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WHAT MEDICARE'S ADVISERS ARE TELLING CONGRESS ABOUT MEDICARE REFORM

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Two key advisory boards for the Medicare program, the Prospective Payment Assessment Commission (PROPAC) and Physician Payment Review Commission (PPRC), have joined in the calls for Congress and the President to slow the explosive growth in Medicare spending. The annual reports of both official panels also shed light on the deficiencies in Medicare's complex system of price controls. In the case of PROPAC, there is a clear acknowledgment that the "dynamic process" works by shifting the rising costs of the Medicare program over to workers and their families in the private sector.

Created by Congress in 1983, the Prospective Payment Assessment Commission (PROPAC) advises Members of Congress and the Secretary of the U.S. Department of Health and Human Services (HHS) on Medicare reimbursement for hospitals and other medical facilities. Created by Congress in 1985, the Physician Payment Review Commission was charged with advising Congress on physician payment reform, and later with advising Congress on Medicare fee schedules for doctors. It also examines the related issues of patient access, utilization, and assignment policies.

In practice, PROPAC's main responsibility is to advise Congress on how to regulate hospital rates under the Prospective Payment System (PPS), Medicare's hospital fee schedule; the PPS is essentially a complicated price control system.[1] PROPAC currently is chaired by Stuart H. Altman, Ph.D., a professor of health care policy at Brandeis University and formerly a key adviser on health care policy to President Clinton.[2] The PPRC's main responsibility is giving advice to Congress on regulating the Medicare fees of doctors, in particular the administration of Medicare's Resource-Based Relative Value Scale (RBRVS),[3] in conjunction with standards governing the volume of

1 For a brief description of the Medicare PPS system, see Robert E. Moffit and John C. Liu, "A Taxpayer's Guide to the Medicare Crisis," Heritage Foundation *Talking Points*, September 27, 1995, pp. 26-29.

2 Professor Altman served on the President's health policy transition team before President Clinton was inaugurated in January 1993.

3 For a discussion of the Medicare fee schedule, see Robert E. Moffit, "Back to the Future: Medicare's Resurrection of the Labor Theory of Value," *Regulation*, Vol. 15, No. 4 (Fall 1992), pp. 54-63; Edmund F. Haislmaier and Robert E. Moffit, "The Medicare Relative Value Scale: Comparable Worth for Doctors," Heritage Foundation *Backgrounder* No. 732, October 25, 1989.

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medical services and limitations on billing. The PPRC is chaired by Gail Wilensky, Ph.D., of Project Hope, formerly the Administrator of the Health Care Financing Administration (HCFA) under President George Bush.

In its most recent report,[4] PROPAC outlines 26 separate recommendations governing various aspects of hospital payment and other features of the Medicare program. Most of these are technical and include detailed recommendations concerning payment schedules. The PPRC's 401-page report also makes numerous technical recommendations on various aspects of Medicare reimbursements.

But more significant are the panels' recommendations on general Medicare reform. These recommendations touch on Medicare's fundamental structure and financing, as well as the growth in overall Medicare spending. Specifically:

- ✓ **Both panels emphasizes the urgent need to control Medicare spending,** and PROPAC notes that despite partisan rhetoric, the White House and Congress are quite close in their targets for spending control;
- ✓ **Both call for giving beneficiaries more choices;**
- ✓ **Neither panel opposes medical savings accounts (MSAs),** in contrast with the White House; and
- ✓ **Both panels note the limitations and heavy costs** associated with today's Medicare price controls.

WHAT THE PANELS SAY ABOUT REFORM

Congress showed great political courage in attempting structural reform of the Medicare program. While that reform was vetoed by President Clinton, recent reports on the operating deficit of the hospital trust fund underscore the need for urgent action to contain costs and reorganize the 30-year-old program. Members of Congress should heed the Commissions' contributions to the reform debate, particularly on technical issues. Many of these are particularly helpful and may suggest ways of resolving some of the disputes between Congress and the White House.

Consider some key observations:

Observation #1: Both panels urge Congress to slow the growth in Medicare spending.

Says PROPAC: "The rise in Medicare spending threatens the solvency of the program's Hospital Insurance Trust Fund, its primary source of income. Moreover, it has been a major contributor to the federal budget deficit."[5] The Commission notes that between 1967 and 1993, Medicare spending jumped thirtyfold. Between 1980 and 1993, Medicare spending was climbing in excess of 11 percent per year. As the Medicare trustees noted last year, the Medicare hospitalization program, which already has run a deficit for the first time in 1995, is expected to go bankrupt in the year 2002 or possibly even sooner. The Medicare payment for physicians services, also known as Medicare Part B, while not facing insolvency, is taking an ever-larger share of general revenues to break even, rising from 49 percent of Part B income in 1972 to 72 percent in 1993.

