

How Medicare Does and Should Shape U.S. Health Care

So what we are trying to do, first of all, is say, “Okay, here is a government monopoly plan. We’re designing a free-market plan . . .” Now we didn’t get rid of it [the “government monopoly plan,” Medicare] in round one because we don’t think that’s politically smart and we don’t think that’s the right way to go through a transition . . . But we think it’s going to wither on the vine, because we think people are going to voluntarily leave it.

—*Newt Gingrich, Speaker of the House of Representatives (1994–98),
in a speech to a Blue Cross Conference, October 24, 1995*

The pricing practices of the medical industry depart sharply from the competitive norm . . . It is clear from everyday observation that the behavior expected of sellers of medical care is different from that of business men in general. These expectations are relevant because medical care belongs to the category of commodities for which the product and the activity of production are identical. In all such cases, the customer cannot test the product before consuming it, and there is an element of trust in the relation. But the ethically understood restrictions on the activities of a physician are much more severe than on those of, say, a barber. His behavior is supposed to be governed by a concern for the customer’s welfare, which would not be expected of a salesman.

—*Kenneth Arrow, recipient of the 1972 Nobel Prize in Economics*

Prospective payment approaches in Medicare represent an important story of success. Although often derided by free market advocates—such as the editors of the *Wall Street Journal*¹—as imposing an ineffectual “Soviet-style bureaucracy” by applying arbitrary and rigid price controls on the health care system, in fact, Medicare has successfully helped shape U.S. health care by converting inflationary cost- and charge-

based payments into prospective payments based on predetermined rates. In most cases, these new payment systems have provided important incentives for economizing on care, while at the same time permitting Medicare beneficiaries access to virtually all the clinicians and institutional providers in the market.

Medicare's administrative prices may not be the prices that would be set by a well-functioning market. But as Kenneth Arrow has persuasively argued, we do not want to try to subject health care to the invisible hand of the market.² We want physicians and other clinicians to act not as marketplace sellers of services to wary consumers, but as trusted professionals with a duty to serve patients' best interests.

Victor Fuchs, the dean of American health economists, made the same point in arguing not only that the conditions for market competition do not exist in health care, but also that—even if the necessary market conditions were present—there is something fundamentally different about health care: “The production function for health is a peculiar one; it usually requires patients and health professionals to work cooperatively rather than as adversarial buyers and sellers. Mutual trust and confidence contribute to the efficiency of production. Thus the model of atomistic competition usually set as the ideal in economics textbooks often is not the right goal for health.”³

Although Internet access permits some individuals the opportunity to learn about illnesses and the performance of providers at their leisure, persistent information asymmetries between providers and patients continue to make the idea of a well-functioning market in health care unlikely. That is, the patient cannot really be a wise and prudent shopper for services because she is dependent on the vendor—in this case, the physician—for specialized information on which to base decisions that the physician has acquired through many years of training and clinical practice. Moreover, a lot of health care does not take place at anyone's leisure. Rather, health problems may arise at times and under circumstances when individuals must question but ultimately trust the judgments of the professionals they have selected—acting as patients, not consumers.

Surely, health care needs to deemphasize reliance on often paternalistic physicians oblivious to the particular preferences and needs of the individuals they are caring for. However, this reorientation should promote patients' sharing decision making with professionals, not taking it over altogether.⁴ The vision promoted by some market advocates—especially those promoting so-called consumer-directed health care (CDHC), in which patients are empowered to become wary consumers carefully navigating a retail marketplace of health care providers who need to promote their own services through aggressive marketing—is not one we endorse.

Due to the potential high costs associated with a sudden illness and the cumulative high costs of chronic conditions, our society wants the protection that third party

insurance provides. Admittedly, broad insurance protection against health care costs creates what economists call “moral hazard,” the natural tendency of individuals to spend more of someone else’s money than their own. Some would seek to address this by decreasing the essential role of health insurance. New insurance products, built on tax-advantaged medical savings accounts (MSAs), impose large deductibles and significant co-payments at the point of service to encourage patients to “take more responsibility for their choices.”⁵ Yet patients, especially older and disabled persons with serious chronic health conditions, are naturally reluctant to give up the economic and psychological security of good health insurance coverage in exchange for more control over how their money is spent. Rather, they want the payers—in this case the Medicare program—and the providers to determine how best to moderate health care cost increases.

Not only, in our judgment, is the public not interested, willing, or able to become the same kind of prudent shoppers for health care services that they are when purchasing cell phones and airline tickets, but the CDHC model will not actually restrain costs very much, because of the uneven distribution of health care spending among the population. Certainly, higher cost sharing might lead a weekend sports enthusiast to defer obtaining a physician-recommended MRI for recurring knee pain, a prototypical example of supposed wasteful health care spending that might be reduced if the person faced the MRI costs directly without health insurance. And health care costs might be reduced somewhat (but so might be the person’s physical and emotional well-being.) Yet, in health insurance programs both public and private, the most costly 20 percent of patients account for 80 percent of health care spending.⁶ Many of the patients who generate high spending have one or more persistent, advancing chronic conditions and, therefore, have annual costs far in excess of what any insurance plan would impose in out-of-pocket expenses.

Thus, turning patients into price-wary consumers will not save the system much. Studies continue to document the excessive, and probably wasteful, spending associated with the care of patients with multiple chronic conditions and those in their last year of life.⁷ Yet insurance products that reasonably provide financial protection—with limits on deductible and annual out-of-pocket spending limits—serve the purpose insurance was designed for, leaving patients cost-unconscious once they reach the deductible or the out-of-pocket spending limit.⁸ Although full insurance coverage surely does produce some excessive spending, as noted, for those who most depend on it, insurance protection provides needed comfort. If anything, Medicare’s basic benefits should be expanded, not only to fill in the donut hole in the new prescription drug benefit, but also to provide better catastrophic coverage, which non-

poor beneficiaries now obtain only if they are fortunate enough to have retiree supplemental coverage or can afford to purchase a supplemental Medigap policy.⁹

Should Medicare Be Allowed to Wither on the Vine?

