

Payment Rates

Under the Administration's proposal, payment rates would be the same as those paid to PMPs--95 percent of AAPCCs. As with PMPs, there is concern that biased selection of healthier enrollees would increase Medicare's costs--paying more in voucher amounts than voucher enrollees would have cost in the standard Medicare program. As discussed above in the section on PMPs, refinement of the AAPCC could help to reduce, but would probably not eliminate, insurers' incentives to seek out only healthier enrollees.

Assignment

Assignment, and the share of costs paid out-of-pocket by enrollees, is a concern whenever services are rendered in the fee-for-service sector. Under the voucher proposal, just as in the standard Medicare program, there would be no limit on out-of-pocket costs for individual enrollees. Qualified plans would need to show only that their enrollees would pay no more out-of-pocket (excluding premium costs), on average, than those in the standard Medicare program. To accomplish this, plans would likely have to obtain participating agreements with physicians at rates similar to those obtained by Medicare. Under the proposal, there would be no restriction on the supplemental premiums (above the voucher amount) that insurers could charge; the voucher system would rely instead on competition to limit premiums. If the total premium charged by an insurer was much greater than the expected value of the benefit package, Medicare enrollees would likely choose another private insurer or return to the standard Medicare program.

Quality and Volume Controls

Federal determination of actuarial equivalence before qualifying plans to participate in the voucher program would provide some protection to enrollees who chose to use the voucher option, facilitating comparison among competing private insurers and between private insurers and Medicare. Obtaining accurate information on out-of-pocket costs for some items could be difficult, though, making the determination of actuarial equivalence problematic. Further, enrollees choosing the voucher option could be committed to their choice for a full year before being permitted to switch plans or return to the Medicare program, with adverse consequences for enrollees in unsatisfactory plans in the interim.

Excessive use of services by enrollees using the voucher option would not be a federal concern. So long as payment rates were not overly generous, plans would have incentives to limit volume through utilization

review. Problems could arise, though, if some plans imposed such stringent controls that medically necessary services were delayed or unavailable.

CARRIER CAPITATION

Enrollment in prepaid medical plans is unlikely to become the dominant form of care for Medicare enrollees so long as they are free to choose between capitated or fee-for-service care. The proposed Medicare voucher would likely be used primarily (at least initially) by the minority of enrollees whose previous employers provide group health benefits to annuitants. Carrier capitation has been suggested as a way to get the advantages of a capitated payment system that would cover all enrollees, without making PMP enrollment or the proposed voucher option mandatory.

Under a carrier capitation system, one organization could be selected to serve as the Medicare carrier for each geographic area, such as a state. In contrast to the responsibilities of current Medicare carriers, though, this organization would not only administer Medicare claims payments but would also be at risk for providing the Medicare benefit package to all Medicare enrollees living in its jurisdiction. In effect, the federal government would buy the Medicare benefit package on behalf of all enrollees in the jurisdiction at a fixed per capita price from a single underwriting agency. (A residual Medicare program would have to be available in the event that no agency was willing to take the area on a capitation basis, however.) ^{17/}

The carrier capitation approach would be similar to an areawide IPA that served all Medicare enrollees. The carrier would assume responsibility for deciding how and how much to pay physicians who treated Medicare enrollees. Carriers would have financial incentives to negotiate discounts from physicians and other providers, and to implement stringent utilization review programs. The federal role would be changed to one that required it to award capitation contracts, monitor enrollees' access to and quality of care, and evaluate the performance of carriers under contract. Some analysts are concerned about the substantial market power this approach would give the carriers selected. Although market power could enable carriers to obtain substantial discounts from health care providers, it could also be used to eliminate competitors for future Medicare capitation contracts. Another major concern is how to implement effective monitoring for access to and quality of care.

17. Ira Burney and others, "Medicare Physician Payment, Participation, and Reform," *Health Affairs*, vol. 3, no. 4 (Winter 1984), pp. 5-24.

Unit of Payment

The unit of payment to carriers would be the Medicare enrollee, and payments would be made for all enrollees in the carrier's jurisdiction. Physicians might continue to treat Medicare enrollees on a fee-for-service basis, however, depending on arrangements made by carriers, since carriers might establish a variety of plans from which enrollees could choose.

