

An “ABC” Proposal to Modernize Medicare

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Congressional Democrats and Republicans continue to spar over how to add a prescription drug benefit to Medicare. Neither party, however, has offered a credible plan for modernizing Medicare itself.

It is true that Medicare needs to catch up with private health insurance plans and offer a prescription drug benefit for seniors. But simply adding drug coverage will not cure what ails Medicare.

The more fundamental problem is this: Medicare is not prepared for the medical challenges posed by the coming retirement of 77 million baby boomers. Medicare is basically a system that pays seniors’ medical bills. It needs to become a system that promotes healthy aging in a rapidly graying society.

Over the last century, we have made tremendous progress against acute or life-threatening illnesses. Americans today routinely survive conditions—strokes, heart attacks, and even cancer—that used to cause quick death. Now it is time to focus on the next big health care challenge: preventing, treating, and reversing the course of chronic health problems that arise later in life. This is the key to successful aging.

By 2030, one out of every five Americans will be over the age of 65. Age-related chronic conditions such as arthritis, Alzheimer’s, heart disease, diabetes, osteoporosis, and breast and prostate cancers are growing concerns. Unless we focus Medicare on healthy aging, the boomers’ retirement will be blighted by preventable illnesses, and future taxpayers will be swamped by unnecessary costs.

Medicare was designed in the 1960s based on the health insurance models of the time. In those days, insurance was mainly intended to shield people from ruinous hospital bills. Both health care

and health insurance were “after the fact.” They kicked in only after a crisis—such as a heart attack or stroke—had already occurred.

Today, health insurance still pays doctor and hospital bills, but the actual practice of medicine is gradually switching to an emphasis on early diagnosis and continuity of monitoring and treatment of chronic illnesses. Some private health plans are taking steps in this direction—they are establishing so-called “disease management” or “care management” programs that help people with chronic ailments monitor their conditions and avoid severe crises. Care management entails arranging for health care professionals to help patients care for themselves through jointly developed treatment plans; self-monitoring and reporting to identify problems or trends early so they can be tackled before hospitalization becomes necessary; assessment of risk factors and methods of risk reduction; optimized drug therapy (especially for patients with multiple prescriptions); improved diets and proper exercise; and even group treatment of chronic illness.

Because Medicare covers seniors and workers with long-term disabilities—precisely the people most likely to have chronic or ongoing health problems—Medicare beneficiaries have the most to gain from continuity of care and comprehensive, coordinated care management systems.

However, Medicare has not kept pace with the movement toward care management—in fact, Medicare’s traditional fee-for-service program has separate and uncoordinated payment rules for inpatient and outpatient hospitalization, physician services, lab tests, and other items, which are in themselves impediments to comprehensive care of chronic illnesses.

Instead of targeting insurance payments to encourage innovations in care management that could help seniors preserve their health, Medicare's fee-for-service program is constrained by decades of regulations that have locked in old, inefficient ways of paying for care. Consider this absurdity: Medicare will pay for an expensive and intrusive bypass operation, but not for the drugs that could prevent it. Medicare will pay for an amputation, but rarely provides the education and continuous monitoring services that can prevent people with diabetes from losing limbs.

It is time to recast the prescription drug debate in light of the larger challenge of improving Medicare's ability to promote healthy aging. The main task facing Congress is to focus Medicare's fee-for-service program on prevention and treatment of chronic diseases; on equipping seniors to manage their own health better; and on linking disjointed benefits into a seamless web of coordinated care. At the same time, seniors' choices of alternative private health plans should be expanded and enriched. New benefits for prescription drugs should be a catalyst for both types of improvements to Medicare.

At its deepest level, modernization means establishing a fundamental basis of accountability for improving Medicare's performance, and seniors' health quality and outcomes. No budgetary shortfall should stop us from making the structural reforms necessary. It is wrong to say that because we no longer have enough money for a generous add-on drug benefit, we should therefore do nothing. On the contrary, we must reform Medicare and create a new results-based management structure, which in turn will be able to accommodate the introduction of new benefits designed to improve health outcomes, if the budget permits.

