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Future of Medicare: Report on Expert Views

by

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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.

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FOREWORD

Over the years, AARP's Public Policy Institute (PPI) has been among those who have attempted to discern the future of Medicare and have suggested ways of improving the Medicare program. For example, in 1995, the Public Policy Institute convened a "Conference on the Future of Medicare," and published the conference proceedings which included papers from eight policy experts. In 1996, PPI published a commissioned paper on reforming Medicare, "Reforming Medicare: Strategies for Higher Quality, Lower Cost Care" by David Nash. PPI subsequently published studies dealing with issues such as Medicare beneficiaries' out-of-pocket spending, the effects of combining Medicare Part A and Part B, and administrative challenges in managing the Medicare program. These and subsequent efforts helped to inform discussion and debate regarding the need for and advisability of policy changes, both small and large, to the Medicare program.

In a similar vein, this PPI issue paper is intended to focus the attention of health policy makers and stakeholders on the future of Medicare. The paper seeks to inform the policy debate by offering a balanced review of the future directions the Medicare program may take. Based on conversations with 20 widely respected experts with divergent views, the paper offers a range of policy options that may be available and, hopefully, will focus consideration on some of the most viable approaches that may be adopted to strengthen and improve this large and vital program.

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Background

To examine key questions and related issues regarding Medicare's future structure and financing and ways to improve the program the AARP Public Policy Institute interviewed nationally recognized health policy experts about policies and practices that could improve the cost, access and/or quality of the Medicare program.

AARP's Public Policy Institute conducted off-the-record interviews with 20 national health policy experts. These interviews were conducted from June through August 2006. Experts were selected with the goal of obtaining knowledgeable insights from a range of perspectives. We sought individuals whose expertise and views might counter-balance each other along a range of dimensions, such as discipline (i.e., economist, physician, lawyer) and political spectrum (i.e., liberal, moderate, conservative). As a result, this is not a random survey and our findings should not be construed as representative of the views of all health policy experts. This PPI issue paper summarizes our findings.

Key Findings

While the experts disagreed with each other about the overall direction they would like to see the program go, most believed that major changes in the Medicare program are unlikely. In addition, they all said that there is little "low hanging fruit" to be picked or "silver bullets" in terms of cost controls that are likely to dramatically slow Medicare spending, at least in the short term. Many of the tools they suggested have been available for some time but are not being used effectively, in some cases due to political limitations and/or budget constraints. Nevertheless, the panel identified the following types of changes, without prompting by the interviewers, as directions in which Medicare needs to move.

1. **Chronic illness** -- *Medicare should expand its use of chronic care coordination as quickly as feasible and test the "medical home" concept, at the very least on a demonstration basis, by paying qualified physicians and other practitioners an additional amount for managing and coordinating the care of fee-for-service patients with chronic conditions.*

Medicare is testing several types of chronic care coordination models, but it has not yet tested the "medical home" model. This model is distinguished by its use of virtual networks for targeted patients, typically with multiple chronic diseases, and its application to individual and small groups of physicians and other practitioners, as opposed to the large organizations that have been the basis of current and previous demonstrations. Key questions that still need to be addressed for the "medical home" model, as well as other chronic care coordination models, are the impact on quality of care, patient outcomes and program costs, as well as specifics regarding the preferred method of delivering care and the appropriate level of payment.

2. **Medicare benefits –** *Medicare benefits should be restructured such that responsibility for catastrophic costs is assumed by the federal government and the need for Medigap policies is lessened. In addition, cost-sharing could be restructured to relieve beneficiaries from burdens that they are not in a position to avoid and to encourage utilization of services likely to prevent further illness.*

Experts identified numerous shortcomings in the Medicare benefit structure and called attention to the inefficiency of Medigap coverage, considered by one to be the "worst buy in health care" both because of its relatively high administrative costs and because it appears to increase utilization of Medicare services. Most experts would prefer that the Medicare benefit structure be comprehensively re-thought in terms of both fairness and efficiency.

3. **Utilization and value –** *The waste of Medicare resources, as evidenced by geographic variations in spending and quality, needs to be addressed.*

Virtually all of the experts mentioned wide variations in practice and spending as evidence of waste in the system. Although none of the experts offered solutions for how to fix the problem of inefficiencies in high-utilization areas, all were willing to apply greater pressure to Medicare providers to operate more efficiently, particularly those who are "outliers." Some suggested that wider use of clinical practice guidelines, where available, could reduce practice variations. When asked, most of the experts were willing to try the local pool approach advocated by Elliott Fisher of Dartmouth, except that two expressed concern that hospitals might not be the ideal locus for such pools.

4. **Purchasing and management** – *Despite the political difficulties (both in terms of constituent opposition and ideological discomfort) inherent in a public agency adopting techniques that might be objectionable when practiced by private insurers, Medicare should adopt new approaches to purchasing.*

Approaches include bundling payments, such as including physician services together with inpatient hospital payments or bundling payments for acute and post-acute care to create greater accountability for hospital re-admissions. Also, allowing traditional Medicare to selectively contract with preferred provider networks, such as centers of excellence or networks based on provider quality.

5. **Revenues** – *Medicare will require additional funding over the long term so new funding sources must be dedicated to the program in order to enhance public support and accountability. Additional Medicare financing should be obtained from sources that distribute the burden progressively. Dedicated funding requires a trust fund, which creates another set of political dilemmas.*

Not all experts on the panel offered options for Medicare's future financing and some first suggested cutting unnecessary costs or profitability. Sources of financing that were most frequently suggested included income taxes and other general revenue (such as corporate taxes, estate taxes and repeal of recent tax cuts). Taxes that are used to deliver

progressive benefits but may be relatively regressive were also mentioned (e.g., payroll taxes and value added taxes).

6. Program Oversight – *Mechanisms to reduce congressional micro-management in operational aspects of Medicare should be adopted in order to substantially increase its efficiency. However, Congress should continue to set broad policy guidelines and, ultimately, must remain accountable for the overall performance of the Medicare program. At the same time, increased funding for administrative and operational functions by federal health care agencies, particularly CMS, is necessary to increase administrative efficiency and effectively carry out their mission.*

Congressional micro-management is characterized as a range of behaviors, most often emanating from Congress, such as requests from individual Members for Medicare coverage of specific new technologies to legislation adopting policies that favor narrow, special interest groups and/or that "micro-manage" the program by severely limiting the discretion of senior program managers to pursue policies that favor broader program interests.

7. Evidence-Based Medicine -- *The scope and intensity of information development necessary for the practice of "evidence-based medicine" through the Medicare program should be rapidly expanded under federal auspices. In addition, a Congressional office should be established with technical capabilities to provide assessment of health care technologies and practices.*

The following are essential federal roles in accelerating the expansion of evidence-based medicine: (1) establishing a central research agenda to guide efforts by multiple public and private organizations, (2) expanding the scope and intensity of research on the clinical effectiveness of what works and for whom, (3) developing clinical practice guidelines for the translation of research results into evidence-based practice, (4) testing and revising guidelines to reflect their most effective application and (5) providing adequate and reliable funding for the full range of these efforts. A basic model for this effort is the Agency for Health Care Policy and Research (AHCPR) as originally conceived and developed. While clinical guidelines produced by AHCPR were advisory, some experts suggested that adherence to clinical guidelines that are well established should be made mandatory, or at least linked to financial incentives that would strongly encourage their adoption. In addition, despite disagreement among experts as to the role cost effectiveness analysis should play in Medicare, there was general agreement that more cost effectiveness analysis studies should be performed and their results should be disseminated to Medicare providers and beneficiaries.