The capitation payment to carriers could cover all Medicare services, or only SMI services. Because the principal savings in prepaid plans come through reduced hospitalization, a capitated payment system that did not cover HI services might generate little or no savings over the fee-for-service alternative. In fact, costs might increase. Unless both HI and SMI services were covered by the capitated payment, carriers would have incentives to induce physicians to shift patient care to the hospital in some cases where it was unnecessary--so that carriers would be liable only for the costs of physicians' services and not for facility, nonphysician personnel, or medical supply costs. This incentive would work in tandem with hospitals' incentives under the prospective payment system to increase admissions, especially for uncomplicated cases, and would intensify the need for PRO review to prevent unnecessary hospital admissions.

A capitated payment for both HI and SMI services would not require dismantling of the prospective payment system for hospital services, although dismantling might be permitted in some areas if carriers wanted to replace it with an alternative payment system for hospital services. If the PPS were continued, the intermediaries who administer hospital reimbursements under Medicare could bill carriers for Medicare's share of costs.

Some analysts argue that HI services should be excluded from the capitated payment, because the financial risk assumed by carriers would be reduced. Given the lower risk, more organizations might be willing to compete for capitation contracts, and the risk premium that Medicare would likely have to pay under this approach could be smaller.^{18/} If only SMI services were included in the capitated payment, carriers' incentives to shift care to hospitals could be reduced by incorporating offsetting incentives to control the rate of hospitalization in Medicare's contract provisions with carriers. The offsetting incentives might, for example, be bonuses paid by Medicare to carriers whose Medicare admission rates (adjusted for characteristics of the carriers' Medicare population) were below the national average. This option would be preferable to a capitated system for both HI

18. Stanley S. Wallack and Elizabeth C. Donovan, "Capitating Physician Services Under Medicare" (Brandeis Health Policy Research Consortium, Waltham, Massachusetts, January 1985).

and SMI services if the cost of the bonuses was more than offset by savings from reduced risk premiums required by carriers.

Payment Rates

Payment rates to carriers would be intended to cover the costs per enrollee of providing the Medicare benefit package to all enrollees in each carrier's jurisdiction. Carriers would establish payment methods and rates for physicians and other providers in their jurisdictions, subject to conditions specified by the federal government. An advantage of the carrier capitation approach is that problems arising from biased selection of enrollees would be reduced, since all enrollees in a carrier's jurisdiction would be covered. These problems would not be eliminated, however, unless only a single health plan was offered in each jurisdiction.

One option for setting carrier capitation rates would be to set initial rates at the AAPCCs computed for each area, and then to update these rates each year based on an index of costs (such as the Medicare Economic Index) or of national income (such as gross national product). Over time, differences across regions in AAPCC rates for each type of enrollee might be modified to reflect differences in living and practice costs across regions but to reduce or eliminate differences caused by variations in practice patterns. This approach might not adequately account for changes in medical technology, though, or for imbalances between the supply of physicians and the Medicare population in some areas.

Because carriers would be assuming financial risks currently borne by the federal government for Medicare enrollees, some risk premium above administrative costs would be required in addition to the estimated cost of providing health care services for the Medicare population. The premium required to induce agencies to apply for carrier contracts would generally be smaller if carriers were given greater latitude in restructuring the health care delivery system in their jurisdictions. The risk premium could also be reduced if the federal government shared the risk with carriers by limiting both profits and losses for carriers. For example, costs that were 5 percent or more above a carrier's capitation payments could be assumed by the federal government, and carriers whose costs were below their capitation payments could be required to refund profits in excess of 5 percent. Experience with carrier-at-risk Medicaid programs in California and Texas indicate that even limited risk-sharing can induce effective efforts by carriers to control costs. 19/

19. Wallack and Donovan, "Capitating Physician Services Under Medicare."

Assignment and Other Conditions Related to Access

The federal government could specify a uniform model for health care delivery to be implemented by all carriers, or it could permit carriers to structure their own delivery systems subject to meeting certain specified conditions related to physician participation and out-of-pocket costs for enrollees. Under the latter approach, a number of different programs would evolve in place of the current nationally uniform Medicare program.

