HEALTH INSURANCE AND THE ELDERLY: MANAGING MEDICARE

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To over 30 million of our senior Medicare-eligible population the Health Care Financing Administration (HCFA) is, if not exactly an Insurance Company, very like one. HCFA, or rather its contracted Carriers and Fiscal Intermediaries (FIs), pays claims received from medical providers — albeit with deductibles and co-payments — not unlike the beneficiary experienced before becoming Medicare eligible and was covered under a private health insurance policy.

However, the differences from the perspective of the beneficiary may appear to be great, when onset of Medicare entitlement drops them from a cohesive employer-sponsored benefit package into a more administratively complex and fragmented benefit system. Claims for Medicare Part A benefits, principally the hospital component, may be administered by a number of fiscal intermediaries, depending on provider type and location. On the other hand, Medicare Part B, the physician component, is administered by carriers which cover a whole state. Furthermore, employer-sponsored supplemental benefits and a whole barrage of choices to purchase additional “Medigap” coverage policies complicate the picture.

Nonetheless, from the perspective of the payor, HCFA/Medicare might be viewed as more alike to, than different from, private sector insurers. Although Medicare is an entitlement program, because it is financed by the trust fund, actuarial projections of program expenditures must be based on demographic and payout trends, estimated impacts of new coverage/payment policies, and potential savings from price and utilization management controls — all very similar to private sector experience rating, although HCFA has no control over demographics and enrollment since entitlement cannot be limited.

If funding is inadequate, HCFA and the Congress must resort to administrative measures to control outlays through price and/or volume controls, or to statutory measures to trim benefits and/or to increase premiums which, unlike private health insurers, are largely constrained by statutory limits, but which, as for private insurers, are quite “politically” difficult.

The elderly have become a vocal force in the determination of their own benefits. Just as private insurers must to be sensitive to consumers’ expectations about their benefits and out-of-pocket costs, the difficulties of imposing premium increases and benefit cuts are tough for both sectors to implement.

Coverage for the elderly under the Medicare program is divided into Part A, Hospital Insurance and Part B, Medical Expenses. Part A coverage pays for the first 60 days of hospital confinement, but does not cover the $592 deductible. From the 61st to 90th day, Medicare pays all except for $148 a day. From the 91st to 150th day, Medicare pays all except $296 per day; these days are known as “reserve days” which are a lifetime limit — once used, never restored. Medicare covers 20 days of skilled nursing care and then subsequently pays all except $74 a day for the next 80 days. Medicare does not cover intermediate or custodial care facilities. Part B, Medical Expenses, are paid, less a $75 deductible, at Medicare approved rates; the beneficiary is liable for additional 20%. The beneficiary who wishes to obtain Part B coverage must enroll when first entitled to avoid a ten percent premium increase for each twelve-month delay. Part A coverage may also be purchased by those who are not eligible but it is extremely expensive.

Private sector “Medigap” supplemental coverage policies can be purchased by beneficiaries for coverage of Medicare deductibles and coinsurance. It is thought that about 45 percent of elderly Medicare beneficiaries (about 13.7 million) had at least one Medigap policy as of July, 1989, and that a third of them had purchased multiple policies. In addition, about 30 percent have employer-sponsored supplemental coverage, and 10 percent are eligible for Medicaid, leaving only about 15 percent of beneficiaries with no supplemental protection.

This supplemental coverage, encompassing about 85 percent of the beneficiaries, largely insulates Medicare beneficiaries from out-of-pocket constraints on cost-conscious utilization behavior. This is particularly so, when coupled with the HCFA finding that 80 percent of the Medicare claims are paid on assignment, with no balance billing liability charged to the beneficiary by the provider.

When Medicare was first proposed, the general plan was to reserve certain allocations of funds and pay on a fee for service basis for physician services and for the reasonable costs of hospital confinements. As the program matured, expectations of the beneficiaries increased as did the ability of physicians to provide increasingly more complex services. Medicare also became responsible for a greater eligible population as the
percentage of elderly grew. Furthermore the numbers of those over the age of 75 is increasing disproportionately, making up 3.7 percent of the population in 1970, to 4.4 percent in 1980, and 4.9 percent in 1986.\(^1\) By the year 2020 there will be 6.7 million over the age of 85, which will almost double by 2040 to 12.2 million.\(^2\)

In April, 1990, the Social Security Board of Trustees reported that the Medicare Hospital Insurance Trust Fund would be exhausted shortly after the turn of the century unless health care costs are curbed.

"These findings underline the urgency of our task in containing health care costs and spending our health care dollars more effectively and efficiently", HHS Secretary Sullivan said.\(^3\)

Not only is the Part A trust fund in a precarious position, there is also unprecedented growth in the Part B program. A recent study concluded that Medicare Part B expenditures grew by almost 15% per enrollee between 1983 and 1985. The majority of the increase came from volume and intensity of service, the study concluded. The authors speculated that the increasing physician assignment rates and the increase in the income of the elderly population could be responsible for some Part B growth, particularly with growing availability of, and demand for, new technologies and procedures. They also noted that the Medicare hospital prospective payment system has apparently and concomitantly shifted some care and costs to settings paid under Part B.\(^4\)

HCFA began in the early 1980s to consider a variety of initiatives that were designed to hold the cost of the program down and to enhance the quality of care that was being delivered. In other words, to bring managed care to the Medicare beneficiaries.

