Symposium

Introduction

The importance of the Medicare and Medicaid programs and the magnitude of their impact is perhaps unparalleled in the history of health care legislation. As a consequence of their importance and the role they play in health care financing and delivery, there is a strong public interest in assessing the Medicare and Medicaid programs as they exist today, and in gaining an informed perspective on the future directions they may take.

Our intent was to solicit ideas and opinions on four fundamental issues relating to Medicare and Medicaid from a group of individuals who were distinguished by their expertise and who represented a range of outlooks and viewpoints. Symposium participants were asked to focus on the same broad issues, providing us with their individual perspectives on these program issues.

The framework for the discussion of the issues follows. We asked them to address the impact of Medicare and Medicaid on beneficiaries, health care providers, and the government, and to consider implications for the future. For the first three issues, highlights of the salient features of the programs were noted. Then we raised a series of questions for the participants to consider in developing their responses.

Impact on beneficiaries

The primary goal of the Medicare and Medicaid programs was to reduce the financial barriers to access to health care services for the subgroups in the Nation with the greatest need for health care services and the least ability to pay for them. The programs were designed to enable the eligible populations to enter the mainstream of health care.

Medicare was established as a uniform federally administered program for persons 65 years of age or over, who were identified as having the greatest need for health care services, the least private health insurance coverage, and the least income to pay for services. Later, Medicare was expanded to cover two additional high-risk groups: the disabled under social security and persons with end-stage renal disease.

Medicaid was established to operate as a State-administered program under Federal guidelines and was designed to include aged poor, low-income blind, or disabled persons under age 65, and poor families with dependent children. In most cases, receipt of cash payments under one of the welfare programs means automatic eligibility for Medicaid. States have considerable freedom in setting income levels and conditions of eligibility and the latitude to provide coverage to "medically needy" persons who fit one of the categories covered by the cash assistance programs.

Medicare was designed to cover payments for acute-care hospital services, post-hospital extended care, outpatient care, and physicians' and related services. Under Medicaid, each State's plan must cover payments for certain basic services, including inpatient and outpatient hospital services, physicians' services, laboratory and X-ray services, and skilled nursing facility care for individuals 21 years of age or over, but States have latitude to establish the scope of benefits, the inclusion of optional ones, and the methods of paying for services.

Medicare was established with cost-sharing features for Part A and Part B, with physicians having the choice of accepting or rejecting assignment. Medicaid was established to provide the basic services to the categorically eligible without a cost-sharing requirement.

What do you see as the most important strengths and accomplishments of the Medicare program and what do you judge to be the most salient shortcomings affecting the beneficiary population in terms of access, quality of care, health status, and financial burden? . . . the Medicaid program?

How have program goals evolved and how have such changes affected beneficiaries over the past two decades?

What do you see as the major challenges faced by beneficiaries under the programs in the future?

Impact on health care providers

The Medicare and Medicaid programs were designed as service benefit programs. The Federal Government and State governments were placed in the role of insurers, guaranteeing payment for covered services to hospitals, physicians, and other providers of services.

Medicare adopted the practice of paying hospitals according to their costs, and physicians according to a customary, prevailing, and reasonable charge method. Fiscal agents were set up to deal with the health care providers, with the major responsibility for providing reimbursements and auditing services.

For the most part, Medicaid adopted the practice of paying hospitals according to the Medicare reimbursement principle. Physicians and other health care providers could be paid under different payment mechanisms.

Though enacted together, Medicare and Medicaid reflected different traditions; Medicare was part of the social security system, and Medicaid was part of the public assistance programs.

What do you see as the key decisions made in the design of each of the two programs with regard to the relationship between government as insurer and hospitals, physicians, and others as health care providers?

What have been the major impacts of the Medicare program on hospitals, physicians, and other providers of care in terms of costs, expansion, technology, education, financial structure, and organization? . . . the Medicaid program?

How have the impacts on the providers evolved over time? And how do you see the programs affecting providers in the future?

Impact on government

Medicare was designed as part of the social insurance system. The hospital insurance (HI) trust fund was established for acute-care hospital and extended-care services. An additional tax on the income of current workers was established to finance the HI system. The supplementary medical insurance (SMI) trust fund was established for the voluntary portion of Medicare that covers physicians and related services. The financing mechanism consisted of contributions from enrollees and the Federal general revenues. It was intended that enrollees would contribute 50 percent. Currently, enrollee contributions cover about 25 percent of outlays, and the Federal general revenues, the remaining 75 percent.

Medicaid is financed jointly by the States and the Federal Government. In some cases, local governments contribute. The Federal share, determined by a formula based on State per capita income, can range from 50 to 83 percent.

The States have altered Medicaid program characteristics over the years in terms of eligibility and benefits much more so than the Federal Government has altered Medicare.

What do you see as the key decisions that were made in the design of the Medicare program that shaped the impact (notably expenditures) on government? . . . the Medicaid program?

What are the key issues regarding the current financing methods? Under Medicare's Part A program, current workers participate in the pay-as-you-go system. Is this inter-generational transfer an effective financing method, or should the burden be shared differently, say by all age groups? If changes are made, how can the Federal Government "re-draw" the contract and maintain confidence and trust in the system?

Under Medicaid, should the burden be shared differently than it is now by the Federal and State governments?

What do you see as the strengths and weaknesses of a uniform federally administered Medicare program in contrast to the experience with State-administered and differing Medicaid programs?

What do you see as the strengths and weaknesses of the major strategies developed (e.g., regulation, competition, flexibility, and others) to implement future policies under the Medicare program? . . . the Medicaid program?

How does society decide on the appropriate share of the gross national product to devote to health care? Should the percentage be open ended? Or controlled by budgetary allocation? Will our health care system need to ration care?

Implications for the future

Many people think that we are at a "crossroads" with regard to the future directions of the Medicare and Medicaid programs. The aging of the population, the expected shifts in the population pyramid, the impact of the growth of medical technology, and the size of public expenditures—these issues and others—appear to many people to represent crucial problems that require some major actions now with regard to the Medicare and Medicaid programs.

Do you think the Nation is at a major "crossroads" with regard to the Medicare program? . . . the Medicaid program? If so, what direction should the Nation take?

Will concerns over expenditures necessarily curtail the access objectives of the programs?

Are there ways to modify the programs that would produce better results for the same or lower expenditures? Or do you recommend major revisions to the Medicare program? . . . the Medicaid program?

Are there lessons that our Nation can learn from the experience of other industrialized countries?

Are there new goals and new perspectives for us to adopt now and in the long run that would serve to strengthen the goal of assuring access to care for the poor, the disabled, and the aged?

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Impact on beneficiaries

There are great differences in the degree of public satisfaction with the Medicare and Medicaid programs, even though they have similar goals and at times overlap each other in program implementation. This is partly because of important differences in their beneficiary populations and partly because of substantial differences in the degree of Federal financial commitment to the two programs. These differences have affected the public's attitude towards these two programs in ways that should have been predictable.

The overwhelming majority of beneficiaries in the Medicare program spent most of their adult lives in productive employment. The group therefore comes from a socioeconomic stratum where individuals either already had, or managed to obtain, enough education, ability, and opportunity to lead to sustained employment. Those very resources also served to help them survive and, at times, avoid entirely the major health problem areas that attack and decimate the poor: childbirth, infectious diseases, and accidents and those cardiovascular, gastrointestinal, and mental illnesses that are often stress-related. These health problems really flourish in an environment of poor nutrition, educational deprivation, and environmental stress, and are both more devastating and recidivistic among low-income groups.

The Medicare population has gotten past those dangers and is instead faced with the major degenerative diseases: cancer, emphysema, and arteriosclerosis in all its various manifestations. The course of this latter group of illnesses is often surprisingly amenable to improvement both by lifestyle modification, if done early enough, and by therapeutic intervention when care is accessible. Such positive results are observed to be occurring in the Medicare population. Many individuals reaching their sixties today do not yet see themselves to be "old," although many of those in the Medicaid program consider themselves to be "burnt out" before the age of 35.

The other major difference is in the funding. Medicare is funded through a combination of Federal dollars and beneficiary dollars (for coinsurance, deductibles, and premiums) which, at least theoretically, ought to assure a little of the individual's vested interest in utilization decisions. Medicaid, however, is only partly Federally funded, with the remainder dependent on the ability and willingness of State legislatures to make discretionary commitments from their treasuries to carry out a Federal mandate. The result for Medicaid is a patchwork quilt of different approaches by each individual State towards limiting the scope of benefits in the program as the State seeks to meet the priorities of its own legislature. Health benefits for the poor have become intertwined with welfare benefits and are usually administered by the same department. In most States, the resulting financial commitment to the individual patient is substantially below that made to the individual Medicare patient.

Medicare beneficiaries have banded together in vocal unity, finding financial and political strength, but the needs and perspectives of the Medicaid patient are not well articulated by the group. Such organizations as they have are not as well financed, as cohesive, or as effective—quite possibly for the very reasons stated earlier.

The stage therefore was set for the public to eventually see the Medicare program as a "medically successful" albeit costly effort. However, the public has felt a gnawing dissatisfaction with the Medicaid program, because expenditures that were grudgingly budgeted to begin with have not yielded similarly enhanced health outcomes. American society must understand the limited ability of the health care system alone to permanently impact the core problems of inadequate nutrition, education, and economic opportunity. The "preventive medicine" for those problems cannot be found in lifestyle changes or on the pharmacy shelf. Therefore, Medicare and Medicaid should never have their success or failure measured by yardsticks that do not adequately allow for these two major differences in the programs and populations served.

The Medicare program clearly has been immensely successful, not only in increasing access to basic care, but also to care of a high quality. This is because it drastically reduced economic barriers which previously existed for many. Before the enactment of the Medicare law, there was very little private health insurance available for those who were over the age of 65 and not employed. As a result of several factors, our Nation's population now enjoys significantly increased longevity. Life expectancy has increased from 70.2 years in 1965, when the law was enacted, to 74.4 years in 1983. These are the basic strengths and

accomplishments of the Medicare program, and they are substantial.

All health care providers have risen in public esteem to the degree that medical care is seen to have contributed increased longevity. With this higher esteem, however, has come additional demand for these apparently valuable medical services. A serious shortcoming in the Medicare program was the failure of the original architects and builders to adequately forecast what the realistic funding requirements would be in the future. They also did not foresee the explosion in technologic medical knowledge or recognize the inherent danger of having a program whose beneficiary eligibility could be so easily modified by the whim of the Congress. It is understandable that they tried to use a flat payroll tax (with a cap) as a means of insulating the program from the effects of long-term changes in our Nation's economy. That may have been an attempt to use insurance concepts for the program. Unfortunately, this was later eroded when Congress wanted to find a "painless" way to fund health care for the totally and permanently disabled. Conveniently, the Medicare program was there. This was followed during a boom economy by adding on the end-stage renal disease program by a Congress that was sensitive to pressure groups.

The Medicaid program has attempted to bring the poor into the "mainstream" of the health care system. It clearly did improve access to high quality care for about 15 years. However, that progress has been progressively eroded during the last few years because of a receding fiscal base of support in States that do not have the same luxury of sustained deficit budgeting as enjoyed by the Federal Government. For all of its encumbrances, the Medicaid program has had definite impact in improving the national survival rates of both mother and child in full-term pregnancies. Unfortunately, the gap between the poor and the affluent is still unacceptably large and will predictably increase with the projected Federal budget cuts in maternal and child health care programs.

No one could predict that, for more than a decade, successive Presidents and Congresses would create consecutive deficit Federal budgets which, combined with an energy crunch in later years, has lead to the current fiscal crisis of today. That crisis is directly responsible for the two major challenges to both the Medicaid and Medicare programs. Both groups must fight the threat of reduced benefits as cost savings measures on the one hand, while each simultaneously works to encourage the more efficient use of the system by their unique group of beneficiaries. As alluded to earlier, Medicaid beneficiaries have a muted voice, which adds to their difficulties in this political struggle.

Impact on health care providers

As far as providers are concerned, the choice of precisely how the hospital was to be paid has turned out to be easily the most pivotal decision in the design of both the Medicare and Medicaid programs. Evidently, the designers did not foresee the grossly inflationary and ultimately harmful effect on health care costs that would result from the decision to pay hospitals on a cost-only basis. Probably in innocence, the position was taken that it would be wrong for an institution to profit from providing care for the elderly. If the designers had prepared an environmental impact study at the time, they might have come to understand that institutions often act just like individuals; when there is no incentive or capability to make a profit, there is often virtually no incentive to be efficient. If a hospital with a large percentage of its patient population covered by Federal funds had to choose between getting a manual typewriter, an electric typewriter, or a word processor, they soon learned to choose the word processor. The design of the system told them costs were all they were going to get from the transaction, so they might as well go first class. The cost-based reimbursement of hospitals became the engine that drove health care costs beyond anyone's wildest projections. Thus, review of Medical Care Price Index data (which used 1950 as the index year for plotting subsequent changes) shows that between 1965 and 1975 (the first decade after the Medicare law was enacted) physician fees in this Nation rose by 12 percent. During the same timeframe, hospital semi-private rooms rates rose by 171 percent. Understandably, the rate of escalation of overall costs has attracted public attention. Because Medicaid, for the most part, has also paid hospitals according to the Medicare reimbursement principle, it has come under the same jaundiced eye of concern.

The customary, prevailing, and reasonable (CPR) method of deciding the amount Government is willing to pay for physician services under Medicare was designed to assure access to the wide spectrum of physician skills that specialization and new technologies have brought us. The CPR method was roughly patterned after the usual, customary, and reasonable (UCR) concept developed more than a decade earlier to help certain private insurers in determining if a specific fee was excessive or not. The unadulterated concept of UCR, as originally devised, was relatively faultless. Several modifications occurred on the way to the CPR method of deciding payment amounts, but a close resemblance to the UCR concept was retained. However, a problem developed when the private insurance industry stepped in and began to offer Medigap coverage. This assured first-dollar coverage and, unwittingly, effectively removed the patient from the payment transaction. No one who made health policy at the time thought this was too important, but any practicing physician can tell you that discussing the fee with a patient on a face-to-face basis tends to have an important modulating effect that is totally absent when one is billing a distant third party. Without that modulating effect, an inflationary trend has prevailed,

adding a booster rocket to the engine of rapid cost escalation.

The Medicare program has also been a boon to the further development and spread of specialization in medicine and health technology. However, what started as the tail is now wagging the dog. Government programs collectively have now become the single dominant insurer for adult health care in America. Because of concern about their growing costs, Government program managers initially sought more and more regulatory controls to bridle those costs. Although the effect of these controls is still debated, the majority opinion seems to be that regulation has not worked. Regulation could probably never simultaneously deliver both high quality care and the "right" cost because it tends to stifle creativity. Many physicians giving care today have come into the system within the last 20 years and have never known any other way. It is predictable that any change in the system will be difficult for many of them to understand, and accommodation may not be easy.

As these programs change in the future, they will almost surely establish the path in which private-sector-financed health care will follow. Just as access and quality can have a substantial impact on cost, the reverse is equally true; efforts at cost control have a like potential for influencing access and quality. Those providers of care who seek to find continued personal satisfaction and excellence in their work will need to have adaptability. The great danger for all parties, however, is that concerns about cost could express themselves in sufficient "carrots and/or sticks" to drive physicians into a retreat from professionalism. Their credo must always be "healing first and profit second." National deficit spending because of defense and energy priorities, however, is now creating tremendous social and economic pressure on that credo, driving it towards a concern about dollars first and healing second.

Involving the greater society in a more equitable sharing of the financial burden of caring for the poor under Medicaid was certainly a plus, but an important side issue here is that Government also specifically introduced the concept of entitlement to health care funding based on age alone rather than the ability to pay. Many senior citizens who would have experienced no financial hardships in purchasing health insurance, if it had been made *available* before 1965, now have that availability, but they also have their care largely paid for by younger generations who are still working. A political gift has been made to both the needy and the self-sufficient, and I feel we have crossed a threshold over which there is no easy retreat.

Impact on government

Two critical decision points occurred in both the Medicare and Medicaid programs that affected our Government significantly economically and indelibly sociologically. The first, common to both programs, was the decision by Government to use the cost-based approach as the basis for payment of hospitals. This approach simultaneously destroyed opportunity for hospitals to profit from their services and removed their incentive for efficiency. This also created the propulsion system that drove health care costs inexorably upward. More important, hospital administrators were diverted from competition with each other to the new objective of attaining maximal flow of these "nonfat, zero-calorie" Federal dollars.

The other critical decision point in the two programs happened to be entirely different for each, and in neither instance did Government offer a definitive answer to the problem.

In the Medicare program a problem arose because of a decision by the private insurers to enter the picture and offer Medigap coverage. This provided first-dollar coverage and effectively removed many patients from having significant concern about the cost of physician services. This proved to be another inflationary stimulus, gradually adding to Government's financial concerns. Government did not address this in any direct fashion, thus giving up one of the original build-in checks and balances in the program. This might be called an example of a nondecision.

On the Medicaid side, the second critical point was probably the failure to sustain President Lyndon B. Johnson's War on Poverty, which was the only attempt of our country to confront the core issues of why Americans have an economically poor segment of our population. That program, and its successors, have fallen victim to other priorities. Even the finest health care system in the world (which I consider to be the case here in America) cannot provide adequate nutrition, education, and economic opportunity out of the doctor's house-call bag. Unless that prescription for the Nation is filled, those health care needs unique to the poor will continue to exist and probably increase in size.

The key issues now facing Government for the Medicare program are, on the one hand, the lack of predictability for overall Federal costs each year and, on the other hand, the fiscally unsound manner in which the Part A program is currently funded. The transfer of funds across generations is robbing-Peter-to-pay-Paul economics at its worst, and it has come to be recognized for what it is—a growing percentage of elderly citizens receiving health care that is largely paid for by a correspondingly dwindling percentage of workers.

A major flaw in the current Medicaid program is the unevenness from one State to another of the health care benefits to which beneficiaries have access. A strong case can be made, particularly in the Medicaid program, that inadequately funded health care is actually significantly more expensive, in the long run, to the Nation as a whole. Inadequate funding leads to suboptimal outcomes which have their own costs to the Nation, not only in mortality and morbidity, but also in lost economic and creative productivity. America must have the vision to realize

this is not a guns versus butter issue. We have not been "saving" in the overall sense, because the eventual total cost in resources has been much greater than the sterile dollar estimates usually made by statisticians.

As with many other things in life, health care services done well and promptly are far more cost effective than any other alternative. This means the health benefits package in Medicaid must become both adequate, as defined by the American Medical Association in 1983, as well as uniform across the country. In its first term, the Reagan Administration made clear its desire to see welfare program funding shifted to the States. Whether a national uniform health benefits package for the poor that is truly adequate can be mandated within the confines of the Reagan goals remains to be seen. Until now, the individual State's contribution to the funding of health care under Medicaid has been according to its estimate of its ability to pay. The program's dependency on that concept no longer seems practical.

Whatever future form these programs take, they must have administrators and here there is clearly room for improvement. I believe the private insurance industry is far more capable than Government to function as administrators of a health insurance program. If the public and health care providers can be assured that these health insurance programs would contain, as a minimum, the health insurance package of adequate benefits as defined by the American Medical Association in 1983, a voucher system would clearly lead to great economies and, simultaneously, take Government out of the insurance business.

For four decades, the hallmark of American medicine has been creativity and innovation. Thirty years ago this past April, the Salk vaccine passed its last tests and was released for public consumption. A Nation of approximately 165 million was enduring 55,000 new cases of paralytic polio every year. Overnight that changed, and today the Nation has less than 20 new cases each year, thanks to creative genius.

Regulation can never work as a cost-containment tool in the provision of high quality health care. Under regulation, creative energy, if not stifled, tends largely to be channeled into trying to circumvent this regulation. Health care needs are far too individualistic to be determined by any single inflexible agency. Every individual has priorities that are unique to that person at any particular point in his or her life: education, recreation, family, religion, housing, etc. Health care must find its place among many items, and the amount of personal resources that should be committed will vary in a personal way. Hence, a variety of options must be available. Society will only know the appropriate share of the gross national product to devote to health care when it not only allows, but encourages, involvement of patients in health care decisionmaking for themselves. This is best done by allowing a modest amount of cost sharing in all decisions by those who can afford to pay for their health care. The cost-sharing amount should ordinarily not be enough to prohibit an individual from having the service so much as to simply sensitize and make the person interested in the cost of health care decisions. Conversely, for those who cannot afford to pay for care, positive incentives consisting of rewards for good decisionmaking should be used. In my opinion, the use of penalties for poor decisionmaking by the indigent simply does not work and is self-defeating in the long run.

Returning to the subject of those who can afford to pay for care, the question of how much should the American public pay for health care is often raised. Where any third party (Government or insurance entity) is involved as a fiscal agent, all it needs do is determine how much is the maximum its program will pay for specific services, based on its available premium resources and a reasonable projection of what is the expected pattern of utilization. Any difference between what the third party determines to be the maximum sum payable for a given service and what the health provider charges should be open to discussion and negotiation between the patient and the health care provider. Obviously, people have to have the opportunity to know what those charges are likely to be before they agree to have the service. That is essential. If these concepts are adhered to, there will be no need for care to be artificially "rationed". At the same time, each third party will have the predictable outlay it desires, and Government will have the answer to its conundrum of "What is the appropriate share of the gross national product to go to health services?"

Implications for the future

We have a growing national budgetary crisis that has been fueled by many other, often larger, factors than health care costs. Nevertheless, largely because of this, health care financing is already undergoing change. It will doubtless experience more change in their near term. With change there are rather obvious dangers, but change also provides an opportunity for creativity.

Entitlement by age as a concept has been sold politically to our electorate and is undoubtedly here to stay, but it must be made fiscally sound. If we are to continue the concept of entitlement by a defined age, then eventually each group achieving that age must have paid its way, but based on each individual's ability to pay. There are already a large number of individuals operating under the old social contract, and any change that occurs must be phased in (with the funding mechanism of the old contract simultaneously being gradually phased out) over a period of time. This would require a minimum of two, perhaps three, decades. Since the new entitlement approach I am suggesting would also apply to everyone based on age, there can be no opting out of this new system either. All must pay as they go along, but contributions would be targeted to fund the needs of each specific age group. In the meantime, until the existing Medicare program is phased out, its source of

funding should remain basically as is. As one progam is phased in and the other is phased out, there will necessarily be a dovetailing in sources of funding, but the benefit package should remain the same. This can be worked out both actuarially and politically.

Two important additional points should be made when thinking of how we address the future. They concern the Federal commitment to education and to the poor.

Medicare has been an important source of funding for residency training programs. As a practicing physician, I can identify with the desire to see patient care funds targeted to result in more benefit to patients. I recognize the common perception that medical education costs are somehow more beneficial to physicians than the patients they serve. Although I cannot quantitate it, I know the scales have been improperly balanced. House staff training programs have always given back significant advances in medical knowledge far more often then they are credited for. Let me give just two brief examples. Few people know that the entire field of cardiac enzyme analysis to detect a myocardial infarction was initiated by the ingenious seminal work of an American resident physician, Arthur Karmen. His work with the serum transaminase enzyme opened a doorway of information ultimately benefiting millions of people around the world. His only significant reward was that for a few years the SGOT (serum glutamic oxalacetic transaminase) was measured in Karmen units; then "international units" supplanted his name in the terminology. In the early 1970's, another American resident physician, Bergein Overholt, was the first person to use a colonoscope with flexible fiberoptics on a human being. That development has since spared hundreds of thousands of patients around the world of the need for major abdominal surgery in instances now manageable by the colonoscopic approach. One could list many more instances; the point is that there has been, and continues to be, substantial public benefit from residency and fellowship training programs. These benefits go beyond the patient care rendered, but this reality has not been recognized by the public. Shifts in the funding of medical education will undoubtedly occur but, before they occur, reasonable and rational efforts must be made to replace that funding. Much more is at stake than simply the direct patient care rendered.

As we move into the future, I hope it will be with wisdom gained from our past. I have touched on the experience of the Medicaid program and dwelled not unduly on its inadequacies. There is good reason for every American to view those inadequacies with concern. The economic experiences of the last 5 years have shown many middle-income Americans that they are not as insulated and secure as they once believed. Many should realize they are really only two, or perhaps three, paychecks away from welfare themselves.

The original goal of increasing access for the two defined populations was, and continues to be, worthy. We have seen flaws develop, as must occur in every human endeavor, however, as a Nation, we now have a base on which to build while we correct the flaws. We should carefully assess what has occurred in other industrialized countries, both the good and the bad, although we should not lose sight of the important differences in culture and resources that can make transplanting of ideas quite hazardous. Most important, it is not idle jingoism to say health care in America is more effective today than that rendered anywhere else in the world. As we make needed adjustments, we should ensure that we protect what we have already achieved.

We have finally moved away from cost-based payment for hospitals, but prospective pricing for hospitals is not, and should never be considered as, an end point because it only moves Government over into a different version of the regulation game. We should recognize that our objective must be to move towards a true market concept where the beneficiary has an opportunity to know enough about both the product and the providers to be selective, and has a vested interest in making prudent decisions. The public must have, as much as possible, access to enough information about hospital prices and physician fees to make an informed choice. Such information must be made easily available, but in a way that recognizes both the dignity of the professional and also the right of the patient to know.

Even with better-informed, economically sensitive beneficiaries and providers, the funding of both programs will still need to be changed, as I have suggested earlier, to make them fiscally sound for Medicare, and socially equitable for Medicaid. With positive incentives for all parties, it is possible to achieve efficiency and yet maintain individual freedom. That would be a goal worthy of our unique national heritage.

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Impact on beneficiaries

"Everything begins in sentiment and assumption and finds its issue in political action and institutions." Lionel Trilling's remark is especially apropos to Medicare and Medicaid. These two programs began with utopian sentiments and assumptions of unlimited resources. The vocabulary of unconditional entitlement is still used, but other themes, stressing individual responsibility and entitlement based on means, are becoming more prominent. In general, overly optimistic assumptions have been replaced with a realistic sense of fiscal limits.

The new realism is forcing a recognition that major reforms are necessary. It is both morally and economically unacceptable to burden future generations with our health care bills. Adding to our children's and grandchildren's debt without adding to their inheritance is like trying to get something for nothing without the other person's consent. Yet, people who became eligible for Medicare in 1983, for example, will receive between 6 and 25 times as much in Medicare benefits as they contributed (Health Care Financing Administration, 1983). The ratio of people's contributions to Medicare payments in their behalf will probably rise as more people spend their working lives paying into Medicare; but, even under rosy projections, current generations will be getting more than they give.

Although Medicare beneficiaries today have access to high quality health care, many would argue that they do not receive the best value per health care dollar spent; for some elderly, out-of-pocket health care spending is still a high proportion of income. The social contracts between society and Medicare beneficiaries and Medicaid eligibles need modification as does the way health care to the elderly is financed.

Granting that basic changes in the sentiments of beneficiaries, providers, and Government are vital, there is nevertheless ample gestation time for the creation of new institutional arrangements. According to the latest projections from the trustees of the hospital insurance trust fund, it is not likely to go into deficit until late this century or early the next (Health Care Financing Administration, 1985).

Medicare has been a brillant success in lowering financial barriers to access to health care services. Since its inception, the percent of people 65 years of age and over using the hospital has risen significantly (Lubitz and Deacon, 1982); about one-third of the Nation's health care spending today is for people 65 years of age and over, up from less than one-quarter in 1965 (Fuchs, 1984). These clearly are indicators of success.

Because funds available to pay for the aged's health care over the long run appear likely to fall well short of projected demand, rationing is inevitable. There are two fundamentally opposing rationing principles. One is the egalitarian: If everyone cannot have a certain kind or level of service, then no one should. The other is what I call the humane pluralism principle that:

- Guarantees everybody both access to good care and freedom from the fear of financial devastation by catastrophic illness.
- Gives precedence in public programs to the less fortunate.
- Requires greater self-reliance of the more fortunate.
- Puts a high value on a wide variety of health plan choice and, therefore, tolerates many different health care systems with access to care, above what Government payments will buy, subject to ability to pay.

I advocate reliance on humane pluralism for several reasons. First, it best promotes that level and mix of health spending that will give Medicare beneficiaries the best possible health care for the dollar. With a pluralistic rationing system, millions of beneficiaries will be searching for the best buys in health care coverage. This process will reveal the best value versus cost tradeoffs far faster and better than the central rationing authority that would be required under the egalitarian principle. Second, adoption of the egalitarian approach in a democrary that exalts individual rights is almost certain to overburden future generations. If each person wants more but can only have it if everyone has equal access, then the pressure on politicians will be overwhelming to offer a new benefit and let future generations worry about how to pay the bills. Third, if authority to make rationing decisions with life or death implications were concentrated in our political institutions, the respect, trust, and affection politicians must have to govern well would be weakened. Who wants leaders who feel comfortable denying care because it is too expensive?