One option might be to require that carriers implement an areawide preferred provider organization (PPO) for all Medicare enrollees who do not elect to enroll in prepaid medical plans. (A PPO is a consortium of physicians and perhaps other health care providers who have agreed with an insurer to treat its enrollees at negotiated prices, generally discounted from usual charges.) To assure enrollees' access to care at reasonable out-of-pocket costs, Medicare could require that carriers obtain participation agreements from at least some specified proportion of physicians in each specialty for each locality in their jurisdictions. With the market power of the Medicare population, carriers might be able to obtain substantial discounts on fees from physicians and other providers in the area, although this possibility is untested as yet.

An alternative approach would require carriers to offer Medicare enrollees a choice of options, including the current fee-for-service Medicare package, enrollment in PMPs, and enrollment in PPOs. Again, federal specifications about minimum physician participation rates would be desirable to ensure enrollees' access. This approach would preserve the current Medicare package for enrollees who would prefer it, while expanding their choices to include PPOs and other managed care systems as well. Offering these choices could be confusing for enrollees, however, and difficult for carriers to implement.

Quality and Volume Controls

Under the carrier capitation approach, the major concern for the federal government would be to ensure that carriers were providing at least the minimum package of Medicare benefits to enrollees while keeping their out-of-pocket costs within reasonable limits. Controlling excessive volume would be the carriers' concern. In fact, the principal effect of the carrier capitation approach would likely be to provide carriers with strong financial incentives to implement effective utilization review systems. Medicare, however, might get the same benefits from utilization review through regulatory requirements on carriers under the current system.

APPENDIXES





APPENDIX A

FOREIGN HEALTH CARE SYSTEMS

This appendix discusses financing and delivery of health care in the United States and in four other countries--Canada, the Federal Republic of Germany, the United Kingdom, and Sweden. These four countries were selected for comparison for several reasons. First, they are wealthy industrialized countries like the United States. Second, they provide two contrasts to the United States' mixed public/private health care system: in Canada and West Germany, most of the population is covered by comprehensive public insurance, but the health care delivery system is largely private and similar to that of the United States; in the United Kingdom and Sweden, most health care is provided through a national health service so that both financing and delivery are public.

COMPARISON OF HEALTH CARE SYSTEMS

The U.S. health care system is unusual among industrialized countries: first, because there is no comprehensive public provision for health care; and second, because third-party payers, both public and private, historically have tended to be passive, accepting charges by providers with little effort to negotiate better rates or lower utilization. Only recently have third-party payers in the United States begun to reconsider the blank-check approach to reimbursing providers of health care. In Canada and West Germany, public insurers negotiate rates of reimbursement with private-sector providers, monitor utilization, and control capital expansion. In the United Kingdom and Sweden, most health care is delivered through their national health services, which pay physicians and which own and operate hospitals. (See Table A-1 for a summary comparison of these countries.)

Among the countries selected for comparison, the United States has the smallest percentage of the population covered by public insurance--

TABLE A-1. COMPARISON OF HEALTH CARE SYSTEMS,
SELECTED COUNTRIES

	United States	Canada
Characterization of System	Mixed public and private	Comprehensive public insurance
Delivery System	Mostly private	Mostly private
Coverage for Basic Health Care	20 percent public insurance, a/ 65 percent private insurance, 15 percent without coverage	99 percent public insurance, 1 percent without coverage
Number of Third-Party Payers	Many	One in each province
Cost-sharing by Patients for Covered Services	Considerable	Nominal
Percentage of All Health Care Costs Paid Out-of-Pocket by Patients b/	27	N.A.
Physicians' Reimbursement	Primarily fee-for-service payments based on physicians' charges	Negotiated fee schedules
Hospital Reimbursement for Operating Expenses	Varies by payer; payment often based on reported costs or charges	Global budgets

SOURCE: Congressional Budget Office from data provided in American Medical Association, *International Lessons: Medical Societies and Health Policy* (AMA, Chicago, Illinois, 1984); Robert J. Maxwell, *Health and Wealth* (Lexington, Massachusetts: Lexington Books, 1981); and Uwe E. Reinhardt, "The Compensation of Physicians: Approaches Used in Other Countries," HCFA Grant No. 95-P-97309/2 (Princeton University, Princeton, New Jersey, 1985).