BACKGROUND

As part of its effort to inform the national debate over the long-term future health and economic security of Medicare, AARP reached out to a limited number of policy experts whose perspectives, we felt, would reflect the best thinking on the complex and critical issues facing this vital federal program. The objective was to capture the best thinking of outside experts about directions the Medicare program could and should take with respect to structure and financing, as well as policies and practices that could improve the program from the perspective of cost, quality and/or access.

METHODOLOGY

A total of 20 experts were interviewed from June through August 2006. Experts were selected with the goal of obtaining knowledgeable insights from a range of perspectives. We sought individuals whose expertise and views might counter-balance each other along a range of dimensions, such as discipline (i.e., economist, physician, lawyer) and political spectrum (i.e., liberal, moderate, conservative). As a result, this is not a random survey and our findings should not be construed as representative of the views of all health policy experts.

Our interviews were based on a structured questionnaire administered by the authors who exercised discretion as to when and how to pursue topics in more depth. Experts were given the questionnaire in advance so as to allow better preparation and more in-depth responses. In order to assure the candor of their responses, experts were assured their remarks would not be publicly quoted for attribution.

FINDINGS

The summary of results follows the general pattern of questions included in the interview. While comments are attributed to experts by their initials, not all comments are attributed to all experts who may have made them.

1. LONG-TERM FINANCIAL CONDITION

Experts were asked about their level of agreement with publicly available assessments that rising health care costs and the retirement of the "boomer" cohort will cause severe financial strains for the Medicare program in the long term.

All experts agreed that Medicare is under severe financial strain and that these financial pressures are likely to intensify over time. All agreed that the sooner steps are taken, the easier it would be to address the program's financial situation. However, there was no consensus within either group as to what steps should be taken and when. Views on the implications of the financial pressures tended to fall into two different camps.

One group referred to Medicare's financial situation as a "staggering problem," "a cliff", and "a wall." One expert qualified this urgency by suggesting that "now" would <u>not</u> be a

good time to address the problem due to the political environment. In general, those who favored a premium support model, discussed below, tended to regard the program's financial pressures as more severe and more likely to warrant change. The first group indicated that the Trustees' intermediate projection that Medicare will continue to grow at the rate of GDP plus 1% is too optimistic based on historical growth rates. At least one has estimated that full funding for the cost of the Medicare program might require the payroll tax rate to rise from its current effective rate of about 4.3% for Parts A and B combined to exceed 12% by 2035.[1]

The second group was skeptical of government projections and did not agree that the situation should be characterized with as much "doom and gloom" as are many government projections. They said government projections tend to be overly pessimistic because they are not permitted to take into account factors, such as reductions in provider payments that have not yet been enacted into law but are routinely adopted by Congress. More than one expert suggested that it seems inappropriate to single out Medicare for projections of 75 years (and now an infinite horizon) when CBO only performs 10 year projections for other programs and most financial projections have little reliability after more than about five years. A larger group of experts tended to characterize the situation as less urgent and more in need of "political will" to raise revenues for a program that is otherwise "affordable." More than one attributed the problem to growth in health care costs, in general, rather than to an isolated Medicare problem or the result of an aging society. Several experts identified the addition of new medical technologies as the primary driver of the growth in health care costs.

2. NEED FOR CHANGE

Experts were asked to leave aside Medicare's long term financial picture and, considering solely the current structure and operation of the program, rate the extent and urgency of changes needed for the program.

Experts disagreed with each other as to the nature and urgency of changes that are needed to the program. While some experts felt that the need for change is immediate or past due, more felt that, while the program could use improvement in both financing and delivery, the need for change was less urgent. Some felt that the problems are "system-wide" so we will not be able to resolve Medicare's programs until we change the entire health care system. More importantly, views diverged about what changes should be implemented most urgently. The following changes were mentioned most frequently (in parens):

- Need to better coordinate care (8);
- Need to improve fee-for-service (FFS) "prudent purchasing" through such approaches as selective provider contracting, wider use of bundled payments, and negotiated drug prices (8);
- Need to provide better coverage through such things as lower cost sharing and catastrophic loss protection (6);

[1] Pauly, Mark. "Means-Testing in Medicare", *Health Affairs*, Dec 8, 2004.

- Need better cost containment through measures such as using the most appropriate intervention based on comparative effectiveness research, narrowing geographic payment variations, and reducing congressional micro-management (4);
- Need less ideological support and "level playing field" for all coverage options (3).

Less frequent suggestions for change included eliminating traditional indemnity fee-for-service (FFS) from the program, improving Part D , and limiting private Medigap coverage . More than one expert noted that Medicare's financial problems are unlike those of Social Security because Social Security's costs are more predictable and its projected deficit is more manageable. These suggested program changes are discussed in more detail below.

3. ALTERNATIVE MODELS

Experts were presented with several alternative models for the Medicare program, including the "traditional" fee-for-service social insurance program with a defined benefit package as currently in effect and other models, such as a "premium support" model with a defined contribution from the government and greater private-sector competition. They were then asked to predict how likely it would be that Medicare will resemble one of these models in 5, 10, or 20 years.

Experts predicted with near unanimity that extreme changes to the Medicare program are unlikely and that political pressures are likely to keep the program more or less similar to the current mix of traditional FFS and enrollment in private plans (Medicare Advantage). More than one expert pointed out that traditional Medicare is likely to remain available for the next 20 years, at least for older beneficiaries. Most felt that increased enrollment in Medicare Advantage plans will continue only as long as these managed care organizations (MCOs) and other types of private plans continue to enjoy a payment advantage over traditional FFS Medicare. Most experts said they expect increases in beneficiary out-of-pocket costs due to continuing budget pressures. Most were reluctant to speculate about the direction that the political leadership would take the program. Those who preferred a premium support model tended to expect a modest shift toward MCOs, while those who favor traditional Medicare tended to highlight potential weaknesses in the Medicare Advantage program and potential budget cuts that are likely to adversely affect MCO enrollment. Several experts said the evolution of the program would be entirely dependent on politics and the political make-up of the Congress and the Administration.

One expert suggested that, due to limitations of the political process, Congress is more likely to adopt short term budget-related cuts than major design changes to the Medicare program.

4. PREFERRED VISION

Experts were asked to characterize their "preferred vision" for the Medicare program of the future, that is, which alternative paradigm they found more desirable than others and whether there were any alternative paradigms they viewed as unacceptable or not politically viable.

Most experts offered a preferred vision for the program that tilted toward one of two alternative models that were proposed in the question, including either the traditional FFS Medicare model with defined benefit package or the premium support model with defined contribution . Most indicated that the preferred model would be to rely on an integrated delivery model, regardless of whether the government's financial contribution was fixed or variable. There was general agreement that the FFS payment method does not promote efficiency or quality of care as well as an integrated delivery model.

One expert who typified several others but spoke in greater depth on the topic, emphasized that his preferred model is a defined contribution plan in which the government would be permitted to control its contribution by "ratcheting down" its contribution as a percentage of total program costs. He contrasted this model with FEHBP which he characterized as a "premium support" model in which the government's contribution is set as a fixed percentage of private premium costs. He advocated that Medicare should have a long term, planned budget, like the Defense Department, that is subject to annual appropriations for separate categories (i.e., operating, capital and emergency budget) and should be a "retirement insurance" program, rather than a "social insurance" program by which he meant that it should be a "need-based" (i.e., welfare) program.

