A Ten-Year Perspective on Medicare

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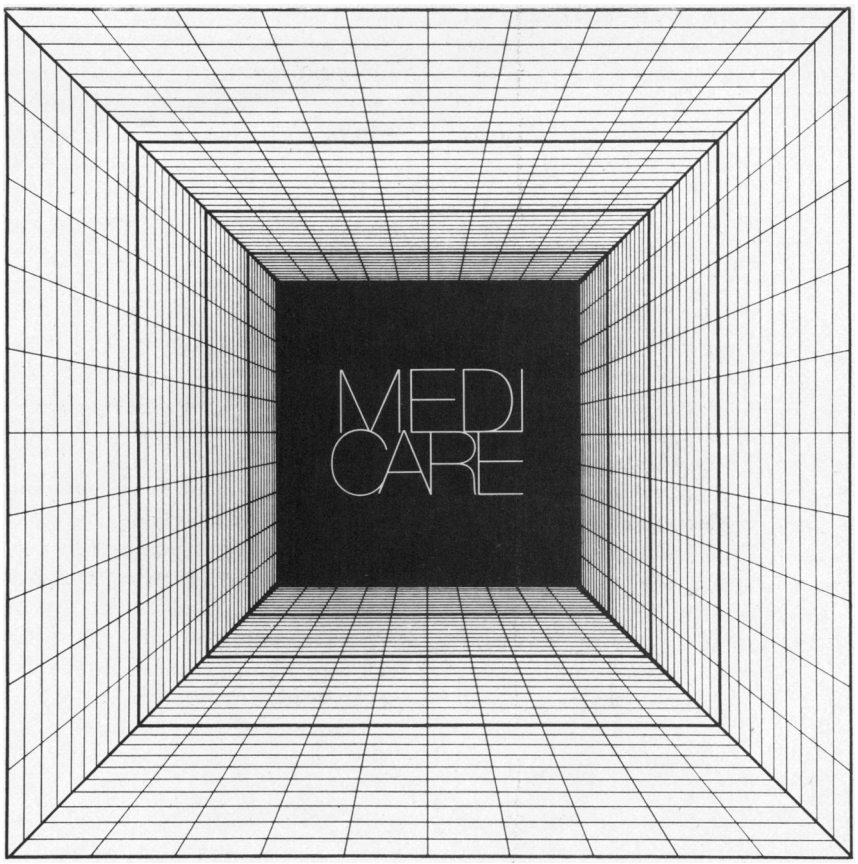

MEDICARE IS VIEWED by its supporters as a trail-blazing accomplishment and by its critics as a costly and temporary approach to the long-run issue of constructing a more logical system for financing and delivering health services to all, not just the elderly. The fact is, however, that Medicare provides the only significant Federal experience in the large-scale administration of health insurance for an across-the-board population. As a result, Medicare has flushed out a host of basic problems and highlighted anomalies in our health care system. It is unfortunate that it has become fashionable to disparage Medicare's accomplishments.

We tend to forget that Medicare's enactment was preceded by almost three decades of acrimonious debate

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over the question of whether national health insurance was necessary or desirable to provide access to care for those who could not afford it or for those to whom health insurance was not available. During the years that this debate went on, a remarkable development took place in the underwriting and administration of voluntary insurance to cover the cost of hospitalization for short-term illness. The patterns of coverage (for example, definitions and duration) and methods of reimbursement for services were refined to the point that it could be argued that government needed only to extend the same assurances of payment for services to the elderly that were used to guarantee the access of most of the working population to hospital care and accompanying medical and surgical services.