If adaptation to the need to ration is based on the pluralism principle, the following changes affecting beneficiary participation in financing their own health care would be fitting:

- Medicare would assure that the minimum benefits guaranteed to all beneficiaries would include coverage for the costs of catastrophic illness. Besides relieving the aged of the worry that catastrophic illness will leave them destitute, this reform would significantly reduce beneficiary confusion as to what is covered. To the extent that this feature would require additional outlays, it could be financed by an income-related premium surcharge. Actuarial analysis indicates that the extra cost per enrollee would not be prohibitive (Gornick, Beebe, and Prihoda, 1983).
- The noncontributed portion of the average annual Medicare cost per beneficiary would be included in the calculation of taxable income for Medicare beneficiaries (aged only). To avoid double taxation of beneficiaries, the amount added to taxable income would have an equal Medicare's per beneficiary cost multiplied by the percent of payments to the hospital insurance trust fund and the supplemental medical insurance trust fund *not* financed by employees directly. (Adjustments like those made to social security would be necessary to avoid taxing Medicare contributions in behalf of people with low incomes.) In an era of huge budget deficits, it makes little sense to excuse the affluent elderly from the societal obligation to assure that the financially stressed elderly have access to good care.
- Eligibility for Medicare should be raised to 67 years of age over a multi-year period so that it eventually conforms with eligibility for social security. To assure that people 65 years of age or over have the opportunity to be productively employed and therefore self-reliant, this reform should be accompanied by more flexible arrangments as to wages, benefits, and hours of work. Given the increase in life expectancy, a new definition of old age seems in order. In 1935, when the social security program was born, life expectancy at age 65 was 12.5 years. By 1982, life expectancy at age 65 had increased to 16.8 years (Waldo and Lazenby, 1984).
- To preserve beneficiary choice, beneficiaries must have the right to pay health plans extra if they want a higher level of service than could be offered at the Government payment rate.
- There should be an inquiry into the desirability and feasibility of asking each generation to take responsibility for financing its own retirement health care needs. Specifically, thought should be given to establishing, over the long run, a link—not by individual but by age cohort—between funds contributed by and for Medicare beneficiaries during their working years and funds made available by Medicare for health care coverage during their retirement.

The enactment of Medicaid represented society's recognition that financial barriers to adequate health services ought to be removed and the cost borne by all taxpayers. For the poor, this program has been a huge success. Per capita visits to physicians and other health providers by low-income individuals have increased dramatically (National Center for Health Statistics, 1984).

The failures of the Medicaid program are directly related to the fact that there are 49 State programs with widely varying income eligibility and coverage provisions. As a result, there is no national eligibility floor, and access to governmental assistance for health services is denied to many near poor and medically disadvantaged Americans. Those individuals who remain uninsured form a large block of our population known as indigents in health care terminology; until society defines its commitment to them, our national health policy will remain incomplete and unsatisfactory. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983) questioned the logic of national policy that subsidizes employer-paid health insurance through the income-tax exclusion while spending substantially less on health programs for the poor. The Commission said, "This pattern of care is difficult to justify from an ethical standpoint. There seems to be little reason for such Government assistance to middle- and upper-income individuals, most of whom could take financial responsibility for their own care . . . without undue hardship."

As the States attempt to make more cost-effective use of their Medicaid funds, the major challenge to Medicaid eligibles will be to maintain access to adequate quality of care as their freedom of choice to select providers is necessarily restricted. Alternative health plans will be utilized increasingly by State governments to fix a capitated price per eligible for total health care. We can and must assure that quality is assured as that shift to restricted freedom of choice occurs.

Impact on health care providers

The key features of Medicare's payments to providers have been service-specific payment, different coverage for different services, reasonable charge-based payment to physicians, and, until 1983, retrospective, cost-based payment to hospitals. The defects of Medicare's payment system are serious and well known, but we should not forget that it did what it was originally designed to do very well. No other form of payment would have spawned so rapid an increase in the availability of state-of-the-art care for acute illness. Whatever else it did, Medicare gave a powerful boost to the spread of new technology and to an upgrading of the Nation's hospital plant and equipment.

Although Medicare's payment system was suitable for an era dedicated to greater access, it is not appropriate today. When there is not enough money to meet everybody's perceived needs, a focus on productivity must be paramount. However, the incentives inherent in Medicare's coverage and payment policies remain at odds with the behavior needed to deliver the best care possible per available

dollar. The completeness of insurance coverage varies greatly and payments are service-specific rather than patient-specific, i.e., capitation based. A fragmented payment system means that it is in no one's interest to manage the course of a patient's care from prevention to treatment so as to provide high quality at minimum cost. The care that would produce the best health outcome per dollar almost never is the same as the mix and level of care that maximizes reimbursement. This arrangement condemns Government and providers to an unending battle over the appropriateness of care with the best judges—the beneficiary and his physician—remaining on the sidelines.

With Medicare's introduction of its prospective payment system, the conflict between provider incentives and Medicare's goals was diminished. By cutting the link between cost and payment, Medicare's prospective payment system forces hospitals and physicians to strike a balance between the patient's interest in having the best of everything and society's interest in containing costs. Besides substituting cost-cutting incentives for cost-increasing incentives per case, prospective payment also has forced physicians and hospitals to work together as an economic unit. This cooperation is a prerequisite for delivery of better care at less cost.

Although an improvement over cost-based reimbursement, prosective payment itself must be replaced if further progress is to be made toward better quality per Medicare dollar. Prospective payment has all the defects of a centrally administered pricing system. The variety of local supply and demand conditions for both hospital inputs and outputs is, for all practical purposes, limitless. Thus, no general rules (necessarily based on averages) will appropriately account for the specific circumstances of many and perhaps most hospitals. On the other hand, it is impossible for the Health Care Financing Administration (HCFA) to collect the information needed to set prices properly for several thousand hospitals. Even if HCFA could set prices just right at one point in time, it could not adjust to changes fast enough to avoid large arbitrary shortfalls and windfalls.

Because Medicare, as often as not, will miss the mark, it will be subject to intense, unending pressure to grant exceptions. The process of adjustment will become increasingly politicized, and adjustments will become increasingly remote from what is necessary to set prices at the right level, as close as possible to individual hospital long-run average costs. Winners will keep quiet. Losers, almost always having legitimate reasons for complaint, will petition vigorously. Over time, the exceptions will become the program; both hospitals and Government will be entangled in an ever-spreading regulatory snarl, characterized by costly and time-consuming administrative and judicial appeals.

The losers will be not only politically weak hospitals, but Medicare beneficiaries and taxpayers as well. Medicare enrollees benefit the most and taxpayers get the most productive use of their dollars if hospitals have to compete for patients, with the biggest share going to those hospitals that, in the perception of patients and their physicians, provide the best care per dollar available. By contrast, under prospective payment, Medicare payments to hospitals are allocated by bureaucrats and politicians. The result is misallocation and inefficiency. This happens not because of the lack of competence or good will. It occurs because of lack of information and the fact that the hospital groups with the most political power are not necessarily the ones that would win in a competition where physicians and patients are the judges.

If Medicare is to contain costs while still meeting beneficiary expectations for quality and access, I believe a two-track strategy is necessary. In the short term, payment rates should be adjusted to better reflect factors affecting a hospital's costs but beyond its control. To minimize arguments over fairness and to make the greatest possible progress toward this goal in the least amount of time, HCFA needs an adjustment measure that meets two tests:

- It is based on objective, replicable measures whose variations are strongly associated with patient cost variations.
- It accounts for the biggest part of the difference between the current payment rate and the rate that would fully, but exclusively, reflect cost-influencing factors beyond the hospital's control.

A severity measure (if one could be developed in a reasonable amount of time) would best meet these tests. Recent research (Brewster, 1984 a and b) indicates a high association between severity and cost; the addition of some severity adjustment, even though not a perfect one, might do more to account for uncontrollable cost-influencing factors than anything else. Since factors such as bed size, urban area population, and proportion of low-income patients served are useful mainly as proxies for patient health status, the adjustment of payment rates by a direct measure of health status might make the need to use such proxies moot.

Long-term, fixed price should supplant a la carte. Specifically, HCFA's fragmented, service-specific payment system should be replaced with a fixed payment per year to a health plan of a beneficiary's choice. All plans would be required to cover a specified set of services, including catastrophic coverage. Beneficiaries should be allowed to keep the difference between the per beneficiary amount and the actual amount charged by the private health plan. Conversely, if Medicare beneficiaries wanted a more generous health insurance package than the fixed Government payment would buy, they would have to pay the difference.

The advantages of a capitation approach with providers at financial risk are compelling:

- Providers would have the flexibility and the incentive both to minimize cost per unit of service and to find for each patient the most efficient mix of services.

- No longer would providers find a conflict between the mix of services that paid the most and the mix that provided the most cost-effective care; nor would they have an incentive to increase the volume of services.
- Problems with either the total cost or the quality of any aspect of a patient's care would be more rapidly identified and remedied because accountability for both the cost and quality of health care would be combined and therefore much more focused. One organization would be at financial risk for the total cost of covered services and solely responsible for their qualilty.
- Beneficiary paperwork and confusion over what was covered would be minimized.
- By offering beneficiaries a much greater choice among health plans, Medicare would better accommodate individual beneficiary preferences.
- Perhaps most important, rationing decisions would be decentralized. Above a mandatory minimum level of coverage, health plans would be free to compete according to different coverages as well as by price. Difficult decisions as to who should be covered for what, above certain societally mandated minimums, would be decentralized and depoliticized. The unavoidable process of making painful rationing decisions would devolve to those people best qualified to make them.

Although I believe that capitation-based payment is clearly superior, there are implementation problems. The most serious are the related problems of adverse selection and the setting of capitation rates. Adverse selection occurs when, by provider design and/or by consumer choice, people likely to be above average users of health care services are concentrated in a few plans. Adverse selection would not be that serious a difficulty if fixed Government capitation payments could be set accurately to reflect the cost of each patient's expected usage, given his or her health status upon entering a health plan or renewing participation. The technology needed to identify high-cost users in advance, however, is not well developed. The capitation rate-setting process would also be plagued with many of the same problems besetting the prospective payment program, e.g., how to measure and account for uncontrollable cost-influencing factors in addition to patient health status.

No one knows the dimensions of these issues:

- How serious the adverse selection problem really is.
- How popular capitation payment will be with Medicare beneficiaries.
- How to provide for good quality control, adequate patient information, a smooth transition from the current payment system, and adequate policing to assure that health plans compete on price and quality dimensions, not on who can best avoid the sick.

Given our ignorance and the great potential advantages of capitation payment, HCFA should concentrate its research and demonstration program efforts on finding answers to these capitation-related issues.

Ultimately, the choice between capitation or a much more regulatory approach to Medicare payment will turn not on technical issues but on a political judgment: Do we want to concentrate or decentralize the process of deciding how to reconcile the patient's interest in the best of everything with society's interest in containing costs? With concentration, providers will have to accept a higher level of coercion than they are used to and the range of available treatments will be narrowed. With decentralization, society will have to be willing to accept many different levels of care with access to exotic but expensive new treatments partially dependent on income.

The limited State resources devoted to Medicaid providers have reduced the pool of physicians and other providers willing to serve this population. There is an opportunity to remedy this situation and stimulate price competition among groups of providers by encouraging alternative health plans to bid for government contracts to deliver health care at a fixed price to Medicaid eligibles. As these alternative health plans mature as contractors with private employers and the Medicare program, their services can be utilized by State Medicaid programs to lower costs through health prevention and maintenance, utilization controls, and integrated management.

Impact on government

If the decentralizing strategy I propose is to deliver its promised benefits, Government must design and enforce rules to assure that the markets for health plans are properly structured so that there is maximum feasible competition of the right kind. Government must, at minimum, do the following:

- Mandate the collection and dissemination of the information required for Medicare beneficiaries to make intelligent choices as to which plan best fits their needs.
- Enforce antitrust laws.
- Minimize both the temptation and the opportunity for providers to compete by shunning sick patients.
- Establish a single basic Medicare benefits package that all American eligible for Medicare will have access to regardless of financial circumstances.
- Provide for the protection of beneficiaries of plans that cannot or will not meet their commitments.
- Act as agent for those beneficiaries who cannot make their own choices and who do not have family.

For Medicaid, the differing programs resulting from State administration illustrate a weakness in terms of economic eligibility and national policy, but they provide certain strengths in terms of allowing innovations and testing the cost effectiveness of different delivery systems.

Implications for the future

Besides designing and enforcing rules to assure vigorous competition of the right kind, price and quality, Government also has a role in financing

health care services whose collective benefits are great, but which would not be produced in private markets because suppliers could not appropriate enough of the value created to make their efforts worthwhile. Care for the indigent, most kinds of research, and, arguably, medical education are examples of health services that require subsidy. The problem is how to subsidize these services. Currently, Medicare subsidizes teaching and research indirectly through its payments from the hospital insurance trust fund. With an indirect subsidy, nobody is quite sure who is getting how much money and what is being done with it. Teaching, research, and indigent care especially should be financed by Government, but by direct appropriation. A direct subsidy makes recipients much more accountable to public officials. The seperation of payment for teaching and research from payment for patient care also will make it easier to compare teaching hospital performance with that of its competitors according to criteria most important to patients.

Assumptions have changed; sentiments are changing; the Medicare and Medicaid programs must change. As we struggle to reform these two programs in a climate of finite Government resources, we must not overlook the option of finding new revenues to finance health care needed by program beneficiaries. One option that should be considered is the use of cigarette and alcohol taxes to increase the pool of monies available to meet society's commitments to treat patients covered by Government programs. Cost effectiveness is a primary goal, but a balanced program of spending restraint and adequate revenues is necessary to guarantee the future health of all Americans.

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Senator Dave Durenberger

Republican Dave Durenberger is serving his second term as Minnesota's senior Senator. As Chairman of the Senate Finance Committee's Health Subcommittee (which oversees the Medicare and Medicaid programs) he has led the drive to improve the Nation's health care system through cost efficiency, competition, and consumer choice, as well as more comprehensive preventive care. He was instrumental in the Medicare prospective payment system, as well as other current and proposed financing reforms. He also chairs the Intergovernmental Relations Subcommittee of the Committee on Governmental Affairs.

Impact on beneficiaries

More than three decades ago, in 1954, the U.S. Congress made subsidization of health care for certain segments of the population a national Government responsibility by broadening the tax exclusions for employer-paid health insurance.

It was within that framework that the Medicare and Medicaid programs were adopted in 1965, to help fill the gaps that employer-paid coverage could not fill for the elderly, the disabled, and the poor.

During the past 20 years, Medicare and Medicaid have removed obstacles to quality health care for millions of elderly, disabled, and low-income Americans. These programs have grown substantially in both the number of beneficiaries that they serve and in the percentage of public and private resources that they absorb.

The size of these programs has been a significant factor in fueling the dynamic growth we have experienced in our Nation's health care system as a whole. And, now, in the 1980's, the Medicare and Medicaid programs have become critical forces in helping to shape needed changes in both the financing and delivery of health care.

By any measure, the beneficiaries of Medicare and Medicaid are better off today than they would have been without these two programs. For millions of Americans, Medicare and Medicaid have meant the difference between living out the final years of life in a caring environment, or in fear and solitude.

Despite these achievements, most beneficiaries realize that Medicare and Medicaid are not perfect. Although many obstacles to obtaining quality health care have been eliminated, important gaps still remain. A substantial financial burden has been lifted from the shoulders of most beneficiaries, but many others are still not adequately covered or are spending an unconscionably large percentage of their income on health care.

Research recently done for the American Association of Retired Persons, for example, indicates that the elderly earning less than $10,000 per year spend an average of 60 percent of their income on medical and health premium costs. The well-to-do, earning in excess of $40,000, spend only 3 percent. Because elderly Americans do not receive catastrophic coverage under Medicare, hundreds of millions of dollars are also being spent each year on unnecessary supplemental "Medigap" coverage.

Also, because Medicare does not structure premiums and benefits to promote disease prevention (that is, "wellness" care), beneficiaries do not have the incentives they need to live longer and more productive lives, altogether avoiding what I would prefer to call our Nation's "sick-care system."

Perhaps the biggest impact, in the recent past, of Medicare on beneficiaries has been the effect of changes in the system that promote choice. The option the elderly now have to buy into a risk-bearing health plan, for example, has the potential for revolutionizing the role that beneficiaries play in selecting the most cost-effective plans with the best reputation for quality.

Under this new relationship with providers, beneficiaries now relate to Medicare much as an employee relates to the employer who provides a choice of health coverage. As this option continues to grow, the Medicare program will oversee and coordinate the plans offered and must offer sufficient choices. However, the provision and purchase of health care will be left to those who know the most about selecting cost-effective and high-quality health care services—competing health plans.

Medicare should and will remain a uniform, federally administered program. The new role and responsibility for beneficiaries as informed and involved consumers will evolve slowly as more areas of the country are served by competing health plans.

Impact on health care providers

The history of health care in America in much of the past two decades has been one of phenomenal growth. As the largest single purchaser of health care, the Federal Government—through its Medicare and Medicaid programs—has been the driving force behind much of the growth that has occurred.

During the past 20 years, Medicare and Medicaid have grown to be 10 percent of the national budget. In 1985, the total health care bill for Americans reached an estimated $450 billion, a more than 80-percent increase in just the past 5 years. That figure represents nearly 11 percent of all the goods and services we produce and consume as a society.

With health care costs reaching these levels, politicians have been getting the message that we are nearing the edge of what people are willing to pay, not just for health care, but for many other things we finance together as a society.

Initially, as the Federal Government looked for ways to address this concern, much of the emphasis was on regulating providers. Facilities regulation, through the certificate of need process and through regional health care planning agencies, was seen as a central feature in controlling the rising cost of health care services.

The Carter Administration also tried to temper rising health care costs through controls on hospital budgets. This approach was flawed in the message it gave to hospitals, that the Government knows better than you do what you should spend and how you should best allocate your resources.

In the late 1970's and early 1980's, however, this emphasis on regulation began to give way to more fundamental health systems reform, through consumer choice and competition. Those of us who have supported this strategy argue that, by changing the economic incentives, doctors and hospitals themselves will determine the best route to a more cost-effective health care system while maintaining quality of care.

In 1982, the Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA) which sets out a three-point agenda for reform in the Medicare system. Because Medicare is such a large factor in the Nation's health care system, these changes are now being used as a model to alter the financing and delivery of health care for virtually every American.

First on the TEFRA agenda were the limits placed on Medicare payments to hospitals. Medicare no longer makes open-ended payments for whatever costs hospitals formerly claimed were due. The day of the "free lunch" is over. Under open ended, cost-based reimbursements, hospitals had no incentive for constraint. On the contrary, doctors and hospitals had every incentive to apply as many costs per day to a patient's bill as possible. The more charges levied, the more the hospitals would be paid.

Second, TEFRA required the Secretary of the Department of Health and Human Services to report to the Congress on the design for a prospective payment system. In 1983, the Congress incorporated the Secretary's report into the Social Security Act Amendments; these provided that hospital reimbursement be based on the diagnosis assigned to each patient, rather than the sum total for expenses charged that patient each day. This reform, under which patients are now assigned to one of several hundred diagnosis-related groups, has fundamentally changed the way hospital and inpatient care for the elderly is managed. The result so far has been a dramatic decline in admissions and average length of stay. The message is out: "Hospitalize with care and use hospitals frugally."

The third major reform in TEFRA was the provision allowing Medicare beneficiaries a choice of competing health plans that are responsible for providing a wide range of health services to the enrollees. Under this new option, Medicare makes a monthly payment to a health maintenance organization (HMO) or other health plan on the beneficiary's behalf. The beneficiary must, in most cases, also pay an additional monthly premium to the HMO and must agree to receive all medical services through the HMO's physicians, clinics, and hospitals. In exchange, the HMO agrees to provide all the Medicare benefits, handle all paperwork, and pay the Medicare deductible and coinsurance charges.

Although this option has been in effect nationwide for less than 1 year, I am convinced that this type of option provides our best opportunity for ensuring the most cost-effective and appropriate use of health care as determined by providers who are properly rewarded when they succeed.

An important safeguard in the new emphasis on appropriate utilization of hospitals is the peer review organization system under which doctors review each other's admissions and treatments. The peer review process, established under separate legislation passed in 1982, helps ensure that quality care is provided in the hospital and that unnecessary admissions and procedures are not undertaken.

Preadmission screening, which is part of the peer review process, also helps to protect Medicare beneficiaries from having to pay out-of-pocket costs for treatments not covered by Medicare because they could have been provided in a more appropriate setting.

All of these changes are having a dramatic impact on how health care is being delivered. They have an effect on the type of services provided in hospitals, the growth in out-patient services, the new relationships evolving among providers, and the emphasis on prevention and wellness being given by all health care providers.

Throughout much of the history of professional medicine, the emphasis on research, education, new technology, and new facilities has been heavily weighted toward repairing the damage to the human body that occurs after an illness or accident strikes. All of us who are alive today can be thankful for the advances in medical science that have made it possible to cure illnesses and heal injuries that could have resulted in premature death or painful, long-term disability.

However, the greatest challenge now facing health care providers lies in wellness and disease prevention—helping people to avoid altogether the use of the "sick-care system." Many of the changes made during the past several years in the Medicare program are directed at meeting this challenge.

Impact on government

Government's role in authorizing and financing health care programs, or any other programs for that matter, must be partly proactive. Government must be prepared to occasionally change the rules not only in response to change but also to provide incentives for change.

Medicare's traditional split in trust funds, the Part A hospital insurance trust fund and the Part B supplementary medical insurance trust fund, is a good

example of a rule of the game that may now need to be redrawn. In the earliest days of Medicare, when the most significant model for health insurance was Blue Cross and Blue Shield, this division in trust funds made sense. Generally, a clear distinction existed between the kinds of services that beneficiaries received in hospitals and those they received in doctor's offices or other nonhospital settings.

But, today, as Part B is being used to pay for outpatient surgery and other procedures as well as traditional doctor office visits, it may be time to reconsider this historic split between Medicare Part A and Part B. The two parts of Medicare are combined for the HMO voucher option. If capitated payments to competitive health plans represents the wave of the future, we may be moving to a defacto combination of the two trust funds, regardless of formal legislative changes.

The relative roles of Medicare and Medicaid in financing long-term care for the elderly may be another major policy question that deserves to be revisited. Viewing the Social Security Act as a whole, for example, one might question whether the income security and health care needs of the elderly might not be better served under a single unit, Medicare. This would allow the transfer of the long-term portion of Medicaid, at least as it affects the elderly, to Medicare.

Currently, almost one-half of Medicaid's expenditures are for outpatient services. This amount, largely for long-term care for the elderly, is growing and rapidly taking funds away from the acute and preventive health care needs of the younger poor, especially young mothers and children. Because of the high cost of traditional long-term care in nursing homes, many older Americans are faced with the inevitability of "spending-down" their resources until they are so impoverished as to qualify for Medicaid. Ironically, many of these individuals would have had resources during their working years to contribute to social insurance for long-term care, if such insurance had been available.

According to a recent survey by the American Association of Retired Persons, 80 percent of the elderly believe that Medicare will cover all their health care needs, both acute and long term. It does not; this leaves many elderly persons with the inevitability of spending themselves poor in order to qualify for Medicaid-financed long-term care. From this perspective, long-term care is as much an income security issue as it is an issue of health care.

Medicaid, in 1985, suffers from a pattern of widely differing and inconsistent funding and benefit levels across the country. For at least 4 years now, we have been practicing a gradual transfer of responsibility for meeting human needs from the Federal to State and local governments. Unfortunately, there has not been a corresponding transfer of resources.

Tax reform, as it has been proposed by the President, may make a bad situation even worse by eliminating the deductability of State and local taxes and tax-exempt bond financing, while increasing the Federal Government's role in levying excise taxes—a field, except in wartime, that has been historically left to the States.

This loss of Federal revenue and increasing pressure on State and local governments to finance programs for the poor is coming at a time when States are facing mounting pressures to lower their own taxes and to grant tax breaks and other incentives to industry for job creation. Even before the most recent scramble for new industry began, the disparity in State commitment to the poor was evident and cause for great concern among individuals who, like myself, believe in a national commitment to our Nation's poor.

Under Aid to Families with Dependent Children, maximum payments to a family of four now vary from $168 a month in Tennessee (the new home of the much-sought-after Saturn auto plant) to $676 per month in New York and $611 a month in Minnesota. Medicaid eligibility and benefit levels follow the same pattern because these two programs are generally linked.

Clearly, Medicaid is not fulfilling its intended purpose of providing a reasonably uniform level of health care subsidies for low-income people throughout the country. Addressing the disparity that exists is one of the major challenges facing policymakers as the Medicaid program prepares to enter its third decade.

Implications for the future

When Medicare and Medicaid were first established, there was also pressure from some quarters to establish national health insurance or even a British-style national health service. But, Medicare and Medicaid were structured to finance health care, not deliver it, indicating the clear intent of Congress not to take over the Nation's largely private health care delivery system. Beyond concerns over cost, a national health insurance system was not adopted largely because it was not needed. The private sector, with tax subsidized, employer-paid health insurance, now provides nearly universal coverage when linked with Medicare and Medicaid.

Before one becomes too complacent about the extent of coverage, however, it is important to recognize that no fewer than 20 million Americans are currently underinsured, having been left out of the Government's complex safety net of tax subsidies, social insurance, and direct Government support. These individuals include those just above the income limits for Medicaid, many of the self-employed and unemployed, spouses who are no longer covered under a group plan because of a recent death or divorce, and individuals who work for employers who do not provide group coverage but who cannot afford the horrendous cost of buying health insurance protection on their own.

The health care these individuals receive is spotty and often available only when the cost of treatment becomes very expensive. In the past, the uninsured

have largely depended on public hospitals or the good graces of private institutions. However, both public and private hospitals are much less able to subsidize care for the indigent in today's competitive, cost-conscious environment. There is also little room for prevention and wellness care under these kinds of circumstances because health care is generally not sought out until an accident or serious illness occurs.

Filling these gaps in coverage is one of the major challenges now facing Federal health policymakers. The Federal Government must recognize its responsibility to provide targeted and adequate subsidies to get all Americans into health plans, and, thus, into the health care system, while at the same time not wasting scarce resources on excessive levels of coverage. At a minimum, Federal tax law should recognize the current inequity of providing an unlimited tax subsidy for health insurance to individuals who are in employer-financed group plans, but no tax subsidy to those who are not. If we were to cap the tax subsidy for employer-paid health premiums, then we could use the savings to provide a tax deduction for those without employer-provided group coverage, such as the self-employed and the unemployed. For those who continue to fall between the cracks, States and local governments may have to provide additional services and funding. But the Federal Government must provide its share of financial support as well, so that all Americans will have fair access to the Nation's health care system.

The greatest failing of the current Medicare system is its absence of coverage for catastrophic illness. One can see this weakness in the hundreds of millions of dollars that the elderly spend each year on expensive and often unnecessary supplemental or catastrophic coverage.

In an era of $200-billion-per-year deficits, however, there will be considerable pressure to make the addition of catastrophic coverage to Medicare revenue neutral. The answer to this seeming dilemma may be to recognize that current cost-sharing in Medicare is not sensitive enough to the range of incomes available to Medicare beneficiaries. Many of the well-to-do elderly, in other words, could afford to pay more.

It is unconscionable that the elderly earning less than $10,000 a year spend 60 percent of their incomes on medical and health premium costs while those with incomes in excess of $40,000 spend only 3 percent, particularly when Medicare continues to ignore the kind of catastrophic illness expenses that most older Americans fear most. To address these concerns, I have proposed that we use a modest extension of cost sharing at the high end of the income scale to finance a catastrophic insurance program under Medicare for all beneficiaries. Such a change could be made budget neutral, could save hundreds of millions of dollars a year in supplemental coverage, and would satisfy one of the Medicare program's greatest failings.

Beyond efforts to fill gaps in coverage for beneficiaries, I would expect that much of the attention of the Congress will continue to be directed toward expanding the twin principles of prospective payment and capitation. I expect that the Congress will labor long and hard, for example, over how to extend prospective payment concepts to physicians, skilled nursing facilities, home health care providers, and hospices. This time will not be badly spent, but I am hopeful that eventually the decision on how health care providers are reimbursed will not rest with the Congress or the Medicare system, but with competing health plans.