Asked what changes they would oppose or would find unacceptable, experts who favored the traditional Medicare model would oppose premium support, vouchers and health savings accounts (HSAs), and visa versa. Some who favor traditional Medicare were concerned that a defined contribution model would erode coverage offered by Medicare without controlling health care costs in general and further aggravate disparities in access to health care for those who could not afford supplemental Medigap coverage.

Several experts suggested that the efficiency of the Medicare program is impaired by frequent congressional micro-management. Experts also suggested that under-funding for CMS administrative and oversight activities was a form of congressional micro-management which tends to undermine its effectiveness and cost containment capacity. It was suggested that the problem of congressional micro-management is likely to continue regardless of which direction (i.e., FFS, premium support or other) Medicare takes in the future. Some experts emphasized that by "congressional micro-management," they were not referring to the normal congressional oversight process which they viewed as an important part of accountability. In addition, others noted that Congress's continuous rewriting of the Medicare statute makes governing the program difficult, if not impossible.

5. MEDICARE FUNDING WARNING

Experts were asked what changes, if any, could be made to respond to the "Medicare funding warning," which will be triggered when financing from general federal revenues exceeds 45% of total program spending for the second year in a row.

There was a unanimous belief that the Medicare funding warning is a political artifact. Most experts were not inclined to take it seriously. Those who felt greater urgency to reduce Medicare spending agreed that sounding a "warning" is probably a good idea, at least in principle, even if the specific warning is not very realistic. Most of the other experts thought that the warning was completely arbitrary and/or should be repealed.

None was able to offer "low hanging fruit" that would seriously address the spending warning. When pressed, their responses tended to fall into the category of the "usual" cost cutting measures, such as cutting provider payment updates, and tighter controls on utilization. Some responses were more tongue-in-cheek, such as move payments for home health agencies (which BBA moved from Part A to Part B) back into Part A to reduce the drain on general revenues even though this would obviously accelerate the decline in Part A trust fund. Although the funding warning is intended to intensify short term pressure for Congressional action, at least one expert noted that exhaustion of the Part A Trust Fund is more likely to force changes due to the finite nature of the Trust Fund. More than one expert noted that, in part, the increase in Part B spending merely reflects a shift in Medicare payments from Part A inpatient settings to Part B outpatient and home care so, as a policy matter, we should not want to discourage this shift.

6. MEDICARE FINANCING

Experts were asked what options should be considered with regard to financing Medicare in the future.

While some attempted to side-step the question of revenue sources, there was unanimous agreement that adequate financing for Medicare, as currently in effect, will require additional revenue. Most of our experts believed that this would require raising taxes of some sort, despite the strongly held view of some that tax increases should be the avenue of last resort. Two began their response by noting that there is room to cut unnecessary costs in Medicare and that this avenue should be pursued first. Another suggested that the profitability of health care services should be reduced first.

Several panelists were concerned about the regressive nature of payroll taxes. One pointed out that payroll taxes push jobs "off shore." Most, if not all, felt that tax increases should be progressive so as to minimize the impact on low income people and, for this reason, they preferred general revenue sources over payroll taxes. One expert suggested that, if payroll taxes were raised, this should be done that the payroll tax be imposed at a progressively higher rate on higher earning brackets.

While more than one expert said that a value-added tax (VAT) would be a reasonable source of revenue which could be dedicated to Medicare, most experts were unenthusiastic about this as a revenue source. One observed that a VAT might be an appropriate mechanism to balance contributions across the age spectrum since it would be based on spending of both income and assets, whereas income and payroll taxes leave assets unaffected. However, others pointed out that a VAT would be regressive. Some objected to a VAT as either unnecessary or "a gimmick." Several experts suggested repealing the most recent tax cuts and/or increasing estate taxes and dedicating these sources to the Medicare program. One suggested increasing corporate taxes. One suggested that the tax system unfairly favors the wealthy through lower rates on investment gains (i.e., dividends and capital gains) than on wages and that, therefore, revenue for Medicare should first be recaptured from this "wealth bias" in the tax system. One suggested eliminating health care expenses and insurance premiums as tax deductions for employers.

Even those who favored a defined contribution model agreed that Medicare will require additional revenue, although probably not as much revenue as was believed needed by those who advocate preserving the traditional FFS program, and suggested that tapping income related premiums could provide sufficient revenue to close the gap. Some suggested income-relating Medicare copayments, since this approach would dampen demand for services and Part D appears to have demonstrated its technical feasibility. However, others , while agreeing that income-relating premiums is a reasonable approach to raising revenue, noted that income-relating copayments is more likely to foster discrimination by providers and resentment among upper income beneficiaries.

Most experts suggested "earmarking" additional revenue sources for Medicare. At least one suggested earmarking "sin taxes," such as tobacco and alcohol taxes, for Medicare. However, some felt that "public accountability" means that Medicare financing should be put on the table for Congressional scrutiny along with all other public programs (i.e., education, Social Security, defense, etc). More than one expert pointed out that earmarked funding for Medicare tends to create targets for political wrangling, as has been seen with the Part A Trust Fund and general revenue funding warning. The obvious advantage of earmarked funding is that it establishes a base of political support, not to mention a presumption of continued funding because a super majority (i.e., 60 votes) margin is required in the Senate to overturn it, at least as long as the funding source holds out.

7. SACRIFICES AND TRADE-OFFS

Experts were asked, if some type of beneficiary sacrifice were needed to improve Medicare or ensure its financial viability, what types of sacrifices or trade-offs would be reasonable to ask of beneficiaries and what sacrifices should be avoided?

Most seemed comfortable with the idea of "shared sacrifice" by which they meant that Medicare program financing would need to be brought into alignment with a combination

of revenue increases, increased beneficiary cost sharing and provider payment cuts. [See "Beneficiary Needs" below.]

Most experts cited *income-relating of premiums* as an acceptable or even desirable sacrifice for wealthy retirees to make.[2] However, they did not clarify what they would do differently from the current income related Part B premium.[3]

More than one expert cautioned that income relating premiums risked undermining political support for the program among those who represent a particularly articulate and politically potent segment of the population. At least one pointed out that, if the premiums get too high, well-to-do beneficiaries may begin to drop out of the program, entirely, that is, they will stop paying Part B or Part D premiums and seek coverage from the private sector or self-insure. One suggested that income-related premiums would not raise much revenue. For instance, as currently structured, income-related premiums are expected to raise about $2 billion per year from about 5% of beneficiaries.

Several experts suggested that, since Part D has demonstrated that technology is available to permit individually adjusted copayments for drugs, copayments for other services could also be income related. This approach would reduce problems of disenrollment and adverse selection that could arise from income related premiums.

Another expert suggested that upper income beneficiaries should be required to pay the cost of coverage for new technologies through the purchase of supplemental Medigap policies. While his approach would be voluntary, he also suggested that people should be encouraged to fund the cost of such coverage with pre-retirement income.

