

THE FUTURE OF MEDICARE

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The future of Medicare will almost certainly involve continued change because we want two things, and we cannot get as much of each as we want. As a result, we are likely to keep trying methods that will give us more of one or more of the other, or, if we are very clever, more of both. The two things we want go under codewords in the political debate. One is usually called "efficiency" or "cost containment." Of course efficiency and cost containment really aren't the same thing, and what we really want is efficiency (in the sense that economists mean), but cost containment has been talked about so much that it is hard not to use that term.

The second thing we want is usually called "access." We're used to thinking about access as a problem for the poor, or for people who do not have insurance, or whose insurance isn't very good, but in the future we may be talking about access as a problem for more people.

One may ask why it is hard to have both efficiency and access. I think it is easiest to explain by looking back at the history of the Medicare program. We had almost two decades of relative stability in the program. Then we began a revolt in 1982 that blossomed into a full scale revolution in 1983 with the enactment of legislation that brought about the Prospective Payment System.

Let us look first at the relatively stable period from 1966 to 1982. Medicare began with the goal of taking the financial worry out of sickness, and, to a large degree it succeeded. The most glaring exception is people who need to spend much of the rest of their lives in a nursing home. But, despite that exception, Medicare was a Godsend to

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many elderly people who, prior to 1966, either could not get insurance at all or who found insurance premiums a heavy burden. Medicare was (and I think largely still is) seen as an enormously successful government program, right up there with social security. For example, for many years the late Senator Jacob Javits proposed legislation that would have brought about national health insurance simply by extending Medicare to the entire population.

One of the keys to Medicare's early success was that almost all doctors and hospitals were willing to treat almost all its beneficiaries. They did so because, unlike its sibling Medicaid, Medicare essentially paid the going rate to hospitals and doctors. Specifically, it reimbursed hospitals its share of costs, and it paid doctors what it considered their reasonable fee. Although many doctors may grouse about Medicare's definition of reasonable, in fact doctors accept Medicare's definition about 70 percent of the time and are free to charge more the rest of the time.

In sum, paying going rates meant as good access for Medicare beneficiaries as for those with private insurance. But the price for this ease of access was steep. Because Medicare would pay for virtually any medical treatment that could be shown to improve health, as did private insurance, physicians, researchers, developers, and entrepreneurs had a much stronger signal to develop new procedures and new products than did developers and entrepreneurs in the rest of the economy.

Consider briefly the calculations of entrepreneurs outside health. Think of a firm that is making personal computers and is considering developing a new printer. In order to invest in this project, the firm has to believe that consumers will pay enough for the new printer to recover the costs of developing it. If the printer is only a little better than what is already on the market, and the development costs are high, the firm may decide not to invest in developing the new printer, and we would never see it on the market.

But health was different. If there was a new pacemaker, say, the price mattered rather little because it could get passed along to insurance. What happened? We saw a veritable flood of new technology and new capabilities, ranging from artificial joints, to radiation

therapy, to much more sophisticated and safe diagnostic techniques, such as computed axial tomography and magnetic resonance imaging, and much much more. In short, we had very good access, but we were not sure we wanted to pay the price.

It is time to turn to chapter 2. As the proportion of GNP in health rose to exceed 10 percent, in 1983 Congress decided to change the rules. The old rules had not really imposed much budget discipline on medical care; when it came to health we acted pretty much as if cost was no object. By contrast, the new rules were that hospitals, at least, should have limits of sorts. These limits were introduced in the form of fixed payments for given diagnoses. Alternatively, some beneficiaries joined up with health maintenance organizations, which agree to provide medical care for a fixed fee per year. These new rules have, in fact, changed behavior; hospital stays among those over 65 have fallen by 10 percent in two years, a historically unprecedented rate, and even admissions are falling. (That was not expected, but that is another story.) In most quarters, although not all, these changes are taken to mean more efficiency.

These new rules are also leading to some different kinds of calculations by entrepreneurs and doctors. Entrepreneurs are starting to make similar calculations in medical care to those made by computer companies and every other company; they may now not bring out some products because they cannot recover development costs. The pace of innovation is likely to slow somewhat, but in principle the innovation that will be cut back will be the kind that would be expensive and provide relatively little in the way of benefits. So this slowing down is probably a good thing.