The shift toward prospective payment and capitation will also require that attention be given to parts of the health system that were formerly subsidized within fee-for-service reimbursement. Graduate medical education, care for the indigent, research, and new technology development are also needed services that have, heretofore, been financed indirectly, but which, in the future, may need to be financed directly and explicitly.

As for Medicaid, the States are currently awash with reforms, many of them aimed at holding down costs in response to Federal cutbacks and increased pressure to lower taxes as a way of attracting new jobs and industry. Capitation through Medicaid voucher programs is being tried in a number of States, along with strong efforts to utilize more cost-effective settings for the delivery of health care services to the poor.

With these changes, access may become a real problem for many Medicaid beneficiaries. The purpose of Medicaid was, traditionally, to avoid the continuation of a two-tiered system of health care delivery, one for the rich and one for the poor. Unfortunately, Medicaid has not fulfilled its promise in meeting this goal.

As more Medicaid beneficiaries are encouraged to seek the services of competing health plans, this problem may be alleviated. Capitation of health care for the poor carries with it the potential for abuse, the "Medicaid milk" of the early 1970's being indelibly etched on the minds of policymakers. The potential for abuse should not stop us, however, from making choices of competing health plans a goal of the Medicaid program as it has become a goal of Medicare.

As we continue to adapt Medicare and Medicaid to the changing health care environment of the 1980's, both programs will need benefit restructuring that takes into account disease prevention and health promotion as well as protection against acute illness. Medicare, in particular, was designed on the model of Blue Cross and Blue Shield, an insurance program largely for the employed population. Medicare was developed at a time when the importance of lifestyles in health was much less understood.

Today, however, we know more about the hazards of smoking and other abuses and the potential of prevention. Changing lifestyles can alter the risk of illness for the elderly just as much as for any other age group in the population. It is time that Medicare recognized this reality.

The same is true for low-income people. In many States, for example, relatively inexpensive prenatal

care is not funded under Medicaid. Yet, we know that low birth weight is one of the primary causes of early childhood illnesses, as well as long-term health problems such as mental retardation, cerebral palsy, epilepsy, and learning disabilities. By spending just a little extra money at the front-end of life, studies have shown that big-dollar savings and generations of healthier babies can result from a greater emphasis on the most cost-effective incubator of all, the mother's womb.

Finally, any examination of the future of the Federal Government's role in financing health care cannot ignore the issue I raised earlier about long-term care.

On the one hand, I believe it is not appropriate to continually drain the resources of Medicaid to finance the long-term care needs of the frail elderly and disabled. However, there is something drastically wrong with a system under which millions of elderly Americans must spend themselves into poverty to qualify for a Medicaid program that will finance increasingly expensive long-term care.

Although the appropriate directions for health system reform in long-term care are not as clear cut as they are on the acute side, I am convinced that the principles of consumer choice and competition are relevant and need to be further explored.

Rethinking the relationship of long-term care to income security as well as health care may result in linking social insurance benefits provided under Social Security, acute care financed under Medicare, and long-term care financed under Medicaid. We may also need a new financing mechanism that allows individuals to purchase long-term care insurance while they are still working.

These challenges of filling in gaps of coverage, encouraging the use of the most cost-effective quality care available, encouraging an increased emphasis on health prevention and wellness, and continuing the evolution toward increased competition and consumer choice, are all at the top of the health care policy agenda as Medicare and Medicaid prepare to enter their third decade.

These are not easy challenges to meet, but I am confident that we will address them with the same spirit of caring and high quality that has driven these two programs in their first 20 years of service to the American people.

Karen M. Ignagni

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Impact on beneficiaries

Like a proud relative offering a toast to the birth of a child, President Lyndon B. Johnson articulated the hopes and aspirations of all Americans when, at the signing of the Medicare Act, he declared:

> "No longer will older Americans be denied the healing miracles of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years."

The goal of Medicaid was equally far-reaching. The poor were promised that within a few short years after enactment of the legislation they would have access to the medical mainstream. Unfortunately, because of a series of political compromises made to secure passage of both Medicare and Medicaid, not all of these promises have been kept.

To deflect opposition from physicians, Congress agreed not to attempt to control the future cost of the Medicare program by limiting provider reimbursement. However, Congress was willing to use the goal of cost containment as the justification for restricting the scope of Medicare benefits. In Medicaid, for the alleged goal of "administrative simplicity," Congress tied eligibility for benefits to preexisting State welfare categories. As a way of avoiding opposition to the Medicaid legislation from advocates of States' rights, Congress conceded control over the development and administration of the program to the States. This action was justified by then Secretary of Health, Education, and Welfare, John Gardner, who described the Medicaid legislation as an example of "creative federalism."

To be sure, Medicare has had impressive results. Since its passage, overall access to care has improved, especially for poor beneficiaries, and mortality rates for the aged have sharply declined. For the disabled and victims of end-stage renal disease, Medicare has filled a major gap created by the unwillingness of private insurers to design an insurance product that could affordably and effectively meet their health care needs. With Medicare expenditures consuming a growing share of the entire Federal budget, voices that call for placing limits on the program and forcing the elderly to pay a larger share of program costs have grown stronger. At this writing, Congress appears on the verge of authorizing cutbacks that could jeopardize some of the improvements in health brought about since the beginning of the program. Those who hope to reduce Medicare costs by merely shifting a greater financial burden to senior citizens will only move us further away from President Johnson's 20-year-old goal of providing health security to beneficiaries.

At present, Medicare offers inadequate protection against the high cost of health care and the prospect of financial ruin associated with a serious illness. Senior citizens now are paying out of pocket the same percent of income that they did prior to the enactment of the program. Currently, that amount averages approximately $1,700 per individual. For catastrophically ill beneficiaries, the out-of-pocket burden is much higher, because the Medicare benefit package was modeled after the basic insurance package of the early 1960's. It was designed to cover acute care at a time when chronic conditions could not be managed as effectively on an outpatient basis as they are today, and when patients did not live as long as they now do. Consequently, Medicare has limited the number of covered days per spell of illness and requires steep beneficiary copayments after the 60th day of hospital care.

The emphasis on inpatient care is further reflected in the refusal of the program to pay more than 80 percent of the cost of outpatient physician services up to a certain level. However, because physicians are not compelled to limit their overall charges to what the Government is willing to reimburse, the 20-percent cost of physicians' fees that beneficiaries are required to cover actually ends up being much higher. In 1984, for example, Medicare paid less than 60 percent of the elderly's cost for outpatient physicians services. This situation will only get worse as the configuration of the health care delivery system changes and more emphasis is placed on outpatient physician services, where there are no limits on what physicians can charge, only what Medicare will reimburse.

In addition to cost-sharing requirements, many benefits (including routine physicals, dental care, and outpatient prescription drugs) that would significantly improve the health status of the entire Medicare population remain uncovered. Special mention should be made of the complete lack of protection under Medicare for long-term care. Because Medicare has refused to accept its fair share of the burden for chronic care, the responsibility has fallen on State Medicaid systems, where the aged are required to pauperize themselves and, in some cases, sign away their homes before becoming eligible for benefits.

Senior citizens in need of long-term care should not be forced to make such draconian choices.

The Medicaid legislation gave a State the option "as far as practicable under the conditions in such State" to provide medical assistance to categorically eligible individuals "whose incomes and resources are insufficient to meet the costs of necessary medical services." In effect, the crucial decisions concerning Medicaid were not what was put into the legislation, but what was left out. Medicaid was never designed to provide medical assistance to all of the poor and, as a result, today less than 50 percent of the population living below the poverty line are eligible for services. States were not required to participate in the program. Nor did the legislation provide specific guidelines on coverage (i.e., number of visits) that were to be provided for each benefit category. Because of this, considerable variation in coverage exists among States.

Unlike Medicare, Medicaid does not cover all of its beneficiaries on the same basis. There are no national income guidelines for qualification, and the system for determining Federal Medicaid matching payments has substantially contributed to inequities among States in the percent of the poor covered by the program.

The present system of basing Federal matching payments to States on the average of per capita income for the 3 years prior to the current year, means that payments are based on income data going back 4 years. This time lag makes Medicaid an inappropriate countercyclical tool. In addition, basing the formula on average per capita incomes disproportionately penalizes States with a relatively high concentration of people below the poverty line. In effect, if States A and B receive approximately the same Federal match but B has more people living below the poverty line and eligible for benefits, B will have to put in more of its own resources or cut back on benefits. Although the issue of the Medicaid match is quite controversial, it must be addressed. Per capita income should not be the primary determinant for assistance. A more equitable balance could be struck in the distribution of matching payments across States if income per person in poverty were used instead of per capita income.

Even once individuals are deemed eligible for Medicaid they have far from unlimited access to providers. Research has indicated that only 6 percent of all physicians care for one-third of the beneficiary population. Delays in payment, burdensome paperwork requirements, or an overall unwillingness on the part of physicians to treat Medicaid patients are some of the reasons cited to explain this unacceptably low ratio. Like Medicare, Medicaid encourages the utilization of inpatient care, which accounts for 70 percent of the program's expenditures.

To some extent, Medicaid's unreasonably low payments to providers who perform services on an outpatient basis contributes to the high utilization of inpatient care. A major problem, however, is that Medicaid has become the last resort for senior citizens who have lost their savings because of catastrophic medical expenses not covered by Medicare, for the medically retarded, and for the developmentally disabled in need of chronic care. Medicare's benefit limitations force the elderly to give up everything, including their pride, to be deemed eligible for Medicaid benefits. Similarly, the disabled have no other source to turn to for assistance in meeting high costs associated with chronic care.

The major challenges ahead for Medicaid include improving services to a broader cross section of the poor. Unless Medicare is prepared to assume the long-term care burden for its beneficiaries, States may be financially unable to meet this objective.

Since 1981, cutbacks (as a result of reductions in Federal matching payments and rising program costs) have made almost one million poor women and children ineligible for the program and have narrowed the scope of benefits to which others are entitled. These changes have negatively affected the health of certain beneficiaries and, in some States, have contributed to a dramatic reversal in the progress which had been made in reducing infant mortality.

Impact on health care providers

The original Medicare bill did virtually nothing to control provider behavior for fear that the entire legislation would be killed by physicians who opposed it. In 20 years, the Nation has paid dearly for that decision. The reticence to create a public insurance system where the relationship between payer and insurer differed in any respect from the insurance model prevalent at the time only institutionalized the problems inherent in that system and paved the way for a potential solvency crisis in the Medicare Part A trust fund.

Several years ago, when it was thought that Medicare's hospital insurance trust fund would go bankrupt, public policymakers desperately sought solutions to ward off a potential crisis. This collective concern about the political fallout that would occur were Medicare to become insolvent led to a major revision in the method of paying hospitals participating in Medicare. The Federal Government tore up the blank checks it had been giving to providers since the start of the program and began reimbursing hospitals on a prospective basis, by letting them know ahead of time how much they would receive for each diagnosis.

Although organized labor has long advocated prospective reimbursement, we have reservations about this particular approach. Not only should it be closely monitored to gauge its impact on access to and quality of health care for beneficiaries, the prospective payment system (PPS) should be modified to address the following concerns. Preliminary evidence indicates that hospitals may be releasing beneficiaries before they are ready to be discharged; readmitting patients with the same diagnosis; improperly classifying patients; and unbundling services to shift the source

of payment from Part A to the unregulated Part B. These changes should be investigated and appropriate actions taken.

The Department of Health and Human Services must make adjustments in payments for hospitals that serve a disproportionate number of low-income people, and Congress must address the inequity of expecting providers to treat more complex cases without adjusting the payment rate. Absent these changes, the current system makes certain patients undesirable to treat, will continue to be a barrier for these patients, and will drive public and inner-city hospitals further into the red.

Confining PPS to operating costs has encouraged hospitals to substitute capital for labor. This is potentially detrimental to both quality of care and low-waged hospital workers who, as a result of PPS, are being shifted from full-time to part-time status or laid off altogether. Return on equity allowances, which gives an unfair advantage to for-profit facilities, should be eliminated. Limiting PPS to Medicare has created an incentive for hospitals to shift to the private sector costs in excess of the amounts reimbursed by Medicare. Finally, a cost-containment program that excludes physicians, who play such an essential role in the system, does not offer a permanent solution for reform. From the standpoint of the beneficiaries, it would be far better to increase physicians' payments in accordance with an exogenous price indicator, rather than freezing the level of payments and encouraging more physicians to refuse to accept assignment.

In addition to modifying PPS, other changes could be implemented to improve the program's infrastructure. Medicare has encouraged physicians to perform as many procedures as possible on an inpatient basis. Indeed, hospitalization has become the Medicare norm. Although the trends in hospital utilization and length of stay for all patients, including Medicare, continue to drop, now is the time for Congress to consider implementing changes to assure that providers participating in Medicare practice in an efficient and effective manner. At the same time as changes are being made in the system that result in shorter, more intensive hospital stays, it is totally inequitable to continue to peg beneficiaries' hospital deductible to the cost per hospital day.

The international unions affiliated with the American Federation of Labor and the Congress of Industrial Organizations (AFL-CIO) have been effective in joining with their management counterparts around the country to implement initiatives to reduce the costs of collectively bargained health benefits and improve quality of care. In our view, many of these cost-containment initiatives could and should be incorporated into Medicare's benefit structure. The following changes could be considered:

- Instituting a prior authorization program for hospital stays and mandatory second surgical opinion requirements.
- Developing a program to prospectively assign length of stay for inpatient services. Rebasing the current payment system, which rewards physicians for unnecessary testing and penalizes them (in a relative sense) for spending time with patients to diagnose their problems.
- Reimbursing at a higher rate certain surgical procedures that can be safely done on an outpatient basis.
- Authorizing the development of a broad range of alternative delivery systems to be offered to beneficiaries, including preferred provider organizations (PPO's) in addition to health maintenance organizations which beneficiaries are now entitled to join.

To implement these proposals, the Department of Health and Human Services would have to broaden the scope of administrative responsibilities assigned to Medicare intermediaries, and establish a competitive bidding process. In the case of PPO's, one option might include allowing States, in addition to Blue Cross and private health insurers, to function as brokers and negotiate new purchasing arrangements with providers. Intermediaries should be directed, to the extent practicable, to give priority to negotiating capitation arrangements with providers.

No discussion of the impact of Medicare on providers would be complete without discussing the issue of long-term care. Because Medicare has not provided coverage in this area, it has taken no action to attempt to influence or even encourage the development of a long-term care delivery system. Medicare's limited attempt to provide narrow coverage for skilled nursing home care has been fraught with administrative problems. Program intermediaries are virtually left to their own devices in administering this service, and there currently exists a patchwork system of varying effectiveness from State to State.

The realization that Medicaid costs would have to be controlled was the excuse given early on by States to prevent broadening of coverage. Ironically, Medicaid amendments that were designed to limit reimbursement to providers were largely ineffective and, throughout the 1970's, costs rose at double-digit rates. As Medicaid began to crowd out spending for other services, States sought to contain costs by instituting changes in the Medicaid delivery system that limited beneficiaries' freedom of choice of provider. In 1981, the Omnibus Budget Reconciliation Act gave States this desired flexibility.

Initiatives launched under this legislation have included case-management programs, alternative delivery systems, and selective contracting. Some have expressed fear that these changes will only reduce quality and restrict access for the poor. However, given the low provider participation rate for Medicaid, few beneficiaries have ever had real freedom of choice. Indeed, early experience with selective contracting placed a disproportionate emphasis on price and did not give equal weight considerations of quality or access. However, there are growing indications that these issues can and must be addressed.

It is crucial that State Medicaid agencies closely monitor the qualification of participating providers, investigate whether providers are attempting to keep costs down by unfairly restricting access, and explore grievances. Conceivably, well-run case-management systems and selective contracting programs could improve Medicaid's provider participation rate and give beneficiaries broader entry into the health care system.

Impact on government

Whether the health care needs of Medicare beneficiaries can be affordably and adequately met through the current system is an issue that will be debated for years to come. One proposal that has been advanced is the notion of moving Medicare to a voucher system; beneficiaries would receive a chit equivalent to the dollar value they are entitled to and told to go out into the market and "shop" for the health insurance plan that comes closest to meeting their needs. Experience in private sector benefit plans suggests that the largest, most powerful purchasers are able to negotiate the most favorable terms in the health care market. Sending beneficiaries into the system to negotiate individual arrangements would allow insurers to pick and choose among the best risks. As a result, it could leave many seriously ill beneficiaries inadequately protected and the Government extremely vulnerable, having lost the economic advantages inherent in pooling risks and the ability to use its market share to positively influence provider behavior.

Rather than moving in the opposite direction, Medicare, through its intermediaries, should use its market position to negotiate with providers on behalf of beneficiaries. It should also require that, as a condition of doing business with Medicare, physicians should accept assignment and hospitals should be prohibited from refusing to treat certain patients and dumping them onto other facilities.

Another proposal for reducing the costs borne by the Federal Government for providing health insurance to senior citizens would involve creating individual retirement accounts (IRA's) for medical care. Even if a tax credit were proposed to circumvent the criticism that IRA's only benefit those with relatively high disposable income, public policymakers must consider the opportunity costs associated with medical care expense accounts. Private insurers have testified that they cannot duplicate the Medicare benefit package at an affordable cost, because of the minimization of adverse selection and the benefit of combining good and bad risks. How then could individuals afford the cost of health care services? Several hospital stays could quickly drain individuals' resources, which would force the Federal Government to develop an expensive residual program to allow individuals to continue to receive medical care once they exhausted their savings.

Another variant of the philosophy that Medicare eligibility should be contingent on financial need is the proposal to scrap the Medicare social insurance system in favor of a means-tested program. Individuals who have contributed to the social security system should be eligible to receive Medicare as a matter of right so, as President Johnson promised, they might "enjoy dignity in their later years." Moving to a means-tested program only would create similar inequities and coverage gaps that are prevalent in the Medicaid program, which has caused a growing percent of the population to fall through the gaping holes of the so-called "safety net."

The major strengths of the Medicare program are its uniform eligibility and benefit standards. From a cost perspective, a major weakness has been the system of basing physicians' payments on the usual, customary, and reasonable charges of their colleagues. Another major weakness in Medicare is the discretionary nature of assignment, as well as the fact that there is minimum accountability in the system given the geographical remoteness of the Federal Government from local health care providers. The most effective way to circumvent this problem is to empower intermediaries to negotiate with areawide providers on Medicare's behalf.

A final point concerning weaknesses involves the issue of the inclusion of Medicare in the consolidated Federal budget, which results (as it did this year) in arbitrary decisions being made concerning the programs that are not based on the conditions in the trust fund.

Experience in recent years has demonstrated that there are some advantages to States administering Medicaid. The proximity of States to local health care providers puts them in a better position to develop managed health care systems and a range of alternatives to meet the acute as well as chronic health care needs of beneficiaries. The major disadvantage associated with the present system is that States are administering 50 different Medicaid programs with varying eligibility standards and benefit levels, and these are inextricably linked to the overall economic position of each State.

Congress should step in and develop national criteria for Medicaid eligibility and level of benefits. There also is a need for Congress to provide the financial support that would allow Medicaid to begin to address the health care needs of a broader population of economically disadvantaged citizens, including jobless workers and their families. Congress also should explore alternatives for providing countercyclical assistance to States to enable them to maintain their level of Medicaid benefits during periods of recession.

Another issue that Government cannot afford to ignore is the link between the supply of nursing home beds and State efforts to contain the growth in Medicaid expenditures. The percent of the population in need of nursing home care has grown considerably since 1965. However, Medicaid is the lone third-party payer for long-term care. Fifty cents out of every dollar going to nursing homes comes from Medicaid,

and long-term care consumes 50 percent of the Medicaid dollar.

Concern about the growing burden of long-term care has caused States to use their market clout to restrain nursing home capacity for fear that as the supply of beds expands, so will Medicaid expenditures. In effect, States are holding hostage the population in need of long-term care.

Yet, it is difficult to urge States to change their behavior, given the unresponsiveness of the Federal Government and the private sector. Congress has showed no interest in the long-term care needs of Medicare beneficiaries. It has left it to the States to fill in the gaps in Medicare coverage. Based on the data compiled by the Health Care Financing Administration, States have met this challenge, but it has been at the expense of other State programs, other Medicaid beneficiaries, and the elderly themselves who have been forced to turn over their hard-earned savings and, in some cases, their homes in exchange for Medicaid protection. Similarly, the private sector only recently has become more interested in helping to fill this void. It remains to be seen just how affordable and effective potential private insurance products will be in this area. Until Medicare bears a fairer share of the long-term care burden, the States will continue to restrict nursing home capacity and a growing number of citizens could be denied care.

States face another Catch-22 as they attempt to develop home and community-based care. Not only have the States been required to pioneer an entirely new delivery system, but they also have been required to develop procedures for licensing an entirely new group of health care providers. States fear that if these new initiatives result in higher Medicaid costs, the Federal Government will rescind their waivers and reduce matching payments.

Implications for the future

With 20 years of experience with Medicare and Medicaid behind us, we must look back at the compromises that were made to secure congressional passage of these programs. We must ask whether we can afford to let the political situation that prevailed two decades ago continue to stand in the way of comprehensive reform.

Even though both Medicare and Medicaid have significantly improved access to care, they still fall far short of meeting the objectives outlined by President Johnson. In Medicare, a number of essential services remain uncovered and, relatively speaking, the elderly are bearing the same share of the financial burden for health care services as they were prior to enactment of the program. As for Medicaid, 20 years of hindsight have demonstrated the extent of the problems that can occur when the Federal Government shifts its share of the responsibility for implementing social programs to the States. Examples of such problems include the recent wave of cutbacks in Medicaid benefits and restrictions in eligibility as a response to reductions in Federal payments to States and rising program costs.

The results of national polls have demonstrated public support for comprehensive reform of the health care delivery system. Given the interdependent relationship between the public and private health care programs, we cannot effectively improve access, assure quality, and contain costs in Medicare and Medicaid without systemwide reform.

Barbara D. Matula

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Impact on beneficiaries

One of the most important contributions of the Medicare program is that it legitimized the role of the Federal Government in assuring that the basic health care needs of the elderly would be met, regardless of their income or health status. To the elderly, the establishment of Medicare eased their fears that they would be denied or could not afford insurance coverage for expensive health care services when they were most vulnerable and in need.

Government, as the insurer, promised that the Medicare program would be universal in its eligibility requirements, uniform in its benefit package, affordable, simple, fair, and acceptable (i.e., there would be no stigma attached). Because Medicare was modeled after typical private health insurance plans, it encompassed their shortcomings as well as their strengths.

Private plans traditionally emphasized hospital or acute care and were intended for younger healthy workers and their families. Thus, the package of services available for Medicare beneficiaries does not address either their most prevalent primary care needs for eyeglasses, hearing aids, dentures, prescription drugs, etc., or the catastrophic costs of long-term institutional care, which they are at risk of needing.

In addition to out-of-pocket costs for uncovered services, beneficiaries must pay monthly premiums, deductibles, coinsurance and, if the physician does not accept Medicare payment, any charges levied on them by nonparticipating providers. In effect, this means that the financial liability of Medicare beneficiaries is virtually unlimited.

To protect themselves, beneficiaries are apt to purchase any number of supplemental insurance policies, only to find that coverage for expensive long-term care is tied to restrictive Medicare policies and, therefore, of extremely limited value in the event of catastrophic illness.

To its credit, Medicare has been in the forefront promoting home health and hospice benefits, which are seen to be less costly and in many ways more humane than institutional care. But, in another way, Medicare has caused serious concern among beneficiaries because of the decision to move to diagnosis-related groups (DRG's) without assuring adequate alternate support systems. The fear that hospitals will prematurely discharge patients too ill to be released is a real concern among the elderly. Medicare's restrictive nursing home coverage policy lends credence to the notion that "dumping" will take place at the beneficiaries' expense.

Other program goals have evolved that do not relate to existing policies. For example, a recent proposal would have increased beneficiaries' liability for hospital stays in an effort to decrease lengths of stay and avoid unnecessary admissions. This proposal completely ignores the intense emphasis given to pre- and post-admission reviews and the effect of DRG's on lengths of stay; in addition, it gives the appearance of arbitrarily shifting costs to beneficiaries.

There are several fundamental issues that soon must be faced by beneficiaries and policymakers, but first there must be a clearer understanding by the public of the current program limitations, the anticipated demand for services in the future, and the cost of providing these services. Heightened public awareness is critical to the direction Medicare takes.

As Americans live longer, they must be better prepared financially to meet their changing needs over a longer period of time than previously anticipated. Long-term care insurance is one example of assuming this personal fiscal responsibility.

The elderly should have more choices in the kinds of services that are available to them and the amounts to be paid for these services. This "cafeteria" approach would include capitated or prepaid arrangements. They also should be given more information and choices concerning provider fees and participation.

The existence of Medicaid has made health care available to millions who would have had to depend on charity care or on limited local programs to meet their basic needs. Prior to the inception of Medicaid, benefits differed not only among States, but within States.

Medicaid mandated a minimum package of health care services and allowed a wide range of optional services to be offered. Those who meet eligibility standards set by individual States are assured that they will receive medically necessary care, regardless of where they live within the State. There may be minimal copayments for certain services, but providers are not allowed to bill Medicaid recipients in excess of the Medicaid payment.

Children receive the most extensive package of services under the early, periodic screening, diagnosis, and treatment program (EPSDT), and recent

expansions of services to children and to poor pregnant women have been hailed as the most positive steps the program has taken since it began.

The elderly and disabled poor, however, benefit the most from the Medicaid program. If they meet the rather stringent Medicaid eligibility requirements, they are entitled to receive a wide range of services not covered by Medicare, especially long-term institutional care. In addition, Medicaid pays their monthly premiums, coinsurance, and deductibles. Health care providers cannot charge these "dual eligibles" above the Medicare/Medicaid payment rates.

For the disabled, Medicaid is especially valuable in several ways. First, Medicare does not cover the disabled for the first 2 years of their disability, and Medicaid is available to fill the gap for those who qualify. Second, for the seriously disabled requiring institutional care, Medicaid offers unlimited coverage at virtually no cost to the patient or his or her spouse, or, in the case of an institutionalized child, at no cost to the parents.

Although some minor problems exist for Medicaid beneficiaries, the real problems exist for nonrecipients, those who cannot qualify because of differences among and within States.

These differences mean that people of similar economic circumstances may not qualify for or receive help depending on where they live. Equal access is denied geographically because of different income eligibility levels, different categories of eligibility covered, different services offered, different limitations and restrictions on services, and different copay amounts among the States. Even within a State, poor people of equally low income may not qualify because they do not receive public assistance or because they are living at home rather than in an institution. On the other end of the scale, the treatment of family income, "deeming," may mean that the institutionalized spouse or child may be Medicaid eligible regardless of how high the family income is. A family's income is considered to be available to the adult or child living at home; it is not counted if the adult or child is institutionalized.

In States that do cover the "medically needy," people whose income is above the public assistance level but below or near poverty may be required to spend 50 percent or more of their incomes on health care before Medicaid will cover them. Under normal circumstances, 15 percent of income spent on health care is considered to be "catastrophic," yet for these very poorest of the poor, there is no such reasonable limit on the liability they must incur before becoming Medicaid eligible. Medically needy income levels are tied to States' payment levels for Aid to Families with Dependent Children, which in many cases have not kept pace with inflation. Another of Medicaid's shortcomings, most of which are eligibility issues, is the "categorical" nature of the eligibility requirements. It is not enough to be poor; you must fit a "category" of eligibility covered by that State to be eligible, such as over 65 years of age, pregnant, in foster care, etc. A single adult male or childless couple who does not qualify as blind or disabled cannot qualify for Medicaid in any State, no matter how poor they are or how great their medical needs are.

For the beneficiaries then, Medicaid eligibility requirements are, for the most part, too stringent, too complex, too limited in length of time covered, and biased toward institutional care.

The most positive developments in recent years have been the expanded coverage of pregnant women and poor children, regardless of family composition, and the enactment of legislation authorizing home-based and community-based services, innovative payment and delivery systems, and preventive care services for adults similar to those available for children. Each of these measures has great promise of delivering needed services at a lower cost today and, more important, offers long-range benefits to the recipient as well as to the program.

One of the major challenges to the beneficiaries and to the policymakers in the future is to prevent the "institutionalization" of Medicaid and, instead, to make Medicaid services available to more of the Nation's neediest people who are arbitrarily denied eligibility.

To prevent long-term care institutional costs from consuming an even greater share of the Medicaid budget, other sources of funding must be identified for the elderly, disabled, and mentally retarded, and less expensive alternative living arrangements must be developed. This suggests the need for Medicare restructuring, long-term care insurance, increased family responsibility, elimination of abuses wherein wealthy beneficiaries can divest themselves of substantial assets in order to become Medicaid eligible, and innovative private financing arrangements for social support, residential, and health care needs of middle- and upper-income elderly and disabled beneficiaries.