Many experts ruled out any reduction in the generosity of Medicare's *benefit design*, particularly increases in cost-sharing, with several noting that Medicare is not as "rich" a benefit as many employee health plans. One expert suggested that most beneficiaries do not receive as much in Medicare benefits as they contribute in lifetime taxes.[4] All experts believed that low income beneficiaries should be protected from increased costs of the Medicare program although most did not specify a threshold that they would regard as

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[2] Starting in 2007, beneficiaries with higher incomes will pay a progressively greater share of Part B costs ranging from 35% for incomes above $80,000 ($160,000 for couples) up to 80% for incomes over $200,000 ($400,000 for couples). Instead of the standard Part B premium of $93.50 per month for 2007, income related premiums will be as much as $162 per month. By 2009 when fully phased in, premiums for the highest income brackets are expected to reach about $375 per month.

[3] Part A could also be made income-related by subjecting the actuarial value of the Part A benefit to income tax. This approach would tax the Part A benefit at progressively higher rates for beneficiaries in higher income brackets and automatically exempt those in very low income brackets.

[4] Published findings indicated that, on average, current beneficiaries receive more in benefits than they pay in taxes. If their required contribution is increased through proportionately higher taxes or higher premiums, beneficiaries in upper income levels are likely to contribute more than they receive in benefits. Cutler, David M. and Sheiner, Louise, "Generational Aspects of Medicare". Board of Governors of the Federal Reserve System Working Paper No. 2000-9 (2000). Available at SSRN: http://ssrn.com/abstract=223716 or DOI: 10.2139/ssrn.223716. RAND & NBER. "Does Medicare Benefit the Poor?" (Jan 5, 2005).

"low income." However, one expert believed that only the top 40% of beneficiaries in terms of income should be subject to income-related premiums.[5]

Several experts objected to and only a few supported "means testing" the program. Most people understand "means testing" to refer to some type of "welfare program" that would limit eligibility for those with income and/or assets above a certain threshold level. However, it is not clear exactly what was meant since at least one expert has characterized income-related premiums as "means testing."[6]

Most experts believed that *restricting beneficiaries' choice of providers* was a relatively acceptable and perhaps desirable trade-off. Some noted that choice is more a perception or myth than reality, given the limited ability of most patients to evaluate the quality of providers. Many agreed that, in concept, Medicare should be permitted to construct a preferred provider network that would service traditional FFS beneficiaries, although some are skeptical of Medicare's ability, in the near term, to effectively distinguish high-quality providers.

One expert suggested that it would be fair to restrict Medicare beneficiaries' choice of providers to the extent that the private sector has already imposed restrictions on choice of providers within the under 65 working-age population but that Medicare should not be more restrictive than the private sector.

At least two experts opposed the concept of converting traditional Medicare to a PPO network because of their view that part of the traditional Medicare program's "promise to its beneficiaries is that they should have the right to find providers with compatible philosophies about medication and treatment options.

One expert suggested raising the premiums for younger (65-67) beneficiaries to encourage them to continue working.[7] By contrast, most other experts shied away from suggesting increasing the age of eligibility for Medicare entitlement; it would do little to reduce program spending since, unlike Social Security which pays a steady income to beneficiaries of all ages, the youngest beneficiaries who are eligible based on age have lower spending, on average.[8] Several added their concern that the political cost of increasing the eligibility age would probably be high.

While almost all experts believed (for different reasons) that it is probably not feasible to reduce the age of eligibility for Medicare as an entitlement, most agreed that those age 55-64 should be permitted to "buy-into" Medicare for a fair premium. Some suggested that a younger age for "buy-in" might provide a political *quid pro quo* for raising the eligibility age. One suggested that Medicare should cover younger beneficiaries with

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[5] This suggests an income threshold of about $15,000 per year, since about 50% of beneficiaries over 65 had annual incomes above this level in 2005. (PPI analysis of CPS 2005 data.)

[6] Op Cit., Pauly.

[7] He did not suggest approaches that would result in the private market making health insurance available for those who do not work.

[8] One source has estimated that increasing eligibility from 65 to 67 would reduce Medicare spending by only 1% - 2% per year. Op. Cit. (Moon).

chronic conditions, such as diabetes, for which it could be shown to save money for the program over the long term. Others were reluctant to support this approach because of the likelihood that coverage for some conditions might improve quality of care and quality of life but at some cost to the program.

Several experts suggested that Medicare coverage should be limited and/or cost sharing increased for services of little or no value although one noted that such a limitation would hardly constitute a "sacrifice."

Some experts would reduce unnecessary and/or "futile" end-of-life care but not to the extent proposed by Colorado Governor Richard Lamm in 1984 when he reportedly said elderly people who are terminally ill have a "duty to die and get out of the way."[9] None offered concrete suggestions as to suggest how to identify and distinguish such care.

Several experts emphasized that sacrifices ought to be made by providers, such as being forced to accept some at-risk capitation or re-direction of Medicare reimbursement from specialists to primary care physicians. However, as indicated later, others viewed such reallocation efforts as problematic.

8. SPECIFIC POLICY ISSUES

In addition to the overarching issues discussed above, experts were asked to comment on a series of more specific topics.

Level Playing Field

What can be done to level the playing field between private plans and traditional Medicare?

Experts were nearly unanimous that Medicare should pay private plans and FFS Medicare providers comparable rates for comparable patients rather than subsidizing private Medicare Advantage (MA) plans with disproportionately higher payments. While one expert suggested that giving MA plans a financial edge was justified as a political decision, others expressed varying degrees of support for leveling the payment field primarily through mechanisms, such as risk adjusted payments. Some experts suggested that, to remedy the current problem of over payment or under payment, Medicare should remove payment floors and enter into risk sharing arrangements (a/k/a profit sharing) with private plans. This approach would allow the government to capture more of the savings that are realized by private plans.[10]

Some suggested that, in addition to payment subsidies, Medicare favors private plans through simpler design (i.e., a single Part C plan combines Parts A, B and D) and

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[9] Associated Press. "Gov. Lamm Asserts Elderly, If Very Ill, Have 'Duty To Die'." (Mar 29, 1984). Gov. Lamm has asserted that his remarks were misconstrued.

[10] Existing rules require private plans with below benchmark premiums to share 75% of premium savings with beneficiaries.

allowing active marketing of plans. Some experts were particularly concerned that biases that favor Medicare Advantage plans will undermine Medicare's traditional FFS program. For instance, Medicare Advantage plans that offer unmanaged fee-for-service care may offer benefits that are quite similar to those offered through supplemental Medigap policies when combined with traditional FFS Medicare. These private FFS MA plans combine the benefits of Parts A, B and D and frequently offer supplemental Medigap-type coverage, although copayments may be higher than available under stand-alone Medigap policies. In some areas, private FFS MA plans are offered for no additional premium cost to the beneficiary. In this case, any supplemental coverage that is included is paid for by taxpayers, rather than beneficiaries.

Experts were asked to comment on the Comparative Cost Adjustment (CCA) demonstration mandated by A to begin in 2010 under which traditional Medicare will compete with local private plans. This demonstration will be designed to test the efficiency of private plans against traditional FFS Medicare first, by requiring competitive bidding among plans on a local level and second, by adjusting Part B premiums up or down based on the average private plan bid. Most experts had either forgotten about this demonstration or said they assumed it would not take place, even though they conceded that the commencement date is rapidly approaching.

Improving Delivery

What measures hold the greatest promise for improving the delivery of care to Medicare beneficiaries?

There was a general view that increased development of and reliance on evidence-based medicine and practice guidelines would improve the delivery of care. Further discussion of this topic is included under the section on "improving efficiency" below.

