to an aggressive move by the Office of Inspector General, the Department of Justice, and HCFA to reduce Medicare fraud. The provider community experienced uncertainty and changes in billing behavior in addition to the payment reductions. The overall view was to bring prospective or bundled payment to all the areas that had not been covered previously. Physician reimbursement isn’t bundled; it’s disaggregated and subject to an overall cap. It’s hard to disentangle how much of the impact of the Balanced Budget Act was from fear of improper billing. I’ll concede that when there are that many changes, it’s difficult to understand the interactive effects.

I have several brief responses to Bruce’s and Nancy’s presentations (see pages 7 and 10, respectively). First, I agree that we may be forced to rethink or reconsider social insurance. I’d like a program through which the government provides more funding for low-income individuals and less for high-income individuals — not zero for the wealthiest, but not too little for the poorest. It will be a difficult philosophical decision, because it’s contrary to the social insurance concept that initiated Medicare. We will have to deal with it, though. No one gets enough social insurance, so I would be more concerned about what happens to the poor.

Second, you can have a defined contribution tied to a defined benefit, similar to the Federal Employees Health Benefits Program (FEHBP). My concern would be that we do not simply index an amount of money. The federal government should pay three quarters of a defined benefit, or some other agreed-upon share.

My third point is about variations in practice and who decides what is necessary and unnecessary. I agree with Bruce that political appointees should not make these decisions, but practicing physicians can’t make them either, because that’s essentially what we have now. People who are not the payer should be empowered to give us much better information about what works and when, and financial incentives should be in place to back that up.

Fourth, there are many variations of drug benefits on the table. It makes sense to have an integrated, rather than a stand-alone, drug benefit to capture some of the expected savings and avoid the creation of another silo.

Fifth, I think assaying some ideas through demonstration projects is good, but in the past, most demonstrations haven’t brought all the people into the changed environment. If we’re going to test new rules, the demonstration has to include all plans, including traditional fee-for-service plans.

Finally, we will need better information about quality of care and patient satisfaction. CMS also must massively rethink how to pay physicians. Since 1983, we’ve been fixated on every institution getting exactly the same payment (excluding cost-of-living adjustments), which is the opposite of where we need to go. We should reward those areas that practice in a conservative style or, better yet, that provide higher quality.

BRUCE C. VLADECK, PhD: My first observation is on the issue of geographic variations in practice patterns. People have been pointing at variations for 30 years, but there’s a lot of natural variation in the world, as documented in several large Rand Corp. studies. The rate of inappropriate utilization in low-use communities is the same as that in high-use communities. There is more absolute inappropriate utilization in high-use communities, but there is more appropriate utilization as well. To the extent that people have studied it, the problem is not variation, but inappropriate utilization.
The important underlying issue is that Medicare is a lever, and we’ve been using its pricing pattern in areas about which we know little — where the gap between statistical aggregation and clinical practice is considerable. If you look at recent articles, such as one by Stephen Jencks in the *Journal of the American Medical Association*, there’s been enormous improvement in the Medicare population's quality of care in recent years (Jencks 2003). This improvement is largely due to the reorganization of what was then the peer-review organization program. The strategy is to appeal to professional pride by collecting reliable data and feeding it back to physicians through organized mechanisms in local communities. This strategy worked in Medicare at a time when payment incentives may have been going in another direction. Variations among populations and incongruence between our payment system and quality-improvement mechanisms do not make quality improvement impossible.

Another point: Medicare+Choice was meant to create equality between what Medicare paid for fee-for-service delivery and what managed care plans were paid. The motivation for the legislation — both the Democratic and Republican versions — was threefold. First, data were overwhelming that we were overpaying managed care plans in about two thirds of counties. Second, we needed a functional risk adjustment as an integral part of the payment system. Third, we needed comparability in terms of benefit structure. The legislation caused a major national health policy crisis, because many counties had only 450 people and no HMOs. Outside the health policy community, however, there’s no constituency for a level playing field. People who sell services to Medicare want the field tilted in their direction. They are American citizens with the right to make campaign contributions to their congressmen. Within the health policy community, everyone agrees that if you have an equitable and efficient payment mechanism for private health plans, whether it’s the M+C model or the FEHBP model, you need a way to adjust for risk in the population. Throughout the history of Medicare, the managed care industry has used rhetoric to make effective risk adjustment impossible because some plans would get less money. A level playing field can’t be made within the current political system, because it will tilt in the direction of those who are best able to mobilize politically. That isn’t a judgment on my part, but an empirical observation and a prediction.