The ABCs of Modernizing Medicare

The PPI Medicare proposal has three interdependent parts. We believe these essential ABCs of Medicare reform would be more powerful in combination than taken alone, and that together they would remake Medicare to face the challenge of healthy aging.

Accountability. Medicare officials should be held accountable for measuring and improving the health of older Americans. They should be given the freedom to make improvements at the local level, like establishing care management programs appropriate to local needs, with clear public disclosure of results and congressional oversight.

Benefits. Medicare should have a drug benefit that will help improve its performance in treating chronic disease, not further fragment its payment systems. Within that general theme, PPI believes the drug benefit should have three priorities: help the sickest, help the poorest, and help all other seniors get better choices.

First, all Medicare beneficiaries would get basic catastrophic coverage for very high drug expenditures; there would be no premium to pay, and for most beneficiaries the catastrophic benefit would simply be added to their current supplemental coverage. All seniors would get discounts on every prescription as part of the catastrophic benefit. Second, Medicare would give more extensive drug benefits to seniors with incomes below approximately 150 percent of the poverty line. Third, Medicare would provide modest premium subsidies to help beneficiaries with incomes above that level purchase comprehensive drug coverage, either through private health plans like HMOs and preferred provider organizations (PPOs), or from a new, more affordable version of Medigap coverage with drug benefits.

This basic set of drug benefits is *universal*, *progressive*, and *affordable*. It offers all seniors automatic, no-hassle protection against ultra-high drug costs, subsidizes drug coverage for the needy, creates new opportunities for private drug coverage, and comports with fiscal reality. It would reinforce (not replace) existing "retiree" drug coverage provided by employers and drug assistance programs run by states. Because of its universal, high-deductible coverage, the PPI drug proposal would create in Medicare comprehensive information on seniors' drug purchases, which could be used to launch the Medicare program into a new era of results-oriented management and quality improvements.

Choices. Medicare should engage seniors in managing their own health by creating a “Medicare Menu” of choices to spur competition and innovation. The menu would highlight specific care management programs available to beneficiaries; offer “New Medigap” options for coverage of drugs plus other benefit gaps in Medicare’s fee-for-service program in an all-in-one package; and provide a central clearinghouse for alternative private health plans—including HMOs, PPOs, and new comprehensive care management programs—in which Medicare beneficiaries could enroll.

Accountability

The first imperative is to convert Medicare from a mere bill-paying regime into a performance-based system that produces measurable improvements in seniors’ health. To begin that process, PPI proposes a health-care version of the “CompStat” system, which has helped New York City dramatically reduce violent crime rates.

Just as CompStat holds precinct commanders responsible for reporting and reducing crime in their sectors, Medicare should require its local administrators and medical directors to collect information on outcomes of treatment of the most frequently occurring chronic diseases, morbidity and mortality rates, emergency room admissions, access to and use of preventative care, patient satisfaction, availability of private plan options like HMOs and PPOs, availability of care management programs (both comprehensive and educational), cost trends, and other measures of the performance of Medicare within their jurisdiction.

Medicare needs the flexibility to reward its best performing administrators and medical directors, penalize the poorest performers, and develop a health information-sharing network that will support continuous improvement of all services as well as help patients choose health care services on the basis of highest quality, fewest errors, and best outcomes.

Over time, Congress’s role should shift from micromanaging payments and benefits to demanding better overall system performance. To start that transition, PPI proposes establishing

a small new congressional oversight agency—called the Congressional Health Benefits Agency—to track Medicare’s performance at the local level and evaluate proposals by local Medicare administrators. Local administrators and medical directors would have the latitude to implement proposals for minor benefit changes or new care management programs that would pay for themselves over a certain period of time, and the Congressional Health Benefits Agency would be responsible for estimating the costs of those programs and tracking their success.

The CompStat Model—Local Responsibility for Medicare’s Performance

Under the CompStat model, Medicare would divide the United States into approximately 150 local Medicare administrative areas, each with its own Medicare medical director and administrator. The goal of the CompStat system is to allow Medicare to adjust and evolve to fit local needs, and then, via comprehensive information on local successes and failures, encourage Medicare officials in all parts of the country to mimic programs that work and avoid ideas that don’t.