Chronic Care Coordination - Many interviewees suggested that the program could benefit from improved care coordination for chronic conditions. While many did not have strong views or expertise in the area of care delivery models, a few were quite knowledgeable. While one seemed to think that care coordination offers the reasonable hope of cost containment, others observed that evidence of Medicare savings is lacking. However, others were less sanguine about its potential for cost containment. Some thought that care coordination models should be applied more widely to FFS Medicare than currently contemplated even if this were to increase program costs. The most commonly suggested payment mechanism for care coordination services was a monthly capitation fee per enrollee. However, there was general acknowledgement that reliable data are lacking both for determining which payment mechanism may work best and establishing the appropriate amount of payment.

Most experts expressed hope that one or more Medicare chronic care demonstrations that are currently in progress would prove successful in helping to answer these questions but not all were confident that, in their current form, the demonstrations would provide adequate, or even useful, information. Most suggested the need for additional research

and demonstrations in the area of chronic care coordination before a determination could be made as to which models will be most effective for which target populations. As one expert noted, based on current demonstrations, it will be difficult, if not impossible, to generalize about which approaches are most effective since no two demonstrations are alike.

Most experts believe that insistence on "budget neutrality" of chronic care coordination demonstrations will not allow optimal testing of potential applications.

Some suggested that Medicare Special Needs Plans (SNPs) may offer hope of improving quality of care for high cost, chronic care patients, but acknowledged that it is too early to make even preliminary determinations about the relative cost or quality of these plans. They also noted that SNPs have been made widely available without the benefit of any formal demonstration or evaluation program and that they may be over paid under the current methodology.

Medical Home - Only a few interviewees felt knowledgeable enough to comment on patient centered care. Those who did emphasized that a "medical home" is an integral, necessary part of the concept of patient centered care. However, this model has only recently appeared in the literature and has not been tested in Medicare. Some who advocate adoption of a "medical home" model envision that, in this relationship, the primary care provider would serve as the patient's educator, advocate and health care system navigator. Others see the medical home as a care coordination model that could be applied to small practice group through "virtual" electronic networks. At least one suggested that the primary care provider would manage all the care of patients in their medical home. Some experts suggested that a "medical home" should include a contractual agreement regarding the expectations and responsibilities of both parties. The expectation would be that providers might be more responsive to patient needs and patients might be more responsible/ accountable for their own care if they were to sign a written contract. While such a "contract" would not be intended to be legally enforceable, it might help clarify and focus both patients and providers on their respective roles and duties, such as compliance with appointment schedules, drug regimens, and life style changes.

Experts suggested a variety of payment arrangements for primary care providers who accept patients as their "medical home." Some suggested an add-on monthly capitation payment for each patient while others suggested that the primary care provider could be placed "at-risk" for as much as the entire amount of expected annual health care expenditures for each patient and would then serve as the payor for other providers, much like an HMO.

One expert suggested that Medicare should encourage "Concierge Care" as a means of compensating the primary physician for "partnering" with their patients to better navigate the health care system, enhance care coordination and improve patient understanding.[11]

[11] In theory, the primary physician could use this additional revenue to pay for "enhanced care coordination" which might include patient education, navigation, advocacy and electronic medical record

This approach would provide physicians with a monthly or annual fixed fee for each patient who selects the physician as their primary care coordinator.[12] In the context of selecting a primary care physician for care coordination or concierge care, most experts agreed that patients should be strongly encouraged not to change physicians frequently, either through a "hard" lock-in for a fixed contract period or through a "soft" lock-in using a variety of types of incentives that would tend to discourage "switching."

Health Manpower Policy – When asked whether more flexible health manpower policy might improve care delivery to Medicare beneficiaries, there was a widespread view among experts that we probably face or will face shortages in the non-physician workforce. Several suggested we need to increase the number of RNs, pharmacist, and nurse aides. Others would expand this list to include primary care physicians, geriatricians, dentists, nurse practitioners, and physical therapists.

There was mild disagreement among experts as to whether we face a physician shortage. Most experts believed there is an over abundance of physician specialists and that the geographic distribution of physicians is overly concentrated in urban centers. Generally, experts said that we probably need more primary care physicians. More than one expert suggested that physician shortage and allocation issues are unlikely to be dealt with effectively by competitive market forces. Several suggested that shifting the mix of primary care physicians vs. specialist could be accomplished by reallocating Medicare FFS payments to providers. However, others suggested that this approach was fraught with practical and political obstacles. One observed that, historically, the federal government has not been able to establish very effective work force policy.

One expert who was more sophisticated than most in the area of primary care effectiveness indicated that he would oppose wholesale reallocation of payments from specialists to primary care physicians because we simply do not know how to make such adjustments in a FFS context. He said the problem is not simply that financial incentives are not properly aligned (i.e., specialist are over paid) but that physicians lack reliable evidence-based data about effective primary care interventions. He suggested that (1) evaluation of high cost and/or high tech interventions will not produce evidence of effective primary care interventions which, instead, will require extensive, separately funded efforts and (2) even for clinical interventions that are proven effective, the only

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systems, as well as basic coordination with other providers. This model of concierge care is already in use by some physicians who ask private patients to pay their fee out-of-pocket. While the private pay model typically includes additional services, such as easier access and house calls, it offers no assurances that physicians will reinvest this additional revenue to improve their practice management and care coordination, rather than increasing their personal income.

[12] While CMS demonstration projects are in the process of testing whether this approach can improve care coordination for patients with chronic conditions and save Medicare money, these demonstrations involve large physician practice groups or non-practitioner organizations. Currently demonstrations have not been designed to test the viability or appropriate amount of direct Medicare payment for individual practitioners as care coordinators. In any case, the results of care coordination demonstrations are not yet available and, if and when Medicare decides to pay for care coordination, CMS is likely to insist on appropriate criteria to assure that additional resources are invested primarily in patient care, rather than increasing physician income.

way to save money is to target them at high cost patients and limit access by low cost patients, a strategy which he termed "morally bankrupt."

Graduate Medical Education (GME) - Most experts believed that GME should not be funded primarily by Medicare and that private sources should be required to contribute their "fair share." One expert indicated that most of the cost of medical school and residency training are born by medical students and residents so that Medicare's total payment for GME could be reduced by about 50%. More than one suggested that Congress should put "strings" on GME payments to require physicians to work in underserved areas during their residency.

Beneficiary Needs

In what ways can the program be more responsive to beneficiary needs and preferences, i.e., more patient centered? In what ways, if any, should Medicare beneficiaries be better equipped to participate in their health care? What is Medicare's role in achieving this?

Cost Sharing - Despite a general view that beneficiary cost sharing will increase (see Medicare Financing above), a number of experts drew attention to gaps in Medicare's benefits package. They suggested that it is "mediocre" and should be enhanced, especially for low income beneficiaries who are not eligible for Medicaid. While there were a number of suggested enhancements (i.e., improve coverage for mental health services; add coverage for long term care and dental services), many suggestions focused on "rationalizing" cost sharing by providing better financial protection with a catastrophic cap on out-of-pocket spending, at least for low and moderate income beneficiaries, combining deductibles for Parts A and B and reducing the attractiveness of Medigap policies. Several experts suggested that Medicare should adopt differential copayments and coinsurance depending on "clinical need." For instance, patients with chronic illness should face a lower copayment for drugs and follow-up care than low risk patients.