**NANCY-ANN DEPARLE, JD:** Yet, it’s important to start demonstrations, because at some point one of them will show us whether a level playing field works. If there were a strong bipartisan consensus to make the demonstrations real, we would at least have a chance, which is what is important about trying to move forward.

One point about quality, Sam, regarding the effect that Medicare could have with its payment system: You hear about people having an operation on the wrong hip and then having to undergo another operation, both of which are paid for in full by Medicare. Medicare probably does more than any other payer to encourage adherence to professionally recognized standards, yet we spend almost $1 billion a day with practically no idea about the quality of what we’re buying. Instead of peer review and approval, we could reward quality performance with payment. It’s controversial and divisive; trade associations won’t want providers to be treated differently based on the quality of care they deliver.

**WILENSKY:** As an economist, I think financial incentives are important. We’re beginning to see recognition of the value of a reward system for positive outcomes. Sam and I have spoken about an idea his group is pursuing — having private pay-
ers agree to share their gains if the medical group can reduce measurable risks for certain conditions with clearly defined health outcomes, such as diabetes. Pay-
ers would share with participating physicians and the patients themselves to help improve compliance. These adjustments are likely to be made in the private rather than public sector, but the political process might be able to follow suit.

THIER: Let me provide some background on this. Negotiating with the second-
largest HMO in our region, we [Partners HealthCare, a Boston-based integrated health system] agreed to reward physicians for population-health improvement if the HMO could identify three or four patient-care areas that it wanted to im-
prove. For example, physicians had to reduce the diabetic population’s hemo-
globin A1c levels to below a certain threshold, with improvement by a certain per-
centage each year, for 3 years. We paid providers additional money if they achieved the desired outcomes, met the 3-year asthma goal in the first year, and had very good management of diabetes. The local response to this was so positive that the next round of insurers asked for a similar agreement. Then, one of the largest cor-
porations in the country offered to split savings among itself, the patients, and us.

DEPARLE: In the 1990s, Medicare was beginning to negotiate with the University of Pennsylvania Health System about paying for outcomes as opposed to visits. Then the Balanced Budget Act occurred and negotiations fell apart. Maybe Medi-
care can learn from your project.

THIER: Sometimes it takes years for something like this to become accepted and then functional.

END-OF-LIFE CARE

THIER: I have questions from the audience for the panel. The first is: Is there anything that Medicare should do about end-of-life issues, such as utilization of resources?

WILENSKY: This is a difficult issue. First, we have to rethink hospice, because it’s focused on predictable deaths and does not accommodate chronic care. Second, people need encouragement to become more actively involved in living wills and other advance directives, and we need to enforce provider response. It would help to involve people before they are in acute distress. Finally, we need to get inform-
ation out about the probable outcomes of aggressive medical care. These steps would help people make choices in concert with their physicians and families.

VLADECK: The end-of-life issue illustrates Medicare’s limited ability to control provider behavior. Data from SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments) show that the majority of physicians and nurses don’t respond to advance directives, despite the threat of removal of their licenses or Medicare provider agreements (Hamel 1999). The ma-
jority of providers admit they would rather not be bound by advance directives.

Despite mythology about the dollars involved, there has been a trend toward spending less money on the care of people with no real prospect of survival. The older a Medicare beneficiary is when he or she dies, the less money Medicare spends on the beneficiary in the final year of life.

This is a case where some of the leading palliative-care people say Medicare doesn’t let them provide certain services. In fact, Medicare not only lets them pro-
vide those services but gives them incentives to do it. There are good data to show that hospitals do better financially by following palliative-care models as opposed to high-tech invasive models. CMS has removed many barriers to physician payment for in-hospital palliative care. Medicare policies largely have been in front
of the profession. This is a relatively useful illustration of our ability to change the health care delivery system by readjusting Medicare benefits or incentives. We need to be realistic, however, about doctors and nurses reaching a point where they do what they are going to do, regardless of payment and regulations.