In contrast to the consumer-directed health care approach—which would minimize the role of insurance and create more traditional retail markets like those that exist in most other sectors of the economy—Alain Enthoven, a Stanford health economist, has long proposed a markedly different, market-based model of health system reform, one that he has called “managed competition.” The approach relies heavily on group purchasing, competition among an array of private health plans, and restructuring of the health delivery system into organized, integrated delivery systems,¹⁰ which involve the incorporation of large physician group practices with hospitals and other providers into single organizations with the size, scope, and mission to better manage care across a continuum of services that patients need. Kaiser Permanente exemplifies the kind of system that Enthoven wants to see promoted nationally.¹¹ This prescription specifically rejects relying on retail consumer markets where individuals choose among competing professionals and other providers at the point of service.¹²

In the context of the future of Medicare, one can plausibly argue that managed competition makes good policy sense because private health plans are better positioned than a national Medicare program to respond to both the geographic diversity in the preferences of patients and providers and to the particular circumstances that characterize the local markets where health care is delivered.¹³ We are sympathetic with managed competition’s particular vision for reorganizing health care around integrated health care delivery systems. And although some social insurance advocates would disagree, we think that strictly regulated competition among private plans can be made compatible with the basic principles of social insurance.¹⁴

In fact, in some ways, the Medicare environment may be better suited to Enthoven-style managed competition than are private insurance markets. For example, in contrast to employers that typically do not offer a choice of all eligible health plans and do not make equal, fixed-dollar contributions to the employee’s chosen plan, Medicare Advantage provides a choice of all eligible plans and makes a fixed government contribution to plans who submit bids in relation to that contribution. It also adjusts the payments to health plans based on the underlying health status of enrollees. These and other elements of Medicare’s approach to private plan contracting is closer to Enthoven’s approach to competition than currently is present in commercial markets.¹⁵

Unfortunately, although managed health plan competition in Medicare, where there is a competent buyer of services able to shape the competition among the private health plans, might work in theory, as we detailed in Chapter 7, it would very likely fail in practice. And if it can't work in Medicare, it surely won't work for the entire health care system. As Victor Fuchs—who was clearly sympathetic to Enthoven's call for health system restructuring based around health plan competition—documented, the basic conditions for desirable competition do not exist in health care.¹⁶

In many ways, the competitive situation is even worse today than when Fuchs was writing in the 1980s. As providers have learned that contract negotiations with plans over prices are crucial to their financial well-being, they have engaged in various activities to buttress their negotiating strength that, among other things, permits them often to cost shift to private payers when Medicare reduces its prices. Hospitals have consolidated through mergers and acquisitions, and physician specialists have consolidated into larger medical groups, providing hospitals and many physicians the opportunity to exert market power over health plans to push prices up.¹⁷ Contributing to the imbalance in negotiating leverage, hospitals have less excess capacity of hospital beds and fewer physicians have openings on their appointment schedules.¹⁸ At the same time, health insurers have consolidated extensively and are currently enjoying the extraordinary profitability associated with the near-monopoly status they have achieved in many regions throughout most of the country.¹⁹ These and other worsening barriers to efficient market outcomes have led to increased doubts that even well-structured and appropriately regulated market competition among fewer and fewer (but also larger and more profitable) health plans would be able to accomplish the ambitious and laudable goals that market competition advocates have proposed.

The reality is that the admittedly cumbersome Medicare program uses its governmental authority to get better prices than private health plans are able to obtain in most, but certainly not all, local health care markets.²⁰ And although private plans theoretically can do a better job than the traditional Medicare program in restraining the use of services (which, when multiplied by applicable prices, determines program expenditures), in fact, these plans have not done a better job in limiting cost increases than the traditional Medicare program. Over the long term, the rates of growth in per capita spending for Medicare and private insurance have been remarkably similar.

When comparing spending for benefits that private insurance and Medicare have in common—notably excluding prescription drugs—Medicare's per enrollee spending grew at a rate that was about one percentage point lower than that for private insurance over the 1970–2002 period.²¹ This should not be surprising since both pri-

vate insurance and Medicare have been essentially passive payers of what providers determine is needed for patients.

Medicare has done a good job holding down cost increases through prospective payment, but for the most part has not been allowed to proactively address the ever-increasing volume and intensity of services. Having mostly abandoned their managed care tools in the face of the public backlash,²² private plans have even less ability to actually manage costs than does traditional Medicare, which at least has market power as the health care system's largest payer. With the recent migration of insured individuals from HMOs to PPO products whose predominant function is to obtain price discounts from providers but who are not as successful at doing so as Medicare is, even the theoretical advantages of private plans over the traditional Medicare program are disappearing.²³

Except for group- and staff-model HMOs such as Kaiser Permanente, commercial health insurance plans now function much as Medicare, but with no ability to mandate reasonable payment rates. Private plans also have much higher administrative costs and need to make profits to satisfy stockholders and provide often outrageously exorbitant executive salaries.²⁴ As we showed in Chapter 7, private plans need to spend more than the traditional Medicare program does in order to make serving Medicare beneficiaries a profitable business proposition. The evidence of private health plan failure has not deterred the Republican Party, which for more than a decade has been attempting to dismantle the traditional Medicare program. Newt Gingrich explained a decade ago that the goal was to have Medicare "wither on the vine,"²⁵ by which he surely meant the traditional Medicare program, with its "Soviet-style bureaucracy" that relies on price controls.