It is not only entrepreneurs, but also doctors who will adjust their behavior. For centuries, doctors have sworn to do everything possible for their patient, and today's doctors have been trained this way. The problem is that for many centuries after Hippocrates doing everything possible really was not very expensive--it did not mean giving up very much--but the flood of medical innovation has changed all that. Under the new rules doctors are increasingly going to have to make conscious choices about what is worth doing. Doctors are not very comfortable with this unwanted role, and the unsettled state of

liability law only heightens their anxiety. Nonetheless, I expect that doctors will increasingly not do some procedures or not order some tests or not admit some patients that they would have under the old rules. As in the case of new products, these reductions will be concentrated in procedures and tests that provide little benefit relative to their cost.

But as we strive to get more efficiency, it is hard to avoid creating access problems for people that did not used to have them. I think the reason can best be explained if you imagine that you are rolling your supermarket cart down the aisles. You want some cereal, a six-pack of soft drinks, some apples, and some bananas. You breeze down the breakfast cereal aisle, quickly grab a box of cereal, find the soft drinks, pick up a six-pack, and head to the produce. Here you slow down a bit. When you find the apples, you do not just throw a few in your cart; rather you pick up each apple to see if it is bruised. After finding a few that are not, you wheel the cart over to the bananas. Here too you have to dig a bit because most of the bananas seem overripe. But after a minute or so with the bananas, you are ready for the checkstand.

Now think about the breakfast cereal, soft drinks, apples, and bananas that are left for those compulsive workers who cannot find time to shop until just before the store's closing. If they only need breakfast cereal and soft drinks, they will not have a problem. What they will get will be similar to what the early birds got. But the chances are that the apples and bananas that they will find will not be just like the ones the early birds got; the bruised apples and overripe bananas will be what is left. People linger over produce and not over breakfast cereal because there is a fixed price per pound for both, but boxes of cereal are homogeneous and pounds of produce are not.

How does this apply to medical care? To spur efficiency, we are trying to impose fixed prices, but those prices are for heterogeneous products--namely people and their medical problems. Patients who are predictably expensive within each diagnostic category will not be welcome at all doors; they will be like the bruised apples left on the produce stand. For example, patients who have heart attacks that cost more to treat than Medicare will pay could have an access problem. To be sure, because Medicare pays the average amount, hospitals in the

aggregate will not face severe problems; the profitable patients ought to offset the unprofitable ones, the losers. But any individual hospital can improve its bottom line by cutting down its proportion of losers--to the degree it can forecast that a certain patient is a loser. How would it cut down? It would try to get the patient to another hospital. Could that be stopped? If the hospital were subtle, it might well go undetected. In fact, it only has to get a few percent of the potential patients to go elsewhere, provided they are the right few percent, because about 1% of the patients account for about a quarter of the expenditure. Those patients--who were welcome under the old rules--are now like the Queen of Spades in a game of Hearts; anyone who ends up with them is heavily penalized.

But is not trying to steer patients elsewhere unethical? Many will think so. But undoubtedly some will say that if it is legal and profitable, it is acceptable. So they will start to engage in such behavior. They will indeed make money, but the others, who are trying to be ethical, will not. Indeed, it may happen that everybody who wants to stay in business will either have to start acting this way, or else will have to find ways to cut down on the amount of services these very sick patients get. For those of you who remember the 1940s, the situation is analogous to Blue Cross' having to abandon community rating, as commercial insurance companies entered and experience rated.

Suppose we said "there ought to be a law," and we tried to write regulations to prohibit doctors and hospitals from discriminating among patients. If I am a doctor, however, there are many ways for me to convince you to go somewhere else that seem beyond the reach of regulations. I can answer your questions in a way that makes you wonder if I really know what ails you. I can keep you waiting. I can be a little curt with you or even rude. So maybe there ought to be a law, but I would hate to be the person that had to enforce it.

I do not know of a system that we can readily implement today that seems likely to give good incentives for efficiency and pose no access problems. People at universities and research institutes are trying to find better methods than we now have; and they almost certainly will, because this problem has not been worked at for very long. But the sad truth is that the problem is very difficult, and we and other countries

are likely to be working at this for a long time. Thus, I come back to my opening assertion that the future of Medicare is likely to be continued change. My guess is we will keep trying new methods to obtain more efficiency, more access, or both. And from time to time we may decide we want to have more of one and less of another. But I rather suspect that four other people will be able to have an interesting dialogue about this subject at Harvard's 400th birthday.

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