Impact on health care providers

In an effort to dispel the notion that the United States was embarking on a course that would result in "socialized medicine," Congress enacted, and the Administration carried out, a Medicare program that basically mirrored the private health insurance industry, with a segment of that industry employed to run the program. Given the extraordinary benefit of hindsight, it would appear that too many concessions were made to health care providers if not to gain their support, then to diffuse their opposition. Recent developments in reimbursement systems, for example, would suggest that public officials today are taking a harder line and compromising less with these powerful interest groups, in order to gain control of inflationary increases.

The initial key decisions that affected providers most favorably were cost-based reimbursement principles and nonmandatory assignment. An even more favorable decision affecting providers was universal eligibility, in that it relieved them of

burdensome eligibility verifications. What services were covered and what limitations, if any, were placed on them, was important to the providers of those services; for example, the entire nursing home industry was built on Medicaid coverage.

Other key developments in both programs were the primary role of the physician, the emphasis on hospital care, the initial lack of effective utilization controls, and the use of familiar insurance organizations as fiscal intermediaries between Government and the providers.

When compared with Medicare, Medicaid appears to be an afterthought. In some ways, it mimicked Medicare policies, especially in reimbursement methodologies. In other areas, it took a markedly different approach, especially in mandatory assignment for providers. Before Medicaid, providers treated the poor as charity patients, or they received some small reimbursement from governmental, religious, or civic organizations for their efforts. This created a climate quite different from Medicare in which early Medicaid policy decisions were made.

In general, stricter utilization controls were mandated, fraud and abuse detection was emphasized, State options on reimbursement usually meant lower rather than higher reimbursement rates, and the program was more complex so providers usually dealt directly with governmental administrators.

Because States administer the program, the arrangements for claims processing and utilization review are many and varied. How providers view this diverse and decentralized administration depends on their relationship with their State, and this may range from hostile to amicable.

As mentioned earlier, the nursing home industry was launched because of the Medicaid program. In addition, other health care providers such as dentists and pharmacists, who traditionally had not been included in private insurance plans or in most charitable arrangements, were now, for the first time, able to receive payment for services to the poor if the State elected to cover them.

With Medicaid payments came a great deal of oversight and audit, something that was initially strongly resisted.

The future seems to call for more managed-care concepts—the physician or the health maintenance organization as case manager—in an effort to stem abuses arising from fee-for-service and self-referral arrangements. Providers may not have the luxury of independent practice and specialization that they have enjoyed in the past. For Medicaid patients, more effort must also be put into nutritional counseling, early prenatal care, child development counseling, geriatric education and counseling, etc. More inter-disciplinary team work will be needed to offer the services needed by this segment of the population, if their overall health status is to improve.

Impact on government

The key decision to reimburse providers based on cost and intensity fueled the inflationary fires that recently threatened the Medicare program's solvency. As this is brought under control, attention must be given to the inevitable problem of the Government financing a program, with a shrinking labor force, relative to an ever-increasing number of eligibles. Because the demographics are not favorable, the initial inclination is to reduce program benefits.

Any effort to adjust the financing arrangements is going to be met with resistance if beneficiaries see it only as a reduction of benefits and a shifting of costs. You cannot redraw the contract until you have assured the public, both the payers and the beneficiaries, that you have wrung out all the excesses and possible abuses in the current contract. Nor can you take the same package of services, which is now considered inadequate to meet the elderly's needs, and simply charge more for it. It would be difficult, if not impossible, to sell the notion of paying more when so little is actually covered.

At the same time, not only have the numbers of Medicare beneficiaries grown, they are living longer and are more at risk of needing more care as they reach 75 years of age or over. In the earliest planning stages for Medicare, it is unlikely that this phenomenon was predictable. Now it is essential that middle-aged workers anticipate and plan for their lengthened retirement years, and that they approach public policy decisions on health care for the elderly with this in mind.

Possible solutions might include a choice of benefit packages with varying charges for each. New delivery systems and cost-effective alternative care may bring down the unit cost of caring for the elderly and disabled, but it would be unfortunate if we were to delude the public by claiming that we can meet even the most basic needs of a fast-growing number of people without increasing the revenue base. Sources for increased revenues may include taxes, private insurance or investments, such as individual retirement accounts, home equity, liquidation of assets intended for succeeding generations, increased charitable contributions, or increased family responsibility.

How does society decide on the appropriate share of the gross national product to devote to health care? It does not, at least not consciously. The public does not have the opportunity to vote for a budget as such and allocate the funds as it sees fit. Instead, we elect representatives who, in budget deliberations, must consider competing interests and reach compromises. Taxpayers want health benefits for themselves and their family members, but they do not always want to finance them for others. The question is, should the cost of health care be borne by the patient, the

family, neighbors, church and civic groups, or local, State, and Federal governments? In other words, should the cost be distributed as widely as possible, or should it fall to the patient to pay?

Will our system need to ration care? This is a question that evokes emotional responses but little consensus. The answer depends on how you define "rationing." At its worst extreme, rationing could mean withholding treatment from any person whose prognosis for recovery is poor or for whom the cost of care is high. Rationing could mean simply waiting for nonemergency elective hospital admissions rather than building additional hospital beds. Rationing, in a publicly funded program or in a privately financed insurance program, could mean excluding nonessential services from coverage, or limiting the amount, duration, and scope of some services. Rationing exists when we do not routinely provide health care to the working poor and unemployed who do not qualify for governmental programs. Rationing makes no sense when we employ heroic measures at any cost to premature infants whose outlook is grim, but fail to provide basic services to poor children and adults with treatable but potentially disabling conditions.

Rationing is determined by availability of funds and the priorities we set for those funds. Rationing clearly has long-range implications that cannot be ignored.

For Medicaid, several key decisions helped shape the program's impact on government:

- Costs were shared between Federal and State governments.
- Poorer States received more funds.
- A minimum package of services was mandated with a large number of optional services available.
- Minimum categories of eligibles were covered by mandate with numerous categories left to the States' option.
- Once enrolled, it was "all or nothing." States could not arbitrarily limit the amount, duration, or scope of services by eligibility category. The program was an entitlement program with no arbitrary limit on expenditures.

Medicare's uniform eligibility and benefit package would seem to be more equitable and easier to administer than the 54 State Medicaid programs. However, aside from the inequities of program coverage and eligibility requirements from State to State, distinct advantages to State-administered programs exist in other areas. States are more visible, and therefore more accountable, to the public than the fiscal intermediaries in the Medicare program. Also, States have the opportunity to experiment with programs tailored to their individual needs and unique circumstances.

By not requiring uniformity among the States, the Federal Government avoided the initial costs of bringing poorer rural States up to the standards of richer industrial States and allowed States to set their own pace for expansion. But by requiring States to determine eligibility relative to payment levels for Aid to Families with Dependent Children, Federal policy indirectly required the States to increase those payment levels if the States were to benefit from expanded Medicaid participation. This has become a deterrent to States as they attempt to enroll more of their working poor or unemployed residents under Medicaid.

There are only two options in financing Medicaid: either more Federal funding or more State funding. Neither seems very attractive to the affected parties. A "cap" on Federal expenditures for Medicaid negates the entitlement nature of the program, and if we artificially limit Federal responsibility, we force the States to choose between cutting back programs, to live within the cap, or making up the shortfalls with State funds. Increased Federal funding is not likely in light of the Federal budget deficit, but it is to Medicaid's credit that a Federal cap has not been enacted in spite of the Federal budget deficit.

The indigent who do not qualify for Medicaid, but who do require health care, will most likely receive it in some fashion, and that cost will be borne by State or local taxes or by shifting costs to private payers. These become "underground" health care costs, never voted on or properly managed. So when we speak of capping Medicaid, we are in effect considering an option that would force more people into this informal, inequitable, and inefficient system (or nonsystem) of health care delivery and financing.

It is tempting to pursue whatever cost-containment strategies are fashionable at the moment and abandon other simple but effective means of controlling costs. This has its dangers when policymakers and program administrators act in haste and assume that there are single solutions to the complex problems of rising health care costs. Not all strategies are transferrable from one segment of society to another. What may be cost effective for workers and their families may not be appropriate for the mentally retarded or the frail elderly.

In some strategies, such as prepaid or capitated plans where quality of care is considered by some to be at risk, it is desirable for such service delivery systems to be tested on the general population rather than experiment with the poor and dependent. If these new ventures are satisfactory and acceptable to the population as a whole, then publicly supported programs can buy into them.

Ideally, Medicaid administrators should pursue ways of achieving efficiency and effectiveness routinely, not only in times of fiscal crisis. In doing so, a broad range of strategies would be employed with sufficient experimentation and evaluation prior to wide-scale implementation.

In the past, increases in Medicaid budgets have far outstripped increases in State revenue growth to support them. Yet States have continued to meet their obligations while striving to bring the rates of increase down to more manageable levels.

Implications for the future

Concerns about the elderly and disabled have taken a back seat to the Nation's absorption with the Federal budget deficit. Continued delays in exploring restructuring options and alternate financing arrangements will prove costly in both the short and long run.

Medicare program expansion need not be totally at public expense; options could be offered to beneficiaries based on their interest and willingness to pay. Private long-term care insurance should be aggressively pursued; a voluntary Medicare—Part C could be added to finance a long-term care insurance pool.

In exchange for mandatory assignment for physician payments, beneficiaries may be willing to pay graduated levels of deductibles, according to their ability to pay, especially if excesses within supplemental insurance policies were also eliminated. The current direction of requiring increased beneficiary financing, without improving the less-than-adequate benefit package, undercuts the value of Medicare to beneficiaries and diminishes support for the program.

It is difficult to draw accurate comparisons with other nations on how they meet the needs of their elderly. Family size and structure, location of relatives, age of elders, "position" in the family according to culture, religion, and the simple economics of divisions of labor all contribute heavily to the policies that ultimately shape each nation's response.

Any single set of standards could not be transferred easily to, or successfully imposed on, the many diverse cultures residing within our borders. Although we should try to draw lessons from other nations, we must rely on our merged heritage of resourcefulness and compassion to shape America's health policies.

During the past 4 years, the Nation has stood at several major crossroads concerning Medicaid; there have been repeated attempts to "cap" Federal funding as well as a rather short-lived proposal to federalize a portion of the Medicaid program. If both of these directions were permanently abandoned, the next direction the program might take would be to ease Medicaid eligibility rules to allow coverage of more of the country's poor families and individuals.

To afford this, the pressures on the Medicaid program as the sole financier of long-term care services for the elderly and disabled would have to be eased. Concern over expenditures, if not allowed to paralyze us, can inspire us to find innovative ways of financing our future needs, without total reliance on public funds, and delivering necessary services in the least restrictive and most effective way.

As important as cost containment is, we must devote more attention and resources to promoting wellness, preventive care, and early diagnosis and intervention, especially in the provision of prenatal care. Teenage pregnancy, sexually transmitted diseases, and substance abuse all cry out for attention. To ignore them is to invite costly consequences, most of which will become Medicaid liabilities.

During the past 20 years, health care, as a business, has enjoyed the best of all possible worlds. It was seen as a respected healing art, not as a profit-motivated business. Decisions made by health care professionals were rarely questioned; prices were discussed even less frequently. More was always better; patients expected and demanded the best and most at any cost, and they paid very little of it themselves. Even physicians all too often were unaware of the cost of the services they ordered. Anything less than "heroic" medicine was thought to be unacceptable when life itself hung in the balance.

When Medicare and Medicaid were enacted, the climate was such that Government bowed to the medical professions and eagerly sought their support and approval. Today, we value the medical profession for its skills, its ingenuity, and its compassion, but we recognize that it is a business, and that, as a business, it will respond to the market pressures and incentives that we create. It seems likely that Government will take a more aggressive role in the future in its negotiations with the health care professions.

What remains to be decided for ourselves, our parents, and our grandparents, as well as for our children and grandchildren, is how we will share the financial responsibility for meeting the essential needs of the poor, the handicapped, the unemployed, the frail elderly, and the chronically ill.

J. Alexander McMahon

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Impact on beneficiaries

There is no doubt that during the past two decades the Medicare program has done much to reduce financial barriers to access to state-of-the-art health care services for the elderly, the disabled under social security, and persons with end-stage renal disease. This represents an enormous accomplishment for society.

Although much has been accomplished, much still remains to be done. The current Medicare benefit package is fragmented as well as difficult to comprehend and administer. As a result, the beneficiary often feels trapped in an administrative maze, unaware of what services are covered and what is to be paid, to whom and by whom. Recent changes in Part B and the procedures for appeals to Peer Review Organizations have compounded this basic problem.

Another important issue is that the benefits of the program reflect the knowledge, wisdom, and needs of the mid-1960's when the program began. Much has been learned since then and the needs of the population have changed, yet program benefits have not evolved at an adequate pace. This is particularly apparent for long-term care, care of the chronically ill, and benefits for physician services.

Finally, the program has not done enough to safeguard the most vulnerable of our citizens—the poor elderly. This population group has special needs that must be recognized and met. Old answers will no longer suffice. Instead, creativity must be brought to bear in designing and administering Medicare benefits for these citizens.

Despite these shortcomings, the program has succeeded in ensuring access to health care services for millions of people. In the process, it has helped improve the overall health status as well as the quality of life for the Nation's aged.

During the same period, the Medicaid program has reduced financial barriers to access to health care services for millions of economically disadvantaged people throughout the Nation. Moreover, because an insurance mechanism has been used to provide access to care, Medicaid beneficiaries have been able to obtain care with dignity. Like Medicare, the Medicaid program represents an enormous accomplishment for society as well as a promise that must be kept.

Although the Medicaid program has accomplished much, it has not been devoid of problems. Clearly, there have been administrative and fiscal difficulties, resulting in the inability to fulfill completely the promise of Medicaid. Three major types of problems have affected the people the program was intended to assist.

First, the criteria and procedures for obtaining and maintaining eligibility, as well as the content of the benefit coverage itself, have been extremely difficult for beneficiaries to understand. This problem is compounded for those beneficiaries relocating to other States with different eligibility and benefit coverage rules.

Second, cost-sharing features, as well as benefit limitations applied by individual State Medicaid programs, can represent a significant barrier to care for those eligible.

Finally, depending on a State's budget constraints and competing social priorities, many of the economically disadvantaged may not meet the eligibility criteria for Medicaid coverage, yet they are unable to afford private health insurance coverage. Thus, many economically disadvantaged people may be "falling through the cracks" of the Medicaid system, not seeking care when it is needed.

Like the Medicare program, the funding, eligibility, and benefit design features of the Medicaid program reflect in many cases the knowledge, needs, and economic environment of the mid-1960's. Much has been learned and much has changed in the last two decades. In reassessing the Medicaid program, along with other social welfare programs, the changing size, characteristics, and needs of the economically disadvantaged must be considered. Yesterday's solutions will not answer today's and tomorrow's problems and concerns. Despite its shortcomings, however, the Medicaid program has succeeded in helping to provide dignified, high-quality health care services for millions of people, improving their overall health status and quality of life in the process.

Impact on health care providers

The fee-for-service and retrospective cost-based reimbursement mechanisms woven into the original fabric of the Medicare program were entirely consistent with the original, overriding objective of the program to expand beneficiary access to health care services. Combined with the relatively rich benefit coverage provisions of the program, there

were incentives for both providers and beneficiaries to provide more care, and more sophisticated care.

Over time, as Medicare program outlays exceeded the original estimates, a variety of regulatory measures were undertaken to restrain increases in payments to providers from the hospital insurance trust fund. For hospitals, this meant an increasingly complex, sometimes contradictory and arbitrary, array of control mechanisms, growing administrative burdens, decreased management flexibility, and continued tinkering with the payment system without any fundamental changes in incentives.

Various elements of allowable costs were selectively redefined, such as elimination of the "2-percent factor" that was intended by Congress to provide an operating margin factor for not-for-profit hospitals, redefinition of reimbursable malpractice costs, and reduction and eventual elimination of the nursing salary cost differential—an additional payment designed to recognize the greater nursing care requirements of elderly patients. Reasonable cost limits, established for Medicare routine nursing care costs per diem, were tightened over time and eventually were expanded to include all operating costs and were applied on a per-case basis. Professional standards review organizations, established to monitor the medical necessity and appropriateness of care, operated unevenly with unclear objectives and guidance. The Medicare program also entered into contracts with States to review and approve capital expenditure projects and, eventually, separate Federal health planning legislation was enacted that provided for financial sanctions to States that chose not to establish certificate-of-need programs meeting detailed, prescriptive Federal requirements.

All this tinkering yielded little productive good, and for hospitals, it resulted in increased regulatory and administrative burdens and a no-win situation. If hospitals reduced their costs, they were merely paid less. If costs exceeded the mechanically set limits, hospitals were penalized, not necessarily because of performance, but because of inequities in the formulas used to set the limits.

In the last several years the Medicare program has changed its strategy. Repressive controls have been replaced with dynamic incentives. The keystone in this changed strategy has been the prospective payment system. Nonetheless, the mechanics of prospective payment will need to be modified and refined as more is learned about the total effects of its operation. The considerable promise offered by the early experience under the program is threatened by the fact that the system is becoming very complicated. The incentives of the system could be sapped if hospitals cannot predict the price they will receive for their services or if the price is inadequate.

Medicare prospective payment, in combination with changes in private health benefit plans designed to increase patient cost consciousness, medical technology, consumer preferences, and patterns of practice, has produced dramatic results. During calendar year 1984, total hospital expenses rose only 4.5 percent. This was the lowest growth rate in 22 years, and less than one-third of the rate of increase 2 years ago (15.8 percent) and less than one-half the 1983 rate (10.2 percent). Inpatient expenses in 1984 increased only 3.2 percent. Medicare expenditures increased at the lowest rate since the inception of the program.

The dramatic slowing of the rate of increase in costs is largely the result of three factors. First, admissions have declined sharply for both the 65 years of age or over group and the under age 65 group. Second, average length of stay declined significantly. Although lengths of stay have been declining for many years, recently the rates of decline have accelerated. In 1984, the length of stay of patients under age 65 was 3.6 percent lower than the previous year. The length of stay of patients 65 years of age or over declined 7.6 percent between 1983 and 1984. The third major factor responsible for slower growth of expenses is a reduction in hospital employment, made possible not only by lower admissions and lengths of stay, but also by staffing efficiency improvements. Although full-time equivalent employment increased at rates of 3.7 and 1.4 percent in 1982 and 1983, respectively, full-time equivalent employment declined 2.3 percent in 1984.

Continued improved performance can be expected in the future. With a Medicare population that is growing both in size and age, however, it is unrealistic to expect total Medicare expenditures to decrease. A larger and older population will require more services, services that must be provided if the promise of Medicare is to be fulfilled. If these growing demands are met by underpayment to providers, any short-run savings obtained would be at the long-run expense of reduced access of beneficiaries to state-of-the-art medical care. Such a scenario is unacceptable. Avoiding this outcome is possible, but it will require a firm recommitment to the basic principles that guided the original development of the program.

When Medicaid was enacted in 1965, the fee-for-service and retrospective cost-based reimbursement mechanisms woven into the original fabric of the Medicare program also became part of the Medicaid system. As was the case with Medicare, these payment mechanisms were not only entirely consistent with, but also actively supported the Medicaid program's objective of expanding access to health care services to a previously underserved population.

As the Medicaid program moved from a concept to a reality, and as program expenditures began to exceed the original budget estimates, States began to adopt many of the same regulatory measures undertaken by the Federal Government to restrain increases in Medicare provider payments. Some State Medicaid programs also added their own unique cost-containment provisions. As was the case with Medicare, all this tinkering yielded little productive good.

With the enactment and implementation of the Omnibus Budget Reconciliation Act of 1981, States

were given broader discretion in structuring their provider payment methods, as well as program eligibility and benefits. The results of these structural changes have been mixed, coming at a time of high unemployment and substantial Government budget deficits. Some States appear to be trying to use this new-found flexibility imaginatively, tailoring eligibility and benefit coverage to those most in need and changing the basic incentives in provider payment arrangements. Experiments in per case and per capita fixed-price payment systems and case-management delivery arrangements are increasingly common, as are selective contracting and preferred provider approaches. In some States, however, the changes appear to have been more arbitrary, such as across-the-board budget cuts, with eligibility and benefit coverage substantially reduced and provider payments frozen or capped.

Where imaginative State Medicaid programs have been developed, it is reasonable to expect that these programs, in combination with Medicare prospective payment, more demand-sensitive private sector health benefit plans, and changes in medical technology, consumer preferences, and patterns of medical practice, have helped to produce the dramatic cost-control results now being seen on an aggregate level. Because of improved overall cost performance, some States have been able recently to increase their eligibility and benefit coverage.

However, in those States where eligibility, benefit coverage, and provider payments have been substantially reduced, problems inherent in underfinancing, for both providers of care and the economically disadvantaged, are growing. In some communities, the problems are, in fact, reaching crisis proportions. The total amount of uncompensated care provided by hospitals (the sum of bad debts and charity care) doubled between 1979 and 1983, from about $3.9 billion to about $7.8 billion. Public hospitals, in particular, have provided an increasing proportion of this care. Public hospitals, however, are not alone. As a group, private hospitals have provided the bulk of uncompensated care. Also, the financial problems of uncompensated care have not been limited to either the inner cities or the industrialized Northeast. As a percentage of gross revenues, uncompensated care has been highest in the South and Southwest, regions generally characterized by relatively limited Medicaid programs, relatively lower rates of private insurance for the employed population, and, until recently, relatively low income levels.

The problem of uncompensated care is compounded by the fact that hospitals with high proportions of uncompensated care and Medicaid patients already tend to be in financial distress. Further, although more market-oriented, incentive-based financing and payment systems are already demonstrating their effectiveness in containing costs, uncontrolled price competition will tend to exacerbate the financial problems of hospitals providing care to the poor, unless explicit measures are taken to ensure adequate and equitable financing.

Impact on government

The substantial progress that the Medicare program has made during the past 20 years in ensuring the availability of high quality health care for millions of elderly and other citizens has come about at no small cost. However, with a goal of assuring that services were available and accessible to the elderly, this cost was unavoidable.

The problem has not been so much the cost of the Medicare program, but rather that the costs were originally underestimated and other demands on national resources are being met at the expense of social welfare programs.

Underfinancing of the Medicare program through unrealistic reductions in benefits or provider payments, although producing the illusion of savings, is actually a cost-increasing strategy in the long run. Underfinancing is a strategy that the Nation cannot afford, particularly as the Medicare population grows both larger and older. It is unaffordable both in monetary terms and in terms of the effect it will have on our basic social fabric and values.

In lieu of underfinancing must come a full re-examination of the policies that have guided the financing of Medicare. Such a reexamination has been done with respect to hospital payment. The result has been a new approach to payment that has performed well to date and holds great promise. The same imagination and creativity must now be applied to other components of the financing side of the equation.

Medicare financing must be fundamentally reexamined, based on the principles of pluralism, consumer preference, and equity. Equity and uniformity are not synonymous terms, and it is only by reforming the Medicare financing system that the social contract that the Nation made with its elderly can continue to be honored.

As with Medicare, the progress that the Medicaid program has shown in making health care services available and accessible to the economically disadvantaged has cost more than originally estimated, leaving the impression that the program has cost more than it should. In addition, other demands on Federal, State, and local government resources have placed unrealistic pressures on many domestic programs. As a result, both Federal and State governments have sought Medicaid expenditure reductions and savings wherever possible, at times arbitrarily.

Although the original intent of the Medicaid program was not necessarily to meet all the health care needs of all the economically disadvantaged, there are growing concerns that reductions in eligibility, benefits, and provider payments have been so drastic that many citizens feel they no longer have access to health services, except in life-and-death circumstances. County and city governments, as well

as individual hospitals and other providers that have traditionally cared for the economically disadvantaged, increasingly find themselves unable to fill the growing gaps and increasing needs. At the same time, private payers and purchasers of care, which are health maintenance organizations as well as self-insured businesses, Blue Cross/Blue Shield plans, and commercial insurers offering more traditional health benefit plans, have been seeking to limit their own payment liabilities and prevent cross-subsidization of uncompensated care costs. These limitations are compounded by underpayments by State Medicaid programs.

Health care and other leaders in a number of States are currently seeking to develop humane, compassionate strategies for filling the gaps in their current Medicaid programs. At the national level, policymakers will need to monitor this activity closely, learning from both successes and failures. National policymakers must also examine the Federal Government's own role in financing care for the economically disadvantaged and create new answers—matched to the needs of the new economic and demographic realities.

In the broadest sense, the success of any Nation may be gauged ultimately in terms of how well it addresses the needs of its disadvantaged. The issue of adequate and equitable financing of health care services for the economically disadvantaged requires a full reexamination of the policies that have guided the financing of Medicaid. Such a reexamination will require considerable imagination and creativity and, as in the case of Medicare, must be based on the principles of pluralism, consumer choice, and equity. "Choice," however, does not necessarily mean unlimited choice, nor does "equity" necessarily mean uniformity.

Implications for the future

The Nation is approaching a major crossroads with regard to the Medicare program as a result of the Federal budget deficit, competing defense and domestic priorities, and a slowly improving, but fragile, economy that requires fundamental retooling and redirection.

Whether the Medicare program is viewed by the Congress and the general public as a continuing, significant part of the problem and solution to the Federal budget deficit will have a major bearing on the program's future policies and outcomes. If recent and additional reforms in benefits and provider payment systems were to be "over-worked," such that they become reforms in name only, aimed at producing more and more short-term cost savings, the types of access and care to which middle- and low-income beneficiaries have become accustomed would surely change. The changes in many cases would be gradual, but ultimately their aggregate effect would be viewed as sufficiently unacceptable, to both beneficiaries and others, to create a backlash of ill-will toward the program and the Federal Government.

I remain confident that the Federal Government will avoid the temptations and dangers of underfinancing. I also remain confident that the equity questions in payment and broader financing reforms can and will be resolved satisfactorily.

Although the American Hospital Association (AHA) has not yet adopted a specific position on long-term reform, several measures in combination need to be considered seriously as a Medicare reform package:

- Raising the age of eligibility for Medicare benefits by tying it to the age of eligibility for social security benefits.
- Merging existing deductible and copayment provisions under Part A into an all-inclusive deductible, with a partial or total waiver of the deductible for beneficiaries enrolling in various capitation-payment-based organized delivery systems—health maintenance organizations, competitive medical plans, and other new mechanisms that can be identified. The notion of merging Parts A and B also merits attention.
- Increasing or removing the taxable income limit on the hospital insurance trust fund component of the Federal Insurance Compensation Act (FICA) tax, so that higher income workers contribute more to the fund for their future benefits.
- Within the personal income tax system, establishing a Medicare premium contribution by current beneficiaries that is sensitive to differences in their income, with the revenues earmarked for the fund. This approach would take into account the fact that current beneficiaries, during their working years, have contributed far less to the fund than the actuarial value of their current benefit coverage.
- Increasing, and earmarking for the trust fund, Federal excise taxes on selected goods and services, such as alcohol and tobacco, whose voluntary consumption has an adverse effect on health status and contributes to the cost of the Medicare program.

For Medicaid, the Nation is approaching a major crossroads on the broader issue of financing care to the economically disadvantaged. The American Hospital Association has identified financing care for the indigent as its most critical issue for study and resolution. Our Board of Trustees has established a special committee on this issue, and our House of Delegates has adopted an interim position pending the outcome of the special committee's work. Importantly, this position states that the individual self-interests of government and private payers, businesses, providers, and consumers must be held in balance with broader community and society interests, so that needed care is assured for all people. Ultimately, this issue will only satisfactorily be resolved through the ongoing commitment and cooperation not only among Federal, State, and local governments but also including private payer, business, labor and provider forces within each

community. These forces must join together in ways that are uniquely tailored to local circumstances to create and sustain lasting solutions.

Although the total solution will not come from reforming government programs, it must play an important part. The AHA's special committee and other groups must, in their search for answers, develop specific recommendations on needed reforms in the structure of the Medicaid program, including such matters as adequate minimum funding levels, minimum eligibility standards, cost-conscious benefit design, and administrative flexibility.

The fundamental matter of the appropriate future roles and responsibilities of Federal versus State government must also be examined. Other important decisions to make include:

- Whether certain groups of the economically disadvantaged are the particular responsibility of government, and at which level of government.
- Whether certain types of services are more necessary than others for certain segments of the economically disadvantaged.
- Whether and what limitations on choice of delivery settings and arrangements might be appropriate.
- Whether other Federal policies and programs, e.g., Medicare, tax code provisions on charitable contributions, or Aid to Families with Dependent Children, need to be modified simultaneously with any Medicaid reforms to achieve better coordination and synergism.