Coverage for the aged was the primary goal toward which Medicare's compromise legislation was directed. True, it was recognized that the prevailing pattern of service benefits skewed payments for services so as to reward those who treated inpatients and to discourage those who treated outpatients. For this reason, the framers of the Medicare legislation believed it important to bring coverage for the aged into better balance by providing extended care and home care benefits for patients needing skilled nursing services, but not in an acute-care hospital. Moreover, the new program provided striking extensions to the conventional insurance package for physician services. It provided for the reimbursement (subject to coinsurance and deductibles) of virtually unlimited coverage of necessary visits and procedures in the physician's office, the patient's home, and other locations where medical services normally would be provided. Thus, the two parts of Medicare provided almost the equivalent of catastrophic coverage, at least in connection with episodes requiring acute care in a general hospital.

Accomplishments

Viewed from the perspective of 1965, the enactment of Medicare and the first years of its implementation resulted in a tremendous forward thrust of insured hospital and related coverage on an equitable and nondiscriminatory basis to all aged persons. It extended entitlement to all the aged of coverage previously enjoyed only by those who had been able to carry into retirement an insurance coverage equivalent to the best of the service benefits and major medical coverages then provided by voluntary private insurance. Moreover, the new and broader scope of Medicare benefits assured the gradual application to all institutions of quality standards comparable in level and detail to the standards applied by the Joint Commission on Accreditation of Hospitals and to the standards for safety of physical plant embodied in the life safety code.

Foremost among the accomplishments of Medicare, then, is that millions of aged and disabled persons have received care more readily and in greater volume, with less concern for the ultimate financial burden of the costs, than they possibly could have before Medicare. That the program simply paid the bills for care rendered was not viewed at the time by the determining political forces as a matter deserving serious criticism.

In fact, the political consensus necessary to assure the enactment of Medicare could not have been achieved if the law itself, the committee reports, and the accompanying record of legislative intent, as well as the private assurances of leading political figures, had not affirmed the national policy that Medicare was not to "interfere" in the management of institutions or in the practice of medical care for its beneficiaries. Questions concerning appropriate use of services were resolved as "benefit questions" through (*a*) technical definitions of covered and noncovered services, (*b*) claims administration aimed at distinguishing between necessary and unnecessary services (viewed according to conventional practices within the professional community), and (*c*) reimbursement mechanisms designed to meet fully the reasonable "going" costs of services.

Costs were defined as incurred costs, accounted for retrospectively in institutions; charges for physician services were to be based on customary and prevailing charges in a locality. Although both the law and the administration of the law addressed the issues of utilization review and of appropriate accounting and pricing devices to assure "reasonable" costs and charges, it was clear from all the circumstances surrounding enactment that the operating climate was one of accommodation to existing experience in the private health care field. Indeed, the law mandated the use of intermediary insurance organizations, which were to apply their accumulated expertise in administering private health insurance to the administration of claims for governmental health insurance.

Placement of the day-to-day claims administration for Medicare in a private-sector environment was not only a crucial part of the political compromise that resulted in its enactment, but it undoubtedly assured the smooth transition that occurred. The nation's hospitals no longer had to look to voluntary insurance or other sources for payment of many of the bills of the elderly—they now had a public program to assure cash flow and payment for one-third of all the bed days of care rendered. Even with the use of available intermediary mechanisms, there was a massive changeover of systems, procedures, and relationships which would have been difficult for the government to handle through direct administration of claims. Particularly in the case of the part B coverage of indemnification for physicians' services, direct administration of claims by the government would have required procedural and psychological relationships difficult to establish in the climate that prevailed among physicians as a result of the decades of organized opposition to the legislation.

On balance, the use of intermediary organizations assured the success, initially, of program implementation. It is ironic, however, that the experience of volun-

tary insurance in the administration of health insurance claims proved lacking in many regards. As a result, the government was required to interpose increasingly stringent conditions of administration—beyond any thought necessary to claims administration in the private sector. The net effect has been a mutual learning experience for both government and the health insurance industry, but also an increasing disenchantment with each other.