In cooperation with national Medicare officials and the Congressional Health Benefits Agency, local Medicare officials would have the authority to launch care management programs or other benefit initiatives that were “budget neutral” (that is, they would not raise Medicare’s overall spending) over the 10-year federal budget horizon. In some cases, the budget neutrality determinations could also include federal costs or savings from the impact of local Medicare initiatives on other programs, such as Medicaid.

Therefore, the current legislative authority for budget-neutral “demonstration projects” for disease management programs in Medicare would be clarified and expanded. However, the operation of the programs would become more localized, with local Medicare officials in place across the country to organize and oversee them. And for the first time, the new congressional oversight agency would allow Congress and the public to evaluate and compare

the programs and methods used by local Medicare officials within their jurisdictions.

Under the CompStat-style system, local Medicare officials would be rated on the performance of Medicare in their areas, including the quality of and access to care received by patients in the fee-for-service system, and the availability and quality of Medicare+Choice plans.

Medicare and the new Congressional Health Benefits Agency would assess the local officials' progress relative to their peers and to performance benchmarks for health quality and improvements in health outcomes. Those evaluations and the raw data on Medicare's performance would be available to the public and Congress, as would the local officials' plans for improvement. The local Medicare officials would be accountable for improvements in specific measures, such as reductions in hospitalizations for patients with chronic diseases and emergency room visits for preventable illnesses.

Of course, the local officials would not be given large-scale price setting authority—Medicare's main price controls would still be decided by Congress and implemented nationally. However, local officials could submit proposals for budget-neutral adjustments to coverage parameters or smaller-scale payment rules that fit local needs. Likewise, the local officials would not assume primary regulatory authority over hospitals, doctors, private health plans, or other health care providers from the national Medicare administration. That could lead to inefficiencies, like requiring hospital chains or private health plans to set up different computer systems for quality assurance in every area they served.

Even without regulatory authority over health providers, however, the local Medicare officials would have powerful tools at their disposal to improve health care. With a CompStat-style information sharing system, the local officials would be conduits for knowledge on how to best take care of patients, especially those with chronic health conditions. Discovering what works, and spreading that information to patients and health providers, is often the fastest and best way to improve health quality.

The presence of Medicare officials at the local level would help health providers navigate the national Medicare bureaucracy and resolve disputes with Medicare's payment contractors, which are called carriers and intermediaries. The local Medicare officials would work with health plans and providers, educational institutions, the news media, and seniors' groups to improve health quality and help seniors make the choices that best reflect their individual health needs. Local Medicare officials would have a "bully pulpit" from which to prod local health providers and patients to do the right thing.

As the local Medicare offices are ramped up, Medicare should shrink its national bureaucracy. In particular, Medicare's central office of "research and demonstrations" should be scaled back to reflect the establishment of local CompStat systems. Since more experimentation and program innovation would be done in the field by the new local Medicare offices, the need for a large national bureaucracy would be diminished.

Congressional Oversight and Analysis

Congress will not approve new responsibilities and flexibility for Medicare administrators without a much-improved oversight system. A small new Congressional Health Benefits Agency—with perhaps 50 or fewer employees—would evaluate Medicare's performance at the national and local levels. The agency would place special emphasis on evaluating Medicare's progress toward improving measures of beneficiaries' health, not just the program's costs. It would provide rapid analysis of coverage adjustments or care management proposals advanced by local Medicare officials—including estimates of whether or not the proposals would be budget neutral—and would track the cost and effectiveness of ongoing initiatives.

The Congressional Health Benefits Agency would have access to all data within the Medicare program, including all payment data from carriers and intermediaries, and all local officials' information about local initiatives. Despite its oversight role, the congressional agency would make it *easier* for local Medicare officials to launch care management programs

and other initiatives. For practical purposes, having agreement in advance from the congressional agency on the likely health effects and budget neutrality of their initiatives would greatly aid local Medicare officials, and make any subsequent congressional oversight much less contentious. Likewise, local initiatives that were not sent to Congress for analysis, or for which the congressional agency disagreed with Medicare about the likely effects, would be “red flags” for heavy congressional oversight and scrutiny. Local and national Medicare officials would have very strong practical incentives to cooperate with the new congressional agency.