**CARROTS AND STICKS**

**THIER:** There are questions from the audience about financing mechanisms and incentives, and their effect. Can you conceive of a financing mechanism for Medicare that doesn’t create incentives for physicians and hospitals to increase services? I think capitation was the answer, though it hasn’t survived effectively — perhaps due to the way it was financed or how people perceived it. Physicians have been leaving M+C networks in droves and the number of participants in M+C has gone down, against projections.

**WILENSKY:** The notion of rewarding physicians for positive outcomes is important if we are to get around the problem. As identified in the Institute of Medicine reports and elsewhere, physicians often are paid for both an incorrect and then a corrective action. The question is whether we can devise a way other than capitation to reward a conservative, high-quality practice style. An interesting article in the *Annals of Internal Medicine* looked at three diseases in high-spending counties and measured quality or quantity of life and patient satisfaction (Fisher 2003). The authors determined that primarily discretionary expenditures — visits to certain kinds of physicians — were associated with high-spending areas. It strikes me that direct financial reward for institutions and groups that perform better is the best way to get around mindless fee-for-service, as well as capitation that rewards those who do too little.

**THIER:** How do you decide what should be paid for, and how do you make sure the system is paying for what you want?

**DEPARLE:** The study that Bruce referred to [Jencks 2003] shows how to select clinical indicators about which there is a consensus. Most of them are outcomes rather than processes. By measuring aggressively, you can identify the groups that lag.

**VLADECK:** We have to be realistic about how much we know and what the medical care system does. Managed care plans got themselves in trouble by thinking that when people paid for health insurance, they bought outcomes. The plans thought that because two thirds of primary care visits were from the so-called worried well (Diamond 2003), they could eliminate those visits and save money. Instead, they found that the medical care system’s effect on outcomes is tangential compared to education, socioeconomic status, and measures to improve public health, such as clean water. Only a fraction of physician/patient encounters produces an intervention that makes a difference in outcomes. Outcomes are important, valued, and paid for, but the medical care system does more for people than generate outcomes: People need professionals they can turn to for answers about whether they should worry. The social function of medicine is pervasive.

The greatest success in medical-error reduction and safety improvement happens when you engineer systems, such as anesthesia, that are removed from the behavior of providers. If you engineer an operating room correctly, you will get fewer anesthesia-related deaths, regardless of your anesthesiologist’s ability. We have to remind ourselves of how limited and probabilistic the cause-and-effect relationships are between human health, the medical care system, the quality of a particular medical intervention, and outcomes.

“Systems can make a difference in preventing errors, and we should invest in them. The government should require some information technology improvement, and then should pay for it.”

— Nancy-Ann DeParle, JD
THIER: I think that’s an apology for not doing things that have been shown to work. Control of hypertension, cholesterol, and C-reactive protein is documented in terms of long-term outcomes. If you pay for visits to the doctor, you should know whether a hypertensive patient’s blood pressure is under control. We need disincentives for physicians who see a patient 20 times without getting that patient’s blood pressure under control.

VLADECK: Sam, using the hypertension example, we know that compliance with ordinary medical practice is lower among black patients than white patients, for a variety of reasons. Are we going to give less money to doctors who take care of black patients because those patients’ outcomes are not as good? Or should we pay them more because they have to spend more time counseling patients or investigating whether they have coverage for a prescription drug?

THIER: Physicians should know whether the desired outcome has been achieved. If they don’t get the desired outcome, they need to figure out why and take responsibility. One reason our system works is that it doesn’t depend on individual doctors. An outcome must be reached with input across the system.

VLADECK: But we, as a nation, have said we won’t take responsibility for the health of our population, and that even Medicare won’t take responsibility for Medicare beneficiaries. Our national policy is that people are responsible for their own health.

THIER: We’re talking about what we should do in the year 2010 and what approaches are viable going forward. I strongly disagree that that’s the correct approach.

INFORMATION TECHNOLOGY

THIER: Should the government collect and review more data on patient encounters than it currently requires? If so, who should pay for data collection?

VLADECK: Our successor [CMS Administrator Thomas Scully] is getting praise for the new high-quality data being reported on the Web and elsewhere about nursing homes, home-care providers, and so forth. Meanwhile, his boss [Health and Human Services Secretary Tommy Thompson] says that Medicare has to stop collecting home-care data on non-Medicare patients. The current movement, therefore, is toward regulatory reform, which means reducing — and thus making less effective — CMS’s current data-collection efforts.

THIER: Should data-collection improvements be sustained and encouraged?