TABLE A-1. (Continued)

West Germany	United Kingdom	Sweden
Comprehensive public insurance	National health service	National health service
Mostly private	Mostly public	Mostly public
93 percent public insurance, 7 percent private insurance	100 percent public	100 percent public
Many, but strong national guidelines since 1977	1	One in each locality
Nominal	Nominal	Nominal
12	6	8
Negotiated fee schedules for ambulatory care physicians, salary for hospital-based physicians	Salary (or limited form of capitation for primary care physicians)	Salary
Negotiated per diem rates	Global budgets	Global budgets

NOTE: N.A. = not available.

- a. The proportion of the population eligible for Medicare or Medicaid benefits.
- b. Does not include premium payments for insurance. These data are for 1975, the latest available for all countries. The corresponding figure for the United States was 28 percent in 1984.

about 20 percent, compared with 93 percent or more for other countries. ^{1/} Further, the United States has the largest percentage of the population without insurance coverage for basic health care. About 15 percent of the population is without coverage at some time during the year, compared with less than 1 percent for other countries. According to the National Center for Health Services Research, nearly 10 percent of the U.S. population is uninsured throughout the year. ^{2/}

Nearly 30 percent of all health care costs are paid out-of-pocket by patients in the United States, because of a combination of substantial cost-sharing on services covered by insurance, services that are not covered by insurance for any significant part of the population (such as long-term care), and population groups who lack insurance even for basic care. In other countries, out-of-pocket costs are 12 percent or less of the health care total. Most out-of-pocket costs in other countries are for noncovered services-items such as outpatient drugs, dental care, and long-term care. Cost-sharing on covered services is nominal or nonexistent in these other countries.

Other countries provide virtually universal access to comprehensive health care at lower costs relative to gross domestic product (GDP) than the United States (see Table A-2). ^{3/} In 1982, total health care costs in the United States were 10.6 percent of GDP, compared with 8.2 percent in Canada and in West Germany. Health costs were 9.8 percent of GDP in Sweden and only 5.9 percent of GDP in the United Kingdom. Costs relative to GDP were highest in the United States despite the relatively low proportion of the population that is aged--a group with typically large health care needs (see Table A-3). Costs relative to GDP were lowest in the United Kingdom, which has a high proportion of population age 60 or older.

Part of these cost differences may reflect differences in access to and quality of care across countries. Although it is difficult to assess quality

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1. In Germany, health care is financed primarily from employer/employee contributions instead of general revenues, as in the United Kingdom and Sweden. Nevertheless, these contributions are treated as public health insurance since they are mandatory and hence equivalent to a tax. The same is true in some of the Canadian provinces, and for Hospital Insurance under Medicare in the United States.
 2. Pamela J. Farley, "Who are the Underinsured," *Milbank Memorial Fund Quarterly*, vol. 63, no. 3 (Summer 1985), pp. 476-503.
 3. GDP is a measure of domestic production, whether the income goes to domestic or foreign residents. GNP is a measure of domestic income, including income produced abroad and excluding income produced here but sent abroad. Data on GDP are more readily available in foreign countries than GNP.

TABLE A-2. HEALTH CARE SPENDING AS A PERCENT OF GROSS DOMESTIC PRODUCT, SELECTED COUNTRIES

Country	1965	1970	1975	1980	1982
United States	6.1	7.6	8.6	9.6	10.6
Canada	6.1	7.2	7.4	7.3	8.2
West Germany	5.1	5.6	8.1	8.1	8.2
United Kingdom	4.2	4.5	5.5	5.7	5.9
Sweden	5.6	7.2	8.0	9.5	9.8

SOURCE: Organization for Economic Cooperation and Development, *Public Expenditure on Health Under Economic Constraints, Part I, Expenditure Trends, Policies, and Problems* (Paris: OECD, April 1984), Table 4.

TABLE A-3. DISTRIBUTION OF POPULATION BY AGE, SELECTED COUNTRIES, 1980-1981 (In percents)

Country	Total Population (In millions)	Distribution by Age			
		0-19	20-39	40-59	60+
United States	229.3	31	33	20	16
Canada	23.9	33	33	21	13
West Germany	61.6	27	28	26	19
United Kingdom	49.2	29	28	23	20
Sweden	8.3	26	29	23	22

SOURCE: Congressional Budget Office, using data from the *United Nations Demographic Yearbook, 1981*.

accurately, some measures of access are available, including the number (per capita) of hospital beds, inpatient days, physicians, and physician visits.