Although the main public emphasis in Medicare has been on its fiscal operations—primarily benefits paid, to whom, and for what kinds of service—efforts aimed at improving institutional standards have been part of the program since its original enactment. In addition to the requirement that all providers of covered services must meet all licensure and safety standards of their respective State and local jurisdictions, Medicare superimposed a number of statutory and regulatory requirements for health and safety that must be met by any institution wishing to participate in the program. These regulations were worked out before and after enactment by government in close cooperation with professional bodies. The program also brought into being a sizable mechanism for enforcement and inspection by State health departments, with Federal funding of all administrative costs. As a result, there now exists a substantial pool of well-trained manpower and a solid body of State-Federal experience in the important task of applying quality standards to institutional performance.

Cost and Quality Controls

Almost from the beginning, it was clear that the Medicare trust funds could not be effectively conserved in a laissez-faire climate. Potential for abuse as well as fraud existed in the offer of new funding, especially for new services. Moreover, the virtually open-ended offer to institutional and professional providers to pay them for services rendered resulted in a rapid increase in volume as well as an extraordinary rise in prices or costs of service components. Strong inflationary pressures reflecting general economic conditions were linked with special factors bearing on the health industry itself. Indeed, the effects of the rapid increase in the costs of labor and the development of sophisticated technology upon this industry have been widely reported and repeatedly analyzed.

As they cast about for ways to control the mushrooming costs of the health industry, Congress and the Administration increasingly looked to the Medicare program as the way to exert leverage upon health providers. But many of the factors affecting costs were out of control in the health industry itself. Thus, for Medicare and Medicaid (dependent on the payroll tax and on public revenues, respectively) some forms of limitation—other than unacceptable rationing based simply on ability to pay—would have to be found. Accordingly, authority was provided for experimentation with a combination of new methods of payment and new mechanisms for quality control in the hope that they would point to ways by which to restrain increases in cost and establish more acceptable levels of quality and utilization. As the 10-year period drew to a close, general wage and price controls of the Vietnam era were dropped. Public policy again moved toward the concept that ceilings on Medicare reimbursement would set an example for the industry. Of course, although such ceilings help to constrain program outlays, they mainly shift the burden of inflation to the elderly patient and his family.

After the initial implementation period, the first efforts at questioning excessive use of services were conducted by the Social Security Administration through the intermediary mechanisms. Those who reviewed the claims for payment were pressured to question, and even deny, payment for services when their frequency or other characteristics were questionable. Thus, the borderlines between "necessary" and "unnecessary" services and the standards of what were acceptable medical norms for service to the elderly were largely established locally within broad guidelines. These efforts were first concentrated on duration of out-of-hospital services provided by extended care facilities, home health agencies, and certain physicians with high-volume claims. Subsequently, certain kinds of hospital stays were also questioned. This method of policing the utilization of services was, of course, crude and traumatic for both the patient and the provider. Its ultimate sanction was refusal to pay for services already rendered. Yet, the state of the art was such that no body of accepted criteria existed that could be superimposed upon the health delivery system to assure that the need for, and quality of, services would be independently evaluated during rendition, let alone that there could be a preadmission determination of the appropriateness of the services contemplated.

Even more crucial than whether criteria existed or could be established to serve the quality control function was the lack of a generally available review mechanism to build on. The only possibility was to encourage the rudimentary efforts being made in some more-advanced hospitals in which the organized medical staffs were monitoring the use of services, particularly in "tight bed" situations. This was the experience upon which the Medicare law attempted to generalize. A participation requirement was written into the law—all institutions were required to create internal utilization review committees to study admissions, duration, and volume of services. As an educational exercise, this requirement was an important step forward because it engendered a theoretical awareness among many physicians who had had little or no previous experience with peer review. The implementation of the utilization review provisions was spotty and concentrated mainly on long stays, but it undoubtedly helped to lay the groundwork for the subsequent adoption of more stringent peer review requirements. However, the genesis of

the subsequent PSRO (professional standards review organization) legislation undoubtedly was in the experience of the medical foundations and among those who were concerned with removing the locus of decision making on utilization from the hospital and from the claims intermediary to a physician-controlled mechanism.

