Interview

The Medicare World From Both Sides: A Conversation With Tom Scully

The CEO of the largest U.S. health insurer—Medicare—talks candidly about the past, present, and future of this critical program.

by Uwe E. Reinhardt

ABSTRACT: Tom Scully, administrator of the Centers for Medicare and Medicaid Services (CMS), the nation’s largest health insurer, discusses the Medicare program with Princeton University economist Uwe Reinhardt. Scully’s previous appointments in both the public and private sectors have given him a diverse set of experiences from which to draw in his current position. He praises the agency’s staff for devising innovations to cope with a changing health care environment, praises the program for continuing to meet most seniors’ needs, and staunchly defends the Bush administration’s focus on the private sector as the way forward for Medicare.

Uwe Reinhardt: You have seen our health sector from quite diverse perspectives in your career—first, in the late 1980s and early 1990s, as White House adviser to President Bush the elder; then, during the 1990s, as CEO of the Federation of American Health Systems [now the Federation of American Hospitals]; and now, as CEO of the largest insurance company in the world—the Centers for Medicare and Medicaid Services [CMS]—with arguably the most micromanaging and cantankerous board of directors any insurance executive has ever had to endure: the U.S. Congress. In each of these different roles your personal trademark has been outspokenness, which has raised some eyebrows in Washington, D.C., but also has earned you a good deal of respect even among people who might not invariably agree with you. You were recently quoted in the papers as being bluntly critical of Medicare, the very program over which you preside. Could you elaborate on that criticism? What is so wrong with traditional Medicare, which, survey after survey shows, is remarkably popular among Medicare beneficiaries and the public?

Tom Scully: What I said was that Medicare was a “dumb price fixer.” Consider, for example, how Medicare now pays oncologists for the roughly $6 billion of prescription drugs used outside the hospital that Medicare does cover, mainly for health care rendered in the offices of oncologists. We base Medicare’s payments to these physicians on the so-called average wholesale price, which in theory is to represent the physicians’ acquisition price, but in practice is a pure fiction and typically much above the acquisition price actually paid by the oncologists. As a result, Medicare is forced to overpay for these drugs by 25 percent.

Now imagine having Medicare pay for all of...
the drugs used by Medicare beneficiaries, if we just added a new prescription drug benefit to the traditional Medicare program and then let Medicare decide what to pay for Celebrex and Vioxx and Lipitor, and which drugs go on the Medicare drug formulary and which do not. We would have the CMS bureaucracy wrestle with questions such as: “Are we going to cover Prilosec and Nexium or only the former, and if both, how much more do we pay for Nexium than for Prilosec?” Those decisions would have to be made in an unbelievably politicized atmosphere. I doubt even many Democrats would want to go down that route.

The one sorry lesson I have learned as an administrator of Medicare is that we cannot ever seem to get the payment for health care right, because someone always screams and yells that Medicare pays either too much or too little for particular services. Therefore, I called Medicare a “big dumb price fixer,” which, you must admit, is true. And I went on to say that this is not a good a model for a twenty-first-century Medicare, having the government fix prices for so much health care in so highly political an environment.

Praise For Medicare’s Innovations

Reinhardt: On the other hand, though, during the 1970s and 1980s Medicare was the world’s pioneer in the development and implementation of the highly innovative diagnosis-related group [DRG] system of paying hospitals prospectively. That approach has since been adopted by a number of countries around the world, notably by Australia, which is now re-exporting it to Germany. By contrast, most private health plans in the U.S. still pay hospitals the antiquated average per diem, which has long been decried by health economists as providing all the wrong incentives. Would you be willing to give the Medicare bureaucracy some credit for the development of the DRG system and, later, the resource-based relative value scale [RBRVS] now generally used for paying physicians by both Medicare and private health plans?