Medicare has long paid a little more to private plans than it would pay in traditional fee-for-service Medicare, but the Medicare Modernization Act now has it paying private plans much more.²⁶ The MMA's architects apparently hope that over time these overpayments will lead beneficiaries to seek out the additional benefits that private plans will be able to offer. For example, private plans are able to use the extra funds they receive to decrease enrollee's out-of-pocket expenses, provide additional benefits for prevention services, provide good catastrophic coverage, and enhance the rather meager prescription drug benefits that are available to beneficiaries who remain in the regular Medicare program. With the higher payments plans should be able to offer providers, they might also hope providers will steer their patients into the private plans, because the providers will receive higher reimbursements from the private plans than from traditional Medicare. Consistent with Gingrich's strategy, such an approach would lead to traditional Medicare's demise, not through an explicit

political decision that—given Medicare’s enormous popularity—would be very difficult, but rather through the decentralized and diffused decisions of beneficiaries and providers making choices on an unlevel playing field decisively tilted in favor of private plans.

Medicare Shapes Health Care Markets

Conservative rhetoric notwithstanding, Medicare’s payment levels are not arbitrarily set by a large government bureaucracy impervious to the needs of patients and providers. Instead, Medicare’s prices attempt to reflect the underlying costs providers bear for caring for Medicare beneficiaries. Congress, counseled by its Medicare Payment Advisory Commission, attempts to have Medicare pay “the approved costs in full that are incurred by efficient providers when they offer necessary and appropriate care to Medicare beneficiaries,” according to Robert Reischauer, vice-chair of MedPAC. “What this means, in short, is that Medicare should not consider the level of payments relative to costs that other purchasers are paying providers. It should set rates as if it were in a sense the only payer.”²⁷ This discipline generally leads to fair, if sometimes inflated, payment levels. As part of the goal of assuring fair payments, MedPAC and others continually conduct beneficiary surveys and collect other data to assess whether payment levels continue to support adequate beneficiary access to care.

The only major exception to the general proposition that Medicare should pay the costs for its own beneficiaries are the explicit subsidies Congress provides for two hospital sectors whose missions often overlap—teaching hospitals and hospitals that constitute the nation’s safety net for the uninsured—through financial support of the education of thousands of hospital residents-in-training and special financial supplements to so-called disproportionate share hospitals serving the poor.²⁸ And although a less explicit consideration, when budgetary conditions permit, Congress may sometimes pay extra to assure the solvency of important community health care resources.²⁹

Even the United States Supreme Court recently weighed in on whether Medicare payments are designed solely to pay the costs of care for Medicare beneficiaries or to be a primary financial support for providers. In 2000, in a criminal fraud case, *Fisher v. United States*, the Court considered whether participating hospitals should receive actual “benefits” from the Medicare program and not merely compensation for services rendered.³⁰ The Court concluded, in a 7–2 decision, “We do not accept the view that the Medicare payments in question are for the limited purposes of compensating providers or reimbursing them for ordinary expenditures . . . The payments are made not simply to reimburse for treatment for qualifying patients but to

assist the hospital in making available and maintaining a certain level and quality of medical care, all in the interest of both the hospital and the greater community.³¹

So far the Court's dictum, which was provided on a case unrelated to the generosity of Medicare's actual payment rates, has not been invoked to challenge payment policies that pay providers only for their "ordinary expenditures," perhaps because Congress has been relatively generous with Medicare provider payments. Because it must assure acceptable quality care for beneficiaries, Medicare needs to take into account the financial well-being of providers, a consideration to which the invisible hand of a marketplace would be completely indifferent.³²

For example, current payment policy favors the preservation of small, rural hospitals that are viewed as important community resources in rural communities, both as major employers and as part of the basic health care delivery systems in these areas.³³ Thus, Medicare's payment approach has been highly successful not only in paying for the costs of care provided to Medicare beneficiaries, but also for providing important financial support for the nation's health care infrastructure.

In addition, the 1997 Balanced Budget Act demonstrated that imposing relatively modest limits on provider payment increases can generate a substantial reduction in expenditures (at least for a few years). The so-called giveback bills that returned some of the unanticipated savings to hospitals and certain other providers may suggest to some that the cuts were excessive, but no one has shown that Medicare beneficiaries experienced lack of access to needed care or received reduced-quality care. In short, administratively determined, prospective payment can be an effective tool for controlling costs. What is at issue is whether Congress has the political will to apply the tools to control costs for the long term.

The United States spends much more on health care than other developed country, not primarily because more health care services are provided but because we have a more expensive health care enterprise, with more personnel who receive higher wages relative to their counterparts in other industrialized nations.³⁴ Consequently, high prices are driving spending, and Medicare's success in converting payment to prospectively set rates is an important strategy in controlling health care spending. Again, in most local health care markets, Medicare's prices are lower than those of private purchasers and health insurance plans.

Medicare's ability to impose prices on providers derives from the fact that it is a dominant payer, but that dominant position also tempers Medicare's use of its market power. Because relatively few clinicians and institutional providers can afford not to care for the program's beneficiaries as patients, Medicare could probably get away with driving rates down below what a well-functioning marketplace would produce. After all, hospitals, home health agencies, inpatient rehabilitation hospitals, the part

of the nursing home industry that provides skilled nursing, and other providers and suppliers would be out of business without Medicare revenues. But Medicare has an interest in assuring access to needed services for the beneficiaries it serves; correspondingly, it has no interest in abusing its position of market power to the detriment of its beneficiaries and the delivery system.

Even now, when Medicare tempers its market power by tying its payment rates fairly explicitly to estimated provider costs, some medical providers try to cost shift to other payers and, as we demonstrated earlier, often succeed. Indeed, because of the possibility of cost shifting in what can euphemistically be labeled our “pluralistic” health care system, Medicare’s discipline in restraining payment increases does not necessarily guarantee that the health care system as a whole restrains overall cost increases. But the reality of cost shifting, due in part to noncompetitive private health care markets, is not Medicare’s fault.