Managed care in the broadest sense is the delivery of health care services in an environment where utilization and price may potentially be changed. Furthermore, it is the recognition that the direction of each perturbation may be different and that the product is an integration of all extant programs and pressures affecting access to care, quality of the care and cost.

There is an inherent acceptance of the fact that artificial alterations in price may alter volume in a way that tends to nullify the difference in products. For instance, a reduction in price may prompt behavior to increase frequency or intensity of service, to regain lost revenue. Sometimes these effects are desired for an improvement in quality and/or efficiency, such as an increase in expenditures for outpatient services when a procedure previously but unnecessarily provided in a more costly inpatient setting can be more appropriately provided on an outpatient basis.

Managed care can basically be regarded as a combination of Utilization Management and Selective Contracting. Utilization Management is a balance between utilization review and quality assurance. Utilization review may take the form of precertification or prior authorization for service, concurrent review or retrospective review for in-patient care or ambulatory review for out-patient care. Second surgical opinions for targeted procedures may be required. The entire review process will usually take into account medical necessity, appropriateness, cost efficiencies and inefficiencies, quality, and potential abuse or fraud. Quality assessment, on the other hand, is the necessary check and control that prevents inappropriately intrusive or restrictive service delivery from occurring to the detriment of the patient.

To illustrate the inter-relationships and potential relationships, utilization review may be performed to determine if the service is medically necessary, and, if necessary, at what level of care, such as inpatient or outpatient. Retrospective quality assurance may be targeted on a specific procedure or provider to see if appropriate structure and process have been used, and that a satisfactory outcome is obtained. Quality assurance may also be used to determine if the population at risk is under-served, because of inappropriately restricted utilization parameters. The combinations utilization review and quality assurance, utilization management, may result in preconceptual anti-smoking counselling for potential mothers, as a solution to reduce premature baby in-hospital days. Utilization review alone may focus on reducing premature baby days by early discharge from hospital and quality assurance alone focus on the structure and process of care.

Selective Contracting with specific providers, be they physicians or hospitals, potentially enables contractual commitments and obligations for pricing economics and product service delivery. Broadly categorizing these obligations they are designed to focus upon risk management, case management and cost containment.

Pursuing the ultimate goal of realizing maximum value for the health care dollar requires simultaneous attention to the interrelated dynamics of price, volume and quality. How such attention is applied, and who — payor, provider and/or patient — assumes the primary stewardship responsibility, can be loosely characterized along a spectrum of:

- controlling price and process — by setting and enforcing limits on prices and closely supervising the service delivery process, the payor retains "hands on" stewardship responsibility.
- encouraging cost-effective service use — by offering incentives and choices, the payor shares responsibility with providers and patients.
- entrusting care and cost management responsibility — by allowing providers to assume financial risk with greater freedom to manage care and assure patient satisfaction, the payor's attention shifts to the "bottom line" of cost and quality outcomes.

This spectrum of payor-provider relationships and accountability influences health service delivery through a parallel range of utilization management approaches:

- Controlling price and process generally entails intensive oversight by the payor of individual services, through retrospective review of a sample of claims submitted by the universe of providers, and prior authorization of selected high cost services.
- Cost-effective service use can be encouraged by offering consumers incentives to choose efficient providers who might be identified through price and practice pattern.
profile, by payment incentive and/or selective contracting arrangements between the payor and those "preferred" providers, by making a "package payment" for a bundle of related procedures which allows providers some flexibility in managing costs and/or by employing case managers, primary care physicians, or specialist "gatekeepers" to influence service use decisions.

- Entrusting a greater scope of care and cost management responsibility to providers or other non-payor entities can be achieved by having them assume financial risk for the payor's full benefit package, through, e.g., per capita payments to HMOs or for episodes of high-cost care (such as coronary artery bypass graft, cataract surgery or head injury cases).

HCFA's strategy for pursuit of value in expending $111 billion Medicare dollars², and the evolution of HCFA's payment policies and program management initiatives in attending to the dynamics of price, volume and quality, reflect a proactive and persistent progression along the above spectrum. HCFA's policy and research initiatives clearly illustrate a gradual re-positioning of the federal payor role, moving away from intrusive regulatory controls toward offering incentives and choices, and promoting managed care and accountability for outcomes.

The "traditional" Medicare program, characterized by regulatory limits on costs or fees paid to individual providers for individual services and retrospective review of the appropriateness of individual provider-patient encounters, is no longer an accurate representation of the Medicare program today, and is less likely to be so in the future.

Cost reimbursement and regulatory cost limits for hospital care have been replaced by the prospective payment system (PPS) which offers providers incentives for cost-efficiency within each episode of hospitalization. Residual cost-based payments for capital and for certain excluded provider types present opportunities for further realization of hospital prospective payment incentives in the near future.