The foregoing is obviously not an exhaustive list of the issues and concerns; it is simply a starting point for addressing what must come to be understood as one of the most critical issues on the Nation's domestic policy agenda.

Vita R. Ostrander

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Impact on beneficiaries

Few today would argue with the assertion that the Medicare and Medicaid programs have had a profoundly beneficial effect on access to health care by the elderly, the disabled, and the poor, and that, together, the two programs have significantly alleviated the financial burden borne by these people in meeting their health care needs. Nevertheless, significant numbers of elderly, disabled, and poor persons are at risk for sizable out-of-pocket health expenses or, in some cases, may even have to forego medical care because of incomplete and variable levels of health care coverage.

Designed to facilitate access to acute care medical services, the Medicare program, which served 19 million older Americans in 1966, today serves 28 million, (about 98 percent) of the elderly population in this country. A significant subpopulation of this group (about 15 percent) also receives Medicaid benefits.

Since 1966, the portion of the elderly's health care bill covered by Government spending has almost doubled, while that portion paid directly by the elderly themselves has been reduced by half. Further, elderly persons, who prior to the establishment of Medicare were spending roughly 15 percent of their annual income on health care, experienced a substantial decline in this category of household expenditure within a few years of the full implementation of the Medicare program.

Moreover, from a review of life expectancy and mortality rates over the last two decades, we can infer a considerable degree of correlation between greater access to health care and improved health status of the elderly. Not only do we see improvements in life expectancy and mortality rates; the increased availability of such therapeutic surgical interventions as lens implantation and hip replacement under the Medicare program has done much to enhance general functional levels and quality of life for hundreds of thousands of older Americans.

Notwithstanding the impressive accomplishments that have been facilitated in no small part by the Medicare and Medicaid programs, it would be a distortion of fact to suggest that older people are now somehow insulated from the high cost of health care. Indeed, much of the protection originally afforded the elderly by these two public programs has gradually been eroded over time. Today, Medicare covers less than one-half of the elderly's health care bill. Although Medicaid picks up another 14 percent, the beneficiary is responsible for fully one-third of the total, either directly out of pocket or indirectly through supplementary medical insurance and/or private health insurance premium payments.

Today, in fact, older beneficiaries spend as large a portion of their income on their health care needs as they did before the existence of Medicare. Moreover, out-of-pocket medical expenditures for older Americans continue to rise at a faster rate than do their incomes; such expenditures are expected to consume, on average, almost 20 percent of elderly annual income by the year 2000.

Tracing the arc of Medicare and Medicaid protection, one finds troubling irregularities and gaps. Although Medicare coverage of hospital costs is relatively complete (75 percent), the older beneficiary is vulnerable to considerable, and frequently unpredictable, liability for physician services. In 1983, elderly beneficiaries were responsible for more than $7 billion in physician charges alone. Further, Medicare provides only minimal coverage for skilled nursing services, and offers no coverage for long-term nursing care, prescription drugs, dental services, and optical supplies. Medicaid's coverage of long-term nursing care, which requires virtual impoverishment as a condition of eligibility for benefits, still leaves the beneficiary at risk for roughly one-half of the total nursing home bill.

One of the most disquieting aspects of the inadequacy of Medicare coverage for the elderly today is that it tends to disproportionately burden the poor elderly, the sick elderly, and the very old. About one-fifth of all Medicare beneficiaries depend exclusively on Medicare for protection against medical costs. These people, who are likely to be over the age of 75 and in the lower reaches of the income scale, are most vulnerable to increases in health care costs in general and in Medicare cost-sharing requirements in particular. Further, out-of-pocket expenses expressed as a percent of income are six times greater for poor and near-poor older people than for their middle-income counterparts.

Moreover, although Medicaid has done much to improve access to health care for poor and near-poor people, the program covers only 35 percent of the age-undifferentiated poor and near-poor population. About 15 percent of the poor and near-poor have no

form of insurance coverage. Research on the health care utilization patterns of this population suggests that many of its members who are sick have no choice but to forego medical care.

The magnitude of the Federal budget deficit, the projected insolvency of the Medicare hospital insurance trust fund, rising health care costs, and the resource implications of an aging population have conspired to make the Medicare and Medicaid programs prime targets for budget cuts. Preoccupation with such concerns is redirecting emphasis away from the earlier programmatic goal of eliminating inequities in access to medical care toward the goal of containing costs. Traditionally, efforts to control costs have taken the form of increased beneficiary cost-sharing or, in the case of Medicaid, revised eligibility requirements and benefit reductions.

From the beneficiary's standpoint, such approaches are shortsighted and narrow. The persistence of budgetary dilemmas and the inexorable change in demographic patterns must inevitably lead to a reconsideration of the design of the health care system, both in terms of service delivery and financing. The heterogeneity of an aging population dictates the development of a delivery system and financing mechanism that are particularly flexible and responsive to the long-term chronic care needs of its members; redirect the existing bias in favor of institutional care toward care in the community; and fill existing gaps in health care services. Whatever the outcome of the inevitable debate over the structure and funding of such a system, issues of quality of care and quality of life must not be subordinated to issues of cost.

Impact on health care providers

Medicare and Medicaid policies have had a profound impact on the shape of the health care delivery system. In the future, Medicare and Medicaid policies will be the linchpin in refocusing the delivery of care from institutional settings to community-based ones.

To assure financial access of the elderly and the poor to acute medical care, benefits and reimbursement under Medicare and Medicaid have heavily favored hospital care; this has led to excessive inflation in hospital costs and over-expansion of the hospital industry. Under cost-based reimbursement, hospital management has had little incentive for operating efficiently since it was pointless for management to hold the line on operating costs when the end result was a reduction in the institution's revenues. Because depreciation and interest expenses, along with operating revenues generated by capital improvements, were passed on to Medicare and Medicaid without penalty, hospital expansion flourished. In fact, capital payment provisions discouraged institutions from closing underutilized capacity because depreciation payment and cash flow would decrease.

With the financial risk of carrying long-term debt removed, the debt market replaced philanthropy as the principal source of capital funding. In addition, generous return-on-equity payments for investor-owned facilities resulted in rapid growth of for-profit institutions in an industry traditionally concentrated in the nonprofit sector. No longer were hospitals community providers of social goods dependent upon community support; they became instead businesses with sophisticated accounting practices competing in the debt market.

Physician reimbursement under Medicare and Medicaid reinforced the use of the hospital as the provider of first choice. Medicare's usual, customary, and reasonable charge-based methodology was inherently inflationary; it also provided more generous reimbursement for physician services performed in the hospital than for services provided in outpatient settings. Since Medicare paid hospitals for graduate medical education, physicians in training learned hospital care, not ambulatory or long-term care, thus impeding the development of geriatric medicine. Moreover, payment was exclusive to physicians, hindering the use of alternative health practitioners. Medicaid's payments to physicians have been set so low that many physicians refused to treat Medicaid recipients, forcing persons with low income to rely upon hospital outpatient departments and emergency rooms for their care.

Payment policies dramatically influenced the adoption and use of new technology. Since payment levels for the introduction of complex and expensive technology have been disproportionately high, there has been little incentive to evaluate appropriate indications for the use of new technology, to substitute less costly technology, or to adjust payment levels downward as the cost of technology declines over time. The result has been tremendous reliance on the use of specialized, procedure-oriented care rather than cognitive and preventive services.

Benefits and reimbursement for long-term care also favored institutional care, spurring rampant growth of the nursing home industry, particularly the for-profit nursing home. Consequently, well-developed, community-based systems of care have not developed, even though these systems have been found to be cost effective and to better meet the elderly's long-term care needs.

Recognizing the inefficiencies of past policies, the Federal Government, through a variety of financing changes, has begun to place limits on available funds to provide care. For Medicare, the most dramatic change has been the implementation of the prospective payment system and diagnosis-related groups (DRG's); for Medicaid, it has been reductions in Federal matching payments and State experimentation with alternative payment mechanisms. Hospitals must now consider the bottom line and control costs. However, because of uncertainty about future increases in Government financing of care for the elderly and the poor, hospitals serving a disproportionate share of these

patients face financial uncertainty while hospitals, primarily investor-owned, serving better financed, privately insured patients, continue to flourish.

Medicare DRG's could profoundly affect the adoption and use of new technology. Since high technology care (such as intensive care units) becomes a revenue-loser rather than a revenue-enhancer, many hospitals may begin to provide only those services and technologies that promise adequate revenues. And, as long as physician payment continues to reward the use of complex technologies, the development of "mini-hospitals" with physician offices and ambulatory care settings will most likely expand.

Medicare and Medicaid have begun to experiment with capitation, and Medicaid has provided waivers for community-based systems of care. Although home health care and health maintenance organizations were already experiencing unprecedented growth, the Government's entrance into these alternative systems of service delivery will accelerate their expansion. Still, public financing for alternative care arrangements has been slow in coming, and large gaps remain, especially in preventive care, geriatric medicine, community-based long-term care services, and the use of alternative care providers. As institutional and highly technical care is down-sized in response to Government restrictions on funding, many elderly and the poor will be faced with a lack of needed alternatives unless these gaps are closed.

Impact on government

Key decisions in the design of Medicare and Medicaid have shaped the impact of these programs on governmental expenditures. The payment mechanism in Medicare and the broad range of eligible populations in Medicaid have driven Federal expenditures far beyond original projections of program costs in 1965.

The greatest flaw in the design of the Medicare program was the decision to pay hospitals the costs incurred in treating Medicare inpatients and to pay physicians a fee for each service performed. These payment mechanisms are inherently inflationary and have contributed to the relentlessly high rate of inflation in the health care sector of the economy during the past 20 years. It is important to remember, however, that before the establishment of Medicare, millions of elderly people could not afford medical care. Despite its flaws, Medicare has been a huge success. It has provided care for millions who otherwise could not have afforded health care, and in the process has contributed to an almost 5-year increase in the average life span of American citizens.

The greatest flaw in the design of the Medicaid program is of a different character since each State has considerable discretion in establishing its Medicaid reimbursement procedures. The single most important factor influencing Government expenditures in the Medicaid program is the cost of institutional long-term care. The largest share of Medicaid expenditures and the greatest acceleration in program costs have occurred in the provision of institutional long-term care services for both the functionally impaired elderly and disabled as well as the mentally retarded.

From the beneficiaries' point of view, there are profound strengths in the design of Medicare compared with the design of the Medicaid program. The fact that Medicare is a relatively uniform, national insurance program, benefiting a broad cross-section of our society, is a major strength of the program. Medicaid, on the other hand, is not a single unified program, nor even 54 uniform State and territorial programs, but a collection of programs in each State incorporating multiple objectives, target populations, and services in an uneasy, and often antagonistic, relationship.

The experimentation inherent in 54 different State and territorial Medicaid programs is, some believe, an important strength of Medicaid. Medicare, however, has allowed waivers from program requirements since the program was initiated, and thus has been able to experiment and demonstrate a variety of ideas under various waiver authorities. Hence, experimentation is a strength of both programs.

Improving Medicaid will require major structural changes in the program. The national experience with Medicaid underscores the fact that the basic health care needs of individuals and families are fundamentally different from the social and health needs of people with chronic functional impairments. The American Association of Retired Persons questions the efficacy of continuing to finance and administer preventive and acute medical care and long-term maintenance care for disparate target populations within a single program.

Eligibility for preventive and acute care services for the poor and near poor ought to be based on uniform national standards, not 54 different State and territorial standards. Within broad Federal guidelines, States should be able to set up a balanced long-term care system, including community and home-based care services as well as institutional long-term care services.

Medicaid's reliance on States' generosity (or lack of it) to fund the program at an adequate level has labeled it as a welfare program for the poor. Welfare programs have not fared well in both State and Federal Governments' budget-cutting environments. The fact that Medicare is financed, for the most part, through the payroll tax is an important strength of the program.

The most important issue concerning the current financing of Medicare is whether our society will be able to control the rate of inflation in the overall health care sector of the economy. If not, there will continue to be great pressure for major structural changes in the Medicare program. Proposals to "solve" the Medicare problem solely within the boundaries of the program, without addressing the cost problems of the overall health care system, would so erode Medicare coverage that beneficiaries would ultimately receive little benefit from the health

insurance that they had paid for during their working lives.

Even assuming moderation in the rate of growth in the health care sector overall, it is likely that the level of payroll taxes financing Medicare will not be sufficient over time to cover program costs. The Association supports raising the excise taxes on tobacco, and earmarking the additional revenue for the hospital insurance trust fund as a prudent way of increasing the fund's long-term solvency.

Relating the beneficiary's ability to pay to the beneficiary's financial responsibilities under the program (i.e., means-testing) is a popular idea in Washington, but not across the country. Beneficiaries already pay huge sums out of pocket for health care. The Association sees no room to both "redraw" the Medicare contract and continue to maintain confidence and trust in the system.

The Association believes that while the encouragement of choice and competition in the delivery of health services must be part of any solution to the health care cost dilemma, any effective program of cost containment must pursue both regulatory and market approaches together. Competition alone cannot be the answer. Not only does the health care market resist normal forces of supply and demand, but the consumer information that is critical in order to assess efficacy and quality of services in a competitive system is severely lacking.

Further, unlimited competition in the health care industry may not serve the American people well. Under competition, health care providers tend to seek out the healthiest, and hence most "profitable," patients. Under competition, patients may face increased cost-sharing and/or restricted freedom of choice. Under competition, the poor and the very sick may have no place to go for medical care.

The Association advocates instead a comprehensive approach to health care cost containment that focuses for the short term on negotiating—or, if necessary, mandating—limits on the rate of increase in payments to providers for all third-party payers, not just Medicare.

Over the long run, health care delivery should be restructured to expand the supply of more appropriate alternatives to hospitals and nursing homes. The development of competing forms of health care delivery such as health maintenance and preferred provider organizations should be encouraged, as should greater reliance on paramedical personnel (i.e., geriatric nurse practitioners and physician assistants), especially in underserved rural and inner city areas.

Implications for the future

This Nation is at a major crossroads with regard to its entire health care system. Over the course of the last two decades, rising health care costs have begun to threaten its commitment to the provision of health care services to all of its citizens—young and old alike. Certainly no one is immune to the insidious impact of escalating medical costs—not workers who face cutbacks in employer-provided benefits, nor the poor of all ages whose protection under the Medicaid program is gradually being eroded, nor older Americans who are threatened with the insolvency of the Medicare program and who continue to face increased out-of-pocket costs. Without a comprehensive restructuring of the health care delivery system, the future availability of effective and cost-efficient health care is certain to be compromised for all Americans.

Since their very beginnings, Medicare and Medicaid have grown to define the Government's basic commitment to ensuring health care for the elderly, the disabled, and the poor. This basic commitment is now in jeopardy because of continuing, excessive cost escalation in the health care sector of the economy and the correspondingly rapid increase in the costs of the Medicare and Medicaid programs. Solutions to these programs' financing problems will require changes in the manner in which all health care services are delivered and paid for.

Today the Nation is facing the same access to care problems that led to the development of Medicare in 1965. However, the current factors tending to constrict access to needed health care services are more numerous and, because they are systemic and complex, less amenable to correction.

The challenge is to guide the restructuring of the health care system to deemphasise its acute care, institutional bias so that the commitment to accessible, affordable health care for all persons is maintained and expanded in areas where needs are not currently being met. In carrying out such a restructuring, the following objectives should be pursued:

- Cost controls must be implemented without sacrificing quality of care.
- Public financing must not be biased toward acute care institutionalization.
- Emphasis and resources must be redirected toward preventive medicine and community-based care.
- Health care resources that are "freed up" through effective regulatory control (and would otherwise have flowed into hospitals) must be redirected to the promotion of less costly alternatives for delivering health care services.
- Artificial and competition-inhibiting restrictions on the use of nonphysician health professionals in the delivery of medical services must be lifted.
- Proposals to increase beneficiary cost-sharing must reflect an appreciation of the growing health care cost burden borne by older Americans.
- Fraud, waste, and abuse must be sought out and eliminated.
- In the pursuit of the foregoing objectives, consideration must be given to the appropriate development and use of medical technology.

As the health care system is being restructured, the programs within that system must be evaluated in order to determine whether they will continue to meet the needs of the people they serve. An increasingly critical deficiency in the present health care system is

the lack of comprehensive financing and delivery mechanisms for caring for those with chronic illness or disability.

The dramatic anticipated growth over the next several decades in the functionally dependent population (most of whom will be elderly) is being fueled by five trends:

- A growing aged population.
- Continuing increases in life expectancy.
- Greater prevalence of chronic disease as the dominant pattern of illness for older persons.
- A reduction in the availability of family members to serve as caregivers.
- The Medicare prospective payment system's inherent incentive to reduce the length of a hospital stay.

These trends point to the need for the development of a long-term care program that provides not just institutional care, but a complete continuum of services, including home-based and community-based services. Medicare, it must be remembered, is essentially a health insurance plan for acute illness.

Despite the tremendous need looming in the future, policymakers have been reluctant to approach the difficult issues associated with linking medical and nonmedical services to meet the needs of chronic care patients. In view of the demand for service, however, public sector efforts to establish these linkages must become a national priority, and private sector financing of long-term care services must be encouraged to ensure that adequate resources are available to develop a comprehensive community-based system of long-term care.

In the public sector, establishing the link between health services and the broader range of social and personal services requires changing existing policies. To achieve this link, it is necessary to alter the financial incentives for institutional care that currently exist. By providing institutional care as but one benefit in a case-managed system of long-term care and by providing financial incentives through a prospectively determined amount of funds, in-home and community-based care becomes a more feasible and desirable alternative to institutionalization.

Forging the link between long-term care and related social services must begin in the Medicaid program because it finances almost 50 percent of all long-term care services in the United States. Reforming Medicaid in order to address the long-term medical and nonmedical needs of people with chronic functional impairments will require fundamental changes in the program's structure. In seeking such reform, certain other program infirmities should also be addressed. First, it must be acknowledged that the program has grown to encompass multiple and often disparate objectives and services for vastly different populations. Second, both the financing and delivery systems must control costs. Third, administrative responsibility between the State and Federal Governments should be clearly defined. Fourth, program inequities across States must be reduced.

Finally, no amount of restructuring within the Medicare and Medicaid programs will solve the problems that plague this Nation's health care delivery system. Ultimately, it is the entire health care system that must be redesigned, and the objective of its restructure must be twofold: to ensure the availability of adequate health care and the cost-effective delivery of that care to all Americans, and to redirect resources that are "freed up" through the creation of a more efficient health care delivery system to expand services in areas where needs are not currently being met.

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Impact on beneficiaries

Ask a normal human being "How are you?" and you are likely to receive the reply "Fine!"Ask an economist the same question, and the reply is bound to be, "Relative to what?" This is so with perfunctory salutations, and certainly with questions on the impact of the Medicare and Medicaid programs on their beneficiaries. In connection with such questions, one is immediately led to wonder, "Relative to what?"

Those who fought so tenaciously for the two programs during the mid-1960's probably thought of them as logical first steps toward full-blown national health insurance (NHI). Ironically, in retrospect, the two programs may well have deflected American health policy from a path towards national health insurance. With the wisdom of hindsight, the supporters of NHI might now judge these programs as seriously flawed incrementalism, an incrementalism that was just enough to temper the brewing crisis in American health care and divert the Nation's energy from its march towards NHI, but, not enough to free all Americans from anxiety over the financial consequences of illness and grant all Americans access to needed health care on dignified terms.

An argument could thus be made that, relative to a full-fledged NHI program, the Medicare and Medicaid programs actually made millions of the Nation's poor and near poor relatively worse off. This surely must be true of the large number of poor and near-poor Americans who do not now have any health insurance coverage at all, some of whom reportedly are being denied access to health care for want of ability to pay. In its Special Report on this problem, for example, the Robert Wood Johnson Foundation (1983) reported that more than one million families found themselves in that position in 1982. Even the Wall Street Journal (1985), a paper not known for Liberal hysteria, has recently documented cases of gravely ill Americans who have been denied care for lack of insurance coverage and ability to pay. To argue that such families are nevertheless better off than they would be under a national health insurance scheme of, say, the Canadian variety would be to carry ideology to absurd heights.

One can reasonably wonder, however, whether a full-fledged national health insurance program ever has been a realistic option in this country. Quite aside from the Nation's geographic and cultural heterogeneity, its governmental structure—particularly the role interest groups play therein—may well preclude the introduction of so sweeping a social policy as national health insurance. A more realistic baseline from which to judge the Medicare and Medicaid programs may therefore be the situation prevailing prior to 1965. From that baseline, and strictly from the beneficiaries' perspective, one might give the Medicare program the grade of A- and the Medicaid program a plain C, perhaps even a C+.

Whatever shortcomings one may identify in the Medicare program, one would surely not wish to deny that it, along with the entire social security program of which it is a part, has brought about a dramatic improvement in the quality of life of our Nation's senior citizens during the last two decades. As Fuchs (1984) has shown, the average after-tax income per household member of the aged is now about equal to that of the 45-64 years of age group, a fact noted also in the Council of Economic Advisors' *Annual Report* (1985). Before the introduction of Medicare, only one-half of the aged had health insurance, and many of them were quickly driven into indigency when illness struck. Since the onset of Medicare, there has been a substantial increase in the utilization of health services by the aged, most noticeably by the poor aged. If the primary purpose of Medicare has been to bring our aged into the mainstream of American health care, that goal has been reasonably well achieved.

Whether all of the increase in utilization was medically justified can be debated, as can be the precise causal relationship between this increase and the health status of the aged. It is beyond dispute, however, that the increase in utilization has been accompanied by a significant improvement in the health status of the aged, whether one measures it by life expectancy, reductions in age-adjusted death rates, or by age-specific disability days (Fuchs, 1984; and Rogers and Aiken 1984). These improvements in health status are unlikely to have been sheer coincidence.

Yet, unlike the aged in other industrialized societies, our aged still pay for a substantial proportion of their health care out of their own resources. In 1981, for example, Medicare itself covered only about 45 percent of total health care expenditures by the aged. Another 14 percent was picked up by Medicaid, mainly for nursing home care of indigent aged. Fully 36 percent was financed by the aged themselves, either in the form of health insurance premiums or in out-

of-pocket expenditures at point of service. For those aged who did use health services, out-of-pocket expenditures averaged between $500 and $600 that year, an amount that was constant over income classes. As a percent of total per capita health expenditures for the aged, these out-of-pocket expenditures ranged from 20 percent for the poor and near poor to 26 percent for those with high incomes.

It can be argued that there is nothing inherently wicked in requiring such contributions from a group whose average per capita income is close to that of the working population and whose financial responsibilities no longer include the rearing and educating of children. The problem is that the averages mask considerable variance. If one man sits on dry ice and the other on a hot stove they can be said to be, on average, comfortable. Similarly, the fact that, on average, the aged may well be able to absorb 20 or 30 percent of the cost of their health care masks the extraordinary regressivity of this cost sharing. For the poor and near-poor aged, out-of-pocket expenses alone represent an average of 14 percent of their already low incomes. To these outlays must be added the health insurance premiums paid by the aged. Health policy analysts and policymakers, who are young and typically find themselves in the upper 10 percent of the Nation's income distribution,[1] are at a serious disadvantage in imagining just what hardship such out-of-pocket expenditures might wreak among poor aged. That is probably one reason why this problem has persisted to the present.

The considerable financial burden the Medicare program still imposes on some of the poor and sick must be counted as one of its major failures from the beneficiaries' point of view—hence the minus on the grade A. It is also a shortcoming from the viewpoint of every American citizen, for a Nation that allows its aged to be utterly pauperized over illness has an image problem in the rest of the world.

A second major shortcoming is the program's benefit structure. That structure places heavy emphasis upon medical episodes requiring short- to medium-term hospitalization, but it leaves unresolved the problem of protecting the aged against the sustained financial drain of long-term chronic illness. In the short run, a solution to this problem will require additional transfers from the working population to the aged. In the long run, the problem must be solved by goading this Nation to a higher savings ratio, that is, by encouraging or even forcing the current working population to set aside now the resources for their own future long-term care.

In thinking about the challenges faced by Medicare beneficiaries in the future, a distinction obviously must be made between individuals who are now aged or near aged and those who will be aged three to four decades hence.

Those now aged or near aged have few options left to rearrange the financial base for their retirement. To the extent that their assets are inadequate to support their years in retirement, they must seek transfers from younger generations. It seems easy enough to provide a moral foundation for such transfers. After all, generations who experienced the Great Depression, who carried this Nation's flag during World War II, who reconstructed their own country and much of the world they liberated with their sweat and ingenuity, and who, in addition, found it in their heart to bestow upon their children the most generous educational benefits any generation has ever bestowed upon another, can without shame expect that those whom they so endowed now return the favor without rancor. Properly viewed, much of what is now deplored by the working young as the insufferable burden of social security is but a repayment for human capital (education) and physical capital (e.g., the infrastructure) that were financed during the working years by those who are now aged.

The challenge faced by those now aged and near aged is to remind the younger generations of these I.O.U.'s in a manner that does not offend the latter's sense of fairness. It is apparent that, at this time, American voters, both young and old, prefer to shrink or at least to constrain the percentage of the gross national product (GNP) diverted to the public sector. Under these constraints, expenditures for the aged do come, in part, at the expense of the younger poor. Already there is evidence that children represent the most rapidly growing segment of this Nation's poor. Among them are the ever-growing numbers of children born to unwed teenage mothers. To neglect the health care and education of these children would be to mortgage the entire Nation. Trade-offs that divert support from these poor to well-to-do aged are apt to violate the sense of fairness of younger adults, even of those who have traditionally been champions of the aged. To quote economist Victor Fuchs (1984), one of the sagest and most humane health economists in our midst: "Twenty years ago the plight of the elderly was palpable. Today the most pressing social needs may lie elsewhere. The 'good society' needs to balance its efforts, to make hard choices among many worthwhile objectives."

Therefore, in seeking to redress the current regressivity of the financial burden Medicare imposes on the aged, those who represent the aged in the political arena should not dismiss, out of hand, a redistribution of economic privilege among the aged themselves. That redistribution could be effected in a number of obvious ways. Unfortunately, a discussion of these options (Davis and Rowland, 1984; and Meyer 1984) goes beyond the space limitation of this commentary.

For those who will be Medicare beneficiaries three to four decades hence, that program and social security in its entirety probably represent a social contract that has outlived its usefulness. That contract needs to be renegotiated, and now would be a good time to start the process.

In contrast to the Medicare program, from the viewpoint of its intended beneficiaries, Medicaid

[1]Only about 10 percent of American families had incomes above $50,000 in 1983.

deserves, at best, a mixed review. The ostensible goal of the program was to remove the financial barriers to mainstream American health care for the poor. For some of the poor, that goal has been achieved. Unfortunately, many poor who should, in principle, benefit from the program have been eclipsed by it altogether—hence the relatively low grade C or C+.

During the past two decades, there has been a noticeable increase in the utilization of health services by low-income groups. There has also been a dramatic improvement in the health status of the poor. Surely, the Medicaid program can claim partial credit for this achievement. Furthermore, the average cost of health care per Medicaid recipient is about the same as that of roughly comparable age groups not in the program (Rogers, Blendon, and Moloney, 1982). The program does not appear to be less efficient than the private system, occasional incidents of fraud and abuse notwithstanding.

These groups in particular have benefitted substantially from Medicaid coverage: the elderly poor, mentally retarded, physically disabled and blind, and children in low-income, single-parent families. Unfortunately, as Joe, Meltzer, and Yu (1985) so vividly illustrate in their recent paper on Medicaid, eligibility for the program varies considerably and seemingly capriciously from State to State, and there are arbitrary, illogical exclusions even within States.

Overall, in 1985, the Medicaid program covered less than one-half of the families defined as poor and near poor (near poor is defined as an income of $12,722 or less for a family of four). Although some of these families may be covered by employer-paid health insurance, between 25 and 35 million people in this country are without any health insurance coverage. This lack of insurance coverage is not confined strictly to the poor, but it is concentrated within the lower-income strata.

During the 1970's, uninsured poor individuals requiring acute care could usually obtain it, because the cost of that care could be shifted to paying patients. As the Nation moves from passive, retrospective, full-cost reimbursement of hospitals to cost-conscious, price-competitive purchasing of care, these hidden cross-subsidies will be squeezed out of the system like water out of a sponge. The major challenge facing the actual and originally intended beneficiaries of the Medicaid program will be to weather that transition until, at long last, the Nation sees fit to put into place a more coherent, comprehensive program covering all of the Nation's low-income families.

