Can Medicare and Medicaid Promote More Efficient Health Care?

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Thank you for inviting me to appear before you. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. I am also adjunct professor in the School of Public Health at the University of North Carolina at Chapel Hill. I have previously served as the assistant director for health and human resources at the Congressional Budget Office (CBO), and earlier held several research and management positions in the Health Care Financing Administration, the precursor to the Centers for Medicare and Medicaid Services (CMS). The views I present today are my own and do not represent the position of the institutions with which I am associated.

Federal, state, and local governments account for 45 percent of the $1.7 trillion that will be spent in the health sector in 2003. Medicare will spend over $260 billion this year for some 40 million elderly and disabled people. Medicaid, which is funded jointly by the federal and state governments, will spend over $275 billion for about 50 million people, including some who are eligible for both Medicare and Medicaid.

As impressive as those numbers are, they understate the influence that Medicare and Medicaid have on the health care of all Americans. Medicare's administrative requirements shape the business environment for physicians, hospitals, and other providers across the country, and changes in the Medicare program have spillover effects on the rest of the market. Medicaid also has substantial impact on the health system, particularly in the long-term care market.

Some of those spillovers from federal health insurance programs have improved the functioning of the health system and benefited most consumers. For example, Medicare's adoption of prospective payment for hospital services during the mid-1980s caused a massive shift in the way hospitals manage their patients that lowered lengths of stay and cut unnecessary costs. The more efficient use of inpatient services led to an expansion in the use of outpatient facilities and promoted technologies that could treat more severe conditions without having to admit the patient to the hospital.

More often than not, however, Medicare and Medicaid have failed to promote innovation and efficiency in the health sector. Reforms are often met with political gridlock, resulting in the maintenance of the status quo even when conditions in the market are changing dramatically. Even modest initiatives are likely to be controversial because of the enormous financial leverage that Medicare and Medicaid have over the rest of the health system.

The government faces a conflict of interest as a major purchaser of health services and a regulator of the health system. In a period of rising budget deficits, for example, the government-as-purchaser might reduce provider reimbursements spending in ways that result in higher overall health care costs (with those costs borne by beneficiaries or others in the private sector) and worse health outcomes for patients. The Medicare reform debate seems particularly affected by a policy myopia that focuses on budget impact rather than the effects of proposals on broader outcomes for the elderly and the health system as a whole.

The Federal Trade Commission (FTC) and the Department of Justice (DOJ) are promoting vigorous competition within a large and growing health sector. The objective, as

expressed by Chairman Timothy Muris of the FTC, is lower prices, higher quality, greater innovation, and enhanced access to care. However, the FTC and the DOJ are both fighting this battle with one hand tied behind their backs. Medicare and Medicaid continue to rely on regulation and micromanagement rather than competition and consumer choice, and that is a dominant factor in the business environment of the health sector. The FTC and the DOJ should make this point strongly to Congress and the Administration.

The federal government could do more to promote consumer information and efficient health care delivery within Medicare and Medicaid, with positive spillover effects for the private health system. Even seemingly simple actions, such as more widely disseminating data on health care providers, pose considerable technical, legal, and political challenges. Other actions, such as giving Medicare beneficiaries more choices among competing health plans, require broader program reforms that have been the subject of many years of debate. Moreover, some policies might yield short-term improvements in the federal programs while undermining broader efforts to empower consumers and improve health care. The discussion that follows considers each of those points in the context of the Medicare program.

Improving Consumer Information

Consumers make numerous decisions regarding their health care. Many consumers have a choice of health plan or insurance program, offered through their employer or available in the non-group market, as well as the choice to go without coverage. Every consumer at some point picks a primary physician or other caregiver. Increasingly, consumers with health problems are taking an active part in deciding their course of treatment.