Medigap –Many experts suggested that Medigap insurance is a bad bargain, for both beneficiaries and the program. They indicated that the cost of coverage was relatively high compared with the benefits offered. Several experts observed that Medigap insurance contributes to over-utilization of traditional Medicare services by reducing the "demand" impact of Medicare coinsurance. They suggested that Medicare spending could be reduced by limiting the role of Medigap insurance, either by prohibiting Medigap policies which pay the Medicare coinsurance amount or by offering a competing Medicare-sponsored Medigap-type policy with lower premiums but with higher cost sharing than private Medigap policies. They suggested that beneficiary choices for Medigap coverage should be narrowed to provide meaningful alternatives since experts have found that too many consumer choices do not produce efficient competition among suppliers. In lieu of actually limiting benefit packages that plans may offer, either under Part C, Part D or Medigap, or restricting access to some providers, many experts suggested that Medicare should provide better information to beneficiaries about relative quality, price and "value" of options available. Some experts suggested

that a combination of improvements in Medicare benefits should be packaged and offered for an additional premium or, alternatively, as an entirely new option for comprehensive Medicare coverage, such as Part E.[13]

In more detailed remarks, one expert suggested that, if coverage offered by the standard Medicare benefits package is substantially limited due to reductions in the government's contribution, as he advocates, then an "individual mandate" should be imposed to require the purchase of private supplemental Medigap coverage by all Medicare beneficiaries with a subsidy for low income beneficiaries. Although he generally advocates free market solutions, he conceded that a private Medigap insurance market was unlikely to offer affordable policies for the elderly even if premiums were community rated. His solution to this problem would be to impose the individual Medigap mandate at age 20, rather than waiting until age 65, which rather resembles a tax.

Improve Beneficiary Information – Many experts suggested that Medicare should provide or encourage others to provide, more and better information about benefits, treatments options, and provider performance (i.e., both quality and cost). Some examples of information vehicles that were identified include provider report cards, independent personal counselors such as SHIP counselors, enrollment brokers, independent providers who are not engaged in service delivery, such as a nurse consultant, and the emerging concept of a "medical home."

Several experts pointed out that Medicare currently makes available substantial information on providers through its Medicare Compare website. More than one expert pointed out that much of the information offered by provider report cards, such as Medicare Compare, is not useful for assessing the cost or overuse of services, in part, because it is designed to measure under-use of services. Several suggested that Medicare should expand and refine the information available through the Medicare Compare website. For instance, while not currently available, Congress is considering requiring physicians to report quality indicators which could be included in published data. In addition, Medicare could require that, as part of the informed consent process prior to any invasive procedure, physicians disclose in writing the number of similar procedures they have performed and the outcomes.

Some experts pointed out that many types of data and information currently produced are not readily available to patients and purchasers or are not readily understandable. For instance, details of hospital accreditation reports produced by JCAHO remain confidential, settlements and malpractice awards reported to the National Practitioner Data Bank remain confidential, and disciplinary actions by state licensing boards are not widely reported.

One expert suggested that, rather than having the government develop and furnish information, Medicare beneficiaries should be provided with an "information voucher" in

[13] Davis, K, et al. "Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries." *Health Affairs*. (Oct. 4, 2005).

the form of an allowance which could be used to purchase relevant information and, thus, stimulate a competitive market for user-friendly information.

Improving Efficiency & Prudent Purchasing

What measures hold the greatest promise for improving the efficiency with which Medicare operates? What measures hold the greatest promise for improving Medicare's ability to function as a prudent purchaser and/or for introducing greater competition into the program?

Strengthen Government Oversight – A number of experts suggested that the federal government needs to play a stronger leadership role, in general. Several experts felt that, in the past, Medicare had served as a leader in health policy by adopting innovative and effective approaches to control spending and improve quality but that, more recently, Medicare has not been playing a leadership role due to under funding and lack of political leadership. For instance, one expert suggested a "turbo-charged" Agency for Healthcare Research & Quality (AHRQ, f/k/a Agency for Health Care Policy and Research) could require evidence of effectiveness as a condition for Medicare coverage. Others noted that, as originally conceived and developed, the role of AHCPR included a combination of (1) research on clinical effectiveness to identify what works and for whom and (2) development of clinical practice guidelines. They observed that these AHCPR missions combined relatively independent approaches to leverage federal funding, together with access to data and experts, to rapidly expand information available to improve efficiency and quality of care for providers, payors, patients, researchers and the public. However, in 1994, AHCPR was converted to AHRQ, its mission was substantially curtailed, and its funding was reduced as a result of political opposition to its activities.

Despite this experience, more than one expert suggested that the mission of AHCPR, as originally envisioned, presents an important model that government could use to improve quality and efficiency of Medicare and the health care system, in general. At least one expert suggested that the effectiveness of this model could be further improved by using "benchmarking" in an iterative, feedback process to rigorously test the guidelines, once developed, in clinical practice and apply the results to further refine guidelines and the target patient population to which they apply.

More than one expert suggested that the role of Congressional oversight over the emergence of new technologies in health care should be strengthened and offered the now defunct Congressional Office of Technology Assessment (OTA) as a model of how Congress might better fulfill this function.[14]

Reduce Congressional Micro-management – Several experts suggested that the Medicare program would function better if it were insulated from inappropriate congressional

[14] As an independent advisory agency, OTA was charged with assessing a range of new technologies from health and several other program areas. For over two decades, OTA helped Congress oversee its management of new technologies for the Medicare program and the health care system, in general. However, in about 1994, OTA was entirely disbanded by Congressional mandate.

micro-management. For instance, they suggested that, in general, CMS could operate more effectively if it had broader authority to exercise discretion and that better funding for CMS administrative and oversight activities would strengthen its cost containment capacity. More than one expert suggested that congressional micro-management has not given CMS adequate opportunity to implement cost saving measures that it has supposedly been delegated. For instance, CMS has authority to limit payments for durable medical equipment based on "inherent reasonableness" but has never been able to effectively exercise this authority, due to court challenges and congressional micro-management.[15] In another example cited by experts, CMS authority to conduct a competitive bidding demonstration for HMOs was blocked from implementation by congressional micro-management.

According to one expert, the problem of congressional micro-management has been aggravated by increased "transparency" (i.e., public visibility) in the coverage determination process and the addition of an appeals process which has favored manufacturers. He believes CMS has authority to make national coverage determinations based on limited clinical effectiveness but its ability to make these decisions objectively is often hampered by congressional micro-management.

Several experts suggested that congressional micro-management could be reduced by limiting the discretion of individual members of Congress to influence the policy process while emphasizing that Congress should still be able to set broad policy guidelines and be held accountable for overall program results. One expert suggested a Medicare Benefits Commission model, similar to the DoD Base Closing Commission (BRAC) or the Senate treaty approval process, under which the commission would formulate broad Medicare policy while Congress would only be allowed to approve or disapprove it, without amendment.[16] Another expert suggested the style of corporate governance of the traditional Medicare program could be changed to resemble a European model like the German health care system in which social insurance funds representing various segments of the insured population negotiate budgets with authorized provider associations without government interference. He also advocated this European model be adopted for the entire U.S. health care system.[17] A third expert advocated a free market approach to reducing congressional micro-management by privatizing Medicare through adoption of a premium support model which would delegate even more authority to private plans. However, another expert believes that there is little reason to expect Congress to restrain itself from continuing to rewrite the Medicare law, even after adoption of such a private market model.

Expand Evidence-Based Medicine – The experts generally believed that broader availability and application of "evidence-based medicine" could improve the efficiency and quality of Medicare and health care services.