Some are concerned that aggressive price cutting by Medicare would lead providers to view Medicare beneficiaries as second-class patients, a concern that motivated the failed efforts by the Carter administration to impose all-payer hospital cost limits. Although there have been suggestive anecdotes, so far there is no evidence that providers are turning away Medicare patients or subjecting them to second-rate care. MedPAC has looked closely at surveys of Medicare beneficiaries’ ability to access physician services and of physicians’ willingness to serve Medicare patients; it concluded that beneficiary access to physicians remains good overall.³⁵

Medicare’s Problematic Relationship with Physicians

The current problems faced by Medicare’s prospective payment system for physicians illustrate a number of challenges for Medicare payment policies. As emphasized in Chapter 5, Medicare spending for physician services is supposed to be restrained by an expenditure limit, initially called a “volume performance standard” and replaced in the 1997 BBA by the “sustainable growth rate.” The SGR formula ties physician payment rate updates to a number of factors, including growth in input prices for goods and services used in physician practices, the effects of laws and regulations on the kinds of services physicians provide, the growth in enrollment in the traditional Medicare program, and the growth of physician services in relation to growth in the national economy as measured by the gross domestic product. Remarkably, the GDP linkage was an attempt to determine how much volume growth in physician services society can afford.³⁶ It is the only part of Medicare that attempts to formally limit spending by linking it to the contemporary state of the economy rather than to more relevant measures of inflation that medical providers face.³⁷

The basic SGR mechanism compares actual Medicare Part B spending to a spending target calculated through the SGR formula and then adjusts the annual payment update accordingly.³⁸ If Medicare spending for physician services remains on target, the annual increase in physician fees is set equal to the estimated change in physicians' cost of providing care—that is, the change in the Medicare Economic Index, which measures input prices for the resources physician practices use to provide services. However, if the growth in the volume and intensity of services is high enough that Medicare Part B spending exceeds the SGR target, future physician fee increases will be lower than the MEI. And if the gap is wide enough, Medicare's fee update may even be negative, producing fee reductions (as occurred in 2002, when physician fees *decreased* by 5.4 percent).³⁹ Conversely, physicians receive fee increases exceeding the MEI if actual spending is less than that set by the SGR target.

Although the growth in physician volume slowed significantly during the 1990s, following the initial imposition of the VPS,⁴⁰ the situation changed dramatically thereafter. Since 2000, spending has remained above the target in large part because the growth in the volume of services has been greater than the growth allowed by the SGR. From 1999 to 2003, growth in volume of physician services per beneficiary averaged about 5 percent per year. By contrast, the allowance in the target for volume growth—driven mostly by the trend in growth in real GDP per capita—was only about 2 percent.⁴¹ That volume growth, however, pales in comparison to what happened in 1994. In a 2005 letter to the chairman of MedPAC, the Centers for Medicare and Medicaid Services described unprecedented volume increases in physician services. CMS found that expenditures for physician services had increased 15 percent in 2004 due to increases in the volume and intensity of services.⁴²

The services that displayed rapid growth were discretionary ones that do not involve significant potential risk to patients, and therefore can be ordered and provided with relative impunity. The costs from unnecessary use of services are the only major problem for beneficiaries and taxpayers, and do not affect the physicians, who actually benefit from increased revenues. The main sources of these spending increases were payment claims for longer office visits and increased provision of laboratory, radiology, and other tests. For example, the number of claims submitted from the service category labeled “advanced imaging” (CT, MRI, and PET scans) increased 25 percent in just one year.⁴³

Based on Medicare's SGR formula, physicians would have received an estimated 4.3 percent reduction in 2006. However, as it did for 2004 and 2005, Congress in the Deficit Reduction Act of 2006 prevented the formula-driven reduction, freezing 2006 payments at 2005 levels but not raising the spending targets.⁴⁴ The reduction would have been even larger based on the 15 percent physician spending increase, but there

is a limit on how much the physician spending update rate can be cut in any one year.⁴⁵ Nevertheless, the deficits from SGR-allowed spending are cumulative, affecting future years' spending. In other words, excess spending that is not offset in one year accumulates in succeeding years until it is recouped. With Congressional temporizing to fix the SGR mechanism, the CMS Office of the Actuary has projected physician updates of about -5 percent per year for at least nine consecutive years, from 2007 through 2015.⁴⁶

Yet it is unlikely that physicians will actually be asked to absorb a 40 percent decrease in their Medicare fee schedule payments over the next nine years, because just the specter of this level of cutting has raised concerns that many physicians would view Medicare patients as second class, avoid caring for them in non-emergency situations, and replace them with better paying, "easier," younger patients. This scenario needs to be avoided and will be, because Medicare payment levels are responsive to the marketplace—not through an invisible hand but rather through a political process. We are confident that Medicare beneficiaries will not lack access to physician care as payment procedures and payment levels are reconsidered.

Congress and its advisory committees, including MedPAC and the Government Accountability Office (GAO), are studying how to change the SGR mechanism to correct its apparent flaws and are rethinking the assumption that there should be a relationship between Medicare beneficiaries' needs for services and the vagaries of the U.S. economy. If, as most expect, physicians are protected from most of the formula-driven payment cuts, a result will be even more Part B spending and even higher Part B premiums for Medicare beneficiaries. CMS recently reported that the monthly premium for 2007 will rise from the current \$89.50 to \$98.20.⁴⁷ But that assumes the SGR mechanism is in place and working. Relief to physicians will increase the Part B premium substantially. In short, Medicare beneficiaries will bear part of the cost for protecting physician fees.

Ironically, an expenditure limit on physician services was designed, among other things, to protect Medicare beneficiaries from the full effect of volume and cost increases in physician services. By law, the federal government pays 75 percent of the cost of Medicare's Part B benefits—for physician services and outpatient medical care—with beneficiaries' Part B premiums, paid out of pocket or by supplemental insurance, covering the remaining 25 percent. In 2004, a few months before the presidential election, the Bush administration announced that the Part B premium for 2005 would increase from \$66.60 to \$78.20 (a record 17 percent increase that received considerable attention during the presidential campaign).⁴⁸ And now the premiums have risen substantially twice more, to \$88.50 in 2006 and \$98.20 for 2007. Without

an expenditure limit in place, the increase in the Part B premium would surely have been even greater.