The Congressional Health Benefits Agency would be formed on the model of the Joint Committee on Taxation or Congressional Budget Office, with a nonpartisan analytic staff of economists and health care experts. Its responsibilities would not overlap with those of the Medicare Payment Advisory Commission (MedPAC), a congressionally chartered commission that reports on Medicare’s large-scale price control processes.

Benefits

Nothing more graphically illustrates Medicare’s resistance to innovation than its lack of prescription drug coverage. Yet the worst mistake Congress could make would be to simply tack on a new drug entitlement to Medicare without linking it to quality improvements, performance measures, and the discipline of consumer choice. That would be a formula for uncontrollable costs and widespread misuse of drugs.

Given today’s fiscal and political constraints, Congress should begin with a basic drug benefit that has three components: 1) guaranteed, zero-premium coverage for high drug expenses (Medicare would pick up 80 percent of seniors’ drug costs over a high deductible, perhaps \$4,000 or \$5,000 a year); 2) subsidies for low-income seniors to help cover their drug costs below that threshold; and 3) discounts for all seniors on premiums for private health plans that offer

additional drug coverage (below the high deductible), including a new form of Medigap coverage.

By its nature, a universal, high-deductible drug benefit would be a catalyst for linking Medicare benefits, not further separating them into uncoordinated pieces. First, a universal benefit would provide local Medicare medical directors and administrators with comprehensive, real-time data on all seniors’ total drug purchases. (The drug insurance plans and discount card plans would supply that information to Medicare so that the program would know when seniors’ spending hit the deductible and the Medicare benefit would kick in.) With that information, Medicare would be able to alert health care providers and insurance plans to harmful drug interactions and other potential quality shortcomings in seniors’ care. For example, with comprehensive data, Medicare might discover that seniors in one area had twice the tendency to fill multiple prescriptions that were potentially dangerous in combination. Likewise, Medicare researchers might learn that seniors in some areas with certain diagnoses were not getting the proper medications. Local Medicare officials could use that information to target areas in need of professional and patient educational programs and comprehensive care management efforts.

Second, a universal, high-deductible drug benefit would encourage private health plans to offer comprehensive coverage to Medicare beneficiaries. The universal drug benefit would serve as a backstop benefit for every other type of coverage seniors might have—in health insurance terms, the Medicare benefit would be the “primary payer.” That would help HMOs (which serve many low-income Medicare enrollees in urban areas) stay in Medicare as an option, and it would help employers maintain their retiree health benefits. It could help encourage PPOs that have out-of-network coverage (like many Blue Cross plans) to join Medicare and offer coverage, especially in rural areas that HMOs cannot serve.

A Universal, Zero-Premium, High Deductible Drug Benefit

The universal drug benefit would go to all Medicare beneficiaries, without an additional premium or increase in the current “Part B” premium. The universal drug benefit would cover 80 percent of the cost of drug purchases over the deductible, and the deductible would presumably be set at a high level, such as \$4,000 or \$5,000, because of federal budget constraints.

▶ **A drug benefit based on drug spending from all sources, not just out-of-pocket spending.** Unlike the benefits in many congressional proposals, which would only count seniors’ out-of-pocket spending toward proposed Medicare drug benefits, PPI’s universal drug benefit would kick in when seniors’ total drug spending hit the deductible, regardless of whether or not the beneficiary paid out of his or her pocket or had additional insurance coverage underneath the deductible. Therefore, the universal benefit would essentially be a backstop for any other drug coverage seniors had; that is, the Medicare benefit would be the primary payer for drugs once the deductible was met. That would save money for state Medicaid and drug assistance programs, certain employment-based retiree insurance plans and Medigap plans, and Medicare HMO or PPO plans that offered generous or uncapped drug coverage.