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15 Inherent reasonableness gives CMS authority to adjust Medicare payments for Part B items and services when existing payment rates are "inherently unreasonable" because the market is not competitive.

16 "Restructuring Medicare for the Next Century" *Heritage Foundation*, June 16, 1999.

17 "Governing Medicare", *Administrative Law Review*, Winter 1999.

Experts said that more information and studies regarding comparative effectiveness (i.e., using head-to-head trials of comparable interventions, including drugs, devices and procedures) should be performed and disseminated in a form that is readily comprehensible to, not only providers and payors, but patients and the public. Some suggested that, for interventions that have been shown to be essentially equivalent, Medicare should pay only for the lower cost intervention, also known as the *least cost alternative*.[18] Adequate and reliable sources of unbiased funding for comparative effectiveness studies were less apparent. Some experts were skeptical that the federal government can or should be counted on for such funding because the Congressional appropriations process frequently produces results that are uneven and/or influenced by special interests.

When asked specifically about the role of cost effectiveness analysis (CEA) in Medicare, many respondents were circumspect, suggesting that CEA is an arcane, academic exercise that is subject to manipulation and, while it could be a source of useful information, should not be adopted by Medicare as a criterion for coverage decisions. However, several experts suggested that Medicare should adopt CEA as an integral basis for coverage determinations. Some pointed out that CEA is much more value laden and difficult to apply than comparative effectiveness which presumes essentially similar interventions as the basis for comparison without the need for interpersonal comparisons using such metrics as quality adjusted life years (QALYs). One expert suggested that, while CEA can be a very useful tool, Medicare and the health care system in general spend so much money on services for which the clinical effectiveness is either questionable or demonstrably lacking that he sees little reason to spend money and political capital on CEA. Instead, he said, we could more efficiently spend resources on testing the clinical effectiveness of services and adopting best practices. He believes that the results of studies on both clinical effectiveness and health system efficiency improvements need to be rapidly disseminated and adopted and that the task of information dissemination is a natural role for government to play through one or more agencies, such as CMS, AHRQ, NIH and PHS but that this function is not adequately funded or well organized.

Increase Use of Clinical Practice Guidelines / Reduce Geographic Spending Variations

Virtually all of the experts mentioned wide geographic variations in practice patterns and health care spending as strong evidence of inefficiency and poor quality in the system. Most experts believed that increased use of clinical practice guidelines could improve the quality and efficiency of care to the extent that such guidelines are available.[19] More than

[18] Experts did not address whether the higher cost item should continue to be Medicare reimbursable at the lower rate and, if so, whether, Medicare beneficiaries should be allowed to pay the difference to obtain the higher cost intervention if they want it. The alternative approaches of either excluding the intervention from Medicare coverage or prohibiting payment of the cost difference are likely to result in virtual extinction of many higher cost interventions.

[19] Studies on the impact of practice guidelines that were published by AHCPR during the 1990s suggested that the adoption of guidelines by providers resulted in substantial savings in most cases. Nash, David. "Reforming Medicare: Strategies for Higher Quality, Lower Cost Care." AARP Public Policy Institute, Pub # 9621 (Dec 1996). Of course, these findings may have reflected a bias in the services that were selected for development of guidelines (i.e., those viewed *a priori* as inefficient).

one expert suggested that clinical practice guidelines should be established and enforced for interventions for which clinical effectiveness criteria have been established, such as use of antibiotics, mammography screening, etc. Some experts suggested that the net effect on aggregate Medicare spending of increased use of clinical guidelines would be uncertain since it might reduce utilization in some cases while increasing it in others.

Some experts suggested that the use of practice guidelines, along with appropriate financial incentives and/or improved physician training, could be used to improve the efficiency of practice patterns even more effectively than any single approach.[20] However, there was disagreement among experts about the role of financial incentives in changing physician behavior. Some experts suggested that financial incentives undermine good practice patterns and suggested that, to increase their adoption rate, practice guidelines should be accompanied by other non-financial approaches to influence physician behavior, such as "academic detailing" (i.e., sending specially trained physicians to talk to their peers about specific behaviors) and continuing education.[21]

Allow Selective Fee-For-Service Contracting – Several experts suggested allowing Medicare's FFS program to engage in selective contracting like Medicare Advantage plans and commercial preferred provider networks (PPOs). These and other experts suggested offering incentives for beneficiaries, such as lower cost sharing when using preferred providers, to select more efficient, higher quality institutional and individual providers. They pointed out that lower patient cost sharing would reduce the need for Medigap insurance and might, indirectly, reduce Medicare utilization, in addition to directly reducing Medicare payments to preferred providers. Several experts recalled this PPO approach had been tried to a limited extent in demonstrations, such as Centers of Excellence for coronary artery bypass graft (CABG) surgery, and suggested that the chronic care coordination demonstration is a more recent example of this approach at the physician practice level.

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[20] Studies have shown that health care spending for comparable services vary by as much as two fold among different geographic areas, apparently due to variations in practice patterns. Researchers at Dartmouth have estimated that Medicare spending could be reduced by as much as 20% - 30% if physicians followed practiced patterns typical of those in the less expensive areas. Fisher, ES et al. "The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care." *Ann Intern Med*. 138(4):288-98 (Feb 18, 2003). Wennberg, JE et al. "The care of patients with severe chronic illness: An online report on the Medicare program." (2006). Available at http://www.dartmouthatlas.org/atlases/2006_Chronic_Care_Atlas.pdf.

[21] In addition, management tools, such as physician profiling and performance feedback, are likely to enhance adherence to practice guidelines. For instance, a pilot program, called the Independent Drug Information Service, financed by the Commonwealth of Pennsylvania, scans the medical literature for the best evidence on how to treat a given medical problem, boils it down into user-friendly packets of information and then sends nurses and pharmacists out to doctors' offices to recommend optimal treatments. The information provided is unbiased and non-commercial and the savings that result from more cost effective prescribing could more than cover the cost of the program. *New York Times* (Sept 16, 2006).

Bundle Payments - Several experts suggested wider use of bundled payments for combined Medicare services.[22] They suggested that Medicare could better control spending and improve efficiency further by implementing a similar bundled payment system for all post acute care services, regardless of setting, including skilled nursing facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs) and Long Term Care Hospitals (LTCHs). Some experts suggested that bundled payments that encompass both acute (i.e., hospital) and post acute care services could induce even greater efficiency.[23]

Similarly, some experts suggested that efficiency could be improved by bundling Medicare payments for physicians and hospitals for services that are typically delivered in the hospital setting, such as surgery and acute medical episodes (i.e., heart attack, stroke, CHF, pneumonia).[24] Experts said that such "piece-work" payment encourages over-utilization of both physician and hospital services, since it is the same physicians who control hospitalizations. If these physician payments were bundled into hospital payments, experts suggested that Medicare payments could be better controlled without adversely affecting quality of care. While such a system of bundled payments has been tested by Medicare in a demonstration for CABG surgery, it has not been tested for other procedures nor adopted for CABG surgery.[25]

Expand Access to Preventive Services – Some experts suggested that Medicare could save money at the same time as the benefit was improved by facilitating beneficiary access to preventive services. Some suggested waiving the Part B deductible and coinsurance for preventive and screening services, such as Hepatitis B vaccination, colorectal cancer screening, osteoporosis screening (i.e., bone mass measurement), prostate cancer screening, diabetes screening, glaucoma screening, a cardiovascular screening (i.e., cholesterol level).[26] One expert suggested that Medicare should cover smoking cessation at any age.[27]

Strengthen Fraud and Abuse Controls – Some experts suggested cost containment could be improved by tightening controls against fraud and abuse. For instance, one expert

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[22] For instance, Medicare currently uses a prospective payment system of bundled payments (a/k/a DRGs) for all services and supplies related to inpatient hospital episodes. Such bundled payments limit Medicare spending by fixing the amount of payment in advance and allowing providers to retain any savings they may realize, at least during the short term. Medicare usually attempts to recaptures some of these savings by reducing future payments.

