

Beyond the Politics Of Medicare Reform

BY JANE HIEBERT-WHITE

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As we enter the 1996 presidential election year, one issue that promises to figure prominently is Medicare reform. The current political debate surrounding the budget bill and Medicare reform has led to partial government shutdowns in November and December. President Bill Clinton vetoed the Republican-led Congress's budget bill December 6. Clearly, a heated battle is already under way.

What will come next in the political skirmish is less clear. Gail Wilensky, a Republican adviser and director of the Medicare program under President George Bush, suggests that Clinton may veto even a second-round Medicare reform bill, depending on how involved the administration and its Democratic allies are in the compromise bill. The Republican leaders in Congress also need to carefully consider any substantial compromises for fear of losing support from right-wing Republican freshmen, Wilensky says.

Most analysts believe Clinton will ultimately sign a budget reconciliation bill that includes Medicare reforms. The size and scope of those reforms, though unclear at this juncture, are likely to represent significant change. Wilensky said in a recent conversation that she would be "surprised if [the savings from Medicare] were less than \$200 billion" over seven years. The first bill passed by Congress calls for \$270 billion in Medicare savings to help balance the budget by 2002.

Although healthcare providers should prepare themselves for major spending reductions and changes to Medicare, many analysts see this current budget skirmish as only the first round in the debate over the future of Medicare federal entitlements. For instance, the looming Medicare expenses of the baby boom generation, who will begin to turn age 65 in 15 years, are not at all addressed by any of the current Medicare reform proposals.

As Princeton economist Uwe Reinhardt noted: "The Medicare reforms proposed by the 104th



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Congress . . . can be viewed as the first phase of a rather dramatic restructuring of the program that will take place over the next several decades. Unfortunately, those reforms are being marketed with language and imagery that are apt to confuse and even to mislead the general public."¹

This column attempts to sort through some of the confusion in the debate. It goes beyond politics to look at the long-term structural changes being proposed for Medicare and how they might affect healthcare providers.

FRAMING THE DEBATE

Because Medicare is extremely popular with senior citizens, and because any change in the status quo is scary, Republican lawmakers are claiming their bill will "preserve and protect" Medicare from impending bankruptcy (by 2002, according to an April 1995 Medicare Trustees' report). Meanwhile, Democrats are predicting doom and gloom if Medicare "cuts" of \$270 billion are passed.

These strategies represent finely honed politics. Last July two pollsters, representing Republican and Democratic views, shared their insights on what issues will make or break efforts to reform the Medicare program and what messages politicians need to send.

The Republican View According to Republican pollster Bill McInturff, a cofounder of Public Opinion Strategies, "Unless we shift this debate so that people believe that the status quo is scarier than change, we [Republicans] are going to get whopped."

At a July meeting on the Future of Medicare, cosponsored by the American Association of Retired Persons (AARP) and *Health Affairs*, McInturff outlined what he saw as six major hurdles for Medicare reform:

- People fear change. Eighty-one percent of people over age 65 rate Medicare favorably. "Why, if you are a senior, would you want to be talking about major change for a program in which you have satisfaction rates that are as good

as anything you could ever hope for?" asked McInturff.

- Medicare affects many people personally. "It is a lot easier to change something that does not affect real people," said McInturff. "Medicare has enormous personal salience."

- Medicare itself is a tradition resistant to change. McInturff found that, in focus groups, two-thirds believed that if a member of Congress promised not to cut Social Security but then cut Medicare, the member had broken his or her promise. "After 30 years, this program is part of an American tradition in terms of how we deliver services," he explained. "That will be enormously difficult to change, because of its being linked with Social Security."

- The public needs to understand how you are going to get to the reforms proposed from the status quo. "The transition message has to be, not what the Republicans are making people give up. It's what they're going to get," such as "more options" and "less government," said McInturff.

- The reforms need to be incremental. "This is a country that talks much tougher in polls than they do in real life," observed McInturff. Concerning Medicare, he said, "what you have to tell seniors and others is, 'We're making the most minuscule changes in the world.' And you've got to use the language of 'inherent, incremental, and small,' and then propose the most dramatic policy thing you could possibly think of."

- People want to know whether a proposed reform has worked somewhere else before. To overcome this hurdle, Republican strategists, such as Stuart Butler and Bob Moffitt of the Heritage Foundation, tout a Medicare reform plan that uses the example of the Federal Employees Health Benefits Plan.