Impact on health care providers

In their original design, the Medicare and Medicaid programs were conceived of essentially as adaptations to a larger, private health care market. That was one of the key decisions shaping the development of these programs. A second key decision was acceptance of the principle that patients covered by the programs must have free choice among providers. That principle made it virtually impossible for the Government to act as a "prudent purchaser," that is, to seek low prices by playing off one provider against the other. From the perspective of providers, these two decisions fashioned a supplier's dream world.

Practically, the first decision meant that institutions were to be reimbursed on a retrospective, full-cost basis, with only minor constraints on the definition of costs, and that for-profit institutions were to be granted a guaranteed rate of return on the proportion of their equity allocable to Medicare patients. Under the Medicare programs, physicians were to be paid their "customary" fees, if the latter were judged "reasonable" within the pattern of fees "prevailing" in the physicians' market area. Because the specific design of the Medicaid program was left to the States, the Medicare reimbursement formulas could not be imposed upon that program, although many States adopted these methods for their Medicaid programs as well.

It is tempting, in retrospect, to criticize the architects of the two programs for these crucial design parameters, but that would be unfair. First, within the politics of the mid-1960's, these parameters were the price for acceptance of the programs by health care providers. Second, it may not have been foreseen at the time just how dominant the two programs would become in the financing of American health care.

Unfortunately, the "market" to which the two programs sought to adapt themselves was one dominated by a private insurance industry that was itself too splintered to confront the providers of health care with effective countervailing market power, short of violating the antitrust laws. By adapting themselves to this context, the Medicare and Medicaid programs became, for the most part, just one more structurally impotent payer in the health care market.

The principle of "divide and conquer" operating in the market for health services during the past two decades has bestowed truly generous cash flows upon the providers of health care. If the American health care sector today is truly the world's best, as is so often claimed, the credit goes not only to the Nation's well-trained physicians, but also to the taxpayers and patients who have financed for these professionals abundant physical resources with which to ply their trade. Furthermore, our Nation has shown its gratitude by granting the owners of these resources high monetary rewards per unit of resource (e.g., per physician hour, per band-aid, per pill).

It is widely appreciated that lavishing material comforts on children, while failing to discipline them, can lead to turbulent adjustment problems during adolescence. Unfortunately, what is true of children is also true of entire economic sectors, where munificent rewards and a lack of market discipline can foster much untoward behavior. There is now general agreement that our health care sector has suffered this fate. As the health care market shifts from past reimbursement practices toward cost-conscious,

price-competitive, "prudent" purchasing, that sector exhibits all of the symptoms of a spoiled adolescent. There is posturing all around over threats to the "quality of care". There is lamenting over declining incomes. There is pouting aplenty, for example, the threat that the Medicare fee-freeze will lead to "two-tier" health care for the aged, or the practice of 'dumping' patients in response to prospective payments (a practice that gained momentum during 1984, as the hospital industry celebrated its highest profit margins in years!)

The point of the preceding analogy is not to offend. On the contrary, it is intended to remind us that, just as one cannot fairly blame spoiled adolescents for their tantrums, so we should refrain from casting aspersions on the character of our health care providers. By granting them, without so much as an argument, a license to take from our collective insurance treasuries virtually as they pleased, we have educated them to a way of life, and to expectations, from which they can be weaned only gradually, and from which they should be weaned gently and with patience.

Indeed, something more can be said on behalf of our providers. For all we know, certain ethical constraints induced the providers from taking less than they might have. To gain perspective on the issue, one need merely imagine what other actors in our economy would have taken under similar circumstances. Clues can be had by beholding the comportment of our defense industry, and one wonders what investment bankers or the legal profession might have done with such a license.

Now facing the providers of health care is the challenge to adapt to the newly emerging market environment without compromising the ethical standards that lie at the heart of a good health care system. As the choreographers of the system, physicians have a central role to play in this adjustment. The next decade or so will show how faithfully the medical profession will uphold its code of ethics under fiscal siege.

Among the adjustments providers must make in the years ahead is acceptance of the laws of supply and demand. Throughout the past two decades, our providers fought Government regulation with appeals to the putative virtues of a free market. That posture was cheap and easy as long as supply was relatively taut. It is severely tested when there is excess supply. There is now agreement that the Nation has an abundance—if not an outright surplus—of physicians and a glut of acute-care hospital beds. A challenge facing providers is to accommodate to the notion that the purchasers of health care will seek to exploit this surplus to their own economic advantage and that, within a market economy, that form of exploitation is entirely legitimate. Concretely, this will mean that providers must ready themselves to bargain hard with the Government over compensation levels. Alternatively, providers must learn to accept whatever compensation the market permits the Government to impose upon them. Third-party payers, be they private or public, would be derelict in their fiduciary roles if they failed to exploit their new-found market power. It is too late to decry such efforts as "unfair."

Impact on the government

In 1965, Americans spent 6.1 percent of their gross national product on health, of which 26 percent was paid with government funds. By 1983, the Nation spent 10.8 percent of its GNP on health, and 42 percent of that total was paid with government funds. In 1965, State and local governments devoted about 8 percent of their budgets to health care; by 1983, that percentage had risen to about 14. The corresponding figures for the Federal Government are 4.5 and 12.5 percent, respectively. The government sector is now the predominant purchaser of health services in this country, and health care represents one of that sector's major outlays. Because every dollar of health care expenditure represents a dollar of health care income for some providers, we may also say that government today is one of the major suppliers of health care incomes in the Nation.

For the most part, the increased role played by the Government in health care reflects the Nation's decision, in the mid 1960's, to have the Government take on responsibility for the health care of the aged and the poor. To the extent that voters participate in such decisions at all, it was their choice. As was noted earlier, however, a part of the increase can be attributed also to the design parameters of the Medicare and Medicaid programs. These parameters literally entrusted providers with keys to the public treasury.

Private payers and the providers of health care have lamented for years that the Government has not picked up its fair share of the national health care bill, by refusing to pay for bad debts, charity care, and other exclusions from allowable costs, Government has effectively shifted costs to the private sector. One could, however, construct an alternative scenario. Over the 2-year period 1980-82, for example, real (inflation-adjusted) total national health expenditures grew by 12.7 percent. Total real outlays under the Medicare program, on the other hand, grew by 27.9 percent. Medicare outlays on physician services grew even faster, by 30.9 percent (Freeland and Schendler, 1984). It would be difficult to argue that these figures resulted from a growth in the number of the aged or changes in their morbidity. Therefore, the thought occurs that providers found it relatively easier in those 2 years to cull added health care incomes from the public sector than from the private sector—that we were witnessing cost-shifting in reverse.

The apparent ability of providers to effect such shifts raises the question of how Government, hard pressed by voters to control its budgets, might control its outlays on health care. One approach, taken virtually everywhere else in the industrialized world, would be to control overall national health care expenditures along with the Government's share of

that total. That approach is taken by other societies to discourage the emergence of two-tier health care systems. Unfortunately, nonarbitrary criteria do not exist for setting the overall percentage of the Nation's GNP that should go to health care. Furthermore, it is virtually impossible to enforce whatever limit is chosen in the absence of a full-fledged national health insurance system.

For reasons already indicated, Government control over the entire health care sector is out of the question in the United States. On the other hand, the Government can no longer afford the pretense that Medicare and Medicaid programs are mere appendages of the American health care market. In many areas these programs dominate that market. It was therefore inevitable that the two programs would eventually go their own way. Prospective compensation of hospitals by diagnosis-related groups is the first step in that direction. Fee schedules of some sort for physicians is apt to be the second step. As already mentioned, unless health care providers quickly learn to negotiate such compensation levels with the Government, a further logical step will be competitively bid compensation levels, effected either through health maintenance organizations or preferred provider organizations. Although a march in this direction will surely elicit from providers cries of "two-tier" health care, it is hard to think of an alternative approach to budgetary control at this time. In a real sense, it is the approach providers asked for during the health policy debates of the 1970's.

A case can be made that control over public health budgets is far from compelling in the first place, because the United States has one of the smallest public sectors in the industrialized world (Japan being the sole exception). Most other industrialized nations spend between 40 and 50 percent of their GNP on the public sector, but the comparable American figure lies between only 33 and 35 percent. Such an argument, however, carries little political weight at this time. For better or for worse, American voters, both young and old, rich and poor, now wish to see their public sector severely constrained. And, as already noted, there are other priorities with legitimate claims on public funds.

There is one challenge American voters might put to health care providers before voting additional allocations for health care. Neighboring Canada currently spends a little more than 8 percent of its GNP on health care. With that allocation, it has freed every Canadian citizen from anxiety over the financial cost of illness and granted every citizen access to a common health care system. By contrast, the United States is already spending close to 11 percent of its GNP on health care without, however, guaranteeing every American citizen freedom from worry over health care bills and financial access to health care. An allocation of 11 percent of the GNP is not skimpy; it represents a generous supply of health care incomes. The challenge faced by American health care providers is to convince American voters that, relative to the quality of Canadian health care, the quality of American health care is sufficiently superior to warrant an extra 3 percentage points or so of the GNP (and even more) along with the financial distress still suffered by many American patients. It is an interesting challenge, worthy of careful research.

Implications for the future

Throughout the industrialized world, nations are wrestling with the economic implications of an aging population. Many of the European nations already have attained today the top-heavy population pyramid the United States will attain in the early part of the next century. Japan's population pyramid, too, is now rapidly shifting towards the European pattern. These demographic shifts will create intergenerational tension everywhere. The United States by no means stands alone in this struggle.

Every nation, too, has its group of economically disenfranchised citizens who cannot afford to pay fully for what are considered to be the basic necessities of life. How a nation copes with the economic problem presented by its aged and its poor depends only weakly on its overall economic strength. Much more decisive is the amorphous something called a "shared social ethic." Nations differ quite substantially in terms of their dominant social ethic and, also, in the degree to which that dominant ethic is actually shared.

To illustrate, consider the following concise statement by the Government of Canada (1983) on the social ethic governing the distribution of health care in that country:

> "The Government of Canada believes that a civilized and wealthy nation, such as [Canada], should not make the sick bear the financial burden of health care. Everyone benefits from the security and peace of mind that comes with having prepaid insurance. The misfortune of illness, which at some time touches each of us, is burden enough: the cost of care should be borne by society as a whole."

Whatever reaction to this statement one's own ideology may trigger, the statement is a crisp definition of a social ethic, and one that seems widely shared by Canadians of all political stripes. Consistent with that definition, Canada maintains a universal health insurance system financed not through actuarially sound insurance premiums, but through a tax system based on ability to pay.

Most of the European systems have adopted a similar approach. To be sure, all of these nations agonize over the enormous expense of their systems, which absorb anywhere from 6 to 10 percent of their gross national product. But the public debate over health policy in these countries does not take place through special conferences on "financing health care for the aged," or "financing indigent care." These problems have been completely folded into the problem of one health insurance and health care

system imposed on virtually all economic strata of society.[2]

The imposition of one highly regulated health care system upon all members of society inevitably carries with it certain hidden costs, among them loss of the innovative drive of looser systems such as ours, not to mention the frustration that providers suffer over their loss of certain freedoms. Be that as it may, this symposium is not the proper forum to criticize foreign systems nor to advocate them. The reason for describing them briefly here is simply to make an important point, namely, that in terms of strategy and tactics the lessons from health systems in other countries are rather meager, because their approaches are based upon a social ethic that we do not seem to share.

As argued elsewhere (Reinhardt, 1985), it would be difficult for an American to describe to foreigners the social ethic driving American health care, even if an entire page were set aside for that purpose. To be sure, many Americans hold crisp and fully coherent views of their own on this matter. The problem is that these views vary widely among individuals; there does not seem to be a lasting set of ethical precepts that are widely shared. We lack an accepted blueprint on ethics against which to assess alternative strategies for the Medicare and Medicaid programs. Without such a consensus, it is nearly impossible for a policy analyst to render expert advice on the issue without incorporating his or her own ideological predisposition.[3] Rather than proffering such advice, it may therefore be more productive to raise the following fundamental questions:

- Is health care to be viewed primarily as a basic, private consumption good (such as food, clothes, and shelter), or should one view it as primarily a public good, a community service (such as elementary and secondary education)?
- Is access to at least a basic set of health services the right (that is, a basic entitlement) of every American citizen, or is there merely the presumption of a moral obligation on the part of providers to facilitate access to basic health services?
- Even if access to basic health care was deemed a right, should the definition of that right, and responsibility for enforcing it, be the prerogative of State and local governments, or is that the proper responsibility of the Federal Government—that is, should there be nationally defined and nationally enforced standards?

Anyone who has followed our debate on national health policy during the past 20 years must conclude that no clear answers to these questions have emerged. And yet, these fundamental questions lie at the heart of the broader question on what direction the Nation should take with regard to the Medicare and Medicaid programs.

Consider, for example, the first question. To hold that health care is essentially a basic, private consumption good implies that the financing of health care is primarily the responsibility of the individual recipient of that care, although society may well see fit to assist poor individuals financially to gain access to at least a basic set of health services. Our society adopts that view in connection with certain essential commodities, such as food, shelter, and clothing. In the literature, that view is sometimes referred to as the "basic-needs" approach.

The basic-needs approach clearly countenances a two- or multiple-tier health care system, just as we countenance it for food, shelter, and clothing, and even for higher education and jurisprudence, if not de jure, then at least de facto. On that perception of health care, the Medicare program must be judged ill-conceived from the start, for it offers too much to the upper income strata and perhaps not enough to the poorest among the aged. For example, adherents to the basic-needs approach would not deem it essential to offer Medicare beneficiaries complete freedom of choice among providers. Furthermore, it would be deemed quite acceptable to permit well-to-do aged complete freedom of choice (financed, of course, with their own resources), a privilege not made available to their poorer peers.

Under the basic needs approach, it would make sense eventually to fold the Medicare program into governmentally encouraged (or even mandated) life-cycle planning on the part of individuals. Individuals could be encouraged through the tax code (or mandated) to contribute during their worklife stipulated minimum annual payments into individually owned accounts established specifically to finance health and long-term care during retirement. The accounts could be held in the private sector, albeit under public supervision. The Medicare program itself would then convert to essentially a means-tested welfare program, making transfers to individuals only if the funds accumulated during their worklife proved inadequate. Clearly, such an approach would represent a sharp departure from the social ethics originally packaged into the Medicare program, but it would be fully consistent with a basic-needs approach to health care.

Readers may be surprised to see the second question raised at all. It may be thought that this issue had been settled long ago when this Nation subscribed to the much-mouthed political slogan that "health care is a basic right." The mouthing of slogans, however, do not make a "right." Legislating it might. If one surveys the practice of health care in our realm, and

[2]In every one of these nations, there is a small private sector that serves as an escape valve for patients to pay for speedier treatments or treatments as private patients. Usually, much less than 10 percent of the population is privately insured, even in the United Kingdom.

[3]As an immigrant from, first, West Germany and then Canada, and as an erstwhile pauper, I am favorably disposed towards national health insurance systems that offer middle- to low-income families a dignified and anxiety-free health care experience. As a long-time student of the American health care sector, however, I have come to doubt that national health insurance is compatible with the American ethos and, especially, with the political process in this country. For the poor in this country, the most humane, politically feasible system would probably be a multi-track system with a bottom tier served primarily by health maintenance organizations.

even the literature on the subject (Blumstein, 1984), one must conclude that the second question is still a relevant issue.

Consider, finally, the third question that can be rephrased as follows: Should residents in State X be at all concerned over the economic and physical welfare of fellow Americans in State Y, or is that none of their business?

If the answer is, "Yes, residents of State X should be concerned with the welfare of fellow Americans in State Y, and not only when the latter are trapped somewhere abroad," then it would follow that there should be national standards for basic health care; the definition of a basic right to health care and the responsibility for enforcing that right cannot be left fully to the devices of individual States. If that be the dominant social ethic on this point, then the Medicaid program must be judged as ill-conceived and poorly executed.

On the other hand, if the dominant social ethic dictates the answer, "No, the health care experience of residents in State Y is not the business of residents in State X," then the Medicaid program in its present guise makes perfect sense, but the Medicare program becomes suspect. After all, it would reflect a contorted social ethic to state that we should practice nationhood in health care only with respect to people 65 years of age and over, but not with respect to children or middle-aged fellow Americans.

To speculate on the future course of Medicare and Medicaid is to speculate on the dominant answers to the three fundamental questions raised above. If bets had to be made on these answers at this time, it would seem reasonable to place one's marbles as follows:

- Health care is essentially a basic, private consumption good, and we shall countenance two- or multi-tier health care.
- Access to basic health care is not an entitlement, but merely a moral obligation imposed on providers and financed, indirectly, by various formal or informal cross-subsidies.
- The provision of access to health care is a State and local, not a Federal, matter.

Whether the Medicare program can ultimately be made consistent with these tenets—they imply, at the least, the conversion of Medicare into a means-tested program—remains to be seen. Indeed, in the end these tenets may not win out after all. Occasionally, even economists have been wrong in their predictions.

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Congressman Dan Rostenkowski

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Impact on beneficiaries

Since the Committee on Ways and Means has jurisdiction in the health area over Medicare and not Medicaid, I will primarily focus my comments on the impact of the Medicare program on our health system and on our Nation's elderly and disabled beneficiaries.

The primary goals of Medicare were to prevent acute illness from spelling financial disaster for the elderly and disabled and to generally increase the availability of medical services to Medicare beneficiaries. Prior to Medicare, a hospital stay could mean financial ruin. Today, this is generally no longer true. Formerly, the elderly and disabled had immense difficulty buying health insurance. To many, it simply was not available; even if health insurance was theoretically available on the market, it tended to be priced out of reach or riddled with preexisting-condition provisions and exclusions.

Today, Medicare offers a considerable amount of protection against the costs of acute-care hospitalizations. The significant expenditures under the Medicare program indicate that there has been increased access to medical resources for the elderly and disabled. In fiscal year 1986, Medicare program expenditures are projected to be $77.2 billion, largely financed from nonpremium sources of revenue. Yet despite this huge expenditure of public funds, Medicare still covers less than one-half of the total health bill for the elderly. Thus, even though Federal outlays have grown, the elderly continue to expend on personal health care, as a percentage of their real income, as much today as they did prior to the implementation of the Medicare program.

There is, however, no doubt that Medicare has had a favorable health impact on its beneficiaries. One of the strongest, although crude, indicators of the impact of Medicare is what has happened to life expectancy at 65 years of age. During the decade of the 1950's, life expectancy at age 65 increased by less than 5 months. After Medicare, during the decade of the 1970's, life expectancy at age 65 increased by more than 14 months, about three times the increase experienced during the 1950's. Although this may not all be attributable to Medicare, I am sure that Medicare has played a major role.

Furthermore, a statistical measure cannot indicate the peace of mind that many have felt from knowing that a major portion of their hospital and doctor bills would be paid. It does not indicate the relief children of aged parents feel when they no longer have to shoulder the financial burdens of their parents' acute-care medical bills. It does not indicate the extent to which Medicare has fostered the development of medical technology that has served to reduce pain, suffering, and morbidity.

Medicare, along with social security, has contributed to the overall financial soundness of the aged. When Medicare was enacted, 28.5 percent of the aged were living in poverty, compared with 14.7 percent of the entire population. In 1984, the poverty rate for the elderly was 12.4 percent; for the general population it was 14.4 percent. From 1970 to 1983, mean real income increased by 19 percent per capita for the elderly and by 10.5 percent of the non-elderly. Recent data show that the mean per capita income of the elderly now exceeds that of the non-elderly; this was not true when the program began. Although many of the elderly still live at or near poverty, our system of social insurance (of which Medicare is a part) has contributed greatly to the general economic well-being of the elderly. Medicare guards all beneficiaries from financial ruin resulting from an expensive hospital stay.

I do not mean to paint too rosey a picture; there are many challenges that remain. One is the significant increases in out-of-pocket expenses faced by the elderly. This is painfully illustrated by the dramatic increase in the Part A deductible that beneficiaries will be facing in 1986. The Part A deductible will increase from $400 in calendar year 1985 to $492 in calendar year 1986, an increase in excess of 23 percent. Out-of-pocket expenses are increasing, not only under Part A but also Part B of the program, especially when you take into consideration amounts charged by physicians who do not accept Medicare assignment. Despite the economic well-being of many of our elderly, these out-of-pocket expenses can be financially devastating to them.

Serious thought must also be given to the increasing need and demand for long-term care for the elderly. Individuals over 75 years of age currently constitute 4.5 percent of our population; by 2025, they will constitute 8.4 percent of the population. Increasing life expectancy and other demographic change will mean more attention must be given to the long-term and chronic care needs of the elderly. The significant budget constraints that appear likely to be with us for the immediate, if not foreseeable, future, mean that

addressing their needs will be a real challenge for us all.

Impact on health care providers

Medicare has had a tremendous impact on the delivery of health care in the United States, from improving the hospital capital plant to serving as a prime mover in desegregating many hospitals in the mid-1960's.

National health care expenditures have increased form 6.1 percent of the gross national product to nearly 11 percent in 1985. This growth in the health care industry was partially fueled by Medicare and Medicaid; spending by Medicare alone accounts for approximately 30 percent of all short-term hospital revenues. By providing Federal dollars, Medicare and Medicaid have greatly expanded the availability of health services which, in turn, have fostered the development of new medical devices, procedures, and technologies.

It is also clear that Medicare's payment rules and regulations have influenced the practice of medicine. Many argue that cost-based reimbursement for hospitals and charge-based reimbursement for physicians, which governed the system for most of its 20-year history, has contributed to an over-expansion of health care resources and to longer lengths of stays in hospitals. It is widely believed that if most of the cost of services is reimbursed by third parties (Medicare, private insurance), neither the provider nor the patient has significant financial motivation to control utilization. Given that medicine is both an art and a science, there is always pressure, for which there may not be a countervailing force, to order an extra test, take an additional X-ray, or stay in the hospital another day.

This rapid increase in program costs, especially in the late 1970's and early 1980's, led to pressure to enact mandatory hospital cost-containment controls. After several years of debate, mandatory cost-containment legislation was defeated. A voluntary cost-containment program was organized within the health care industry. The failure of the voluntary effort and the double-digit health care inflation that ensued led to the passage of the prospective payment system for hospital payments.

The recently enacted hospital prospective payment system (PPS), a price-based system of payment, represents a radical change, and reverses some of the incentives of the old system. For example, under the prior system, the economic incentives encouraged providers to keep a patient hospitalized for a longer period of time. Under the new system, a hospital is encouraged to reduce the length of stay. Although the downward trend in average hospital length of stay has gone on for several years, it is amazing that over the last 2 years the average hospital length of stay for a Medicare patient has fallen from 9.4 days to 7.7 days.

PPS has created a whole new set of concerns and problems. Under the prior system, many were concerned that too much money was being spent on new technology. Every hospital wanted, and in many cases bought, the most up-to-date equipment. Today's PPS approach has now led many experts to be concerned about the opposite situation arising, that the new financial incentives may lead to an underinvestment in new technology. The Prospective Payment Commission was created, in part, to review issues such as these and to recommend changes that may be needed to counteract inappropriate disincentives for investment in new technology.

Quality of care has always been a high priority in the program. Under the old system, there were few concerns that care would be compromised because of financial incentives. However, under PPS, hospitals have economic incentives to release patients as quickly as possible. I am beginning to see studies and newspaper reports, as well as receive direct complaints, that patients are being pushed out of the hospital door too quickly. Besides controlling admissions, it is hoped that the Peer Review Organizations will take on the important role of ensuring the quality of care, including protecting beneficiaries from early discharges. I know that Congress will exercise its oversight responsibilities diligently in this area and, if necessary, take appropriate action to remedy any problems that may be identified.

Impact on government

In crafting the original Medicare program, there were several key policy decisions made during the initial program design. The most important ones were that Medicare would be: a social insurance system covering all elderly rather than a means-tested program limited to the poor; a program primarily financed by earmarked revenues; a cost-based reimbursement system; and a program providing coverage primarily for acute espisodes of illness.

Each of these decisions has had some impact on Medicare expenditures and on the ability of the program to meet its goals of providing high-quality health care for our Nation's elderly. I believe the principle of universal coverage in a social insurance system should not be altered. All individuals should participate in the system, and it should not become a means-tested program. In the future, however, it might be appropriate to change some aspects of the program, taking into account the income of beneficiaries. For instance, scaling premiums to income does not alter the basic characteristic of a social insurance system that provides benefits alike to both the rich and poor.

Another important policy that should be maintained as Medicare evolves is that the program continue to be financed by earmarked revenues, primarily payroll taxes, thus insuring that the balance between benefits and revenues continue. The fact that both workers and employers contribute has insured the program's sensitivity to the taxpayer. This joint contribution supports the premise that retirement and health benefits are an earned right. The pride of

participating in a fair and universal social insurance system should not be underestimated.

Modeling the financing of the hospital insurance portion of the program after the old-age and survivors insurance program allowed the current cohort of retirees, many of whom lacked health insurance and who could not afford or qualify for private health insurance because of health reasons, to be eligible for benefits. These benefits were financed by workers. These workers, in turn, were promised health benefits when they reached age 65 or became disabled. This is a social contract that must and will be honored in the future.

As a part of the task of assuring the long-term solvency of the hospital insurance trust fund, some changes must be made in financing over the next few years. State and local government employees should be brought into the Medicare program just as Federal workers were in 1983. Perhaps certain excise taxes should be increased and dedicated to the disability or hospital insurance funds. Given the improved financial health of the elderly generally, perhaps a larger share of revenues for Medicare should come from them. However, the principle of earmarking taxes should continue.

The cost-based reimbursement system was thought necessary to secure provider support for the program, thus ensuring enactment of the program. Cost-based reimbursement served the program well and helped to assure the broadest participation of health providers in the Medicare program. However, as program costs have escalated (many believe in large part because of cost reimbursement), the emphasis for public policymakers in the Medicare area over the last few years has been on cost control and reimbursement reform.

A final key issue relates to what is covered by Medicare. The primary concern in 1965 was with the problems that hospital costs presented for the elderly. That concern is reflected in the benefit structure which emphasizes hospital coverage. Over time, policymakers have turned their attention to other areas of health need. For example, the Medicare hospice benefit was added in 1982, payment was allowed for services provided in ambulatory surgery centers, and so on.

This "evolution" of Medicare will continue over time. I have already stated concerns about the elderly's increasing out-of-pocket expenses and their chronic care needs. Exactly how these needs should be met is not clear to me, but which expenses are to be covered by Medicare is not carved in granite.

Implications for the future

Several years ago, experts were predicting that by 1995 the Medicare hospital insurance (HI) trust fund would need at least $500 billion of reduced outlays and/or increased revenues to remain solvent. Now, actuaries predict that, largely as a result of cost-containment efforts, enough has been achieved to provide for sound financing beyond 1995. The Board of Trustees' 1985 report on the status of the health insurance trust fund projects that the HI trust fund will be exhausted sometime between 1998 and the year 2000 using intermediate economic assumptions. In order to maintain actuarial balance, additional financing and probably expenditure control will be needed.

The health system has changed dramatically over the last few years. Given the changing nature of medical care, advances in medical technology, the aging of America, the dramatic changes in the delivery of medical care, and changes in the medical problems faced by the elderly, Medicare will need to continue to evolve during the next 20 years to meet these changing needs.

Medicare is not at a major financing crossroads. The new prospective payment system (PPS) has only recently been enacted. The initial indications are that this change has reduced resource use in hospitals without significantly affecting quality of care. However, the jury is still out on the long-run success of these changes and on the impact they will have on quality and access to care.

There will be a continual need to monitor the quality of care as providers are forced to become more cost conscious. As the initial PPS legislation provided, it is anticipated that the diagnosis-related group (DRG) system will be fine-tuned. There will be periodic adjustments in the relative prices paid for the different procedures. Better adjustments for severity of illness are needed. As a result of the new system, some hospitals will receive large reductions in their Medicare revenues, not necessarily because they are inefficient. My personal view is that the new system should have been phased in over a longer time period, to allow time for correction of imperfections in the construction of the PPS system.

Economists have long argued that expenditures are equal to price times quantity. Regulating the price without volume controls may not bring about the desired result of reducing total expenditures. At the moment, there is no explicit control on the volume of services except that provided by Peer Review Organizations (PRO's) and, to a lesser extent, Medicare intermediaries. The number of admissions is a major indication of the volume of hospital services. Most economists were wrong in predicting that admissions would increase under PPS. Instead, admissions have declined. However, this may be only a short-run phenomenon reflecting changing conditions in the health care delivery system generally. Again, we should be ready, if necessary, to make changes if, for example, hospitals respond to the economic incentives by increasing admissions that may not be warranted.