[23] Neither a post acute payment system nor a broad based system bundling both acute and post acute payments have been developed or tested in the US.

[24] While hospital payments are currently bundled into a lump sum for each episode of care (i.e., DRG), physicians are paid separately for each visit or procedure (i.e., each surgical intervention, consultation and hospital visit).

[25] Such a bundled hospital and physician payment system might appear similar to a budgeted health care system like that used by the British National Health Service, although important differences would remain between these approaches. For instance, the Medicare payment system would be adjusted for changes in patient volume and case mix.

[26] Cost sharing has already been waived for flu and pneumonia vaccinations, mammography, pap smears, and pelvic screening exams.

[27] RAND has estimated that, if no beneficiaries entering the Medicare program at age 65 had ever smoked, Medicare would save about $8 billion per year. RAND; "Future Elderly Model"; (Sept 2004) pg 109.

suggested the Stark physician self referral ban has developed many "loop holes," such as the "in-office ancillary exception" for imaging, labs and therapy, and the exception for complete hospital ownership which has stimulated specialty hospitals. He suggested closing some of these loop holes to reduce unnecessary utilization and using recoveries and fines to increase funding for CMS operations and improve its administrative efficiency.[28]

Regulate New Health Care Spending – More than one expert suggested establishing a federal certificate of need (CON) program for technologies, as well as providers (i.e., facilities and practitioners). While acknowledging that state CON programs had significant limitations and that political resistance to a national CON program was likely to be intense, he thought that, if it could be established, such a CON program could effectively control Medicare costs.

Accounting - From a purely budgetary perspective, one expert suggested that the Medicare budget outlook could be improved by removing items that are not related to direct patient care, such as GME and DSH.

Improve Data Collection and Reporting - Most experts said that an important mechanism for broadly improving efficiency of the health care system would be to require providers and insurers to disclose more and better information.[29] Better data collection and reporting systems are examples of areas where experts thought the government could greatly improve efficiency and oversight, or at least, allow the private sector to manage the health care system more efficiently. While there is currently a great deal of emphasis placed on the potential payoff from adoption of electronic medical records and electronic decision support systems, the effectiveness of these systems commonly depend on well established, broadly based, integrated, data collection and reporting systems.

Some experts suggested merging electronic data that are routinely collected for other purposes from public and private sources, such as claims data from Medicare, Medicaid, private health insurers, and employers, into much larger data sets to identify more efficient patterns of physician practice and improve patient outcomes.[30] They suggested

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[28] Other approaches could be used to reduce incentives which, while they may not constitute outright fraud, still encourage program abuse in the form of over utilization. For instance, government guaranteed loans granted by the Small Business Administration (SBA), about $250 million per year, may encourage over utilization of imaging centers, ambulatory surgical centers, and surgical and specialty hospitals due to physician ownership of these facilities. Eliminating these categories of loans or requiring a demonstration of need for the facilities prior to approving such loans could reduce Medicare program abuse from unnecessary utilization of services.

[29] This principle is the basis for the Bush Administration's current health care "transparency" initiative. However, as currently formulated, this initiative is targeted only at private providers, such as hospitals and physicians, but seems to ignore the Medicare program, itself. For instance, CMS is not making available to researchers data on retail drug prices, except at the individual patient level through the Medicare Plan Finder website. CMS is also not releasing other types of information on Part D, such as plan complaints and appeals, which would improve competition and efficiency in the market place by providing beneficiaries with better information on which to base their plan choices.

[30] Such merged data networks are currently being advocated in a coordinated effort by CMS, AHRQ, and FDA with support from IOM.

starting with merged regional data bases that would integrate clinical, operational and payment data from all public and private payors to allow comprehensive monitoring of provider performance, as well as implementation of appropriate financial and non-financial incentive programs to improve efficiency and quality of care. One expert offered Massachusetts' recent experiment at universal coverage as a model that will include pooling regional payor data to identify problems and improve efficiency of provider practice patterns. They acknowledged that authorizing, organizing and funding such merged data bases on a broad scale will probably require significant involvement by the federal government.[31]

One expert suggested that we track trends in health care spending by disease category in order to provide a more detailed picture of the relative value of health care services both within and across disease categories over time. He said such data on reporting and tracking should include measures of population health in addition to spending, so that policy makers and the public will have a fuller picture of the benefits of health care spending.

Improve Part D - One expert suggested that Medicare would save money on the Part D benefit if CMS were permitted to negotiate prices directly with drug manufacturers. However, another expert who was an avowed skeptic of Part D suggested that private plans may actually be able to negotiate more effectively through competitive private markets than CMS which would probably be constrained by government pricing rules and be subject to political pressures.

CONCLUSIONS

While readers can draw their own conclusions from the discussion of expert interviews above, the authors would summarize the areas of greatest agreement as follows:

1. **Chronic illness** -- *Medicare should expand its use of chronic care coordination as quickly as feasible and test the "medical home" concept, at the very least on a demonstration basis, by paying qualified physicians and other practitioners an additional amount for managing and coordinating the care of fee-for-service patients with chronic conditions.*

2. **Medicare benefits –** *Medicare benefits should be restructured such that responsibility for catastrophic costs is assumed by the federal government and the need for Medigap policies is lessened. In addition, cost-sharing could be restructured to relieve beneficiaries from burdens that they are not in a position to avoid and to encourage utilization of services likely to prevent further illness.*

[31] While the emergence of such merged data bases raise a variety of concerns about health privacy, informed consent and access to care, with proper oversight, it should be possible to adequately address these concerns while increasing the statistical power and information available from such data bases.

3. **Utilization and value –** *The waste of Medicare resources, as evidenced by geographic variations in spending and quality, needs to be addressed.*

4. **Purchasing and management** – *Despite the political difficulties (both in terms of constituent opposition and ideological discomfort) inherent in a public agency adopting techniques that might be objectionable when practiced by private insurers, Medicare should adopt new approaches to purchasing.*

5. **Revenues** – *Medicare will require additional funding over the long term so new funding sources must be dedicated to the program in order to enhance public support and accountability. Additional Medicare financing should be obtained from sources that distribute the burden progressively. Dedicated funding requires a trust fund, which creates another set of political dilemmas.*

6. **Program Oversight** – *Mechanisms to reduce congressional micro-management in operational aspects of Medicare should be adopted in order to substantially increase its efficiency. However, Congress should continue to set broad policy guidelines and, ultimately, must remain accountable for the overall performance of the Medicare program. At the same time, increased funding for administrative and operational functions by federal health care agencies, particularly CMS, is necessary to increase administrative efficiency and effectively carry out their mission.*

7. **Evidence-Based Medicine** -- *The scope and intensity of information development necessary for the practice of "evidence-based medicine" through the Medicare program should be rapidly expanded under federal auspices. In addition, a Congressional office should be established with technical capabilities to provide assessment of health care technologies and practices.*