The Democratic View At the AARP/*Health Affairs* meeting, Democratic pollster Robert Blendon of Harvard University also pointed to barriers to Medicare reform. For instance, "We are going to see a war in the public between different groups over whether or not they would pay additional taxes to maintain the current benefit levels," Blendon predicted.

Generational differences also affect how Americans perceive Medicare reform. Said Blendon:

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"People under the age of 50, when they think of the future of Medicare, would accept a future where the majority of people got a private managed care plan. Those above of the age of 50 find that future completely unacceptable."

PROPOSED CHANGES

To resolve the debate, we need to move beyond the political framing to see what structural changes are really being proposed. Yet even here, one's political viewpoint shapes how one defines the proposed changes. Uwe Reinhardt, an economist who leans toward the Democratic side, said in a conversation that the Republicans in Congress "are setting the platform for very dramatic change." Such changes, according to Reinhardt, include:

- Replacing public regulators with private regulators (i.e., health maintenance organizations [HMOs])

- Turning a defined benefit program into defined contribution

- Making Medicare means tested so that "well-to-do elderly by 2015 will probably get little to no help from Medicare"

Republican Wilensky, on the other hand, remarked that "what is being proposed is not substantially different from what the Clinton administration proposed in the Health Security Act." She does agree that the Medicare reforms proposed by Congress do "raise some fundamental issues we have to resolve as a society." These include:

- How do we want to moderate spending in Medicare? (In the past we used direct controls.)

- How much choice among healthcare plans do we want to give seniors? "Now they have far less [choice of managed care plans] than federal employees," said Wilensky.

- How do we get there from here? What is a sustainable rate of growth? Or, put another way, said Wilensky, "How much do we worry about ramming the medical infrastructure?"

- How do Medicare reforms square with U.S. demographics? Wilensky said she sees some possible problems there.

Although details will change, a look at the Medicare reforms in the first reconciliation bill passed by Congress provide some insight into the

direction Medicare could move in the future. Key changes to watch include promotion of private managed care plans for seniors, development of new provider service organizations (PSOs), changes in premium payment based on income level (means testing), and change in the basis of Medicare from defined benefit to defined contribution.

Managed Care By June 1995 only about 9 percent of seniors (3.2 million) were in a Medicare managed care plan.² Under Medicare reform, Congress aims to achieve major savings by providing incentives for seniors to join managed care plans. Predictions of Medicare managed care enrollment range from 24 percent (by the Congressional Budget Office [CBO]) to more than 40 percent of seniors in managed care by 2002 (according to Thomas Scully, president, Federation of American Health Systems). Of the CBO estimate, said Wilensky, "I personally think that's low." However, as the polls indicate, it may take time—even a generation—to get elders to embrace managed care. It will also take time to build institutional capability to handle chronically ill elderly in managed care settings.

A concern is that cheaper managed care plans will attract the healthiest seniors, leaving the sickest in traditional fee-for-service Medicare. Elder Americans with chronic, complex conditions may have spent years developing networks of healthcare providers to manage their care. The need to replicate such networks will pose a substantial barrier to shifting sizable numbers of seniors into new managed care environments. With the sickest and most complex cases staying in traditional Medicare while healthier ones join managed care plans, the cost of the fee-for-service plan will rise. The question is: Who will be at risk for the cost differential—the elderly or healthcare providers?

Who is at risk depends on what type of Medicare plan the elderly move to. Under the House-Senate Conference agreement, seniors opting out of traditional fee-for-service Medicare and into a "MedicarePlus" plan could choose from one of the following options (among others): (1) a managed care plan such as an HMO or preferred provider organization (PPO), (2) a combination of a high-deductible "catastrophic" coverage plan and contributions to a Medicare

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medical savings account, or (3) plans offered by a PSO. Under the medical savings account "voucher" approach, the senior assumes the risk for coverage. Alternatively, PSOs put the healthcare provider at risk.

Provider Service Organizations PSOs are networks of healthcare providers—hospitals, physicians, and other providers—that provide coordinated care and agree to assume the financial risk of covering the care in return for a capitated payment. According to Wilensky, "PSOs allow physicians and hospitals to come together to challenge insurers on their own turf." She warns, however, that it is hard to run a risk-based organization, particularly for providers who are not used to managing such financial risk. She predicts that institutions such as hospitals stand a better chance than physician groups at risk-based organizing.

