


Medicare: Advancing Towards the 21st Century

This special issue of the *Health Care Financing Review* commemorates and celebrates 30 years of the Medicare program. It contains the articles presented at a symposium held in Austin, Texas, hosted by the Lyndon Baines Johnson Presidential Library and the Lyndon B. Johnson School of Public Affairs. With personal stories, as well as facts and figures, these articles document the enormous impact Medicare has had on the lives of beneficiaries, on providers of health care, and on American society as a whole. They look to the future and examine how the program may evolve as we enter the 21st century.

Few public programs in the history of the United States have brought as much benefit. Medicare meant access to health care coverage for millions of Americans who had none; it opened up our hospitals to people of all races; and it relieved some of the financial burden of health care, helping move many elderly out of poverty.

 Medicare was signed into law by President Johnson on July 1, 1965, in Independence, Missouri. The program was up and running a year later. President Harry Truman summed it up well at the signing of the Medicare legislation when he said: "These are the days that we are trying to celebrate for our nation's senior citizens. These people are our proudest responsibility and they are entitled, among other benefits, to the best medical protection available." For 30 years, the Medicare program has been operating under that assumption.

Today, more than 38 million Americans are Medicare beneficiaries. Since 1966, more than 79 million Americans have enjoyed the benefits of Medicare coverage.

It is only appropriate that Medicare is a major issue, right now, for both policymakers and the public at large. After all, Medicare is one of the most far-reaching and successful things our Government does, not to mention one of the most expensive. Recently, the discussion has taken on a special edge because of the wide publicity given to projections that the Hospital Insurance Trust Fund will be exhausted by 2001. However, it should be noted, particularly as we look back at the past 30 years, that the Hospital Insurance Fund, like the other Social Security Act trust funds, has in fact been in comparably bad shape before.

The projected rapid growth in spending by entitlement programs such as Medicare is widely viewed among policymakers, analysts, and the public as a very serious problem. This perceived problem has led to numerous calls for reducing growth in entitlement spending, through program reforms, means-testing, privatization, and other measures. Recently, for example, Congressional proposals to slow projected Medicare spending have been introduced in an effort to eliminate the Federal budget deficit. The focus, again, is on addressing the perceived problem that Medicare costs have been increasing too rapidly and are projected to continue to do so in the future.

The prevailing view, however, largely overlooks the most important fact underlying these concerns. Specifically, the high projected cost of entitlement programs reflects the growth in economic- and health-security needs that will arise as the population ages. In other words, the fundamental problem is attributable to demographic changes. Dorothy Rice highlights some of

these demographic trends in her article in this issue of the *Review*. What is clear is that this country's elderly and disabled Medicare beneficiaries will consume health care services that will need to be financed in some way. If Medicare is not available to pay for those services, and there are no other options, people will go without needed care.

In practice, both Medicare and Social Security are highly efficient in the provision of health care and retirement income. Administrative expenses for Medicare represent less than 2 percent of total program expenditures and the corresponding figure for Social Security is even lower. Thus, the future cost increases associated with these programs primarily reflect the growth in the number of beneficiaries, wage increases and inflation, and (in the case of Medicare) increases in the utilization and intensity of medical services. As such, the expected cost increases are attributable to the expense of providing *needed* health care services and retirement income for an aging society, and should not be viewed automatically as deficiencies.

As the Health Care Financing Administration (HCFA) thinks about the future of Medicare, we are not thinking solely about the budget deficit or even the Trust Funds. We look at Medicare not as a budget problem, but as a great solution to some of the pressing social problems of this age: the problems of poverty and illness among the elderly. We think about ways to strengthen Medicare through a carefully planned strategy that will take us into the 21st Century. Our goal is to make Medicare a more cost-effective purchaser of high quality health care that meets the needs of all our beneficiaries, especially the most vulnerable. We want to make Medicare a better program, not a lesser program. Some of these changes will come about through

Congressional action and some are already happening and will continue to happen within HCFA.

There are several major areas on which the current Administration is focusing its efforts, including (1) preserving and enhancing beneficiary choice, (2) modernizing Medicare, and (3) improving quality and payment for post-acute care.

Beneficiary Choice

A stronger Medicare means a Medicare which offers beneficiaries a wide range of choices to meet their health care needs, whether through managed care or fee-for-service care. While preserving and strengthening the fee-for-service program, we want to make a broader range of managed care delivery systems available than is currently permissible by statute.

Last year, HCFA announced the Choices demonstration project to demonstrate the benefits of offering a wider range of managed care options. The Choices demonstration will give us an opportunity to work with Provider Sponsored Networks and Preferred Provider Organizations (PPOs) and to test risk adjusters in certain markets. We also are seeking statutory authority to contract generally with PPOs, PSNs, and other alternative delivery systems that meet strong consumer protection standards.