Scully: I give the CMS staff lots of credit. They are great—far better than I expected when I arrived. They have come up with lots of innovations, including implementing DRGs and RBRVS. But what that tells you is that HCFA/CMS has worked to perfect the art of “price fixing.” Sadly, Medicare and Medicaid are such dominant players that the private sector has been forced to follow along—shadow pricing DRGs and the RBRVS in recent years. That whole process troubles me. Everyone with an M.D. or D.O. degree gets the same rate, whether they are the best or worst doc in town? Every hospital gets the same payment for a hip replacement, regardless of quality? We are very good at fixing prices and paying quickly. But we have zero ability to monitor utilization or understand or differentiate payment based on quality. In the long run, government price fixing for services has never worked in any system in any society, and I don’t think it can work here, either. Having federal price fixing, no consumer information or pricing sensitivity, and no measurement of quality has led to predictable results: artificially high prices and uneven quality.

Reinhardt: In effect, DRGs can be viewed as a cost-based relative value scale [CBRVS] for hospital payment. Couldn’t we have avoided making Medicare act as the “big, dumb, top-down price fixer” by asking hospitals to bid monetary conversion factors for this CBRVS—that is, one single dollar figure that would then determine the entire payment schedule? To be sure, such competitive bidding systems are always complex. But they do form the core of the currently proposed reform of Medicare. If they can be made to work for private health plans, why couldn’t they have been made to work for hospitals within the traditional Medicare program?

Scully: I am not sure how this could work. Would hospitals bid on a multiplier of the DRG? Maybe it would be an improvement, but I think that big hospitals with existing market share would dominate that system. The missing link is quality measurement combined with consumer information. Only when educated consumers—or their employers or insurers—are making informed decisions will a quasi-market system have a chance in health.
care. There is less consumer information in health than anywhere else in our economy—including the other two essentials, food and housing—and that shows up in the cost and quality that the system produces.

**Hospital Outlier Payments**

**Reinhardt:** Continuing for the moment with the payment of hospitals, what are we to make of the current brouhaha over the high outlier payments made to the for-profit hospital chain Tenet Healthcare? The trade journal *Modern Healthcare* reported in its 14 July 2003 issue that a number of nonprofit hospitals in New Jersey also had very high percentages of outlier payments. Gary Carter, president and CEO of the New Jersey Hospital Association, explained in a letter to *Modern Healthcare* [21 July 2003] that New Jersey's high outlier payments are "just another symptom of a payment system that was broken and needed to be fixed." What is it that needs to be fixed here, the formula for paying for outliers or the whole DRG system?

**Scully:** I think the DRG system works pretty well for what it is designed to do. But we had about 300 hospitals chronically "gaming" the system for $2 billion a year for four years in a row, and we did not catch it. That is right—$2 billion a year for four years, or $8 billion total—and the system did not catch it (nor is it designed to catch it). That is over 2 percent of inpatient hospital spending a year "out the door and unaccounted for." We pay claims quickly and efficiently, but we have no clue what is actually going on in the system. What is the chance that Blue Cross of New Jersey or Independence Blue Cross in Pennsylvania would have missed that if their money were at risk? I can tell you: zero.

**Regulatory Complexity**

**Reinhardt:** Having studied health systems in many other countries that pay hospitals by some variant of administered prices, I am puzzled why it takes so many thousand pages of regulations just to administer the payment of hospitals by Medicare, why so many hospital executives genuinely fear being inadvertently criminalized by this complex system, and why many of them feel compelled to spend millions on whole compliance departments and consultants to walk a straight path on Medicare reimbursement. Why don't we see this in other countries?

**Scully:** Our system is much larger, much more centralized, and much more inflexible than most European systems. The German system, for example, is much more community-based in its financing. If we can find a way to make Medicare more responsive to local market conditions, local providers, and local patient needs, much of that fear would evaporate, I think. I hope that Medicare reform will move in that direction. I have tried to make Medicare more responsive, but it is a big program with national rules and guidelines that are easily manipulated by the very small minority of bad actors. That unfortunately leads to the need for tough enforcement, and given our limited enforcement resources, we have to be aggressive (but hopefully fair) in pursuing any trends in billing that look unusual.