DEPARLE: Yes.

VLADECK: Sure.

WILENSKY: The first issue is to make sure that researchers request only the pertinent data from institutional providers. We also need to support research on, and analysis of, what works at what times. Information is nice to have, but it isn’t enough.

THIER: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is intended to promote better use of information technology (IT). If IT is necessary for improving health, then perhaps we need a Hill-Burton Act1 for it.

DEPARLE: Well, it’s sad but true: HIPAA wasn’t about anything clinical. It was about administrative simplification. But you and Bruce made the point: Systems can make a difference in preventing errors, and we should invest in them. The government should require some IT improvement and then should pay for it.

1 Known as the Hill-Burton Act, the Hospital Survey and Construction Act of 1946 was a nationwide effort to build hospitals in underserved areas. From 1948 to 1975, the act effectively increased access to care by providing a specific number of staffed beds per 1,000 people through federal matching funds.
VLADÉCK: I see a lot of building projects going on at hospitals and health institutions, so I think it’s a cop-out to say that they don’t have the money to improve their information infrastructure. Some institutions probably cannot afford it, but many can. Rather than debating that, I would prefer to say that IT is worth paying for, because it helps Medicare beneficiaries — and, yes, we should have something like Hill-Burton to help.

WILENSKY: I am concerned that hospitals can come up with money for revenue-producing activities — such as building a cardiac catheterization lab — but say that they can improve the IT infrastructure only if they can get additional funding. If an information system such as with computerized prescription ordering or bar-coding improves patient safety, we can provide a financial incentive for that. We seem to be in a period of substantial capital expansion, presumably in response to current incentives. We need to target the necessary areas and make spending modifications to the less necessary areas that are proliferating.

VLADÉCK: In the last 20 years, we’ve radically changed capital fund-raising to become more market driven. People are spending a fortune in unnecessary areas, because they can achieve a quick return on investment; while other needs, such as an ER renovation or IT are unmet.

A variation of this problem is occurring in New York State. The administration has offered subsidies for community health centers if capital can be raised to build them. In the current market, though, nobody will lend the money. Having all the capital expenditures on the wrong things is a symptom of the same problem.

THIER: In Massachusetts, 80 percent of hospitals are operating in the red, yet — and this is what troubles me — improvement of measurements is mandated without any provision of financial resources to help achieve this. Where do the resources come from, so that you’re not in default of what you’re supposed to be doing?

WILENSKY: My guess is that the HIPAA deadline for compliance with its clinical information standards will be extended, because too many providers — including many Medicaid programs — wouldn’t be able to meet the deadline. But I gather from talking with people that the first wave of HIPAA requirements, the transaction standards, has cost far less than estimated. The other issue is that if we want to get more IT, we need some kind of targeted matching grants or programs, rather than increasing the diagnosis-related group payment by a certain share.

PRESCRIPTION DRUG BENEFIT

THIER: Several members of our audience have posed questions about drug benefits. Our panelists all seem to think a drug benefit is necessary. Nancy-Ann, you’ve said you do not think it can be done right now, but what do you think the drug benefit should look like eventually?

DEPARLE: If I were the queen of policy, I’d have drug benefits now — but that isn’t realistic. It would take a year or so for the agency to get geared up. The money that’s on the table for a drug benefit — about $400 billion over 10 years — is probably not enough. It will take substantially more, perhaps another $200 billion. Plus, a meaningful drug benefit would have beneficiaries paying a fair amount of the cost. There are pluses and minuses as to whether it happens through private plans, pharmacy benefit managers (PBMs), or another approach. The major issue right now is the federal budget deficit.

VLADÉCK: There are several issues, one of which is: How good a benefit will this be? Frankly, the corrosive social effect of a poor benefit almost negates the exis-
tence of the benefit. As scored by the Congressional Budget Office (CBO), $400 billion over 10 years will buy a poor benefit, or a better benefit targeted to an unspecified fraction of the Medicare population. In the latter case, 10 percent of your benefit budget would be spent reaching people rather than helping them.