"PSOs are a very important political opportunity. They may or may not be an important occurrence in fact," said Wilensky. "They let [hospitals and physicians] put their money where their mouth is" in proving they can provide better coverage to patients directly and can save patients the 20 percent profit/administrative cost typical of insurers.

Healthcare provider groups, including the Catholic Health Association (CHA), have been vigorously lobbying Congress and the administration on the PSO option for Medicare. Such efforts have included joint ads in papers such as the *Washington Post*. The American Medical Association has also run full-page ads in papers.

Healthcare providers see PSOs as an opportunity to move healthcare delivery from acute care settings to an integrated setting. According to a November 13, 1995, CHA Advocacy Alert, "Medicare PSOs represent an important strategic opportunity for Catholic healthcare. Done right, PSOs can be the first step toward our vision of Integrated Delivery Networks."

The reality of moving to integration, however, will require much more effort on the part of Catholic healthcare facilities. CHA estimates that although more than 90 percent of Catholic providers are considering integration efforts, only 20 percent to 25 percent of the membership would be ready to move forward if the Medicare

reforms allowing seniors to enroll in PSOs were signed into law tomorrow. Such legislation may provide a "wake-up call" to providers to accelerate their plans for developing integrated managed care networks.

A technical piece of the current Medicare reform proposal that CHA is also lobbying to change concerns the not-for-profit status of integrated delivery networks. Under current tax laws, it is now nearly impossible to move from a not-for-profit acute care status to an integrated system that is competitive on a not-for-profit basis. Changes in tax treatment to encourage not-for-profit integrated delivery networks may be achievable through regulations and might not need to be included in the budget bill.

Means Testing The Republican Medicare reforms call for more well-to-do elderly to pay higher premiums. The last time such means testing was tried for Medicare, Congress got a severe lashing by the elderly and ended up repealing the legislation (the Medicare Catastrophic Care Act of 1987). Under the current Republican plan, by 1997 individual seniors earning \$110,000 and couples earning \$150,000 would pay about triple the standard Medicare premium.

As Medicare expenses increase, lawmakers are faced with the choice of either providing the same level of benefits at the same cost to all elders by raising taxes on a proportionally shrinking working population, or capping payroll taxes and asking wealthier seniors to contribute more toward Medicare premiums. Predicts Reinhardt, "If one had to bet on which strategy will be chosen, one would do well to place one's chits on means testing."³ The question means testing raises is where one draws the line on who pays more.

Defined Contribution Another major structural change in the way Medicare operates is the proposed shift from a "defined-benefit" to a "defined-contribution" program. Currently seniors are promised a set of benefits, and taxpayers bear the risk of paying for the ever-increasing Medicare costs. Congress now proposes shifting that risk to the elderly and to healthcare providers and limiting government (or the taxpayer's) risk to a defined payment level per senior. According to Reinhardt, "The conversion of Medicare into a defined-contribution plan may well be achieved

*Changes
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as early as this year. It is implicit in the proposal to cap the annual contribution Medicare will make to any private health insurance carrier chosen by a Medicare enrollee and to hold the traditional Medicare program to the same cap through the so-called look-back mechanism that will cut fees to providers whenever spending under the traditional program exceeds the targeted expenditure cap."⁴

While this shift is implicit in the Republican Medicare reform proposals, it is also touted by some leading Democratic analysts. Brookings Institution economists Henry Aaron and Robert Reischauer (who formerly headed the CBO) propose converting Medicare from a "service reimbursement" system to a "premium support" system.⁵ Under such a system, they explain, "Medicare would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services." The defined benefit package sets this proposal apart from the Republican proposals. Aaron and Reischauer suggest improving the current Medicare benefit package by including some prescription drug coverage and catastrophic protection.

But Aaron and Reischauer are not optimistic about the Medicare reforms that may emerge from the current budget debate. "Most likely, an already parsimonious system will be made even stingier, the need for supplemental insurance will grow, and the existing hybrid system will be made even more complex and inequitable."

Whether this prediction will come to pass remains to be seen as the Medicare reform debates continue with full force into this presidential election year. □

NOTES

1. Uwe E. Reinhardt, "Demagoguery and Debate over Medicare Reform," *Health Affairs*, Winter 1995, pp. 101-103.
2. Margaret H. Davis and Sally T. Burner, "Three Decades of Medicare: What the Numbers Tell Us," *Health Affairs*, Winter 1995, pp. 231-243.
3. Reinhardt.
4. Reinhardt.
5. Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What is the Next Step?" *Health Affairs*, Winter 1995, pp. 7-30.