In sum, after years of cost stability in the aftermath of the BBA, Medicare again has begun to experience the consequences of health care inflation that far exceeds general inflation, putting pressure on the monthly Part B premiums paid by the program's beneficiaries. Due to the rapid rate of growth in the program's spending on physician and other outpatient services in the early 2000s, a growing proportion of Medicare beneficiaries' Social Security income has become consumed by medical inflation.⁴⁹ The cost of their monthly Part B premiums, which are automatically deducted from their monthly Social Security checks, increased by more than 50 percent during this period (see figure 7.2). Congress may be able to assure that the SGR expenditure control mechanism does not affect beneficiaries' access to physician services, but that assurance comes at a high cost.

It's the Expenditures, Not the Prices, That Finally Matter

The current issues faced in physician payment reform provide timely examples of the broad challenges faced by Medicare's prospective payment systems. In some ways the physician payment system presents these challenges most starkly because it is the payment system that most closely resembles the traditional cost- or charge-based reimbursement that preceded prospective payment. Medicare's payments to physicians, based on the resource-based relative-value scale, are prospective in that payment amounts are predetermined for the class of providers—in this case, physicians and related clinical professionals—and, accordingly, are not related to the actual costs or charges of those submitting claims.

However, physician payment remains fee-for-service in that payments are made for discrete individual transactions, each of which is described using one of thousands of standardized codes. In contrast, as detailed earlier, the more successful prospective payment systems have bundled services or pay for aggregated services over a period of time—whether for a hospital discharge, which covers the costs of care for the duration of a hospitalization, or for sixty days of home health care. The providers under these more advanced prospective payment approaches have incentives to conserve resources, because they receive a lump sum no matter how many services are provided.

Nevertheless, the current problem created by Medicare SGR limits on expenditures for physician services strongly suggests that, at least for some kinds of services, it is not enough to just control prices. Prospective payment has been a very effective tool, first for hospital payment and subsequently for most other providers. Over time,

however, the volume and intensity of services may increase total Medicare expenditures despite (or even as a result of) the savings generated through pricing controls.

In all prospective payment systems, providers receive greater revenues by increasing the number of reimbursable units of service, whether those units are individual services (such as physician services), packages of individual services (such as outpatient hospital services), per diems (skilled nursing and inpatient rehabilitation services), or episodes of care (hospitals and home health services). Health professionals, be they clinicians or administrative staff, believe highly in the value of the services they provide to Medicare patients. And if unconstrained, they will want to offer more services, especially if by doing so they also help their own financial bottom lines.

There are natural limits to providers' opportunity to induce patient demand to meet revenue expectations. We trust that professionals do not knowingly jeopardize patient well-being to support their own incomes. A commitment to such professionalism is one plausible explanation for the fact that the double-digit rise in physician expenditures in 2004 resulted from major increases in the duration of office visits and major increases in provision of diagnostic tests and imaging services, not in invasive surgical procedures, which could place patients in danger.

At the same time, because a great deal of health care is discretionary in nature, the decision whether to provide a medical service often is not clear-cut. Three decades of research by John Wennberg and colleagues at Dartmouth showing major variations in the rates of medical interventions—ranging from simple surgical procedures such as tonsillectomies to days spent in intensive care units for patients in their last months of life—strongly suggests that the practice of medicine currently is as much art as science⁵⁰ and is often practiced without the elegance associated with fine art.

Different practitioners and providers do not make the same decisions when confronted with seemingly identical clinical problems.⁵¹ Patient preferences might explain some of the variation, but Wennberg has found that physician practice styles and the supply of physicians and hospital beds often explain these significant practice variations. Although professionalism surely does provide some constraint on provider generation of services to increase revenues for the practice or institution, the discretionary nature of much medical care suggests that the financial incentives inherent in fee-for-service payments (including prospective payment systems to varying degrees) lead to increased volume and intensity of services and, consequently, to increased expenditures.

Medicare does police the behavior of medical providers, monitoring for activity that is solely intended to generate increased reimbursable services. The success of Operation Restore Trust and other initiatives to crack down on fraud and abuse demonstrates that Medicare can protect spending when provider behavior blatantly crosses

the line. At the same time, though, most overspending does not constitute fraud. And Medicare is allowed to use only gentle, generally unobtrusive approaches to prevent excessive use of services. For example, CMS tries to monitor hospital coding practices to detect systematic “DRG creep” and relies on financially disinterested physicians to certify the need for episodes of home health services. Yet straightforward surveillance can only accomplish so much, especially as providers, with some justification, argue that more ambitious regulatory interventions could become too intrusive or exert a chilling effect on innovation.

Creating incentives for providers to restrain their interest in generating extra services remains a challenge for prospective payment systems that reward provision of additional reimbursable units of care. Julian Pettengill, formerly Research Director for MedPAC, argues that “the eleventh commandment states, ‘Thou shalt not tempt’ . . . Don’t put a pot of money on the table in front of people who could just reach out and take from it. If you don’t want providers to behave badly, then don’t give them the chance.”⁵² Relatively crude approaches, such as a sector-specific expenditure limit or budget, worked for a decade for physician payment but seem to be unraveling now.

Administered Prices Can Lead to Market Distortions

Another problem prospective payment systems face derives from the fact that they are not set by a well functioning market but rather are administered prices set to some extent through a political process. It is difficult to get administered prices “right,” especially in industries such as health care in which technology changes rapidly.⁵³ Payment rates may become “ossified,” set in stone, even when technological change, professional experience, economies of scale and scope, and other factors are interacting to make the established rates of some services no longer accurate. But once set, the generosity of some payments—relative to their changing underlying costs—may distort the behavior of some medical providers, who take advantage of this generosity by steering patients toward more profitable services.⁵⁴