These measures do not indicate that access is markedly better in the United States to account for its higher costs. The number of hospital beds per person is lower in the United States than in the other countries examined, as is the number of inpatient days per person (see Table A-4). The United States is in the middle range compared with the other countries with respect to number of physicians and physicians' visits per capita. The number of physicians' visits per capita in the two countries with national health services is relatively low. One reason for this may be that physicians paid by salary or on a capitated basis (as in the United Kingdom, for primary ambulatory care) have no financial incentives to increase the number of patients seen during the workday. Another reason may be that use of non-physician personnel for minor care is more common in national health services than in the United States.

TABLE A-4. MEASURES OF ACCESS TO HEALTH CARE,
SELECTED COUNTRIES, 1980

Country	Hospital Beds per 1,000 Population	Inpatient Days per Capita	Physicians per 1,000 Population	Physicians' Visits per Capita
United States	6.0	1.7	2.0	4.8
Canada	6.8	2.0	1.8	5.4
West Germany	11.5	3.6	2.3	N.A.
United Kingdom	8.1 ^{a/}	2.4	1.3	4.2
Sweden	14.2	4.7	2.2	2.6

SOURCE: Organization for Economic Cooperation and Development, *Public Expenditure on Health Under Economic Constraints, Part II, Statistical Annex* (Paris: OECD, April 1984).

NOTES: N.A. = not available.

a. For 1979.

Most analysts of foreign health care systems note, though, that waits for many nonemergency services are common in the national health services of both the United Kingdom and Sweden. Furthermore, in the United Kingdom, certain kinds of health care are rationed on an informal basis; dialysis for end-stage renal disease, for example, is rarely provided for people over age 55. ^{4/}

LESSONS FROM FOREIGN EXPERIENCES

The experiences of Canada and West Germany are more applicable to the United States than those of the United Kingdom or Sweden, because the latter two countries deliver health care through a national health service. In Canada and West Germany, by contrast, the delivery systems for health care are very similar to that in the United States, although the financing systems are different. Since both countries have experienced lower rates of growth in health care and physicians' costs in recent years than the United States, their control mechanisms may be of interest in the United States.

In both Canada and West Germany, physicians outside hospitals are paid on a fee-for-service basis, and patients are free to select their own physicians. The only difference in Canada from practices in the United States is that patients are limited in their access to specialists; full insurance reimbursement will be paid for visits to specialists only if the patient was referred to the specialist by a primary care physician. In Germany, as in the United States, access to specialists is not restricted, but there is a dichotomy between office-based and hospital care that does not exist in the United States or Canada. In Germany, office-based physicians must transfer their patients to hospital-based physicians when hospital care is required.

Throughout the 1970s, Canada was quite successful in constraining the rate of growth in both total health care costs and spending for physicians' services, although growth has accelerated recently (see Table A-5). Constraints on spending for physicians' services are imposed through a combination of mechanisms. First, physicians are paid according to a fee schedule, with annual increases in the schedule negotiated by representatives of physicians and of the provincial insurer. Second, constraints on volume

4. *World Health Systems: Lessons for the United States*, Committee Print 98-430, Select Committee on Aging, U.S. House of Representatives, 98:2 (May 1984), p. 16. See also Henry J. Aaron and William B. Schwartz, *The Painful Prescription: Rationing of Hospital Care* (Washington, D.C.: Brookings Institution, 1984).

increases are imposed to prevent physicians from responding to fee constraints by billing for more services. In Canada, the constraints on volume are less formal than they are in Germany (since 1977), which may account for the recent reversal in the success of efforts to contain costs in these two countries.

Both Canada and West Germany construct physician profiles from claims data to identify physicians whose billing patterns differ from the average. Those with profiles that indicate excessive use of services are notified and warned that failure either to justify or to modify these patterns will result in sanctions, such as reclaiming payments, expulsion from participation in the health insurance program, revocation of license, or charges for fraud, depending on the circumstances. Analysts believe that the monitoring system is generally effective in constraining excessive billing, even though sanctions other than reclaiming payments are rarely applied.