**Reinhardt:** You have seen the Medicare world from both sides now: as CEO of a trade association of for-profit hospitals and as CEO of Medicare, which pays those hospitals. In the light of that experience, is there a more streamlined, less contentious way of paying hospitals and other providers of care within the framework of the single-payer, fee-for-service Medicare program, or have you given up hope ever to be able to devise such a system within traditional Medicare?

**Scully:** There are many great things about traditional Medicare, and I would never “give up” on improving it. Over 50 percent of Medicare is likely to be “single payer” for my lifetime. Nobody over age sixty-five is uninsured, and that is terrific. Medicare is community-rated and eliminates risk selection (and though I might prefer some modifications of a “pure” community rate in a modernized system, this too is a great trait). Medicare is a wonderful safety net, but it is a very flawed economic design, in my opinion. In many markets Medicare and Medicaid comprise over 65 percent of the payments to
hospitals, and more than 80 percent in some physician specialties. When one payer is so dominant, it strangles competition and innovation and distorts the system. If Standard Oil had that market share in oil, it would have been broken up much faster. The same goes for Alcoa or AT&T, other large national firms that were “broken up” under antitrust law. How long would Microsoft have lasted under antitrust scrutiny with 65 percent market share? The government dominance of local health care payment has the same strangling effect. Medicare will always be the largest player in health care, as a single payer. Allowing beneficiaries the choice to move to private plans (like PPOs [preferred provider organizations]) will give them more options, and that is the primary motivation for reform. But the ancillary benefit of increasing local market forces—generating multiple well-informed payers that will generate competition over price and quality—is an ancillary benefit that is nothing to sneeze at.

**Medicare’s Sustained Popularity**

Reinhardt: Before we get into the details of Medicare reform, let me first ask you how you explain the sustained popularity of traditional Medicare, especially among the nation's senior citizens who have experience with it, if that program is so flawed?

Scully: I did say in the speech you referred to earlier that Medicare is a wonderful social safety-net program. Everybody over age sixty-five is insured. Seniors love it, because we give them a health insurance package with an average actuarial value of about $7,000 a year virtually free of charge when they receive it. Current taxpayers pay for about 90 percent of the benefits paid for by Medicare, through either payroll or general taxes. Current Medicare beneficiaries pay for only about 10 percent through premiums for Part B. What’s not to love? As a social insurance program, from the beneficiary’s point of view, Medicare does have fabulous qualities.

Reinhardt: Even though Medicare picks up by no means all of the health care costs incurred by beneficiaries?

Scully: You are right, Medicare covers only about 33 percent or so of the average senior’s total health spending. First of all, Medicare beneficiaries face considerable cost sharing for hospital and physician services, and there are upper limits on what Medicare will pay for hospital and nursing home care. In other words, Medicare really does not offer true catastrophic coverage for all items in its benefit package. Second, Medicare’s benefit package has glaring gaps in coverage. So far, it has not covered most outpatient prescription drugs, and it does not cover long term care other than that directly following acute care episodes.

Seniors like my mom can easily spend $200 a month out of pocket for their own health care. Unless their former employer helps with paying for expenses not covered by Medicare, many seniors buy private Medigap insurance. For example, Medigap plans H, I, and J, which do cover drugs, can cost more like $250 a month, even for a single person. Even then, beneficiaries face upper limits on drug coverage, usually $1,000 a year. The premiums of many of the Medigap policies are based on age and are risk related, and some of them have loss ratios as low as 65 percent, which means that they buy only sixty-five cents’ worth of actual health care for the beneficiary per premium dollar collected from the beneficiary.

So, if you look at average American seniors, they now get from their government a benefit with an actuarial average value of about $7,000, which covers only about just over half the average annual cost of health care per senior. Then, unless they have retiree health care coverage from a former employer, seniors spend another maybe $2,500 or $3,000 a year on a Medigap policy, which covers drugs only up to a fairly low upper limit. Beyond that, they still have no drug coverage. If you look at...
the entire pot of money that the government is kicking in and the individual (or former employer) is kicking in, it's a very expensive and sloppy hybrid insurance package that is already substantially private.