Distorted Medicare payments had a lot to do with the recent proliferation of physician-owned specialty hospitals, which have been built in several communities.⁵⁵ Partially owned by physicians, who are in a position to selectively refer their own patients, these cardiac, orthopedic, and general surgical hospitals are described by advocates as “focused factories.”⁵⁶ By offering a limited range of services and allowing physicians to have more control than they have in a general community hospital, such hospitals can arguably care for patients more efficiently and with better outcomes.⁵⁷ However, critics contend that such hospitals skim off the most profitable patients, undermining a community hospital’s ability to subsidize the less-profitable services their com-

munities need, such as emergency services, burn units, inpatient psychiatric facilities, and care for the underinsured and uninsured.⁵⁸

The point here is not to take sides in this ongoing debate, but rather to show that distortions in Medicare DRG payments for inpatient services were a catalyst not only for stimulating a major expansion in specialty hospitals but also for orienting community general hospitals toward overprovision of surgical services in general and cardiac surgical services in particular.⁵⁹ Mandated by Congress to study the specialty hospital issue, MedPAC found that the average relative profitability of these institutions varies considerably by DRG and masks even larger differences in relative profitability by the level of severity of illness for patients within each group. Calculating relative profitability ratios—by comparing DRG payments to underlying costs for providing various services—MedPAC found that surgical cardiovascular DRGs were highly profitable, whereas medical DRGs—DRGs for hospital stays without surgical procedures performed—were relative losers.⁶⁰ Thus, hospitals receive much greater profits for performing cardiac bypass graft operations than for treating patients with uncomplicated heart attacks or congestive heart failure. Indeed, some believe that these distorted payments have been a major contributor to the current “medical arms race,” whereby hospitals try to outdo each other with provision of the same high-tech, high-profit service lines.⁶¹

Serious price distortions also persist in Medicare’s physician RBRVS-based fee schedule, for the most part because adjusting the relative values is largely a political process under the auspices of the American Medical Association, rather than an objective, technical process. Although the elaborate RBRVS process undertaken by Hsiao and colleagues to estimate resource costs for individual physician services corrected some of the worst distortions of the historic, charge-based fee schedules, the process for monitoring and revising relative values established under the new approach does not adequately address the issue of “downward-sticky” prices. In other words, once relative values have been set for new procedures, it remains nearly impossible to revalue them downward even after the procedures become easier, cheaper, and routine.⁶² This is one main reason why the shift away from technologically oriented services toward evaluation and management has been frozen in place for the past decade.⁶³

The health care system relies on professionals to do the right thing for their patients. But there is little question that the tendency for hospitals to invest more heavily in and compete for cardiac surgical services resulted, at least partly, from the distorted profitability signals sent by the Medicare hospital payment system. MedPAC has identified similar problems in the physician fee schedules. Now that particular price distortions have been found and defined, we will see whether the desire to get

administered prices “right” will be able to overcome resistance from those who profit from the current distortions.

Prospective Payment May Reinforce Provider Silos

Medicare payment approaches initially were designed to reflect the organization of health care delivery, with clearly differentiated provider types. Until relatively recently, the functions and clinical jurisdiction of hospitals were decidedly separate from that of the physician office or the nursing home. The lines between different entities providing health care services have become blurred over time, however, as technological and organizational developments permit similar care to be provided in any number of settings. Yet Medicare’s prospective payment systems still assume and, in fact, reinforce existing “silos” of care. Medicare’s payment policies have even generated altogether new provider types (e.g., long-term care hospitals), for which Medicare has created still more prospective payment systems.⁶⁴

Because of provider-specific prospective payment, patients with similar needs are currently served by different types of providers paid on different bases; the amount Medicare pays on behalf of similar patients varies simply by where they receive their care. This is particularly true for postacute care. Patients with similar rehabilitation needs might be cared for at home with outpatient therapy, in a skilled nursing facility, in a rehabilitation hospital, or in a long-term care hospital. Medicare payment, eligibility, coverage, and certification policies for each type of postacute care provider continue to differ even though the variation among the types of providers in services offered, service intensity, and conditions of patients served are becoming less distinct. Completely distinct payment systems derive from the unique perspectives each provider group brought to the table when prospective payment options were researched and developed.⁶⁵

Medicare faces the same situation when paying for acute care services. For example, a patient might undergo a routine colonoscopy in an outpatient department of a hospital, in an ambulatory surgery center, or in a physician’s office. In some ways, given the diversity of health delivery systems across the country, the flexibility to pay on behalf of patients served in different types of facilities makes sense. However, Medicare’s payment methods produce payment levels that are based more on the underlying costs of different provider types than on the costs needed to care for patients with particular health problems.⁶⁶

Further, if changes in technology allow resources to be shifted, for example, out of the hospital and into the community, it will be difficult for the government payer to redistribute the funds from the hospital sector to support the increased financial bur-

den of ambulatory care.⁶⁷ The result is that patients may be cared for in ways that suit the purposes of the providers, rather than the needs of patients, with financial incentives rather than clinical considerations driving decisions about the setting in which care is delivered.

For example, when Robert Berenson was a senior official at CMS, he met with a group of gastroenterologists who came to complain that Medicare was paying too much for performing colonoscopies in physicians' offices. They argued that the much too generous payment was enticing them to perform the procedures in their offices—exposing their patients to risk—rather than in the safety of ambulatory surgery centers (ASCs). In effect, the physicians were asking CMS to “protect them from themselves” by cutting their payments, which was a fairly unusual request, to say the least.

Only later did the rationale for this not entirely selfless plea become apparent. Some gastroenterologists own ASCs, which were losing the business of gastroenterologists now able to perform the procedure in their own offices rather than provide a facility fee for the ASCs. It took a full investigation and report by the GAO to confirm the safety of the office-based colonoscopy in most clinical situations, and to expose the fact that the clinicians' concerns were about the payment differentials (and not really about patients' interests).⁶⁸

Furthermore, siloed payments with incentives to move patients contribute to the growing problem of uncoordinated care, with patients falling through the cracks during transitions across practice settings.⁶⁹ Patients are often transferred without the proper discharge arrangements made to assure a seamless and safe transition to a different facility, again in response to the provider-specific payment incentives that reward earlier hospital discharges.