In sum, the decade of Medicare experience provided much insight and experience concerning utilization review and cost control. But, as the decade closed, the several mechanisms in existence—internal hospitalization review, carrier and intermediary review, the brand new PSRO mechanism, and the demonstration and pricing authorities in the law—had individually and collectively made only small imprints on the volume of procedures and on the selection of appropriate alternatives to inpatient care. Of course, there is no way to measure results or to estimate how much worse the problem might have been without such measures. Yet, it was clear that stronger controls were needed.

The Medicare experience and the attendant mechanisms for monitoring the payment of claims have created a climate of awareness among patients and physicians of the program's increasing costs and of the need for husbanding its resources. But this awareness is not sufficient to overcome the technological imperative. Both patients and physicians know that an increasing array of tests and procedures makes it possible to alleviate discomfort or to achieve better diagnostic results. It becomes increasingly difficult to deny these to the patient simply on the grounds of questionable utility viewed from a cost-benefit relationship perspective.

Discussion and Conclusions

From the viewpoint of dollars expended, the decade of Medicare experience suggests that the population has expansive needs for service and that physicians, hospitals, and other providers of care have an insatiable capacity to absorb reimbursement. Indeed, the question must be asked: Is there any basis for rationing services and controlling costs other than to place arbitrary limitations on the overall availability of the resources to be devoted to the delivery of health care?

Such arbitrary limitations, however, cannot operate only in one segment of the population, nor simply on the benefit package. If the control is to be on resource expenditures, it will require placing stricter limits on capital investment, establishing some limits on prices, and probably mandating new methods of payment under which physicians and other providers will be motivated to deliver the most appropriate kinds of service available for a fixed pool of funds. A great deal of theoretical literature on these subjects was written during the first Medicare decade. Legislation was enacted authorizing demonstrations and experiments. But, few providers could be found in a period of general inflation who were interested in voluntarily adopting self-limiting payment methods.

Obviously, if the nation is to gain substantial experience with new delivery systems and new methods of payment for services, innovations cannot be solely at the option of providers, nor can they apply to public programs alone. Changes are needed that will apply to the health care delivery system as a whole and that also will affect the care funded through private insurance.

As we plan national health insurance—a program potentially encompassing the entire population of this country and covering by payment or regulation the whole health care industry—the experience of Medicare must be carefully examined for indications of what we can expect and what we should avoid. A strong Medicare program can constitute a foundation stone for national health insurance. Medicare by itself, however, cannot serve to bring about necessary but substantial changes in the lifestyles of patients, physicians, and institutions.

Improvement of Medicare now need not be inconsistent with a long-range agenda requiring more sweeping changes. Although some might not agree on an immediate objective of making the Medicare program more all-inclusive for those it now covers, all must wish it to be administratively more effective.

Steps can be taken now, at relatively modest cost, to improve the status of the elderly and the disabled under both Medicare and Medicaid. Patients, as well as providers who serve the elderly, often get an unnecessary administrative run-around because today the financing and the administration of payment for care is badly split among programs. Moreover, much of the cost sharing is carried by supplementary private insurance and by Medicaid, resulting in a myriad of duplicate transactions. The coverage and eligibility requirements of Medicare and Medicaid should be adjusted to make Medicare the basic, comprehensive program for all the aged—and to the extent possible for the disabled—providing them with a full range of hospital and medical services. Certain distinct areas, such as long-term care and services to the nondisabled and nonaged poor, could for the time being be left to Medicaid.

Immediate results could be expected in the form of simplified program administration, improved public understanding, and strengthened organizational accountability to contain medical care costs and to control abuse. These advantages cannot be made to flow simply from a change in the present Federal organizational structure or by moving responsibilities for the present programs from one part of the Department of Health, Education, and Welfare to another. We must sort out and realign the provisions of Medicare and Medicaid. In fact, the steps to be taken toward improving Medicare could be designed so as to make a major contribution toward the ultimate application of any new national health insurance program, a program that must have satisfactory provisions for the aged and dependent populations.