▶ **Coverage through existing insurance plans.** Seniors would have several options for their basic drug coverage. If an enrollee chose (or already had) drug coverage through a Medicare HMO or PPO, retiree plan, state-based plan, or Medigap plan, in most cases that plan would simply cover the new Medicare benefit. Drug cards issued by those plans would be designated a seniors’ official Medicare drug card and would get a Medicare logo; Medicare would reimburse the plans for the cost of benefits (80 percent of spending above the Medicare drug deductible).

▶ **Coverage via discount cards.** Enrollees without other forms of drug coverage would choose a drug card plan from among several new Medicare contractors, which would com-

pete for enrollees based on discounts for drug purchases before the deductible was reached, and then would provide the universal Medicare benefit above the deductible. Medicare would give those contractors some financial incentives for efficient performance and services, but Medicare, not the contractors, would take most of the risk for the cost of benefits above the deductible.

▶ **Equivalent coverage.** Health plans offering the universal, high-deductible benefit to Medicare beneficiaries would not have to strictly pay 80 percent for drug spending above the deductible—equivalent cost sharing methods could be used, such as fixed-dollar or “tiered” copayments (for example, \$5 for generic drugs, \$10 for preferred brand-name drugs, and \$20 for non-preferred, brand-name drugs). Medicare would be the judge of whether or not alternative coverage options were equivalent to 80 percent coverage as part of its approval process for any plan offering Medicare’s universal drug benefit.

▶ **Medicare approval and coordination with plans offering universal, high-deductible benefit.** To pay benefits properly, plans offering Medicare’s universal, high-deductible drug benefit would have to keep track of all drug spending by seniors enrolled in their plans. Seniors would use their Medicare drug card for all their prescriptions, regardless of where or when they were filled. They could still use discount-only cards (which are currently offered by several pharmaceutical companies) for drug purchases, but they would use their Medicare card too, to keep track of their level of spending. Otherwise their drug spending would not add up toward the deductible, and their Medicare benefits would never kick in.

Although most employers providing retiree coverage and private Medigap plans would jump at the chance to cover Medicare’s universal drug benefit—they could do so for free with Medicare paying the cost—they would not be required to do so. Moreover, Medicare would not be required to accept the applications of plans that did not provide sufficient discounts, educational or additional services, financial standards, or quality control measures.

All plans offering the Medicare benefit would be required to transmit day-to-day drug spending data to Medicare as a condition of their approval as a Medicare benefit provider and to get reimbursement from Medicare for the cost of the benefit. Paper-based claims would not be allowed or reimbursed.

► **Complete information on drug spending.** Comprehensive, real-time information on drug spending could be a catalyst for many important reforms in Medicare. For example, information on drug spending would directly feed into the new CompStat-style management system. Medicare should know whether seniors in certain parts of the country have higher-than-expected drug bills, or miss out on drugs known to prevent expensive and deadly diseases. Publishing and acting on that information community by community would improve health outcomes—that is the heart of a CompStat-style management system. Similarly, Medicare should know if doctors in some areas always prescribed high-priced drugs when lower-priced alternatives are often just as good or better. Complete data on patterns of drug prescribing would also be available for researchers to compare against quality benchmarks or best-practice standards. Targeting education initiatives at doctors could save lives and save money, for seniors and taxpayers.

Drug information could even help save Medicare's troubled HMO program, which is called Medicare+Choice. HMOs currently have the sharpest incentives to provide comprehensive care management to Medicare beneficiaries. However, a problem in the Medicare+Choice program is the lack of a trusted, convenient, and accurate method of adjusting payments to HMOs or PPOs based on the relative healthiness or "risk" of their enrollees. Drug spending information would be available in real-time—that should be the foundation of a new "risk-adjustment" method. Certain patterns of prescription drug usage are highly correlated with health risks.

Extra Benefits for Low-Income Beneficiaries

On top of the universal high-deductible drug benefit, PPI proposes additional subsidies for

low-income beneficiaries whose incomes are too high to make them eligible for Medicaid, but are still too poor to afford a Medigap plan or Medicare+Choice coverage from an HMO or PPO to get fuller benefits below Medicare's high-deductible coverage.