Each of those decisions is improved if objective, reliable, timely, accessible, and understandable information is available. Information on price, quality of care, patient outcomes, access to services, and customer satisfaction may all be needed to make a wise decision. However, consumer-friendly information is frequently not available when the need arises. Sadly, many people continue to make health care decisions the old fashioned way, by asking the advice of a friend or relative who has no special expertise in the matter.

The government could help remedy this acute information deficiency by more effectively utilizing the resources that Medicare already has at its disposal. The government is in a better position to collect and disseminate health sector information than private companies. Medicare requires all providers to report certain information as a condition of payment. Moreover, those data are available from nearly every provider, making the information relevant to all consumers.

Caution in developing useful measures of health care performance is needed. Care must be exercised to avoid violating individuals' rights to privacy or jeopardizing the confidentiality of sensitive information from providers and health plans. Government should also avoid the temptation to use clinical information in overly prescriptive ways in Medicare or more broadly. Large variations in practice patterns across the U.S. clearly indicate that medical care is inefficient in many local areas. But the de facto imposition of national standards runs the risk of

stifling innovation and imposing cookie-cutter medicine on patients.

Medicare contracts with nearly every health care provider in the U.S. and has a vast, under-utilized storehouse of information from billing records on beneficiaries, their use of health services, and the providers of those services. In addition, Medicare has information based on facility inspections and mandatory reporting that measure some of the capabilities of health care facilities and their performance in terms of patient outcomes.

Although there are technical and legal barriers to the use of those data, they can in concept be the basis for important information for consumers (including people who are enrolled in private insurance), purchasers (including employers and state governments), and providers of health care. Issues that might be addressed include:

- Tracking the effectiveness of treatments over time,
- Measuring the performance of individual providers or health plans, and
- Determining how the health system adapts to changes in its environment (including changes in policy, clinical practice, and the incidence of disease).

Several decades of research have been invested in making better use of Medicare data, but progress has been slow. Legal and confidentiality issues impede access to data files. The analysis is often complicated and the data must be carefully interpreted if it is to be useful. Moreover, the program's commitment to this research has been limited.

Some provider-specific information has been published that could be useful to all health care consumers. From 1986 through 1992, Medicare published a "report card" on hospitals, reporting patient outcomes for certain health conditions for every acute care hospital in the country. (Former Medicare administrator Bruce Vladeck discontinued that report on the grounds that it misstated the performance of inner city hospitals.) Medicare currently publishes outcomes-based report cards for nursing homes and dialysis facilities, and a report on the quality of home health care available now for agencies in 8 states is scheduled to go nationwide in late 2003.

Medicare's existing database is a valuable resource that was costly to develop. It should be exploited as fully as possible, giving the widest possible access to analysts in the private sector who are likely to develop a variety of useful measures and insights into the quality of care offered by providers. Groups such as the Leapfrog Group, and other coalitions of purchasers, would incorporate data from Medicare to inform their purchasing decisions if those data were more usable and accessible.

Other applications might also be developed if the data were more generally available. Measures of performance from Medicare are good indicators of the overall performance of providers. Competing health plans could be given an overall quality assessment by combining information from each physician and hospital participating in the plan's provider network.

Combined with information on plan premiums, such an assessment would be a useful guide to consumers who have a choice of health plans. This type of analysis is exceptionally challenging and is unlikely to be undertaken without full cooperation between the government and private entities.

Improving Consumer Choice

The ongoing debate in Congress over Medicare reform reflects the tension between the program's regulatory roots and the growing demand for long-needed improvements. Beneficiaries in traditional Medicare cannot use their purchasing power to demand a drug benefit, as they can in private insurance markets. The only recourse is political. It literally takes an act of Congress to make even modest changes to Medicare.

Previous legislation intended to promote competition among health plans and choice for consumers through the Medicare+Choice (M+C) program. That program is a failure. It failed to attract new types of health plans, such as preferred provider organizations (PPOs). It failed to retain the health maintenance organizations (HMOs) that were already participating in Medicare, and half of those HMOs dropped out of M+C within a few years. As a result enrollment in private health plans fell. This year only 13 percent of Medicare beneficiaries are enrolled in M+C plans. The rest are in traditional fee-for-service Medicare.