**The Good And The Bad**

**Reinhardt:** Leaving aside for the moment why Medicare beneficiaries seem to be so fond of this sloppy hybrid, what particular features of this deal would you give high marks to?

**Scully:** In my view, the best thing about Medicare is that it's community-rated social insurance. Everybody's in the same risk pool for those benefits that Medicare does cover. Every beneficiary pays the same Part B premium and faces the same deductibles and coinsurance rates. That's a great feature from society's point of view and worth preserving.

**Reinhardt:** And the bad features, aside from the "dumb" price fixing we already discussed?

**Scully:** Medicare is a very antiquated insurance model, in a couple of ways. Nobody that I know with a private health insurance policy has a $100 deductible for physician care, a separate $900 deductible for hospitals, no catastrophic stop-loss coverage, and no drug benefit. Furthermore, we pay every hospital and doctor exactly the same amount for particular services, regardless of whether they produce health care of a high or low quality.

**Reinhardt:** But, given the apparent preference of current Medicare beneficiaries for the traditional Medicare program, couldn't Congress just update its benefit package to make it resemble more that of a commercial PPO and then allow Medicare to act more like a commercial PPO that manages care in a loosey-goosey way? Why get rid of the old Medicare?

**Scully:** No one is trying to get rid of the old Medicare. The president has said explicitly that we would keep traditional Medicare forever, for everybody, if that's what people want, plus traditional private Medigap insurance. The Hill undoubtedly will say the same thing. All we are saying is that this hybrid might not be the best economic model for the beneficiary. We believe that the integrated insurance model offered by private health plans can more easily change with changes in the way health care is delivered than can traditional Medicare, for which change is a slow, cumbersome, and highly politicized process.

**Reinhardt:** Granted that traditional Medicare has its shortcomings, can one fairly blame the much-maligned CMS bureaucrats for these shortcomings? For example, would any private insurance executives be able to administer as complex an insurance program as Medicare if they were allowed by their board of directors (Congress) to spend only 1.8 percent of total expenditures on administration? Isn't it Congress's fault that this program's benefit package is outdated and plagued by glaring gaps in coverage? Isn't it Congress that legislates the myriad of ambiguous mandates that the CMS bureaucracy then must translate into umpteen thousand pages of workable regulations? Isn't Congress really the chief obstacle to change and efficiency in Medicare?

**Scully:** It's not really Congress's fault, either. It is the general public's fault, in my opinion. Any time a Democrat- or Republican-controlled Congress proposes to change...
Medicare, those proposals trigger so much demagoguery that in the end change turns out to be almost impossible. So we change it slowly with regulatory Band-Aids that do not address the underlying symptoms. Lots of people on both the Democratic and Republican sides know what would be the right thing to do with Medicare, but any debate on such measures is so politically charged and incredibly sensitive to seniors that nobody wants to touch the subject or to speak forthrightly about it.

Reinhardt: Then what makes you think that this is the time at which revolutionary changes to Medicare can be made?

Scully: Actually, the reforms we're talking about are not revolutionary at all; they are incredibly modest. A bolder reform, of the sort contemplated by the Bipartisan Commission on the Future of Medicare, would raise the retirement age to sixty-seven and shift to a premium-support model, which would force the traditional fee-for-service Medicare program to compete against private managed care plans.

In this administration we very intentionally did not ask for raising the retirement age to sixty-seven or shifting to a premium-support model. Basically, we propose to keep fee-for-service Medicare on cruise control forever. But we also want to offer another option. I don't know if folks really understand this, but the reforms we're now talking about are really quite modest by comparison with what was floating around two or three years ago.

Faith In Private Plans

Reinhardt: You and the White House put your faith in private health plans at a time when many of these plans, under the Medicare+Choice option put in place as part of the Balanced Budget Act of 1997, seem to be hitting a brick wall and are pulling out of the program. Doesn't that spotty track record give you pause?