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4 Prospective Payment Assessment Commission, *Report and Recommendations to the Congress, March 1, 1996* (Washington, D.C, 1996); hereafter cited as *PROPAC Report.*

5 *Ibid.*, p. 3.

Under current law, taxpayers are required to cover Part B expenditures automatically: "The growth in Part B Medicare spending, therefore, increases the federal budget and contributes to the deficit."[6] By 1995, Medicare spending reached $177 billion, an amount equal to 12 percent of the federal budget. By the year 2002, it will reach $332 billion, and Medicare, together with Medicaid, which covers the poor and the indigent, will equal approximately 27 percent of the federal budget: "[The Congressional Budget Office] points to the rapid growth in Medicare and Medicaid spending as the major factor driving up its deficit projections."[7]

Likewise, the PPRC says, Medicare's "growth has outpaced defense and social security, and today is second only to net interest payments on the national debt. And while Medicare expenditures are expected to continue accelerating at annual rates of 8.6 percent to 10 percent from now until 2005, rates of growth in federal outlays for other national priorities are expected to decline."[8]

PROPAC notes that the private sector has been more successful in recent years in controlling health care costs and recommends a similar slowing of Medicare costs: "Over time, spending for services furnished to Medicare enrollees should increase at rates comparable to those in a cost- and quality-conscious private sector."[9] Similarly, PPRC says, "recent data showing that private sector health spending is growing more slowly than Medicare expenditures have reinforced the view that greater discipline in spending is possible without threatening access or quality of care."[10]

Observation #2: PROPAC notes that the budget debate obscures a significant fact: Both the White House and Congress are relatively close in their efforts to slow the growth of Medicare spending.

Notes the Commission: "The annual increase in Medicare spending is similar in all proposals, ranging from 7.2 percent to 7.6 percent. The variation in total savings, however, is much greater due to differences in the growth of Part B premiums among the proposals."[11] If nothing is done to curb the growth in Medicare spending, the Congressional Budget Office projects that it will grow between 1995 and 2002 at a rate of 9.4 percent annually. Neither Congress nor the White House regards this rate of growth as acceptable. Under the Balanced Budget Act of 1995, enacted by Congress and vetoed by President Clinton, Medicare spending would rise at an annual rate of 7.2 percent.[12] President Clinton proposed a Medicare reform package that would have established an annual growth rate of 7.6 percent. A third proposal, offered by a coalition of members of the House of Representatives, would have set annual spending increases at 7.5 percent.[13]

Observation #3: Both panels agree that Congress and the President should give Medicare enrollees the personal and financial benefits of consumer choice and competition.

Says PROPAC: "Medicare beneficiaries should have a wider range of health plan options. Under the current program beneficiary choice is largely limited to the traditional fee for service program and, where available, an HMO option. Additional alternatives would let Medicare

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6 *Ibid.*, p. 15.

7 *Ibid.*, p. 17.

8 *Physician Payment Review Commission, Annual Report to Congress 1996* (Washington, D.C.: 1996), p. 3; hereafter cited as *PPRC Report*.

9 *PROPAC Report*, p. 4.

10 *PPRC Report*, p. 3.

11 *PROPAC Report*, p. 18.

12 As the Commission notes, the original congressional proposal was designed to save a total of $270 billion over a seven-year period, but that level of savings was revised downward to $227 billion. *Ibid.*, p. 17.

13 *Ibid.*

beneficiaries choose the type of plan that best meets their needs and would permit new beneficiaries enrolled in a particular type of plan before retirement to stay in that arrangement. In addition, more alternatives could increase plan competition for Medicare beneficiaries on the basis of additional benefits and quality."[14]

Congress's plan would have given enrollees a broad range of choice. PROPAC notes that the congressional "MedicarePlus would allow a broad array of managed care plans, including preferred provider organizations (PPOs) to participate. Fee for service plans also would be permitted. New options not widely available in the private market, such as medical savings accounts (MSAs) and provider sponsored networks, also could be offered to beneficiaries. All MedicarePlus plans would receive a capitation payment from Medicare."[15] PROPAC also acknowledges that the Clinton plan would give less choice to elderly Americans than the congressional plan: "The President also has proposed expanding the risk program, but the changes would be less comprehensive than those Congress has envisioned under MedicarePlus. Beneficiaries would be able to enroll in qualified PPO's and provider sponsored organizations as well as HMOs. Most enrollees would be able to join one of those plans only during annual open enrollment periods. Private fee for service plans and high deductible plans combined with MSAs would not be among the available options."[16]