This record does not mean that competition cannot work in Medicare. On the contrary, competition has yet to be tried. The problems of M+C are simply new variations on the problems of the regulatory Medicare model that has increasingly failed to meet the expectations and needs of consumers and providers alike. Those problems include:

- Unrealistic prices. M+C plans receive a capped payment that is unrelated to the actual cost of providing care. In recent years, most M+C plans received 2 percent annual payment increases while health costs rose at 8 to 10 percent a year, virtually guaranteeing that most plans will drop out of the program. Traditional Medicare is an uncapped entitlement to federal payment. The program relies on administered prices that give health care providers strong incentives to increase the use of covered services.

- Administrative inflexibility. It has been said about Medicare that if something is not mandated, it is prohibited. Congress specifies in detail the benefits that must be offered and other conditions that must be met by health plans and providers for reimbursement. Medicare's benefit package remains largely unchanged after 38 years despite advances in medical science and changes in consumer demand because Congress has failed to take action.

- Unstable business climate. The only certainty about Medicare is that there will be major unpredictable changes every year. Congress micromanages the program through legislation, and the Centers for Medicare and Medicaid Services (CMS) micromanages the program through fiat. The resulting unstable business environment is a major barrier

to plan participation.

Medicare must be reformed if we are to meet the needs of seniors and get the best value from taxpayers' dollars. The Federal Employees Health Benefits Program (FEHBP) provides an immediately usable model of competition that is responsive to consumer demand, successfully controls cost, and provides strong protections for beneficiaries. Under FEHBP, beneficiaries are free to select from a variety of health plans, with federal payments subsidizing about 75 percent of premiums subject to a cap. Beneficiaries who enroll in more expensive plans pay higher premiums. The plans are free to design and manage their benefits in ways that will attract enrollees and limit spending growth.

Unlike Medicare, FEHBP has had a drug benefit and PPOs for many years—innovations that were adopted without new legislation. Unlike Medicare, consumers have a wide choice of health plans and there has not been a mass exodus of plans from FEHBP. Every FEHBP beneficiary has a choice of 12 national plans and, in most cases, a number of local HMOs. About 39,000 Medicare beneficiaries are expected to lose their M+C plans in 2004, which is a big improvement from preceding years. In contrast, FEHBP will be adding 17 new health plans in 2004. Unlike Medicare, FEHBP gives reasonable incentives to plans and beneficiaries to control costs. As a result, the growth of spending under FEHBP has averaged 6.5 percent annually over the past two decades (measured on a per capita basis), while Medicare spending has grown by 6.7 percent annually.

An FEHBP-style reform for Medicare would dramatically alter the incentives in the current program that drive up cost without a commensurate increase in value. Giving seniors an effective market voice would create powerful new incentives for health plans and providers to seek more cost-effective care. With new flexibility under the reformed program, plans would begin to compete on the basis of price, quality, access, convenience, and service, rather than price alone. Beneficiaries would be able to transfer to another health plan if they were discontented with the performance of their current choice, an option not available to most Medicare beneficiaries today.

Because Medicare is such a dominant actor in the health sector, this type of reform would have positive spillover effects in the private market. Business and clinical practices would begin to change, placing greater emphasis on value. Such spillovers have been documented in markets experiencing growth in managed care as providers change their practice styles to satisfy the dominant payers, and the impact of Medicare reform is likely to be even stronger. The structure of health care delivery is likely to evolve and improve for everyone under a less regulatory, consumer-driven Medicare program.

Promoting Innovation

As the dominant purchaser in the health sector, Medicare has substantial market power. That power to affect the market is magnified because it acts as the de facto federal health regulator, establishing conditions of participation that health plans and providers must satisfy to receive Medicare reimbursement. With that much control, Congress can force dramatic changes in the

health sector through Medicare policy if it musters the political will. But such actions often sow the seeds of their own destruction through unexpected, undesirable consequences that are not sustainable politically, socially, or economically. That is, Congress can make pigs fly—but not for long.