One of the new challenges Medicare faces is the growing number of beneficiaries with one or more chronic conditions. Twenty percent of Medicare patients have five or more chronic conditions and are responsible for about 66 percent of Medicare spending.⁷⁰ These beneficiaries have, on average, thirty-seven physician visits in a year and see almost fourteen different physicians.⁷¹ One important implication of these findings is that care needs to be carefully coordinated across different provider domains to reduce medical error and improve efficiency. Unfortunately, provider-specific payment policies frustrate new efforts to improve safe transitions across settings and to make sure that patients' needs, rather than providers' needs, are met.

Another implication is that the current payment orientation that tilts in favor of technically oriented, acute-care services provided by medical specialists in acute-care settings—such as hospitals and ambulatory surgery centers—needs to be reoriented to care provided by generalist physicians in non-acute-care settings, including the physician's office and the patient's residence, whether it be her own home or a long-term

care facility. In short, for many beneficiaries, Medicare needs to be altered from a classic acute illness insurance program to one that also provides high-quality palliative services for persons in their last months of life.⁷²

The potential to shift funds across existing payment silos provides one of the theoretical rationales for private plans being allowed to attempt what Medicare has difficulty accomplishing because of political constraints.⁷³ However, with their broad abandonment of global capitation as a dominant payment method and with their dependence on contractual relationships with providers, such as hospitals, that have substantial market power to assure that the flow of funds continues to support current operations, private health insurance plans have not been more successful than Medicare in shifting health care priorities. Again, although health plan competition makes sense in theory, it fails in fact.

Barriers to Value-Based Purchasing

Rather than using its market power to drive prices below competitive market rates, as some critics feared, it appears that Congress is focused more on satisfying the financial needs of the various provider group interests than on what is good for the program or the taxpayers who support it. Former CMS administrator Bruce Vladeck argued that restrictions on how Medicare pays (and even the payment levels that are written into law) frustrate efforts to permit the program to behave like a “prudent purchaser” or “value-based purchaser,” obtaining greater value for the dollars spent.⁷⁴ Medicare pays providers and other suppliers more than the prices a purchaser of its size could obtain in the marketplace. And now, in administering the Medicare Modernization Act’s new prescription drug benefit, CMS has been precluded by Congress not only from setting prescription drug rates but also from even negotiating with pharmaceutical manufacturers over prices.⁷⁵

Vladeck remains a strong advocate for maintaining the traditional Medicare program’s prominent role in any future redesign of Medicare. Nevertheless, he is concerned that the program is turning “from one that provides a legal entitlement to beneficiaries to one that provides a de facto political entitlement to providers.”⁷⁶ This reality contributes to the difficulty of designing modified payment approaches that better address the needs of beneficiaries and the program overall.

The major challenges Medicare faces going forward are not primarily technical. For example, it is surely technically possible to thoroughly address the distorted payments that contribute to the medical arms race involving hospitals and physician entrepreneurs. The main problem lies in the politics of making changes that could detrimentally affect the financial interests of device manufacturers, pharmaceutical

companies, specialty-hospital investors, physicians who perform well-remunerated procedures, and others who directly benefit from the technological orientation of current payment policies.

Moreover, Medicare is now at a stage of evolution where even “smarter” payment policies would not suffice to assure that it produced higher value (e.g., higher quality at lower cost) for its substantial and growing investment. We have tried to show that, overall, Medicare does a fairly good job at getting prices right in its various prospective payment systems. Yet the program makes payments to all providers at equivalent rates regardless of the quality or efficiency of their performance.

Standard payment approaches using uniform, national formulas will not address the geographic variations in health care spending that result in as much as 30 percent of Medicare spending serving no useful purpose (other than providing decent incomes for health care professionals and other health workers.)⁷⁷ Clearly, a single national payer permitted to use uniform payment formulas would not be well positioned to address local area practice variations or to apply policies on a discretionary basis to accomplish particular policy objectives, as a value-based purchaser would.

Instead of privatizing Medicare, as the MMA would do, we believe the wiser policy course would be to allow Medicare to use some of the tools that in some cases have been pioneered by private purchasers and health plans, introducing them carefully and selectively into the much more publicly accountable Medicare program.⁷⁸ The various political and legal constraints that apply to Medicare—such as the Administrative Procedure Act’s requirements that limit agency discretion and create a lengthy decision-making process with assured public input—would temper the kinds of activities that got many HMOs into so much trouble with the public and produced the managed care backlash.⁷⁹ For example, Medicare could selectively apply prior authorization of expensive, discretionary services, but in a transparent process and based on professionally considered, evidence-based guidelines that would also take into account cultural values, individual patient preferences, and administrative feasibility.⁸⁰

We believe there are a variety of tools available that would permit Medicare to become a purchaser that uses its dominant position to shape the market by forcing suppliers to adjust to its needs and that could pass statutory and constitutional legal challenge.⁸¹ The MMA has sanctioned a few demonstrations of innovative approaches to modernizing the program, with particular emphasis on new payment approaches such as “pay-for-performance,” which rewards providers for achieving specified performance targets with small percentage bonuses, in addition to the uniform payment that comes from application of a national formula.⁸²

Although these demonstrations represent an important departure for Medicare by moving beyond its traditional focus on payment formulas, CMS needs much greater authority (and far more resources) to become a value purchaser than is implied by existing demonstrations. A series of administrative, resource, and political barriers stand in the way of Medicare achieving its potential as a value purchaser.

For example, a major barrier lies in the division of the Medicare budget between “mandatory” dollars to pay for services and “discretionary” dollars to pay for program administration.⁸³ Currently, Medicare spends less than two percent of program outlays on administration, compared to the over ten percent spent by private insurers.⁸⁴ In fact, two percent for administration is too low for a program as complex as Medicare. Adopting important cost-saving administrative tools would involve increased spending on program administration, but the savings would accrue to the trust funds. Currently Medicare cannot spend \$1 million beyond the appropriated administrative budget, even to save \$5 million in decreased health care spending.