The federal government would expand drug coverage for seniors with incomes below approximately 150 percent of the federal poverty line. The coverage itself could take several forms. For example, qualifying beneficiaries could be eligible for free or deeply discounted New Medigap or Medicare+Choice coverage. Alternatively, qualifying beneficiaries could receive extra benefits through the Medicare discount and universal benefit cards.

Local Medicare and Social Security offices would process applications for the extra drug coverage, and would perform the necessary income determinations. Unlike state-based programs for low-income Medicare beneficiaries, which often have a stigma of welfare and therefore enroll fewer seniors than would otherwise be the case, a Medicare-run system would be likely to expand the benefits of a very high fraction of low-income seniors. Seniors could also use web-based and other electronic methods to apply for extra benefits.

Premium Discounts for Enrollees in New Medigap Plans

Many beneficiaries supplement their fee-for-service Medicare benefits with Medigap supplemental coverage. Medigap plans that cover the coinsurance and deductibles required by Medicare's hospital and outpatient benefits are especially popular. However, Medigap plans with drug benefits have a severe problem with an insurance phenomenon called "adverse selection." That is, only people who know they are likely to have high drug expenditures purchase the coverage, and therefore premiums for Medigap plans with drug benefits are extremely high.

To help solve the problem, PPI proposes a new form of Medigap that would cover drugs plus other gaps in Medicare's fee-for-service benefits. New Medigap plans would automatically cover the universal, high-deductible drug benefit, and would also be required to have ad-

ditional drug benefits with a value of at least \$800, plus benefits to fill in some of the coinsurance and deductibles for Medicare's hospital and outpatient benefits. Because New Medigap plans would cover hospital and outpatient services in addition to drugs, they would have at least some incentive to offer rudimentary patient education programs or care coordination programs that could cost more in areas like drug spending, but save money in reduced hospitalizations or outpatient care.

Unlike current Medigap plans, New Medigap plans would be required to collect at least some beneficiary coinsurance or copayments to help keep premiums down—absolute “first-dollar” coverage (literally benefits that begin with the first dollar of health spending) would not be allowed except in cases where collecting copayments would be inefficient or medically inappropriate.

Seniors enrolling in New Medigap plans receive discounts off the enrollee premium. The premium subsidy would be \$240 a year toward the premium for New Medigap plans that had additional drug benefits worth at least \$800 (on an actuarial basis). The subsidy amount would be indexed higher over time.

The combination of broad coverage of the gaps in Medicare's benefits, including drugs, the convenience of the Social Security check deduction of the premium, and the \$240 annual subsidy should allow New Medigap plans to avoid or at least minimize adverse selection problems, and therefore provide good coverage at reasonable rates.

Premium Discounts for Enrollees in HMO or PPO Plans With Extra Drug Benefits

All HMOs and PPOs in the Medicare+Choice program would be required to cover the high-deductible drug benefit, and would be reimbursed by Medicare for the cost. Medicare+Choice plans with *additional* drug benefits would be eligible for the same premium discounts available to enrollees purchasing New Medigap coverage: \$240 toward the premium for a Medicare+Choice plan that had additional drug benefits worth at least \$800 a year, or \$120 toward the purchase of a plan with drug benefits worth at least \$400 dollars.

Choices

The basic problem with Medicare today is that it lacks the capacity to evolve. Its benefits, fixed in law by Congress, have lagged behind those provided most Americans in private insurance markets. What is essential now is to build into Medicare the capacity for continuous innovation and improvement. Placing Medicare administrators and medical directors “on the ground” in all parts of the country, and adding more modern benefits like drug benefits are the first steps. Next, we should finally give all Medicare beneficiaries a genuine choice between the traditional fee-for-service system and private health insurance options.

Medicare's participating HMOs have unquestionably prodded the program toward modernization. For example, Medicare HMOs flourished in the mid-1990s by offering drug benefits. Eventually, Congress noticed that the private health plans were filling an important need, especially for poor seniors in urban areas, and at least began debating broader drug benefits in Medicare.

PPI proposes to establish a new “Medicare Menu” that would allow seniors—including those who live in rural areas—to have a range of choices of private health plans, and a convenient place to see a list of their coverage options. In particular, seniors living in rural areas that HMOs do not serve would be able to choose a PPO for comprehensive benefits, or the New Medigap coverage for drugs and other benefits to supplement their fee-for-service plan.