As the prospective payment system matures, we as a society will need to rethink how we reimburse providers for educational costs, as well as develop adjustments for severity of illness and for hospitals that serve a disproportionate share of low-income beneficiaries. We need to revise the method of payment for capital costs. PPS raises concerns about

the cost of medical education, new technology, and care for the poor, and forces explicit decisions about who will bear these costs. The benign cross-subsidy arrangements of the past are breaking down under the DRG approach and the more rigorous "prudent purchasing policies" of the private sector. Government (or society in general) will soon need to confront these issues. Many members of Congress on a bi-partisan basis understand the implications of the new system and are ready to address these concerns. Some of these issues are currently being considered by the House and Senate in legislation pending before both Houses.

Physician reimbursement will require serious attention over the next few years. Many argue that the fees for some procedures are inflated. They argue that the current system rewards doctors who do procedures and tests, compared with doctors who utilize cognitive or other skills to a greater extent. Adopting a single new universal mechanism for changing reimbursement to physicians may not be feasible or viable. Although it may be appropriate to extend the DRG system to include physician fees for surgical cases, services provided by doctors when treating hospital-based medical cases vary widely, and extension of the DRG payment system to those cases may not be as equitable. How to change compensation to physicians for office-based care is also difficult.

In many ways, changing the way Medicare pays for physician services will be a more complex and politically difficult task than reforming hospital payments. Just one issue is the fact that we are dealing with 400,000 sometimes very independent physicians, compared with 7,000 hospitals, and that we are dealing with 7,500 physician procedure codes, compared with 468 diagnosis-related groups for the hospitals. Another issue is how to assure continued financial protection for Medicare beneficiaries under reformed physician reimbursement arrangements. Under the hospital payment system, hospitals are required to accept the Medicare payment as payment in full. Physicians, on the other hand, have not been required to accept the Medicare payment as payment in full, and are allowed to bill Medicare beneficiaries in excess of the Medicare allowable charge. A precondition for continued beneficiary protection seems to be adequate and equitable physician payment levels and arrangements. This is a delicate issue that challenges Congress and the Executive Branch.

The evolution of the Medicare program will reflect the changing health needs of the elderly. The addition of the hospice benefit is one example of how Medicare has evolved to meet a need. Hospice care did not exist in 1965. Today, some 175 institutions are authorized to provide hospice care under the Medicare program.

For several reasons, the distinction between Part A and Part B services may no longer be necessary. Historically, Part A covered hospital bills and Part B covered physician bills. The variety of new practice settings, including surgicenters and other ambulatory treatment centers, has blurred the distinction. The desire to limit out-of-pocket expenses and provide fair competition between different modes of delivering quality care dictates that the distinction be reconsidered.

We should consider what Medicare can learn from the experience of employer health plans in the private sector. Just as many employees are provided choice among plans, some argue that Medicare beneficiaries could be provided similar choices among alternative plans. Medicare has taken the first tentative step in this direction in providing, as an option, enrollment in Medicare certified health maintenance organizations (or competitive medical plans). There is a significant amount of resistance to going beyond this first step until experience is gained.

Nonetheless, some have argued that Medicare beneficiaries should be provided with a "voucher" and that the beneficiary could then choose which plan to enroll in. Under this scenario, Medicare beneficiaries could choose between the standard Medicare cost-sharing package; more comprehensive plans that provide catastrophic protection, less cost sharing, and an expanded scope of benefits; and preferred provider plans that enlist physicians who are willing to accept assignments and/or "manage" or control utilization. There are many concerns with this type of choice. The so-called "Medigap" insurance market has taught us some lessons about how difficult it is for Medicare beneficiaries to make choices between many different health plans. Difficulty in choosing wisely in not limited to the elderly, I might add. Large numbers of Federal employees (who have a wide range of plans from which to choose) have tended to enroll in the most expensive "high-option" plans, even when their age and health status make this choice unnecessary and imprudent.

What confronts us in the future is how to continue to provide high quality care to beneficiaries in an era of significant budget restraint. This will mean that there will have to be a high degree of communication and cooperation between Medicare beneficiaries, providers, and the Government. Working together, I believe that we can continue to provide good quality health care to our Nation's elderly.

To conclude, let me make it plain that I consider the Medicare program an overwhelming success. I am proud to have participated in its original enactment and in the improvements we have been able to achieve through changes in the law over the years.

Some of Medicare's current problems are by-products of its success. High costs, for example, are partly a reflection of the improved access to better care that Medicare has brought to the Nation's elderly and disabled. We can, so to speak, feel good that these are the kinds of problems we need to solve.

There is no question about the commitment of Congress, and the American people, to the preservation, continuation, and improvement of this popular and important program. For my part, I look forward to playing a role in assuring the program's continued success.

James H. Sammons, M.D.

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Impact on beneficiaries

Without question, Medicare and Medicaid have expanded access to high quality medical and health services for millions of elderly and financially disadvantaged Americans, a social and medical milestone. Together with private insurance and public financing mechanisms, the vast majority of Americans have been provided with access to the finest medical and health services system in the world. However, weaknesses in the Medicare and Medicaid programs can be found in a number of problem areas, some of which were evident and some of which were not evident when the programs were enacted.

The total cost of providing Medicare services to all eligible recipients, regardless of income, was underestimated. During the 1970's, constraints in the general economy also created constraints in government budgets. Although the number of workers per beneficiary supporting the social security program, including the Medicare trust fund, has decreased, the number of eligible recipients has increased; this disparity will widen further with the progressive "greying" of the population.

Consider the realities. Patients over the age of 65 are the largest users of hospital services, accounting for almost 40 percent of inpatient days. About 5 percent of the elderly occupy 90 percent of the beds in more than 2,100 nursing homes nationwide. Almost 15 percent of aged households live below the official poverty line. By all estimates, problems associated with funding care for older Americans will grow as the demographics change. Over the next 40 years, while the total population grows by 40 percent, the number of Americans over age 65 will double, and the number over age 85 will more than triple. The Medicare financing implications are sobering, to say the least.

Medicaid has helped many low-income Americans secure access to medical and health services despite uneven eligibility, regulations, benefits, and funding from State to State. The irony is that in many, if not most States, inadequate Medicaid funding, coupled with the prospective pricing of Medicare services, is posing a serious threat to teaching hospitals, many of which are located in the inner city and have traditionally served a disproportionate number of needy patients. The problem is compounded by reduced differential payments to teaching hospitals, which incur overhead expenses of about 33 percent because of the greater intensity of services they provide. The American Hospital Association reports that hospitals in general provided $2.1 billion in charity care in 1982, and incurred bad debts of $4.7 billion.

The goals of Medicare and Medicaid have been to assure the target populations' access to mainstream medicine along with the rest of the Nation. It was expected that a continuum of care would be provided, extending from the doctor's office to the clinic or hospital to the nursing home. But persistent financing problems have made these goals elusive. Under both Medicare and Medicaid, there is a movement towards restricting or rationing care through prospective pricing, with some risk of a return to "two-tiered" care. Stringent controls over hospital utilization, through Peer Review Organizations or PRO's, could and probably have accelerated this trend. There have been some reports of and concern about patients being prematurely discharged.

Also, because funding of some Medicaid and Medicare services have fallen short of promised levels, recipients are paying progressively more out-of-pocket costs. One wonders at the wisdom or justice of having Medicare patients at, near, or under the poverty line, in effect, "subsidizing" care for wealthier Americans.

In any case, future challenges facing beneficiaries will evolve from changes within the financing and delivery systems themselves. The use of vouchers as a financing alternative, for example, means recipients would have to learn to "shop" the delivery system to buy access to the kind and amount of services they need. Beneficiaries also will have less freedom of choice if the trends toward restricted or directed access to care continue. Another challenge that is bound to grow is how do we provide adequate funding for nursing home care, especially as the number of Americans over 75 and 85 years of age increases, heating up demands for care. The need for more catastrophic care coverage is likely to pose a parallel challenge.

In short, Medicare and Medicaid beneficiaries have to persuade Federal and State governments to adequately fund their access to mainstream medicine as originally promised, at least to the extent that beneficiaries receive the care they really need.

Impact on health providers

Design of the Medicare program differs markedly from that of Medicaid, so the impact on providers differs accordingly. At its inception, Medicare, with the Federal Government as insurer, was meant to minimally disrupt existing mechanisms for payment, administration of claims, and provision of services. State governments are not insurers under Medicaid, but make direct payments to providers.

Medicaid and Medicare financing, particularly the open-ended nature of the latter, along with first-dollar financing by the private insurance industry and other financing sources, have had a revolutionary impact on health care providers and institutions. In the 1960's, buoyed by a strong economy, the Great Society programs were enacted, including government health care financing programs. Public and private funds were used to expand insurance coverage, train more physicians and other health professionals, build or enlarge community hospitals, and equip them with state-of-the-art technology and resources. The United States created the finest medical and health services system in the world, in terms of quality, and then made it available to most Americans.

Physicians were now being paid for some services they previously provided at little or no cost; hospitals were paid on a cost-plus basis. And total cost was not perceived as a problem until the economic downturn of the 1970's, when the Great Society programs dwindled and some disappeared. The high cost of medical and health services suddenly became a national concern, with physicians, as purchasing agents for patients, and hospitals, as the most expensive locations for care, subject to considerable criticism. The truth is, however, that we the people—all of the people—wanted, even demanded, a system that provided the best kind of care. So we financed and built one.

Now, because of the current gap between virtually unlimited health care wants and needs and limited national resources, providers, along with other private and public entities and individuals, will have to deliver care as efficiently and cost effectively as possible while meeting real patient needs. This is a problem that also confronts other industrialized nations. Considerable progress already has been made in moderating annual health care cost inflation. Meanwhile, this Nation will have to determine how much of its financial resources it will devote to the health of its people, including those who are medically needy—especially those with limited financial resources of their own.

We must recognize that modern medicine *is* expensive; the challenge is to operate in a cost-effective way and yet maintain the quality of medical and health services and the real needs of patients. This will require the concern, commitment, and cooperation of everyone involved.

Impact on government

As the disproportionate growth of the elderly segment of the population continues, government health care financing problems are bound to intensify. Current financing methods already are in question to some extent. Can a comparatively smaller, younger generation continue to pay the health care bills of the older generation, even the wealthy? Should a means test or something like it be required? Should the tax system be changed to more evenly spread the financing burden among all age groups? Are there alternatives to Medicaid? Are there policies that would encourage people to buy private health insurance from sources other than the workplace? Should changes in the tax laws be used to create a gradual shift toward a new private health insurance structure? The fact that government has no money of its own, only that which it gets from the people, means the people, all of the people, ultimately will have to find answers to such questions. That is the only way to maintain public faith in the "system." And these issues are of great interest to the public. In a recent AMA survey of public opinion on what major issues are facing the Nation, aid to the elderly emerged as our first societal priority.

No matter how Federal or State governments fund and administer Medicare or Medicaid, what is needed, from the Government's point of view, is certainty regarding the total amount of annual expenditures. For example, cost-plus reimbursement under Medicare encouraged cost overruns, so Government didn't know the total cost figure until the end of its fiscal year. At the same time, Government support should be adequate to meet real patient needs. This represents an ongoing dilemma of addressing beneficiary requirements while attempting to control costs.

As enacted, Medicare and Medicaid did encourage flexibility in terms of freedom of choice for patients and providers in seeking and delivering care. More recently, the programs have added elements of competition to the marketplace. But the programs also have become more inflexible through regulatory and budgetary controls over the kind, amount, and locales for care. We must avoid a situation where Government, through its health care financing programs, becomes a kind of catchall or second-hand regulator of the entire medical and health services system. No specific, rational policy has surfaced regarding what share of the gross national product should be devoted to health care for the people, except for critics who say it is already too high. Voters might agree. Patients might disagree. And in fact, AMA surveys have revealed the public does see the cost of health care as a major problem; at the same time, the public believes the Nation is not spending enough for the care of its people. To create a more rational, long-term, overall policy for health,

the AMA has brought together the representatives of about 150 private and public organizations involved in or concerned about the financing and delivery of care. As a 3-year project, these representatives are developing a health policy agenda for the American people, to be completed by the end of 1986. This agenda will provide the Nation with a set of health policy principles and plans that the organizations involved can use in health policymaking. Through this project, we hope to give the American people a durable and doable health policy with which to address present and future problems in the financing and delivery of health care.

Implications for the future

It can be said that most western, industrialized nations have reached a crossroads in the financing of health care. Some have given total control to the public sector; others, like our own, use a combination of public and private sector control. Given the social and political philosophies and traditions that prevail in this democracy of ours, I believe the American system will continue to be pluralistic. But the public and private sectors together need to face the difficult issues before us and find answers—some of them soon—to the problems of our day, including those associated with the funding of Medicare and Medicaid.

If we are indeed at a crossroads, some of these roads offer us opportunity as well as concerns. Millions of Americans have now adopted healthier lifestyles. There is evidence to suggest that two of every three Americans have improved their eating habits. Many have stopped smoking. Regular exercise is helping to improve the health status of millions more with sports such as racquetball, tennis, bicycling, jogging, swimming, and other activities. Consumer and business fitness converts bought an estimated $960.3 million worth of gymnastic equipment in 1983, up 33 percent from 1982.

More than 160 medical societies nationwide have joined business and civic groups in creating local health care coalitions to address community health problems, and the focus is not only on those issues related to cost. They are promoting wellness programs, safety in the workplace, and better health habits by employees and local residents. By one recent count, more than 50,000 companies have developed employee fitness programs. Fitness pays big dividends in lower health care costs and absenteeism and higher morale and productivity. One company with an elaborate employee fitness center reported the average health care claim for exercisers was $562, compared with $1,003 for nonexercisers.

The results of such developments, along with improvements in medical science, technology, and techniques, have been gratifying. Average life expectancy is nearing 75 years. Since 1940, deaths from heart disease have dropped by 25 percent and from stroke, by 40 percent. Similar improvements have been made in other disease categories.

Medical device manufacturers are concentrating on technology that makes care more cost effective. Now under development is a $15,000 device that can accurately tell what allergies a patient has through a simple blood test. New devices such as computerized tomographic scanners and nuclear magnetic resonance, that allow physicians to "see" inside the body, have greatly enhanced their ability to make rapid and more accurate diagnoses, obviating the need for more risky—and costly—invasive procedures. In 1950—not that long ago—there was no such thing as a joint replacement, organ transplant, artificial heart, amniocentesis, ultrasound, heart-lung machine, open-heart surgery, polio or measles vaccines, or coronary bypass surgery.

At the same time, less-expensive alternatives to hospitalization are being emphasized. American Hospital Association data show that outpatient surgery increased by 77 percent between 1979 and 1983, while inpatient surgery decreased by 7 percent. The American College of Surgeons reports that more than 300 surgicenters now exist, about half of them certified by Medicare. Physicians also are doing more procedures that were once done in the hospital in their offices or clinics. More diagnostic tests are being made on an outpatient basis, with the results given to the hospital when necessary, avoiding duplication.

Also, both the private and the public sectors are experimenting with new methods of financing and delivering care in more efficient and cost-effective ways. It is hard to tell at this point what will or will not work, what is or is not desirable. But I believe this Nation, as a Nation, will determine what is ultimately best for the health of the people, and then we will act accordingly. America's physicians will continue to give the real needs of their patients the highest priority. We believe that to be our foremost professional and ethical obligation. And we do not think the American people, our patients, would have it any other way.

Bernard R. Tresnowski

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Impact on beneficiaries

The Medicare-Medicaid partnership of government and the private sector has endured for 20 years, with everlasting benefit for the millions of American men, women, and children who have received care as Medicare and Medicaid beneficiaries. They have also been relieved of the major part of the burden of expense for illness and injury and spared the anxiety that is so often the accessory of illness, especially for elderly people with limited resources. The 20-year partnership is thus a success in the eyes of the American people.

On the 20th anniversary of the historic Social Security Amendments of 1965, it seems appropriate for those of us in the Blue Cross and Blue Shield organization to take a moment to recall what it was like as we crossed that threshold into public service. It is no secret that some among us had misgivings, from physicians who feared that the practice of medicine would never be the same to hospital executives who envisioned aged and penniless hordes streaming into hospital corridors, crowding out the ill and orderly patients who paid their own bills.

A year later, with 5 million Medicare patients cared for and paid for and doctors' bills paid for another 20 million, it was possible to take a calmer look. "Nobody can say just what services these millions of people would have had if we had not had Medicare and Medicaid," said a commentator at the time, "but it seems reasonable to suggest that some of them may have had no care at all, and many of them would have been cared for at considerable sacrifice or hardship to themselves and their families, and many would have had care as public patients without the freedom of choice of doctor and hospital they enjoyed as Medicare and Medicaid beneficiaries. All this has been accomplished without replacing or dangerously invading the voluntary health service establishment, but by using it and supporting it." (Cunningham, 1968)

The comment seemed apposite at the time, and it seems equally so 19 years and so many millions of patients later. It is still possible to assert, without reservation, that Medicare works, although not many would say the same of Medicaid. Because of the differences in goals and jurisdictions, however, the two programs obviously cannot be judged by the same standard. For all its shortfalls and its failure to "bring the poor into the mainstream of medicine," as sponsors of the legislation had expected it would do, Medicaid has nevertheless made strides toward that brave goal.

Despite problems, Medicare and Medicaid must be scored as a triumph of government for the people, if one considers that respect for the essential dignity and worth of the individual is a characteristic of democratic government. The magnitude of this respect is suggested by the 45 million hospital claims and 200 million professional service claims processed by Blue Cross and Blue Shield Plans, and the $48 billion paid under social security for the most recent Medicare year.

These are massive benefits bestowed on a substantial portion of the population by the people's Government, but this is not to say, of course, that the beneficiaries are uniformly grateful for the beneficence. It is commonly viewed instead as a right, and those who receive Medicare service are as likely as not to criticize. Illness is seen as misfortune; the instinctive reaction is resentment. The Good Samaritan got no praise from the wounded traveler. For Medicare, both Government, as payer, and Blue Cross and Blue Shield, as intermediary, have engaged in extensive and continuing education aimed at making certain that beneficiaries will understand their entitlements and know what part they must pay for themselves and why. But inevitably, the expectation exceeds the reality; the messages are not read or not understood, and there are disappointments.

An estimated three-fifths of all Medicare beneficiaries have private Medigap insurance covering the patient's share of hospital and medical expense. But, understandably, those with private supplementary insurance are those who can afford to pay for private supplementary insurance and those who can least afford to pay are without it. So dissatisfaction and misunderstanding continue, and, if anything, the incidence of disappointment has increased in recent years as budgetary constraints have dictated increases in the share of premium cost paid by beneficiaries for Part B (professional services) Medicare coverage. And for the least fortunate, those for whom repeated or prolonged hospitalized illness may become a drain on resources or assets, recourse to Medicaid may be unavoidable.

Critical as the hardships may be for those who must endure them until they can be eased or eliminated, they are minuscule alongside the monumental contribution Medicare and Medicaid have made, and continue to make, to the welfare and well-being of the aged and the poor. In short, the programs are doing the jobs for which they were created.

Impact on health care providers

Because the Blue Cross and Blue Shield organization has specific assigned responsibilities in the operation of Medicare and no comparable broad-scale functions in Medicaid, I focus largely on our part in the 20-year Medicare experience. It was not by accident that we became involved in what is a unique shared responsibility of Government and the private sector. As early as 1962, the Blue Cross Association (then still separate from the Blue Shield Association; the two were not merged until some years later) and the American Hospital Association (AHA) both had recognized that the problem of care for the aged would continue to grow along with the growing aged population, then already more than 15 million. We recognized that the need for assistance to this vulnerable group was already exceeding the abilities of State and local communities. Both organizations agreed that more Federal funds than were available under the Kerr-Mills Act, passed by the Congress in 1960, would be needed. In a joint statement that marked a sharp departure from earlier positions held by both groups, the associations' 1962 statement said that as long as the administration of the proposed Medicare plan remained in the voluntary prepayment system, the tax source of the funds would be considered of secondary importance. An earlier AHA statement had acknowledged that the use of social security to provide the mechanism to assist in the solution of the problem of financing these needs might be necessary ultimately.

As it turned out, ultimately was not that far away. Medicare and Medicaid were priority legislative objectives of the new Administration that took office following the 1964 election; passage of the Administration bill was a foregone conclusion, taken for granted, in fact, when AHA and State hospital association leaders met early in 1965 to talk over plans for making the program work. Social security would be paying the bills, and social security's representative at the meeting, Arthur E. Hess (who became the first director of the Bureau of Health Insurance and, later, Deputy Commissioner of the Social Security Administration), described what was meant by using and supporting the health service establishment, a concept that included, in his words, "professional leadership and the partnership of government and voluntary efforts." Every effort would be made, he assured the group, to arrive at policies, formulas, and methods that could be carried out at the local level, "by organizations that are already in the business of ascertaining costs for third-party reimbursement." (Cunningham, 1968)

The bill would permit any group of hospitals or other providers to designate a private organization to serve as a fiscal intermediary for carrying out reimbursement activities, Hess explained. The intermediary would receive and review bills from hospitals and other providers to determine the amounts of payment due, and make payment; the intermediary, later to be designated as "carrier" in the case of physician payments, would receive advances of funds from the social security program and be responsible for their prompt, proper, and efficient disbursement, accounting, in turn, to the Federal program.

Obviously, there would have to be boundaries on hospital and intermediary autonomy, and there were. "Of course, the Social Security Administration would still have the overall responsibility for sound administration of the program and would have to retain authority for final administrative decisions," Mr. Hess warned. As it turned out, there have not been that many changes in the ground rules over the years, though there have been repeated changes and improvements of procedures, methods, and practices. But the concept of Government as payer and the "voluntary establishment" as payment vehicle remains. This relationship has not been without strain. The partners at times have disagreed about tasks to be performed, methods to be pursued, and goals to be sought, but when the focus is enlarged to comprehend the achievement in terms of suffering eased, minds put at rest, and families made whole, strains and disagreements fade.

When the programs were initiated, the then Under Secretary of the Department of Health, Education, and Welfare, Wilbur J. Cohen, who later became Secretary, was seen as having formulated what journalists referred to as a "three-layered cake," with Medicare Part A (hospital insurance) as its base, Medicare Part B (professional services insurance portion) added next, and the cake topped off by Medicaid, which had comparatively little public discussion until it appeared as Title XIX of the proposed legislation. In contrast, the hospital and medical insurance benefit, Title XVIII, had been debated and reported at length and was well known to anybody who could read a headline. As Secretary Cohen explained to professional groups that were nervous about how the legislation would affect their status and their practice, the program was complicated and difficult to administer, "but if you want a simple law, the only place you can get it is in a totalitarian country." (Cunningham, 1968)

It was not an especially reassuring message, particularly not to doctors, who were far from convinced by the language of the law. It stated that there would be no Federal supervision or control over the practice of medicine or the administration of any institution, agency, or person providing health services, and there would be free choice of institution and physician by any patient entitled to benefits. "We shall adhere scrupulously to this congressional intent," the Secretary said. But doctors did not really believe it (Cunningham, 1968).

Today, every provider in the country is absolutely certain of one thing that the Secretary said: It is not a simple law.

Although there is no reason to believe anything other than that the Secretary and the Congress were both sincere in stating there would be no control over the practice of medicine or any institution or person,

there is no question, either, that the effect on institutions and people has been, to put it succinctly, conform or forget it.

The fact that providers, with only a few exceptions, have chosen to put their shoulders to the wheel has been partly because, from the beginning, they have had their backs to the wall. Since shortly after the program began, hospitals and doctors have known they were dependent on Medicare. Although the numbers of beneficiaries varied according to the location of the hospital and characteristics of the population, generally, they exceeded expectations and were growing. Payment was based on cost, and these were not low-cost patients. Few hospitals could then, or can now, get along without Medicare. And depending on the nature of their practice, doctors to some degree faced the same situation. There was no compulsion, no supervision, as promised. But there was also no choice.

There was no warfare, either, and considering the pressure on providers to get paid enough and the pressure on Government to save money, the absence of warfare is a tribute to the wisdom of the intermediary principle. In view of the intensity with which both providers and payers necessarily approached considerations of cost during the 17 years payment was on a cost basis, the principle must have been right and the performance must have been equitable. And now that payment is moving to a fixed-price basis, the pressure on providers is increasing, if anything; fairness is critical, and the confidence in the intermediary system that has been generated over the years is working well in the switchover, although strain is never absent.

Certainly, any analysis of what has been taking place must include the influence of employers as purchasers of health care, through their contribution to employee health insurance, along with Government, in bringing about the reconfiguration of the marketplace. The fundamental change has been a reversal of the movement, which began in the late 19th century, of medical services out of patients' homes and doctors' offices and into hospitals, following the lead of specialization and technology. This trend continued until the reversal was touched off by the buyers' rebellion against high prices. Now medical services are moving out of hospitals and going back to where the people are, in neighborhoods where urgicenters, surgicenters, outpatient clinics, group practices, and other innovative medical delivery approaches are locating.

Impelled by the new forces now at work, physicians and patients are finding that many diagnostic and treatment procedures that have always routinely called for hospitalization can be performed safely and effectively in outpatient facilities and offices, including an astonishing range of surgical procedures. Medicare's fixed-price per case based on diagnosis has been, without any question, a chief impelling force. However, major employers, paying $600 a car and $20 a ton of steel for health care, also have joined the demand for change, and they are getting it. As the chairman of a Fortune 500 diversified manufacturing corporation described it, what is going on is "permanent structural change in the American health care system." (*Hospitals*, 1984)

At the same time, other cost-containment efforts are increasing in intensity as the pressures on cost have been rising. Deductibles and coinsurance or cost sharing are now the rule rather than the exception in employer contracts. Other methods in common practice among Blue Cross and Blue Shield Plans and insurance companies include preadmission certification and preadmission testing, second surgical opinion requirements, concurrent review, medical necessity requirements, discharge planning, and new benefits encouraging use of outpatient facilities and nursing homes instead of hospitalization. With all these safeguards in place, it is no longer possible for patients to tell their physicians, "Whatever you say. It is all paid for!" Instead, they are more likely to ask, "How much will it cost, and how much of that can we save?"

Impact on government

In an analysis a few years ago, at a time when changes in the intermediary contracting arrangements had been proposed, the Government's General Accounting Office (GAO) studied the existing contract performance and a proposed alternative arrangement and concluded that the existing contract with the Blue Cross and Blue Shield Association and individual intermediaries should be continued. The GAO referred specifically to the importance of the following: the interface of local subcontract intermediaries and providers; the efficiencies of the prime contract operations of the national telecommunications and data processing systems; and the many administrative tools and procedures for accounting, data processing, management, utilization review, cost containment, and other applications. For all these reasons, and for the important protection of the "special way of franchising," as the existing intermediary arrangement has been called, it would appear to be prudent to continue the arrangement at a time when the health care system itself is in the process of adjusting to the many new forms of delivery and financing that are emerging.

Although there have been and continue to be problems in the operation of Medicare, these problems are dealt with and either resolved or relieved over time. But these problems must be viewed in relation to the overall accomplishment of the program. Considering the millions of complex transactions handled every month, Medicare is an extraordinary administrative achievement. The only serious problem with Medicare has been its cost, which has exceeded estimates to an extent that at times has appeared to threaten the stability and adequacy of the Medicare trust funds.

Troublesome elements of the payment system have been recognized almost from the beginning of the program; the first national conference on medical

costs, with Medicare costs as its principal focus, was convened by the Secretary of the Department of Health, Education, and Welfare John Gardner at the request of President Lyndon B. Johnson in the summer of 1967, when the program was barely a year old. The problem then was basically the same thing as it has been ever since. As the conference summarizer said, "Unlike scientific medicine, organization of health services is a field that more than most others has been dedicated unflinchingly to the rediscovery of the wheel. Many of the concepts that have been discussed here such as incentives, productivity, group practice, community health systems, and utilization controls—these and other organizational and procedural goals have been lying around in plain view, some of them for 20 years or more, now and again being re-invented, and re-explained, and re-exclaimed over, as succeeding generations of physicians, administrators, economists, social scientists, and journalists have entered or turned their attention to the health field." (Cunningham, 1968)

Two methods of control that were overlooked in the summary were payment method and competition. Both were discussed during conference sessions; provider payment methods were examined in detail, but prospective payment and prospectively approved budgets were not particularly emphasized, and competition among providers was mentioned chiefly to express regret for its absence. Health care enterprise in the 1960's was still firmly ruled by, or under the spell of, the doctor's concept of right and wrong behavior. Competing for patients was not ruled out, but talking about it was, and advocating it was unthinkable. With profit-making chains on the horizon and advancing, hospitals were beginning to shake off the spell, but aggressive marketing and advertising services were still more than a decade away.