HCFA is developing a prospective payment system for hospital outpatient facility and ambulatory surgical center services, with capability to bundle related ancillary procedures such as laboratory and radiology services with payments for a clinically defined set of surgical and medical procedures. A prospective payment system for Medicare home health services will be tested in demonstrations beginning in late 1990, first on a per visit, and then on a per episode basis.

Incentives for efficiency offered by such prospective payment approaches necessarily prompt greater payor attention to potential volume increases (since providers can only generate additional revenue by increasing admissions) and to quality assurance, as providers trim costs of services within the prospectively-set payment rates. Witness the emergence of the Medicare peer review organizations (PROs) for medical necessity review, growing research investments in severity-adjusted rate-setting and outcome-oriented quality measures, and public information releases of hospital-specific mortality rates and nursing home deficiencies.

New initiatives for physician payment reform, based on a relative value scale of allowable fees for a defined set of services, represent a major step beyond the historical "usual/customary/prevailing" charge-based limits and the current regulatory payment incentives for physicians to keep their charges down and to accept assignment. Especially when coupled with Medicare volume performance standards which link fee increases to total program payouts for physician services, physician payment reform will effectively complete a systemic, albeit incremental, transformation away from the "traditional" Medicare program.

Other HCFA initiatives represent forays further along the spectrum — toward stronger incentives for providers to manage service delivery and more choices for value-conscious consumers, the Medicare beneficiaries. Simultaneous with the Medicare HMO/CMP program, through which over one million beneficiaries have chosen to enroll in a fully risk-based managed care plan for the entire Medicare benefit package, HCFA is pursuing a variety of alternative experimental efforts in the mid-range of the managed care spectrum:

- Demonstration projects will test the feasibility of negotiated package prices for episodes of high-cost care, for coronary artery bypass graft (CABG) and, potentially, cataract cases. Designated providers who agree to accept the package price will coordinate and pay for all institutional and ambulatory services needed within the episode. Providers not participating in the demonstrations will continue to receive "traditional" Medicare payments.

- Preferred provider organization (PPO) demonstrations, focused on encouraging beneficiary use of networks of efficient physicians, and testing different beneficiary incentive and physician network management models, are underway. Alternative models being tested include offering beneficiaries incentives to enroll in the PPO through reduced supplemental health insurance premiums (with Blue Cross and Blue Shield of Arizona), and a non-enrollment model oriented toward network physician compliance with stringent practice pattern guidelines (with CAPPCARE in Orange County, California).

- HCFA has invested in design/development work toward potential demonstrations of competitive bidding for laboratory services and durable medical equipment (DME), and in prospects for a "bundled" PPS payment for post-acute services such as home health, rehabilitation, skill nursing and/or DME routinely provided following hospital discharge.

- Joint ventures with employers and/or unions as risk-bearing sponsors of "Medicare Insured Group" demonstrations, for retiree group enrollment in managed care plans for Medicare and supplemental benefits, are being developed for demonstrations.

HCFA's experiences through these initiatives, which bear watching by the private sector, will surface valuable "lessons learned" in price and utilization management techniques that will foster further evolution toward a managed-care oriented, financially viable Medicare program. Nonetheless, there are
some constraints inherent in the essential makeup of Medicare that impose caution and limitations not necessarily applicable to more dramatic initiatives that might be pursued by private sector payors.

While Medicare certainly commands sufficient financial and administrative leverage to set or negotiate prices and to enforce stringent utilization management techniques, such as a monopsony perceived as too powerful. The intricate infrastructure of the health service delivery and financing system is perhaps too fragile to sustain dramatic or sudden re-posturing by such a large payor. Also, Medicare beneficiaries and, to some extent, the provider industries tend to cling tenaciously to the “traditional” Medicare program, in all its inefficiency, as an entitlement to be preserved and protected from too much innovation, too fast.

As cases in point, note that HCFA’s mid-spectrum initiatives are not “selective contracting” or “exclusive provider” arrangements, but rather offer providers the choice to become, and beneficiaries the choice to use, “designated” or “preferred” providers — retaining also the choice for beneficiaries to use “traditional” providers who choose to be paid in the “traditional” way. Note also that demonstrations of competitive bidding for laboratory and DME services were “constrained” by a statutory moratorium prohibiting the field test, and that the post-acute bundling and cataract PPO ventures continue to generate strong opposition from the affected and well-organized provider communities. Furthermore, in the Medicare Insured Group initiative, employers and unions have found it difficult to reach common ground with each other and with HCFA on acceptable balances of financial risk and utilization management responsibilities.

The “giant step”, from traditional Medicare to HMO/CMP enrollment options for beneficiaries, remains on HCFA’s managed care menu, and with some time and refinements, can mature to become a major factor in reshaping the Medicare program.

Although the federal government must proceed with caution and sensitivity, HCFA is persistently pursuing managed care avenues that promise greater value for the health care dollar. What is perhaps most notable is the variety and multiplicity of HCFA’s initiatives, to create momentum wherever and however it can be generated along the spectrum of approaches toward managed care.

REFERENCES