Beneficiary choice also requires making more and better information available to beneficiaries in a timely way. Through our "HCFA Online" project, we are developing a range of communications techniques, from the most technologically advanced Internet messages to a revised set of publications in multiple languages. We also are engaged in systematic and continuing market research to better understand what information beneficiaries *want*, and how they like to receive it.

As we strive to expand beneficiary choice, we have taken steps to protect Medicare managed care enrollees. For example, HCFA has: implemented the Anti-Gag Rule policy to assure that beneficiaries have information about all the health care options appropriate for them; implemented the Physician Incentive regulation so that abusive financial arrangements between physicians and health plans will be prohibited and permissible arrangements more fully disclosed; taken the lead in setting quality standards for managed care through efforts such as the implementation of HEDIS for Medicaid and Medicare and our partnership with the Foundation for Accountability; and we also are planning to improve the managed care grievances and appeals process.

Modernizing Medicare

Over the past several years, private sector purchasers of health services have developed a variety of innovations in the way they pay for health services. It is ironic that HCFA, the largest purchaser of health services in the United States, has been shackled by outdated statutory payment provisions which prevent us from making similar adaptations to today's marketplace. These rules have limited our ability to pursue cost savings and quality.

HCFA's "Beneficiary Centered Purchasing Initiative" proposals, if approved by Congress, would give Medicare the authority to adopt the following payment methods which are currently allowable only as demonstrations:

*Centers of Excellence contracting, in which Medicare pays selected, high quality facilities a flat fee for all services associated with a given surgical procedure, such as knee replacement;

- Competitive Bidding, through which Medicare would set payment rates for non-physician Part B services such as medical equipment and laboratory services;
- Global Payment purchasing, in which Medicare would selectively purchase services directed at specific conditions or individual needs;
- Flexible Purchasing Authority, in which Medicare would be able to negotiate alternative administrative arrangements with providers, suppliers, and physicians who agree to provide price discounts to Medicare.

Improving beneficiary services is also critical to modernizing Medicare. Examples of these initiatives include: 24-hour, toll-free telephone access to highly trained individuals capable of helping with basic eligibility and reimbursement issues; and a Monthly Summary Notice, similar to a credit card statement, to replace the tons of paper now consumed by Explanation of Benefits notices. This notice would provide beneficiaries with the status of all claims, include health reminders about health needs such as flu shots and mammograms, send alerts on supplier scams and other fraudulent activity, and eventually coordinate fully with medigap and primary payer coverages.

As we improve the Medicare program, we are cleaning up after years of insufficiently aggressive management. In 1994, the Secretary of HHS and the President, in launching the anti-fraud and abuse campaign known as Operation Restore Trust, declared "zero tolerance" for fraud. HCFA has developed parallel initiatives to achieve our goal of ending the practice of "paying and chasing" in favor of paying right the first time. We have developed standards for all providers, and now have a system to gather and verify provider information prior to dispensing a Provider Identification

Number. Our anti-fraud initiative has been further strengthened by the Health Insurance Portability and Accountability Act which gives Medicare greater flexibility in contracting for program integrity work.

Medicare Post-Acute Care Services

This year, Medicare will spend more than \$30 billion on post-acute services, despite serious questions about the effectiveness and appropriateness of those services in meeting the needs of our beneficiaries. Judith Feder and Jeanne Lambrew look at some of these expenditures in their article in this issue of the *Review*. It is past time for Medicare to have a long-term care policy.

At HCFA, we are laying the foundation for a more rational long-term care system, starting with Medicare post-acute care services. The model we are developing for post-acute care is one in which payment, care-planning, quality assurance, and program monitoring will be driven according to the individual beneficiary's needs. This system will build on current assessment and tracking tools, such as the Uniform Needs Assessment Instrument (UNAI), the nursing home Minimum Data Set (MDS), and the Outcomes and Assessment Information Set (OASIS) for home health care, to evaluate beneficiaries' functional and medical needs to permit case-mix adjusted payments. The integrated approach to patient assessment also will give providers in different settings more

information about a beneficiary's previous medical and health history to better plan and manage patient care, and give us all the tools for better quality assessment and monitoring.

All of these activities—expanding beneficiary choice, modernizing Medicare, and rationalizing Medicare post-acute care—are central elements of a strategy to improve and strengthen Medicare for future beneficiaries.

The articles presented in this issue of the *Review* comprise an important resource that can be used to understand the history and impact of the Medicare program. It is critical not to lose sight of the influential role the program has had on this country's health care system, and the benefits it has brought to all our citizens. Prior to the symposium at the LBJ School of Public Affairs, I received a letter from Congressman Charles Vanik, who was a member of the Ways and Means Committee that helped send the Medicare legislation to President Johnson, expressing his regrets that he could not attend, and sharing some of his thoughts on the subject: "I tell my young friends that three generations of Americans were spared the awesome task of taking care of their parents so that they could concentrate on the care and education of their children. The security of the elderly and the health of the American people should be built on the experience and the foundation provided by Medicare and Social Security." How right he is.

Bruce C. Vladeck, Ph.D.
Administrator