PROPAC observes that the creation of a market-oriented Medicare system characterized by consumer choice and competition would encourage private organizations to promote and disseminate vital consumer information: "As the number of choices under Medicare increases either through the current program or expansions, private entities likely will begin distributing information about these choices to beneficiaries. Although this is appropriate, Medicare should not abandon its responsibility to ensure that beneficiaries receive unbiased, comparable and reliable data."[17] The Secretary of HHS, much like the Director of the United States Office of Personnel Management (OPM) in administering the consumer-based Federal Employees Health Benefits Program (FEHBP) for federal workers and retirees, could play an important role in providing unbiased plan information to Medicare enrollees, according to PROPAC: "The Secretary should continue efforts to identify the information beneficiaries need to make informed health plan choices and the most appropriate format for it. This is even more critical as health plan choices are expanded for Medicare beneficiaries. The Secretary should explore initiatives that would, for example, measure the satisfaction of beneficiaries who used services, describe total benefits available in an area (including those covered under insurance policies offered as supplements to Medicare) and document performance of individual providers within a plan."[18]

The PPRC similarly favors an aggressive information program for Medicare consumers on plan options in a reformed and modernized Medicare system, showing consumers costs and benefits, including the costs and benefits of enrollment in health maintenance organization (HMO) plans. Says the PPRC: "Plans should disclose information about the general nature of the financial incentives faced by providers who contract with a health plan."[19]

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14 *PROPAC Report*, p. 37.

15 *Ibid.*, p. 33.

16 *Ibid.*, p. 36.

17 *Ibid.*, p. 39.

18 *Ibid.* For a description of the role of both the Office of Personnel Management and private organizations and associations in providing information to active and retired federal workers and Members of Congress, see Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (Winter 1995), pp. 47-61.

19 *PPRC Report*, p. xx.

PROPAC recommends the expansion of Medicare's limited capitation program and patient choice: "The Commission supports reforming the Medicare captitation program to control spending while expanding beneficiary choice."[20]

Observation #4: Surprisingly, neither official panel comes out in opposition to medical savings accounts (MSAs). Both panels acknowledge that MSAs would provide additional choice for the elderly and note that most, though not all, Medicare beneficiaries choosing MSAs would benefit financially from their choices. The panels do emphasize that MSAs must be carefully designed.

According to PROPAC, "Most beneficiaries who selected the Medicare MSA option probably would benefit financially. Beneficiaries who did not anticipate using health services would be attracted to this option, because they would expect to keep unspent MSA funds."[21] The Commission notes that the effectiveness of MSAs in the area of cost control would be determined largely by the way they are designed. Specifically, senior citizens would likely be prudent purchasers of medical services if they saw the money in their MSAs as their own money and viewed anything unspent as personal savings. The MSAs must be designed as a savings vehicle. If they are improperly designed or presented, and if the elderly do not understand the money in the account to be potential savings, and not just an account for health services, the MSA could become a "spending plan" and, PROPAC notes, thus would "tend to reduce beneficiaries' restraint in purchasing health services."[22]

Another issue related to MSAs is the problem of adverse selection. Critics claim that MSAs would be selected mainly by healthy seniors, which could lead to a large increase in Medicare spending rather than a reduction. PROPAC says that the current risk adjustment mechanism in the Medicare system is inadequate to deal with the problem of adverse selection. This has consequences for MSAs. PROPAC suggests that in developing an MSA program, policymakers should scrutinize its design carefully, with special attention to the amount of funds deposited, the length of time before persons may disenroll, and the "features" of the high-deductible plan.[23]

There is strong opposition to MSAs among liberals in Congress, particularly in the Senate, and in the Clinton Administration. Thus, it is significant that PROPAC, which serves as an official advisory board for Medicare, does not oppose MSAs. Instead, PROPAC favors improved risk adjustment and says that "The likelihood that rates would better reflect risk would be enhanced if Medicare enrollees were required to remain in the MSA option at least for several years."[24]

Likewise, the PPRC recommends that "The enrollment and disenrollment rules of Medicare medical savings account plans should be structured to reduce the potential risk for risk selection. Examples of restructured rules include a minimum enrollment period of several years in an MSA or requiring beneficiaries to announce their disenrollment from an MSA one or more years in advance."[25] The PPRC calls for careful monitoring of risk selection and its impact on Medicare costs. Moreover, says the Commission, Medicare MSA plans should be on a level playing field with other plans. In this respect, it says, MSA plans should be held to the same standards as other plans in reporting data to Medicare. Moreover, there should be "no undue legal restriction of managed care plans' ability to offer this product."[26]

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20 *PROPAC Report*, p. 37.
21 *PROPAC Report*, p. 33.
22 *Ibid.*
23 *Ibid.*, p. 39.
24 *Ibid.*
25 *PPRC Report*, p. xxv.
26 *Ibid.*, p. xxvi.