Medicare Choice Menu

PPI believes that all private health plan options, including HMO, PPO, and New Medigap plans should be available for purchase through a standard Medicare Menu, with any premiums deducted from the beneficiaries' Social Security checks (as most Medicare Part B premiums are deducted today). That would facilitate beneficiary awareness of the new options, and help encourage private plans to offer alternative and supplemental coverage in Medicare.

Seniors without supplemental coverage would choose a discount card and catastrophic

drug coverage plan through the Medicare Menu. The discount card plans would have no premiums, of course, but their presence on the menu would highlight for beneficiaries that they can choose the plan that best suits their needs. Plans would compete based on discounts offered—some might offer greater discounts for some types of drugs than others, and all could offer extra services or benefits to attract enrollees (subject to Medicare approval).

Finally, comprehensive care management programs for seniors with particular health conditions or multiple chronic illnesses would be publicized and offered through the menu system. The PPI proposal would encourage Medicare's local administrators to develop (or facilitate the private development of) disease management or care management programs for enrollees with chronic conditions. Under these programs, beneficiaries could be given better benefits for structured preventive care or coordinated collaborative care of chronic illness in exchange for using specific health providers or hospitals that specialize in helping patients with particular health conditions, and that consistently report and achieve best outcomes. Local or regional Medicare administrators would approve disease or care management entities, publicize them on the local Medicare Menu, target outreach programs based on regional and (possibly) individual drug spending data, and oversee the health results and any cost savings. The Congressional Benefits Agency would oversee the results of these programs for Congress.

Risk Sharing with HMOs and PPOs

Under the Medicare+Choice program, HMOs accept a flat payment from Medicare and are financially at risk for providing full coverage to seniors who enrolled in their plans. The HMO program expanded rapidly in the 1990s, but under pressure from budget cuts, a hostile political environment, and an increasingly needy roster of enrollees, HMOs are currently dropping coverage and benefits. Many have ceased offering coverage in large areas, or dropped out of Medicare entirely.

Meanwhile, PPOs and looser forms of managed care now dominate the market for employment-

based coverage. But the Medicare+Choice program is still geared to HMOs, and Medicare beneficiaries do not have PPO options to choose from.

Probably the most important factor preventing private health plans from entering or staying in the Medicare+Choice system is risk of enrollees having catastrophically high expenses; therefore, Medicare should offer a risk sharing or reinsurance protection (at subsidized rates for the first several years) to new PPOs and HMOs joining Medicare. The risk sharing program should be roughly budget neutral—after all, if riskier-than-average beneficiaries surged from the traditional fee-for-service program into a private health plan, triggering extra reinsurance payments, then the fee-for-service program would presumably save a similar amount because its remaining enrollees were relatively less risky.

Medicare administrators recently announced a new demonstration program that would create risk sharing arrangements with PPOs that began offering comprehensive coverage to certain Medicare beneficiaries. This is exactly what Medicare needs, and at the first opportunity, Congress should expand the demonstration nationwide, and include HMOs.

Advantages of the ABC Proposal

Most of the Medicare drug proposals currently in Congress—including Republican, Democratic, and the “tripartisan” proposals—would create a separate “stand-alone,” drug-only coverage option, which beneficiaries could purchase for an extra premium. The presence of an extra premium causes a common problem—unless the premium is quite low, only those beneficiaries with high drug expenses would be sure to purchase the coverage. This is the same sort of adverse selection problem that plagues current Medigap and Medicare+Choice plans that have drug benefits. Seniors often know with great precision how much their drug spending will be when they enroll in a health plan. When beneficiaries face a choice of whether or not to purchase drug coverage as an add-on to their regular benefits, they will only do so if the premium is lower than the expected drug expenses that would be covered.