TABLE A-5. AVERAGE ANNUAL RATE OF GROWTH IN HEALTH CARE SPENDING AS A PERCENT OF GROSS DOMESTIC PRODUCT, 1970-1982 (In percents)

Country	Growth Rates			
	Total Health Care Spending		Spending for Physicians' Services	
	1970-1977	1977-1982	1970-1977	1977-1982
United States	2.3	3.6	2.1	4.0
Canada	0.2	2.4	-1.5	2.1
West Germany	4.9	1.0	3.9 <u>a/</u>	0.2 <u>a/ b/</u>

SOURCE: Organization for Economic Cooperation and Development, *Public Expenditure on Health Under Economic Constraints, Part II, Statistical Annex* (Paris: OECD, April 1984). Also, Health and Welfare Canada, *National Health Expenditures in Canada, 1970-1982* (Ottawa, Ontario).

NOTE: N.A. = not available.

a. Includes the services of dentists and clinics as well as physicians.

b. For 1977-1980.

In addition, the two countries impose global caps on total reimbursements for physicians.^{5/} If average practice income increases by more than the negotiated fee increase in the previous year--indicating volume increases per physician--then the insurance negotiators are less generous in the fee increase they will approve. Through this mechanism, net income for physicians in Canada fell slightly relative to the average for all workers in Canada during the 1970s. In recent years, however, physicians have become more militant about demanding large fee increases, as indicated by the reversal from declines to increases in spending for physicians' services relative to GDP (see Table A-5). As a result, spending for physicians' services as a percentage of GDP regained in 1982 the level it had in 1970. Physicians have backed their demands for greater fee increases by threatening to bill patients a supplemental charge if the insurance fee is not adequate, a practice that is discouraged by provincial insurers and that is very limited even in those provinces that permit it. Refusing to accept insured patients is not a viable option for physicians who object to fee levels in Canada, since virtually the entire population is covered by the provincial health insurance plans.

Until new legislation on cost control was implemented in 1977, the rate of increase in total health care costs relative to GDP in West Germany was high. Among the measures introduced in 1977 were controls on physicians that are similar to those used in Canada. Physicians (outside of hospitals) were already paid according to a fee schedule, but they had successfully negotiated large rates of increase in the schedule each year, and volume increases had occurred as well. Under the new controls, the central government issued guidelines limiting the increase in fees and in total reimbursements for physicians under each sickness fund (or insurer) to the increase in the earnings of the insured population; thus, in the aggregate, spending for physicians' services has remained fairly constant relative to national income. If total billings increase by more than the allowed amount, the rate of reimbursement is cut back to maintain the cap on total spending. The result is that physicians as a group have been unable to gain through volume increases, although individual physicians might increase their practice incomes relative to the group by greater-than-average billing increases. Monitoring individual physician profiles, as in Canada, helps to reduce this problem.

5. In Quebec, negotiations between physicians and the provincial health plan focus on income. In the other Canadian provinces, negotiations are on fees, but incomes are monitored and fees may be reduced, as discussed in the text.

One factor that appears to facilitate cost control is the existence of a single payer within an appropriately inclusive region to negotiate with providers. Under these circumstances, providers can neither opt out of the public health system nor play one payer off against another. Negotiations in Canada are provincewide. Negotiations in Germany are local and involve multiple competitive payers (trade-based sickness funds and private insurance companies); this was probably a factor in the rapidly rising fees for physicians before 1977. Since 1977, however, fees and their rate of increase have essentially been set by the central government. 6/

Substantial cost-sharing does not seem to be necessary to contain costs, if effective provider controls exist. Cost-sharing is nominal or non-existent in both Canada and West Germany, because of the belief that co-payments large enough to reduce the demand for care appreciably would reduce access to an undesirable extent.

6. Centralized control may be important even in countries with a national health service. The United Kingdom, which has a centralized health care system, has been more successful at containing the growth of costs than Sweden, where negotiations between a single payer and providers take place at the local level. Competition among localities in Sweden may have spurred more generous settlements and more rapid expansion of health care resources.