In the debate over a Medicare prescription drug benefit, concern about federal spending has resulted in various proposals to control costs by limiting drug prices. Some policymakers favor direct price controls, euphemistically referred to as price negotiation that would be conducted by the Secretary of Health and Human Services (HHS). Others support indirect means of establishing price controls. The Senate bill, for example, includes a fallback plan in certain geographic regions that would effectively require a federal price list for pharmaceuticals. Proposals to allow individuals and commercial distributors to import pharmaceuticals (often called reimportation) attempt to lower U.S. drug prices to levels established in countries that have their own price controls.

Medicare's market power ensures that the program could set pharmaceutical prices at levels well below those available to even the best customers in the private sector. If past practice is a guide, HHS would establish an initial federal price schedule for the thousands of drugs used by Medicare beneficiaries—literally every prescription drug on the market in every dosage form, strength, and packaging. An inflation factor would ratchet up the entire price structure after the first year, as is the case with the physician fee schedule.

Negotiations would be necessary whenever a new drug appeared on the market. The Secretary would be able to withhold access to any new pharmaceutical, a powerful threat that could lead to low prices for new drugs under Medicare. However, there are bad side effects with this policy prescription:

- Competition from generics and therapeutically similar drugs would no longer force down prices of branded drugs under a rigid federal price structure.

- Delaying the entry of a new drug onto the federal formulary could hurt some patients.

- If Medicare set prescription prices at very low levels, manufacturers will try to raise prices to private purchasers, including most people under age 65.

- The threat of a low launch price set by the government would deter the research and development of potentially valuable or life-saving drugs, particularly those that treat illnesses associated with older age groups.

A competitive approach can strike a better balance between lowering prices and promoting innovation. This is the conceptual basis of the House prescription drug provisions, and it relies on the proven ability of competing private plans to negotiate substantial discounts and manage the cost of the benefit.

If private drug plans are placed at risk for the cost of providing prescription drugs to their Medicare enrollees, they have a strong incentive to limit cost growth. The plans can act on that incentive if they are given the flexibility to manage the benefit aggressively. With a wide choice of plans, beneficiaries will be able to select a plan that meets their needs—and change plans if they are dissatisfied.

The budget savings from top-down regulation are immediate and seductive. But the consequences of such an approach are long-term and serious, discouraging the research and development that could lead to more effective and potentially cost-saving drug therapies. Even in the near term, lower prices for Medicare could mean higher prices for everyone else. Instead of creating an elaborate new price-setting scheme that can have dire consequences for health care, Medicare should rely on the proven ability of pharmacy benefits managers (PBMs) to manage costs through careful benefit design and effective price negotiation.

Conclusion

Government policies implemented through Medicare and Medicaid directly impact the health care, and ultimately the health, of every American. Those programs are the largest purchasers of health services, and for that reason alone would be able to dictate the terms under which services are delivered, even if they were private health plans. However, the legal authority to compel consumer, providers, and health plans to modify their behavior conveys a far greater responsibility on Congress and the managers of those programs to consider the greater public good in establishing policies and procedures. Regrettably, that is often not the case. Actions that might achieve important policy goals for Medicare or Medicaid impose inefficiencies on the private health sector or unnecessary constraints on consumers.

The Medicare reform debate brings to light many of these conflicts. Congress has a second chance to design a competitive Medicare program that will work and that can begin to transform the health sector. Reforms should give more flexibility to health plans and beneficiaries alike. Restrictions on the number and types of plans that may compete in Medicare, and on the way those plans design and manage the benefit, should be relaxed. The government should work hard to overcome its well-deserved reputation as a bad business partner by reducing administrative burden and opening lines of communication. And the government should shed the conceit that it can control a complex and inherently unpredictable health system by the application of more and better laws and regulations.