Finally, the PPRC notes that the personal choice of an MSA plan is not, of course, a risk free option and estimates that 28 percent of Medicare beneficiaries probably would reach the $3,000 deductible limit that qualifies them for catastrophic coverage under the congressional Medicare reform plan.[27] Consumers therefore should fully understand the potential costs, including out-of-pocket costs. Thus, the PPRC recommends: "Medicare MSA plans should be required to disclose beneficiaries' typical (and potential) out-of pocket spending including exposure to balance billing. This information should be provided to beneficiaries in a uniform format so that they can easily compare insurers."[28] It should be noted that in the Federal Employees Health Benefits Program, health plan cost comparison data, including potential out-of-pocket costs, are made available routinely through private sources to Members of Congress, federal workers, and retirees during the annual "Open Season," the special time of year when these consumers pick and choose among a variety of health plans.

Observation #5: Both panels say that Medicare should improve risk adjustment mechanisms to reduce the problems of adverse selection and to control costs in the Medicare program.

In 1985, Congress established a "risk contracting program" under which health maintenance organizations (HMOs) would receive a per capita payment from Medicare for providing medical services to the elderly. Through this capitation system, Medicare beneficiaries would be able to enroll in these special HMOs and get extra benefits, while Medicare would be able to realize savings through a fixed payment. Today, about 8 percent of Medicare beneficiaries are enrolled in the program. The government's pricing system is inefficient and does not reflect market conditions. As PROPAC notes, "The program's capitation rates appear to be too high in some markets and too low in others, discouraging plan participation. Further, it appears that healthier beneficiaries are likelier than others to enroll, and the payment rates do not adequately reflect this lower risk of illness. Thus, Medicare may pay more for beneficiaries in its risk program than it would have had they stayed in the fee for service program."[29]

PROPAC argues that Medicare needs a better risk adjustment method in setting rates to reflect more accurately the differences among individuals in their use of medical services. Without this effective risk adjustment, especially if capitated plans and traditional fee for service plans are competing in a reformed system, the result could be higher-than-expected costs. PROPAC suggests that while no ideal risk adjustment mechanism exists, the Secretary of HHS should "implement interim improvements as soon as possible."[30]

In order to meet budgetary targets, Congress included a "fail safe mechanism" in the Medicare reform legislation last year. This would have meant automatic reductions in payments to doctors, hospitals, and other health care providers if specified budget targets were not met. The mechanism would rely on the existing apparatus of Medicare price regulations. With respect to this approach, PROPAC says, "Any fail-safe budget mechanism should include a more effective risk adjustment factor to ensure payment equity between the Medicare capitation and traditional fee for service programs."[31]

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27 *Ibid.*, p. 131.

28 *Ibid.*, p. xxvi.

29 *PROPAC Report*, p. 29.

30 *Ibid.*, p. 4.

31 *Ibid.*

Given its limited experience with managed care options, the PPRC agrees substantively with PROPAC on the issue of risk selection: "Although Medicare's per capita payment should be adjusted to reflect the risk mix of each plan's enrollees, current risk adjustment approaches capture relatively little of any biased selection across plans."[32]

Observation #6: Medicare's price controls have their cost.

The Physician Payment Review Commission is charged with advising Congress on how to pay doctors the "right price" for their professional services. Given the complexities of the cumbersome Resource-Based Relative Value Scale (RBRVS), this is an inherently formidable task. As the PPRC puts it, with classic understatement:

> In hindsight, however, physician payment reform has not been an unqualified success. In part this reflects inconsistencies within the policy that resulted from compromises made in crafting the reform. For example, distortions in relative values have been reintroduced owing to the existence of separate volume performance standards (VPSs) for different categories of services: surgical, primary care and non surgical. As a result, shifts in relative payments accomplished over the past several years will likely be reversed unless further legislative changes are made. In addition, some expectations about payment reform's effects may have been unrealistic given the underlying incentives of fee for service medicine. Despite progress in slowing the rate of growth in physicians services, for instance, overall Medicare expenditures continue to increase at a rate many consider unaffordable.[33]

If Medicare's price control regime governing doctors has not been an "unqualified success," neither has its system governing hospitals. Since 1983, Congress has imposed a complex system of price controls on hospitals called the Prospective Payment System. Under this system, hospitals are prospectively reimbursed for medical services; almost 500 of these medical services are grouped according to categories, each called a diagnostic related group (DRG), for which there are fixed payments. Hospitals may not charge more for the services to Medicare payments, nor may hospitals rebate funds to Medicare enrollees if they can provide a medical service more cheaply.