One way to address the adverse selection problem in a stand-alone drug benefit is to charge low premiums and offer first-dollar benefits, or at least very generous coverage with only a very small deductible. Low premiums and first-dollar coverage would indeed induce many beneficiaries to purchase coverage, not just those with high drug costs. However, providing a Medicare benefit with low premiums and first-dollar benefits can be very expensive for taxpayers, and could end up replacing coverage that many beneficiaries already have. A generous benefit package—such as those that workers with employment-based insurance often have—could cost over \$1 trillion dollars over the next 10 years and trillions more in the following decades. On the other hand, a stand-alone drug benefit with a premium to pay and a meager or unusual benefit package—such as those with “doughnut holes” (internal gaps in the benefit) proposed by Republicans in Congress—would probably not work at all, either because of adverse selection or the disruption of employment-based retiree coverage. Those sorts of proposals were designed more for short-term political appeal than for functionality in the real world.

PPI’s zero-premium, universal approach to Medicare drug benefits, with additional help for low-income seniors and premium discounts for other seniors purchasing additional drug benefits, is both affordable and realistic. The cost of the PPI Medicare proposal is scalable, based on the budget funds available. If the budget allows, the deductible could be set lower; if not, the deductible could be set at a very high level.

Of all the current proposals, the PPI plan would work best and disrupt seniors’ current coverage least. It would enhance seniors’ current coverage, not force them to choose whether or not to switch to a new stand-alone plan that might not work. It would reinforce current coverage offered by employers and states, rather than create a poor substitute.

Although PPI’s high deductible drug benefit would be small (most seniors do not have drug costs as high as \$4,000 or \$5,000 a year), it would not have adverse selection problems or other workability concerns inherent in the main congressional proposals.

Even with a high deductible, PPI’s universal Medicare drug plan has the potential to greatly enhance the quality of seniors’ health care, help prevent adverse drug reactions, initiate some beneficial links within Medicare’s fee-for-service program, and spark care management efforts that would pay off in the years to come.

Conclusion: A New Approach to Medicare Reform

The original vision of Medicare reform—which stemmed from the bipartisan “Breux-Thomas” Medicare Commission’s work in 1998 and 1999—included a robust menu of private health plans competing for enrollees with an updated version of Medicare’s traditional fee-for-service program. Both the private health plans and the updated fee-for-service plan would have complete sets of benefits—without gaps—so that supplemental coverage would not be required. Under the original Medicare reform proposals, private plans would be rated on outcomes, not processes, and the updated government-run fee-for-service plan would operate with considerably less interference and micromanagement from Congress. Prescription drugs, of course, would be standard coverage in all plans.

The main principles behind the original vision of reform were complete benefits and real competition. Complete or integrated benefits create the incentives for proper disease and care management, patient self-help, and efficiency. Competition and consumer choice allows seniors to express their preferences and helps keep costs under control.

Although adding drug benefits costs money, in the long run, modern benefits, choice, competition, and the disclosure of health outcomes will help keep the growth of Medicare spending within reason. Moreover, a healthy rivalry between private and public health plans will force Medicare’s benefits and systems to evolve by more quickly spotlighting the sorts of benefits seniors need and the methods of health insurance and health care that work.

The new Medicare proposal in this report represents a big step in the direction of that original vision of comprehensive Medicare reform. The

CompStat system will start the process of reforming and updating the fee-for-service program. The universal high-deductible drug coverage begins the necessary benefit improvements, and also helps link (if not fully integrate) benefits across health plans. The Medicare Menu provides a real and legitimate place for private health plans in Medicare. Even the New Medigap plans—a new form of supplemental coverage—would have greater linkages between benefits and stronger incentives for rudimentary care management.

The U.S. health system is moving toward continuity of health care, including disease management and monitoring, outcome-based performance measurement and quality

improvements, and patient education and self-help. The broad distribution of health information to people who can use it to keep themselves well, linked to a continuously improving, outcomes-based, coordinated care management system—supported by strengthened relationships, communication, and trust between people and health professionals—is key to healthy aging. PPI's proposed ABCs of *accountability* and performance-based management, modern drug *benefits*, and widespread *choices* of coverage, would reposition Medicare as a national leader for health insurance quality, efficiency, and effectiveness, and would steer the program toward linked health benefits, comprehensive care management, and healthy aging.

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