Another issue: How much it will cost? The CBO or CMS actuaries have no way of accounting for this in advance; it depends on how long you keep current players and what the incentives are. Employer-provided retiree benefits will fade away over the next 20 to 25 years, as the people who have legal entitlement to those benefits die. Until then, a great deal of money will be spent on these very good supplemental benefits. There’s a deal to be cut with the states, which are spending a lot of Medicaid dollars on prescription drugs for Medicare beneficiaries, in terms of some financing of this kind of arrangement. Cost control might be achieved through full capitation or next-generation PBMs operating under new rules. In the private sector, the per-member, per-month cost for a prescription drug benefit varies as much as 20 to 25 percent, depending on how the benefit is designed — e.g., tiering, copayment, deductibles, and formulary inclusions.

WILENSKY: I am amazed at Nancy-Ann’s comment about CMS gearing up to do this in a year. We’d be lucky if it gets the regulations out in 2 years, and then, in another year or two, actually be in a position to act.

Regarding when and how to start the drug benefit, there is the issue of whether to use private-sector entities, such as PBMs, or to enact administered pricing. Under President Clinton, we had the first indication that Democrats weren’t going to pursue administered pricing. It isn’t clear how much power people will give PBMs to engage in channeling individuals’ choices. Medicare normally does not allow intermediaries to engage in that kind of activity, but we can either allow it or spend a lot of money. Having separate entities worries me because, ideally, you would like to affect both physician prescribing and what is prescribed, which will never happen with PBMs.

I’d like to see two versions of a drug benefit: a Medicare-integrated benefit for people in private plans, along with a benefit for enrollees in traditional Medicare that is administered by a PBM or other entity. I don’t think this is the way we’re going, but I’d start selectively on those two populations and then open it up.

DEPARLE: Regarding the $400 million estimate, if that’s all we have, then I’d be in favor of establishing a better benefit for low-income people. However, I wouldn’t pretend that it’s a meaningful drug benefit for the entire population.

CONCLUSIONS

THIER: Will the panelists please summarize three or four things that were agreed on, as we go toward the year 2010?

VLADECK: We agree that from a macroeconomic standpoint, an increased demand on society to finance Medicare, either as currently constructed or with modified generosity, would be significant but not impossible. It will be a big hit, but this is a big country that will have a big economy by 2010. We will be able to afford spending 20 to 22 percent of our gross domestic product on health care, with some of it running through the public.

There’s also agreement among us about needing to invest more, economically and otherwise, in data collection. Data will allow us to evaluate the content and quality of medical services, as defined by professionals and consumers. This substantial need for investment is unlikely to be met without government help. Given
Medicare’s large stake in improving quality of care, we need to provide funding without just throwing money at providers who then spend it on new atriums.

We seem to agree that the fee-for-service program, what there is of it and as long it may last, should be more intelligent and responsive about payment. It would improve with advanced private-sector technologies, such as competitive bidding, negotiated pricing, and less micromanagement. All three of us have promoted programs and proposals along those lines, though none have made it through Congress.

We disagree about the ability of financial incentives to change clinical behavior, relative to measurable dimensions of quality. We know from experience that this lever is more limited than it seems, and that many variables affect consumer and provider behavior.

WILENSKY: We agree that Medicare will remain with us for a substantial time to come and that it must be modernized and improved. We also agree that Medicare has yet to recognize the shift from acute to chronic care. Resistance about payment is more clear-cut in traditional Medicare than in some of the private plans.

We sense the need for quality improvement, as Bruce indicated, but we differ on whether improvement should be rewarded. Incremental change may be an attractive way — or the only way — to move ahead. There are some differences in our visions of the Medicare of the future and how to get to there from here, but in some fundamental principles we stand in agreement.

DEPARLE: First, we agree that Medicare beneficiaries need a meaningful prescription drug benefit. Second, we agree that CMS needs more resources, more administrative flexibility, and less micromanagement. Third, we agree that Medicare should try to improve quality of care, or at least monitor, evaluate, and understand the quality of care beneficiaries receive. While we disagree on how to improve quality after the collection of better data, we agree about the need to encourage or require improved clinical information systems in hospitals and elsewhere.

Fourth, we would like to inject more cost-consciousness into the system, although we may differ regarding how to do that without hurting low-income beneficiaries. Finally, we’re relatively optimistic about our country’s ability to meet the looming challenges. While we identify these challenges as daunting, we see people summoning the political will to meet them.

THIER: This situation isn’t hopeless. There’s going to be Medicare, but it needs simplification and improvement. I thank the panelists, particularly for focusing on the definition of what should be financed rather than on financing itself.

References