A value purchaser would also use tools to influence care that go well beyond the current focus on payment and prospective payment systems. The companion of payment policy is coverage policy, that is, the benefit package of specific items and services to which beneficiaries are entitled. For more than twenty-five years, Medicare has tried to promulgate administrative rules to implement the Medicare statutory directive to cover those items and services that are “reasonable and necessary,” for the treatment of illness and injury. The rules are needed in a public program to clarify CMS’s legal authority and to describe specific criteria for determining which new technologies would be covered and paid for.

CMS administrators in both Republican and Democratic presidential administrations have attempted to develop criteria that emphasize coverage decisions based on scientific evidence of effectiveness. They have proposed introducing considerations of costs and cost-effectiveness to such decision making. Yet when CMS attempted in various ways to issue rules defining the statutory “reasonable and necessary” language, it was defeated by coalitions headed by the medical device industry, which have an interest in the approval of new technology, regardless of the relative worth of the technology under consideration.⁸⁵

As a value purchaser, Medicare should be allowed to prioritize which services it makes available to its beneficiaries, given the growing recognition of a need for budgetary restraints to program spending. Furthermore, such a purchaser would require convincing, scientific evidence to justify that a particular technological innovation would provide greater benefit than harm, much less that it would represent a good use of program funds. Yet, most of the time CMS determines that a new service is rea-

sonable and necessary based on evidence from scientific studies that the agency itself thinks is only fair or even poor.⁸⁶

Furthermore, the coverage determination process is very much subject to political pressures, usually subtle but sometimes unabashedly overt, such as on the various occasions when the chairman of the Senate Appropriations Committee, Republican senator Ted Stevens of Alaska, essentially mandated that CMS approve expanded coverage for PET scans, regardless of what the relevant evidence from medical research studies showed.⁸⁷ More generally, Congress's seemingly unassailable requirements that Medicare assure greater procedural transparency to promote consistency, predictability, and accountability in coverage decision making often serves stakeholder interests more than the public interest.

In many areas of public policy, parties with a strongly concentrated interest in a particular issue are much more likely to take action to influence legislation and administrative decisions than are either the public at large or the Medicare beneficiary population, which has a more diffuse interest in any particular action. Coverage of new technology is an example where the general interest in promoting cost-effective, evidence-based decisions is much weaker than the dedicated interest of the owner or promoter of a new technology.⁸⁸ Although the public agency, in this case CMS, attempts to evaluate new technologies primarily based on their scientific merits, arguably transparency only strengthens the hand of the proponents of the technology, who are consistently monitoring and using all available procedural avenues to influence the process. Indeed, some argue that the device industry's push for more formal processes and transparency, which has been resisted at times by CMS, has actually represented a battle for control of the decision-making process, with the manufacturers winning as a result of Congress-imposed procedural requirements.⁸⁹

PET scans are another example of how influential Medicare policies are in shaping the behavior of the health delivery system. Medicare's decision to cover PET scans for use in a variety of clinical conditions, without restrictions—and to reimburse their use generously—has had an important impact on health care delivery. Given Medicare's coverage decision, private insurers have little choice but to also cover PET scans under similar clinical circumstances. Again, although one can plausibly argue that private insurers might be better able to resist what Victor Fuchs labeled the "technological imperative"⁹⁰ to adopt and use the newest and best of new technology regardless of the value it provides, health plan executives acknowledge that the adoption of medical innovation is mostly driven by factors outside of their control.⁹¹ As a result of decisions by Medicare and private insurers to cover the scans, hospitals and, increasingly, medical specialty groups (such as oncologists) have made business decisions to acquire PET scanners and refer their own patients for scans.⁹²

Medicare's coverage and payment policies, in this case, directly increase the health care system's PET scanner capacity and have made patient access to obtaining a PET scan easier, but at a major cost not only to Medicare but to private payers as well. Although in this book we have emphasized that Medicare payment policies may lead to cost shifting from public to private payers, often Medicare and private payers actually share a common interest in resisting unfettered access to new technology—much as they share a common interest in reinforcing each others' payment methods, sharing data on provider performance, and collaborating on a myriad of other activities.

Though its attempt to rate and rank every nation's health system on multiple dimensions of performance in the *World Health Report 2000* (in which the United States ranked thirty-seventh in the world) was controversial and probably overly ambitious, the World Health Organization (WHO) nevertheless identified an attribute that needs to be addressed in all health systems.⁹³ The WHO asserted that governments should be the “stewards of their national resources, maintaining and improving them for the benefits of their populations. In health, this means being ultimately responsible for the careful management of their citizens' well-being.”⁹⁴ Even in systems that rely extensively on private sector financing and delivery of services, the WHO argued, government's health policy and strategies help assure that health systems are oriented to the public interest.⁹⁵

The lack of government stewardship over health care is becoming increasingly evident in the United States. Even private-sector market leaders in organization, delivery, and financing of health care are growing pessimistic about the future of local health care systems left to unfettered market forces. Although usually not supportive of moving to a government-run, single-payer system, these market participants nevertheless see a role for more government intervention to try to bring greater order to the health care systems in the core areas of insurance coverage, cost, and quality.⁹⁶

In short, government needs to assume much greater responsibility as steward of the health care system, not necessarily to take over a larger share of financing and delivery, but rather to oversee the deployment of existing resources in the public interest. Unfortunately, the public overall does not support major expansions of government responsibilities, even in areas such as health care where market failures are manifest.

We think the Medicare program is well positioned to take on many of the most important stewardship responsibilities for the government, while continuing to serve as a crucial social insurance program for the more than forty-two million seniors and people with disabilities who depend on the program. Medicare's prospective payment systems have created a stable funding base for the nation's providers. They have led to

important changes in how providers deliver care, producing improved quality and efficiency that have spilled over to better the care provided to Americans. Medicare can shape health care in other ways as well—such as improving access to care, expanding individuals’ protection against the cost of illness, and lowering administrative costs—if allowed to do so.