Scully: The Medicare+Choice plans pulled out of these counties for a good reason. They got creamed. As you know, many private plans served Medicare beneficiaries even before the BBA came along. Their history goes back to 1982. During the 1980s and especially the 1990s their enrollment kept growing rapidly. They were incredibly popular in 1997, enrolling close to 18 percent of the Medicare population. Prior to 1997 Medicare paid the plans 95 percent of the adjusted average per capita cost [AAPCC] under the traditional fee-for-service program for beneficiaries of a particular actuarial risk. This meant that in Miami and New York City, Medicare paid 95 percent of $8,000, all the while paying 95 percent of $4,000 in Iowa and Minnesota.

Members of Congress from the low-cost areas, among them Senators Grassley [Nebraska] and Domenici [New Mexico], considered this unfair. So a higher floor for the premiums was enacted for traditionally low-cost counties, many of them rural, and a 2 percent ceiling was put on the growth of the premium paid to private plans in the high-cost counties. As a result, the rural counties got a ton more money, but nobody showed up, because there's no managed care there. On the other hand, in many high-cost urban areas, where managed care is popular and available, it got strangled. When you look at 1997–2003, these plans got a 2 percent increase in reimbursement six years in a row, as they faced increases of 8–12 percent a year in their costs of serving beneficiaries. They raised their premiums to beneficiaries, they raised their copayments, they watered down the drug benefit, they irritated seniors, and they triggered a lot of anger. At some point, plans basically said, “This is a rotten business; I’m getting out.”

Reinhardt: You and I both know that the staffers of the House Ways and Means and Senate Finance Committees who actually got their bosses to vote for the BBA are not stupid. When they wrote the BBA, they must...
have thought, as I have all along, that for Medicare+Choice plans doing business in the high-cost counties (such as Dade County, Florida; Baton Rouge, Louisiana; McAllen, Texas; and New York City), making money with the lower-cost medical practice styles one observes in Minnesota and on the West Coast should be like shooting fish in a barrel. Am I wrong to assume that the 2 percent limit was triggered by that kind of thinking, which, as I recall, was bipartisan?

Scully: It was really driven more by the rural guys, who wanted to direct more Medicare money to their counties within overall budget-neutrality. I think at that time, in 1997, many of the plans might have thought they were going to be OK. But I was on the board of Oxford Health Plan then, and I could immediately see that we were going to drop out of several counties as a result of the BBA.

Coping With Geographic Variation

Reinhardt: Then how are you going to avoid the same fiasco with the newly proposed “Enhanced Medicare” or whatever the Hill will ultimately call the private health plan option? Is the idea in Medicare reform to perpetuate the huge geographic variations in Medicare outlays per statistically identical Medicare beneficiary—per capita costs that now vary by a factor of more than three over the U.S.? Why should American taxpayers have to pay a private health plan two to three times as high a premium per Medicare beneficiary in some areas (Miami, Baton Rouge, or New York City) than is paid for statistically the same beneficiary in other areas (like Rochester, Minnesota, home of the Mayo Clinic)? After all, as John Wennberg and his associates at Dartmouth have shown, the higher payments do not seem to beget better access, higher quality of care, or greater patient satisfaction.

Scully: We envisage a structure under which private health plans cannot cherry-pick county by county. Instead, they would have to bid for Medicare business for very large regions—like the entire Northeast or the mid-Atlantic region, which blends together Maryland, Virginia, Delaware, West Virginia, and Pennsylvania. You take five or six big states, throw them together into one “region,” and say to the health plans that they’ve got to take everybody at the blended premium paid by Medicare for all residents in that “region.” That blended rate could initially be 100 percent of the blended AAPCC for traditional Medicare and, later, based on plans’ competitive bids for those large regions.

Competitive Bidding Redux

Reinhardt: In the past the private health plans have never shown any enthusiasm for competitive bidding. Every single demonstration project with competitive bidding that Medicare tried to field during the 1990s was stopped dead in its tracks by someone in Congress, at the behest of the private health plans. What if Medicare threw a competitive bidding party, so to speak, and no one came?

Scully: I think as an insurance plan, if you were not a player in the Medicare market, you’d give up a lot of leverage vis-à-vis providers, especially the powerful hospital sector. So, if there were three health plans in, say, the mid-Atlantic region whose bids won them the right to play in the Medicare market, and you are not one of these plans, you’d have a real problem negotiating rates with hospitals and other providers.