After several years of controlled tests, Government implemented the prospective payment system (PPS) for Medicare. This has been one of the leading causes of the first real turnaround in hospital costs, not just since Medicare was introduced but actually since World War II, when hospital utilization dropped because one-third of the Nation's doctors had gone to war. Although there is no direct linking of PPS and the rise of competition, the fact that they have come on together has made both of them, unquestionably, more effective. The combination of PPS and competition, too, has helped to make price a foremost measure of value in the market for medical services, instead of a negligible, if not unmentionable, consideration.

The combined efforts of Government, employers, insurers, and patients themselves are taking effect for the first time since the early 1970's, when rigid wage and price controls were imposed and costs flattened out for as long as the controls lasted. Overall hospital expense was held close to the Consumer Price Index in 1984, and as the new market forces gather momentum, hospital admissions, lengths of stay, and occupancies are declining at an even sharper pace in 1985. Rates of decline vary by area, type of community, size and type of hospital, and local economy, but utilization as a whole is down by 5 percent in some cases and as much as 15 percent in others.

With so much changing so rapidly, there are bound to be disjunctions, dislocations, and resulting hardships. Some hospitals have been closed, and more unquestionably will have to close as the readjustment goes on. Up to now, most of those that have had to close have been small—50 beds or fewer—but the resulting hardship is no less severe for those whose lives are affected. Other hardships occur in cities where voluntary hospitals with depleted resources are compelled to turn away patients seeking care who are without insurance and without funds. Except in life-threatening emergencies, such patients in growing numbers are being referred instead to public hospitals, whose facilities and funds are already under stress and, in some cases, threatened with failure. In States where Medicaid budgets have been cut while Medicaid demands are increasing, corrective action may be needed to avert serious breakdowns.

Implications for the future

A problem that, although not widespread, is disquieting nevertheless is the possibility that the quality of care may be eroded by the pressures on hospitals, which devolve on physicians, to avoid admissions, hold down stays, and speed up discharges in order to keep costs within limits under diagnosis-related groups (DRG's). Ever since the system was first introduced in the New Jersey trials and, increasingly, since Medicare PPS became law, hospital people have been aware of the need for trustees, management, and medical staffs to develop specific procedures for safeguarding against excessive admissions, stays, and services. Figures just now becoming available suggest that the goal is being pursued; the journals are awash in articles describing the methods.

There has been less talk, and fewer articles, about the need for avoiding excesses of zeal, and one hears stories of coronary bypasses discharged on the fifth postoperative day, outpatient prostatectomies on 80 year olds, and patients suffering transient ischemic attack sent home with no neurological workups. This is not a problem for Medicare, or for intermediaries, employers, medical societies, or hospital associations. It is a problem for individual physicians and individual hospitals and their trustees, managements, and medical staffs, and it is a problem of conscience. Administrators may excuse excessive pressure to avoid loss at fixed prices by telling themselves, and their doctors, that "we can't help anybody unless we stay in business." But this dodges the real issue, which is that a hospital business is still a hospital, with a mission to treat the ill and injured and a special ethic that puts the mission ahead of the business when circumstance calls for choice. Without the special

ethic there is no mission, and without the mission, what is the hospital there for?

Safeguarding the Medicare trust funds for the future has been a preoccupation of Government, providers, and interested segments of the population ever since the first questions about its security began to emerge several years ago. There has been no lack of suggestions. One proposed solution has been to meld the hospital insurance and supplementary medical insurance trust funds; this would permit greater flexibility and adjustments as needed, with access to general treasury funds. A voucher system with beneficiary choice of health maintenance organizations as opposed to traditional insured practice is now being tested; this approach is seen by many, in and out of Government, as promising the substantial savings that have been demonstrated in capitation plans. Others are convinced that consumer choice is an invitation to adverse selection and a sure road to disaster over time, pointing to the Federal Employees Health Benefits Program as an example. DRG's for physicians have been under study and may yet be tried.

For the long term, tax increases in one form or another may be inevitable, either separately or in combination with some kind of means test for beneficiaries and perhaps, also a system of adjusting benefits according to age as well as income. People over age 65 are neither as vulnerable nor as hard up as they were 20 years ago; they are robust and rich in comparison with their counterparts of the 1930's, when social security began and age 65 was seen as the end of living instead of the beginning of leisure. It may take another generation to get it done, but the means test, at any rate, is a certainty. Whatever else may be done, it no longer makes sense for the Medicare trust funds to be depleted to pay for pacemakers and bypasses so yachtsmen and golfers at Boca Raton and Hilton Head can enjoy the sun without calling the bank.

The future of Medicaid is something else. A sobering study 2 years ago by the Robert Wood Johnson Foundation (1983) counted 28 million Americans who had been without needed medical care during the year preceding the study. Since that time, both State and Federal budgets have been reduced and State Medicaid eligibility rules have been tightened, in some cases drastically. In fact, if there has been a time when any part of the health care system established by the Social Security Amendments of 1965 has been close to failure, the part is Medicaid and the time is now. One of the reasons is money. Up until 1983, at least, hospitals had become accustomed to accepting and treating whoever showed up at the door, confident and content that whatever was done would be paid for. There were always discounts, often steep ones, from actual costs, to be sure. But as long as there were beds, it was better for them to be full than empty; without doubt, some hospitals became relaxed, if not negligent, about investigating patient resources and pursuing patient payments.

Not much laxity is left in the system today. Any laxity remaining, when the unemployment of 1981 and 1982 began to recede, vanished as DRG's advanced and below-cost arrangements with local authorities could no longer be supported by above-cost payments by private and insured patients. With occupancies going down, there are empty beds all over, but not in public hospitals, where beds are filled with the sickest patients and others are sitting and standing in corridors and reception areas, waiting to be seen. Visitors to a Bellevue or Boston City or D.C. General or Metropolitan or Charity or Cook County hospital today can see the problem plainly as soon as they open the door. The problem is money; money would make it possible for the patients overloading public hospitals to get care where they got it before, in all the other hospitals that for years had been charging those who would be paid for or could pay themselves for those who could not pay.

There is little likelihood that we shall go back to the old way. It was uneven, illogical, unfair—a "tax on the sick." But unevenness is inherent in most of the solutions that are being proposed and tried out now—the new tax on hospital revenues in Florida, allocations of funds of one kind or another in New York and Massachusetts, a law in California that makes county institutions responsible for medically indigent adults. Most of the proposed solutions turn out to be taxes on the sick, at least indirectly. A tax on employers as payers for private health insurance has been suggested, and voluntary coalitions of business, providers, insurers, and local public health people have proposed local responses to community needs, although no notable success has been reported.

Also failing to evoke enthusiastic response is the one proposed solution that would eliminate the unevenness, if only to spread the hardship around equally from State to State, by federalizing Medicaid. Nobody has been willing to say more than that a federalized Medicaid would be the least objectionable method of seeking to make sure the unprotected are protected. There is now widespread recognition that the problem is already out of hand in many communities and growing. Remarking on the foundation report 2 years ago, of the 28 million uncared for, a respected health care economist predicted that if the number were to reach 40 million, the public outcry would become overpowering.

Action taken in crisis is not the ideal way to solve problems, but it is better than no action. So there will be action. There will be no failure of Medicaid that can diminish the success of Medicare, which must also expect and prepare for change in the future as it has done in the past. Some adjustments of eligibility requirements are inevitable to keep income in manageable proportion to outgo as the elderly population continues to grow at an accelerating rate. The forthright change in payment practice introduced in 1983 has already demonstrated its effectiveness in

restraining utilization. What is needed now is continued adjustment to compensate imbalances and forestall injustices that may develop and, especially, to protect against impairment or erosion of the integrity and quality of institutional and professional services. The quality of the services and the success of the program over two decades have demonstrated that the special partnership of Government and the private sector works. It was needed for the program to get started, and it is needed as the program goes on.

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Impact on beneficiaries

The achievements of Medicare and Medicaid are dramatic and should not be minimized. These programs have largely achieved their original purpose of assuring access to health care for the elderly and the poor. Although other major industrialized nations have similar accomplishments, only the United States has not resorted to nationalization of health care in order to achieve this goal. Instead, we have parallel public and private financing systems that utilize the same private delivery system.

As purchasers, many of the problems facing the public and private systems are similar. We are both seeking to cover only medically necessary care and to encourage cost-effectiveness in the health care delivery system. We are both wrestling with issues created by new technologies. But we have far more in common than just our problems. When Medicare and Medicaid were created, their coverage and payment systems were modeled after private insurance plans. In the 20 years since then, we have learned from one another's successes and failures.

In 1984, these programs together spent $97 billion in Federal and State funds to provide access to a wide range of quality services for 49 million people. Despite this level of effort, our Nation has fallen short of its original goal. Even more troublesome, we have many difficult choices ahead if we are to sustain our current degree of success.

The original goal of removing financial barriers to those who need care the most is not yet complete. At the end of 1982, between 10 and 15 million Americans were without public or private coverage. In 1983, Medicaid covered only 40 percent of those with incomes below the Federal poverty level. To the extent these people obtain access to care, providers incur costs that are often uncompensated. In 1983, such costs exceeded $7 billion to hospitals alone. In turn, hospitals shift such costs by increasing charges to private patients. These remaining gaps in entitlement thereby create a fearful hardship for the unprotected and a growing burden on the insured.

For those entitled to Medicare and Medicaid, the programs' success needs closer examination. The past 20 years has seen a slow increase in the number of Medicare eligibles (approximately 3 percent per year) and no sustained increase in the number of Medicaid recipients. Yet expenditures have increased annually at 18 percent for Medicare and 11 percent for Medicaid.

What has been responsible for these increases? Increased costs were not a result of reductions in beneficiary's personal liability. On the whole, the elderly now spend the same percentage of their income on health care as they did before Medicare was enacted. Nor was expansion of covered benefits responsible for increased outlays. Numerous States have reduced the scope of Medicaid benefits, including implementation of annual limits on hospital days and physician office visits. Although Medicare has avoided similar limitations, benefits for retirees have not kept pace with private sector coverage for either minor medical needs or catastrophic illness.

From the Medicare beneficiaries' viewpoint, there remain significant coverage gaps. These gaps include long-term care, outpatient drugs, eyeglasses, dental care, and hearing aids. Beneficiaries are also liable for any doctor's fee above the charge level recognized by Medicare. Some of these gaps may be covered through privately purchased Medicare supplemental insurance. Protection against a catastrophic illness, especially one requiring long-term care, is not provided by Medicare nor readily available in the private market.

An obstacle to the emergence of private insurance for long-term care is Medicaid eligibility loopholes. Through the use of certain tax devices, elderly persons with personal resources are able to obtain Medicaid benefits. Although the motivations of these elderly individuals are understandable, such tax devices divert limited resources away from other eligible low-income groups that include children and their families and the disabled. Many States have been forced to restrain Medicaid eligibility and benefits as the program's long-term care outlays continue to escalate. In 1980, elderly Medicaid patients represented only 16 percent of all Medicaid eligibles, yet consumed 37 percent of all Medicaid funds. This is even more disproportionate when you consider that nearly all elderly Medicaid patients are eligible for both programs and continue to receive payment for basic medical care under Medicare.

In summarizing past accomplishments, it is fair to say that the initial designs of Medicare and Medicaid greatly enhanced access to basic quality care. But, with the exception of increased Medicaid funding of long-term care, these programs have not used significant increases in funding to expand eligibility or coverage. Rather, expenditures by all purchasers, Government and private alike, have steadily risen to pay for more costly, more frequent, and more

intensive treatments per patient. In response, the management focus for Medicare and Medicaid has been narrowed from access, quality, and adequate coverage to cost containment.

Far more difficult than financing current benefits for current Medicare beneficiaries will be retaining those benefits for future retirees. Enormous burdens are being placed on Medicare by increased longevity, decreased birth rates, and the rising cost of care. Over the next quarter-century, the number of retirees will expand rapidly in comparison to the workers who finance their Medicare benefits. This larger retired population will include more frail elderly who require extensive care. Meanwhile, the cost and volume of both acute and chronic treatment will continue to escalate.

As the population ages and the cost per beneficiary continues to rise, some areas of Medicare eligibility will come under additional scrutiny. First, the availability of identical Medicare benefits to all elderly, regardless of their financial resources, will face additional criticism, because, in general, the economic position of the elderly has improved in recent decades relative to the nonelderly population. Second, eligibility based solely on a disabling disease may well be viewed as a personal or private sector obligation. Given the aging of the population, the Medicare program is inadequately financed to provide care for a very small percentage of the population that accounts for a significant percentage of total funding. Thus, it is increasingly unlikely that new entitlements will be created by diagnosis, despite advancements in technology.

In addition to possible eligibility reductions, Medicare and Medicaid patients have reason to fear future reductions in access and quality. If payment levels to providers are steadily reduced under these programs, providers will increasingly favor treatment of private paying patients. So long as the Government legislates cost containment for its own programs, yet fails to address restraints on private payments, Medicare and Medicaid beneficiaries are at risk for second-class care.

Another payment reform initiative, capitation, may well pose the most difficult challenge facing Medicare and Medicaid patients. Under capitation, a provider agrees to deliver a certain range of services in exchange for a fixed dollar amount per beneficiary. The most comprehensive and well-known capitation model is the health maintenance organization. New models are emerging in response to initiatives by State Medicaid agencies, private insurers, and various health care providers. These models include preferred provider organizations, competitive medical plans, competitive bidding arrangements, and some prospective payment mechanisms.

Beneficiaries have three risks under capitation arrangements. First, access and quality of care are at risk whenever providers have financial incentives to provide as little care as possible. This is true even if the fixed payment per beneficiary is reasonable. So long as patients can choose between capitation and independent traditional fee-for-service practitioners, this risk is minimized. Second, proposals to increase capitation for Medicare beneficiaries, including the voluntary voucher proposal, risk adverse selection. Beneficiaries may elect capitated systems while they are healthy, but return to the basic program if their health deteriorates. Without an adjustment for health status, Medicare funding to capitated plans may therefore be too generous, while the costs for the noncapitated portion of the program may increase even more rapidly. Third, if the Government sets its price per capita below a reasonable level, providers will have a strong incentive to reduce benefits, access, or quality.

Finally, the beneficiaries of the Medicare and Medicaid programs will face increased pressure to become more aggressive consumers of health care. Similar expectations are now being placed on the working public by private insurers and employers. As all payers struggle to better manage health care costs and utilization, patients will be asked to make more sophisticated choices between providers and to experiment with limited freedom of choice. It remains to be seen whether many of us, as individual patients, can adequately fulfill such expectations.

Impact of health care providers

Government financing of health care was in many ways a dream come true for providers. The structure of both programs enabled providers to generate demand for their services and to receive payment for their services regardless of the cost. Health care providers had such latitude because of cost-based reimbursement and weak coverage controls initially adopted by Medicare and Medicaid. But Congress and most State legislatures have found the resulting costs to be unsupportable. Only the future will show whether recent cost-containment efforts have found a better balance between the interests of beneficiaries and those of providers.

The designers of these programs had cost containment in mind at the onset. Their choice of cost-based reimbursement had certain advantages over payments of charges, the only other alternative in use at the time. Charge-based payers, such as commercial insurers and nearly half of all Blue Cross plans, pay their share of all the costs of operating a hospital. A hospital's financial requirements include costs directly related to patient care as well as bad debt, charity care, working capital, and operating margins. In establishing cost-based reimbursement, Medicare selected those hospital costs that it would recognize as related to the treatment of Medicare patients. Such costs as charity care and non-Medicare bad debt were not included. Since most States initially adopted Medicare's payment rules for Medicaid, hospitals have been forced to recover charity and bad debt costs disproportionately from private payers.

Nonetheless, cost-based reimbursement proved to be unacceptably expensive. Providers could not increase their margins except by reporting cost and volume

increases. Productivity gains by the hospital actually reduced Government revenues. As a result, an incentive was created for the use of expensive new technologies and services. A disincentive was simultaneously created for cost-conscious care.

The Government first attempted to regain control over provider expenditures by the placement of "reasonable upper limits" on those costs that were recognized for payment. Beginning in 1974, Medicare compared the costs of inpatient routine per diems and disallowed costs too far above those typical for similar hospitals. In response, many hospitals effectively claimed increased ancillary services and costs for their Medicare patients. As a result, only a tiny percentage of Medicare funds were actually saved by these limits.

Medicare has experienced a similar lack of control over covered services. Providers have needed little more than a physician's signature to dramatically expand the range and volume of care provided to beneficiaries. Once the medical community has endorsed the safety and efficacy of a new procedure, it soon becomes readily available for use. On the other hand, the cost effectiveness of new treatments and individual patient need are difficult to measure and even more difficult to enforce. Medicare has recently taken more serious steps to discourage unnecessary utilization. Medicare's newly established peer review organizations, for example, will increase efforts to reduce unnecessary admissions.

Medicare's utilization problems are similar to those driving up private sector costs. Our solutions have a somewhat different focus because we have neither data nor authority similar to Medicare's. Without a community-wide data base, it is difficult to identify treatment norms and abusive practioners. Without the force of law, it is often impossible to obtain provider cooperation in utilization review and control. Therefore, private payers are increasingly emphasizing patient use of second opinions and preadmission review, as well as selection of physicians who practice conservatively. Despite their effectiveness to date, current utilization controls will become inadequate as advancement in medical technology continues. Complex financial, social, ethical, and medical issues with intensify. We hope private and public payers will pool their resources and work with the medical community to more effectively address these issues.

Medicaid began operation with similar blank checks to physicians and providers. But as soon as Federal law allowed more flexibility, States tightened their control on both reimbursement and utilization. Innovative Medicaid reimbursement reforms include physician fee schedules, competitive bidding for Medicaid services, and hospital prospective payment systems. States also continue to aggressively experiment with utilization controls including preadmission authorization, waiver of freedom of choice, enrollment in alternative delivery systems, and limits on the amount and duration of provider visits. Admittedly, the results have been mixed. On the positive side, statewide all-payer systems have saved money for Government programs and private payers alike while stabilizing the financing of charity care and medical education. On the negative side, underpayment of providers has led to early abuses such as Medicaid mills and unscrupulous health maintenance organizations for the poor. Current Medicaid underpayment to hospitals in some States encourages cost shifting to private patients who are not protected by State cost controls.

Providers have prospered continuously since Medicare and Medicaid were created, despite numerous attempts to slow their growth. From 1976 to 1982, hospital revenues have increased by 162 percent and, despite excess capacity, the number of hospital beds increased by another 13 percent. From 1978 to 1983, the salaries of hospital workers increased by 60 percent. Between 1976 and 1983, hospital margins (the difference between revenues and costs) increased steadily from 2 to 4 percent, despite fluctuations in the general economy. Hospital occupancy has declined dramatically because of recent changes in private and public benefit designs. Although hospitals have decreased their staff size somewhat, the ratio of employees to patients still increased between 1982 and 1983, as did hospital workers' wages. It is therefore questionable whether hospital productivity gains are keeping pace with recent utilization controls and payment reforms by public and private payers.

Hospitals have prospered so well for so long because most controls that were enacted were relatively ineffective. Medicare's limits on inpatient routine per diem rates were largely avoided by increasing inpatient ancillary costs or by shifting unreimbursed Medicare costs to private charges. The effectiveness of Medicare's new prospective payment system, which fixes the full payment by diagnosis, may be reduced by increased delivery of Medicare services pre- and post-discharge. Likewise, any Medicare costs not actually recovered can still be shifted to private charges. In contrast, statewide payment reforms have demonstrated that cost controls and productivity incentives can be effective when applied to all payers for a comprehensive set of services.

The battle by all payers to rationalize their health care expenditures will continue for the forseeable future. For their part, Medicare and many Medicaid programs seem intent on offsetting any growth in eligibles and services by further reductions in payments to providers. Government reliance on the private sector to absorb additional cost shifting may prove faulty because of more statewide regulation and increased competition. Several more States have enacted legislation for all-payer systems that would guard against cost shifting. Increased data capability is encouraging price and utilization comparisons among providers. Employees are increasingly rewarded for selecting less expensive providers.

Although these initiatives may encourage some competition, it is critical to note that the providers with the least charity care, the fewest Medicare and

Medicaid patients, and no medical education costs can offer lower prices to the private sector. These providers and private payers who continue to bear the costs of such services are being placed at a competitive disadvantage that cannot be sustained indefinitely. If the cross-subsidies for the poor and the elderly continue to erode, problems with quality and access will re-emerge.

Impact on government

Pay-as-you-go financing has proven inadequate for Medicare and Medicaid. Yet most financing reforms seek to shift, rather than reduce, program liability. A more responsible way to reduce program liability is to expand experimentation with State and Federal program design. Research and demonstrations, coupled with independent evaluation of their results, have paved the way for more effective program reforms. By getting more health care benefit per dollar, we may avoid depletion of funds, rationing of benefits, and a greater burden on workers and those with limited resources.

One of the key decisions that affected Government expenditures for Medicare and Medicaid was the concept of current financing. The funding of health care on this pay-as-you-go basis has been an insurance tradition and we find it generally acceptable. Under Medicare and Medicaid, the burden of financing health care for the elderly and the poor is thereby spread across all workers. However, the Government's use of current financing has suffered from two erroneous assumptions. First, the shift toward an older population with a corresponding decline in the ratio of workers to retirees was not adequately anticipated. Second, increases in the cost of health care have exceeded increases in workers' wages. Because of these two factors combined, outlays have outpaced revenues.

Federal and State contributions to Medicaid were rendered less predictable because of frequent changes in the design of the Medicaid program. Since Medicaid's inception, each State has had considerable latitude in eligibility and coverage and, more recently, in reimbursement policy. Over the years, congressional mandates have alternated between specific eligibility and coverage expansions, overall expenditure reductions, and widespread eligibility contractions. The cycle is now turning to mandated eligibility, coverage expansions, and renewed debate on overall expenditure caps.

The Medicare financing solutions most frequently discussed do little to reduce program liabilities or inequities. Most proposals merely increase or shift program liability to non-Government entities. Before resorting to increased payroll taxes or means-testing of retirees' benefits, Medicare should further reform the payment system. Our first line of defense against Medicare bankruptcy should be to pay out less from the Medicare trust funds rather than to expect workers and elders to simply pay more into it.

A recurring proposal for Medicaid financing is to cap Federal contributions at some historical level. This proposal has substantive defects. It ignores the fact that any decline in a State's economy will simultaneously increase the number of poor people eligible for Medicaid and decrease the State's ability to care for them. To maximize the cost effectiveness of Medicaid funds, the States need greater program flexibility and the time and Federal encouragement to use it.

A major advantage of State administration of Medicaid has been the opportunity for experimentation with program design. State fiscal constraints combined with local ingenuity have resulted in the New Jersey diagnosis-related groups system, channeling experiments for long-term care, social health maintenance organizations, competitive bidding for a range of services, and primary care case-management systems.

With respect to the strengths and weaknesses of federally-administered versus State-administered programs, payers should have the right to control expenditures for which they are responsible. That right clearly would argue against Federal administration of Medicaid so long as States have significant financial obligations under the program.

The uniform administration of Medicare has resulted in a high level of efficiency. The Medicare program has been a successful, cooperative effort, jointly administered by the Federal government and private companies on a contractual basis of no profit, no loss. Since Medicare's inception, nine of our national carriers have contracted with the Federal Government to provide prompt services to beneficiaries and providers at the lowest possible cost. The quality of service has been high and the administrative costs to Medicare are now less than 1 percent of total outlays, a truly remarkable record.

Despite its quality and consistent cost effectiveness, Medicare's uniform system of administration has two significant shortcomings. First, there is insufficient linkage between Parts A and B to permit a comprehensive analysis of cost and utilization data. Such analysis would facilitate development of additional utilization controls and payment alternatives. Second, Medicare's long-standing partnership with private carriers may be jeopardized by imprudent budget cuts. Proposals to reduce contractor budgets ignore both workload and cost increases. Experience has shown that such reductions are likely to delay payments to beneficiaries and increase program overpayments to providers.

Regarding competition versus regulation, the greatest cost-effectiveness will come from a balance of these strategies. In a sense, Medicare combined competition and regulation when creating its new prospective payment system. First, Medicare calculated a fair market price for hospital services using actual program data. Then this price was enforced through regulation. This in turn forced hospitals to compete based on their productivity. A similar use of regulation to foster competition has

been undertaken in several States where Medicaid now uses some form of prospective payment.

Unfortunately, regulatory authority can become protective or destructive, if it is abused. Regulation becomes too protective if, in a State rate-setting program, hospitals are guaranteed solvency without regard for their efficiency or for community need. We believe it is also an abuse of regulatory power to set prices below a fair market value. This will occur if diagnosis-related group prices are frozen without a reasonable adjustment for inflation.

Competition, just like regulation, can result in greater general good or in harm to the public. For example, the widespread availability of meaningful price data is the key to any competitive industry. But unfettered price competition would erode and eventually destroy current financing for indigent care and for medical education. Expensive, low-volume services such as neonatal, burn, and cardiac care could also become scarce.

The primary weakness in both the Medicare and Medicaid programs is the failure to recognize that the same health care delivery system provides services to both private and public patients. Public and private financing and expenditure levels are fundamentally interrelated. If Government, as the predominant payer, infuses the system with unlimited capital, all other patients pay for capital expansions. Conversely, if Government relentlessly reduces revenues, someone will suffer. Either private patients will pay more, or Government patients will not be treated as well, if they are treated at all. If competition is to mean more than simply maximizing profit, if it is to mean getting the most health benefit for every patient's dollar, then competition has to be fair. A level playing field has to be established so that all payers and providers can compete on an equitable basis.

Implications for the future

Medicaid will face three basic issues in the future. First, who will be responsible for those poor people whose care is currently financed by hospitals through cost shifting to the private sector? Second, how can access to mainstream quality health care be retained despite reduced payment levels and limited freedom of choice? Third, given the increased need for long-term care and the opportunity for Medicaid eligibility, how can private financing options for the nonpoor elderly be encouraged?

There are Medicaid program design problems that also need resolution. First, more frequent manipulation of Medicaid eligibility rules will increase the need for alternative sources of long-term care for the nonpoor elderly. Second, the annual financing crisis may also force Government officials to reconcile competing political pressures to fund transplants for a handful of children while thousands more have inadequate access to basic medical care.

The fundamental question for Medicare's future is how to maintain the scope and quality of current benefits despite the growth in the elderly population.

To resolve these problems without substantial additional financing will require both programs to achieve greater cost effectiveness in medical treatment and to implement additional payment reforms.

Several treatment issues must be addressed by all payers. Substantial and inexplicable variations in admission rates and in the use of common diagnostic and treatment procedures must be confronted. Just as data collection and analysis revealed unacceptable variations in cost, similar work must be completed with regard to utilization. Better measures of outcome for medical treatments must also be developed if both resources and health are to be maximized. Establishment of criteria for appropriate use is especially important as expensive new technologies continue to outpace our ability to make ethical, moral, political, or financial decisions concerning their dispersion. Furthermore, if fears of abuse arise under public or private prospective payment systems, providers will be called on to demonstrate adequate levels of quality in order to retain public confidence.

Payment reforms must continue so that providers become more conscious, not simply of cost or profit, but of cost benefit to the patient. Work should therefore be completed on physician payment reforms. Current payments to physicians appear to favor new physicians just establishing their practices, as well as new specialities and new treatments. Reform is also needed to rationalize financing of graduate medical education, the distribution of physicians, and incentives in the practice of cost-effective medicine. Additional bundling of services into prospective payment systems should be undertaken to reward cost consciousness by all providers. Finally, additional capitation models should be explored so that quality becomes a major concern for patient and practitioner alike.

After much success, Medicare and Medicaid still have a job that is incomplete and problems that threaten to undo past accomplishments. Although there are no obvious and palatable answers, past experience indicates a path toward workable solutions.

Medicare and Medicaid need continued program flexibility and experimentation. Without that flexibility, the rising cost crisis will recreate the access and quality problems these programs were intended to solve. Such experimentation must result in better payment incentives and new safeguards for quality. These must be accompanied by a new focus on health promotion and patient education, along with a further de-emphasis of acute and high-technology delivery settings. And, if all patients are to benefit from emerging competition in health care, there must be regulatory oversight to assure consistent rewards for all cost-effective providers and purchasers.

Medicare and Medicaid have indeed come to a crossroads. Despite a projected delay in Medicare bankruptcy and surpluses in a few States, we cannot afford to allow time to pass without reassessment and revisions. If we do not address the fundamental incentives in these programs now, we will later have only simplistic and harsh alternatives such as benefit

cuts, payment reductions, and increased taxes. Genuine reform requires more time, thought, and initiative, but it is in the best interest of these programs and the people they were designed to serve.

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