Over the years, the impact of the PPS/DRG system on inpatient care has been to reduce the rate of growth in Medicare's hospital costs. The economic incentives in the system have reduced the length of inpatient hospital stays, especially for older Medicare patients. Says PROPAC: "The rapid fall of Medicare length of stay may partially reflect a trend toward discharging some patients to post-acute settings earlier in the course of their treatment, representing a change in the hospital product. This has led to concern about how Medicare pays for patients who are discharged from PPS hospitals to inpatient post-acute care providers."[34] Price controls always encourage a shifting of resources from the controlled to the less controlled or uncontrolled sectors

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32 *PPRC Report*, p. xxxviii. PPRC further notes, "HCFA has developed approaches that use diagnosis data to predict beneficiaries' health care costs, and results suggest that these diagnosis based risk adjusters offer a significant improvement over current Medicare risk adjustment techniques. Alternatively, methods that would pay plans partly on a capitation basis and partly on a fee for service basis would also reduce overpayments and underpayments because of selection. As this work proceeds, data requirements and the need for testing and validation must be addressed." *Ibid.*, p. xxxix.

33 *Ibid.*, pp. 1-2. None of this is surprising. For a description of the inevitable problems of implementation of the RBRVS, see Robert E. Moffit, "Comparable Worth for Doctors: A Severe Case of Government Malpractice," Heritage Foundation *Backgrounder* No. 855, September 23, 1991.

34 *PROPAC Report*, p. 45.

of the economy. This, of course, invariably generates a demand for an extension of the price controls, an absurd process that distorts economic arrangements even more.

A clear example of hospital gaming has been the broader shifting of Medicare hospital costs since the inception of PPS to the private sector. Says the Commission: "During this period, hospitals generally were able to obtain the revenue they needed to cover additional losses from treating Medicare patients by cost shifting to private insurers. This was accomplished by obtaining payment increases from private payers that exceeded the corresponding cost increases. As a result, the average payment to cost ratio for private payers went from 116 percent in 1986 to 131 percent in 1992. Primarily because of cost shifting, hospitals were able to maintain fairly stable total margins, which reflect gains and losses from all payers as well as from non-patient care activities."[35] In other words, Americans with private insurance pay extra to offset the relatively low reimbursements received by providers from the Medicare program.

CONCLUSION

Medicare's official advisors have strongly reaffirmed the need to reform the Medicare system. This is welcome support for necessary changes in the program. Failure to enact reform means either huge future cuts in Medicare benefits for the elderly or huge tax increases on working families.

Medicare's advisory panels have argued forcefully in their reports that Medicare spending should be slowed, and that the failure to do so threatens Medicare's financial solvency and aggravates the federal budget deficit. But Medicare's advisers also have endorsed broader consumer choice while declining to oppose medical savings accounts (MSAs). Moreover, they have made constructive proposals in the technical areas of risk adjustment and information sharing for a modernized Medicare system characterized by consumer choice and competition. And, finally, they have been forthright in their description of the operations of the system's price regulations. PROPAC, in particular, has noted that price regulation of hospital services—long the official recipe for slowing down Medicare's rising costs—imposes its own costs on workers and their families in the private insurance market. Obviously, any "reform" of Medicare that relies on clamping down even more tightly on payments to hospitals and physicians will aggravate that cost shifting to the private sector.

The reports of these two commissions underscore the need for fundamental reform, and they indicate yet again that there is bipartisan support among experts for that reform.

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35 *Ibid.*, p. 46. Note the Prospective Payment Assessment Commission's description of cost shifting: "PROPAC views cost shifting as a dynamic process whereby changes in payments relative to costs for some payers are offset by changes for other payers. During the 1980's, increasing losses from Medicare, Medicaid and uncompensated care were offset by increasing gains from private payers." See "Notes to Chapter 3," footnote 3, *Ibid.*, p. 62.