Reinhardt: We could probably talk about an hour or more about the exact nature of the proposed bidding process and precisely how much premium beneficiaries would have to pay the private health plans, but those parameters ultimately will be set by Congress, so we would merely be theorizing at this point. Let’s leave these fine points aside and talk about the following question: What persuades you or other proponents of Medicare reform that delivery of benefits through private health plans actually will yield savings relative to delivering the same benefits through traditional Medicare, especially at a time when the premiums private plans charge employers are not rising at rates far in excess of annual increases in Medicare spending per beneficiary?

Scully: Well, that’s a hot debate right now in health policy circles. The Congressional Bud-
get Office [CBO] estimates that with the private health plans we’re going to spend 8–12 percent more than we do now on traditional Medicare fee-for-service. On the other hand, Medicare’s own actuaries estimate that we’d spend less.

**Reinhardt:** But many proponents of Medicare reform commonly promote it with appeal to Medicare’s future “sustainability” in the face of the retiring baby-boom generation. In your view, would the reform as it is likely to emerge from the Hill—if it emerges at all—meet that long-run objective?

**Scully:** We’re adding a drug benefit that will cost an extra $400 billion in Medicare spending over the first decade alone, and whose cost will rise steadily thereafter. Even if, as the administration hopes, private health plans eventually did manage to deliver the mandated benefits at lower cost than traditional Medicare could, those savings would not be enough to offset the huge cost of this new benefit.

Our aim in this reform is, basically, to place the administration of Medicare benefits on a competitive basis, in place of one big government-run program. We hope that once we’re getting to the point where more local insurance companies make decisions and drive behavior, the entire Medicare system will be much more efficient.

**Reinhardt:** But when all is said and done, this particular reform does not really address the long-run solvency issue for Medicare, does it?

**Scully:** No, it doesn’t. That is a problem whose solution is for another day.

**On A Personal Note**

**Reinhardt:** Let me now ask you a personal question that may interest Health Affairs’ younger readers. You have been a powerful player in American health policy for about a decade and a half now, starting in the White House at a relatively young age. Was that all of that just good luck, or is there a strategy that you would recommend to younger people with similar ambitions?

**Scully:** Just blind dumb luck. I was a telecom lawyer in the early 1980s who happened into health policy when I joined the first Bush administration—at the Office of Management and Budget. I liked health issues, so I stuck with them. That is the advice I would give young people: Find something you like and stick with it. Substance matters, of course. Eventually you will become an “expert” (although I won’t claim to be one yet) in your chosen field, and then you will have an impact—and have fun at the same time.

**Reinhardt:** A telecom lawyer? Look at your staggering opportunity costs of becoming a health policy wonk, Tom. You could have become chief legal counsel for WorldCom instead and be even more famous today than you already are.

Let me end by asking you about something that has puzzled me for some time. Your first act as the newly appointed CMS administrator (or HCFA, as it was then called) was to field a contest for a new name for your agency. I had submitted to your staff the name “Senior Health Insurance Trust,” but for some reason that mellow name got no response. You chose instead “Centers for Medicare and Medicaid Services” and collapsed it into the acronym CMS. What has intrigued me ever since is this: When you chose that acronym, CMS, of the two Ms—Medicare or Medicaid—didn’t you give a dang about?

**Scully:** [HHS] Secretary [Tommy] Thompson and I had an employee contest, and we picked the name from a group of finalists. He liked Medicare and Medicaid Administration, but our focus groups showed that MMA—pronounced “Mama”—would not be funny to half the population. So we went with CMS—but since I already mumble anyway, I suggested that we shorten it to CMS. He agreed.

**Reinhardt:** For heaven’s sake, Tom, don’t admit that you just mumbled one of the Ms away. Claim instead that it’s more efficient not to repeat the M, because a gazillion Ms then won’t have to get printed, saving America zillions of dollars in printer’s ink and copying toner. After all, that’s what we all want in health care: greater efficiency.