

Medicare Reform Without Fireworks

BY JANE HIEBERT-WHITE

On May 15, White House and congressional negotiators agreed to a balanced budget proposal that set a goal of \$115 billion in Medicare cuts over five years. Although the budget agreement is just a guideline, congressional committees have moved with stunning speed to "mark up" and vote on legislation to meet this goal. In the process, the Medicare program may be restructured to lay the groundwork for the more sweeping, long-term reforms that will be necessary when the baby-boom generation begins to swell the ranks of Medicare enrollees in 2010.

William J. Cox, executive vice president of the Catholic Health Association (CHA), said, "This budget agreement is a big deal. It will have significant impact on healthcare and will help accelerate trends" already under way in Medicare and the healthcare system. "It will also create a lot of disequilibrium across the country," he added, "but I think it is a foregone conclusion that it's going to be adopted."

This column examines some key current trends and discusses the significant reforms under consideration.

WHY MEDICARE CUTS NOW?

The \$115 billion in cuts to Medicare represent 55 percent of the total net savings in the balanced budget agreement, according to Brian Biles, vice president of the *Commonwealth Fund*. Medicare is a growing part of the federal budget—an area ripe for cutting. One factor that is driving politicians to seek deep cuts in Medicare spending growth is the projected insolvency of Medicare's Hospital Insurance Trust Fund by 2001. The April 1997 report of the Medicare trustees concludes: "The HI trust fund's projected exhaustion by 2001 dictates the need for prompt, effective, and decisive action."¹ This report, in addition to highlighting concern about Medicare's sustainability, also provides politicians with crucial political cover as they seek to balance the budget primarily through savings in a very politi-



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cally popular entitlement.

According to the trustee's report, trust fund expenses have exceeded revenues since 1995. Even in the short term, before the baby boomers retire, this discrepancy between income and expense is expected to balloon. In 1996 the trust fund brought in \$124.6 billion in income and spent \$129.9 billion, resulting in a \$5.3 billion shortfall. By 2006, a \$120 billion shortfall is expected in that year alone, according to the trustees' report. The problem is that expenses are projected to increase at an average annual rate of 8.1 percent, under the trustees' "intermediate" assumptions, while the income from taxes to the trust fund will rise by only 4.7 percent per year on average.

The balanced budget agreement aims to reduce Medicare spending growth to about 6 percent per year. Although this would help extend the short-term solvency of the trust fund, it won't solve the longer-term problems of a large enrollment of baby-boom retirees who have higher medical expenses that must be supported by taxes from a proportionally smaller workforce. In 1996 there were 3.9 workers per Medicare beneficiary. By 2030, when the last baby boomer retires, there will only be 2.3.

In agreeing to the massive Medicare cuts and in marking up legislation to put the proposal into policy, Congress has done surprisingly little partisan politicking—especially in comparison to previous major Medicare debates, those accompanying the Republicans' balanced budget plan of 1995 and the election campaign of 1996. On June 9, the House Ways and Means Committee passed its version of Medicare budget legislation by an astoundingly bipartisan vote of 36-3. The Senate Finance Committee also approved its Medicare reform legislation June 18 with bipartisan support. The House Commerce Committee, led by Rep. Bill Archer, R-TX, put on the most partisan debate and approved its Medicare reform package by a nearly party-line vote on June 12. On June 24, the full Senate, with bipartisan support, approved such controversial measures as means testing and raising

the Medicare eligibility age to 67. The Senate and House passed their separate versions of the legislation on June 26. Although conference negotiations between the two versions were expected to follow the annual July 4 recess, and had not yet begun at press time, the early bipartisan support indicates that significant Medicare reform will be approved.

The fact that Congress is unlikely to get a new shot at significant reform soon is another reason policymakers are anxious to make more structural changes—and not just budget cuts—in Medicare. According to Biles, who previously served as a staff person for healthcare matters on the Ways and Means committee and as a staffer for both Rep. Henry Waxman, D-CA, and Sen. Edward Kennedy, D-MA, “This is likely to be the only reconciliation bill over the next eight years. So this is the major Medicare legislation over the next eight years.” Gail Wilensky, administrator of the Medicare program under former President George Bush, said she is “pleasantly surprised that [the proposed legislation] contains as many reforms as it does.” Wilensky, who is currently senior fellow at Project HOPE and chair of the Physician Payment Review Commission, made her remarks at the annual meeting of the Association for Health Services Research (AHSR), in Chicago, June 16.

IN SEARCH OF STRUCTURAL REFORM

Some of the structural Medicare reforms policymakers are seeking will accelerate enrollment in managed care. Managed care now dominates the private insurance market, with nearly three-quarters of insured working Americans covered by such plans. In contrast, only 10 percent of Medicare enrollees are in Medicare health maintenance organizations (HMOs). Analysts predict, however, that “even in the absence of congressional action, enrollment in risk-contract Medicare HMOs is projected to multiply . . . to more than one-third of all beneficiaries within the next ten years.”²

In fact, Medicare managed care has grown rapidly in recent years. Between 1994 and 1996 enrollment in Medicare “risk contract” HMOs grew more than 40 percent per year, compared with an annual average growth rate of 22 percent from 1992 to 1994. Analysts from the Washington, DC-based Barents Group, LLC, and the Henry J. Kaiser Family Foundation suggest that as “commercial HMO enrollment among workers and their families has slowed . . . the Medicare market offers an avenue for managed care entities to expand.”³

Growth in Medicare managed care is somewhat constrained by the strict limits on qualifying plans. About 90 percent of Medicare managed care enrollees are in risk contract plans. These plans

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agree to bear the full financial risk for providing care to their Medicare beneficiaries under a fixed monthly “capitated” payment per enrollee. Growth in the private-sector side of managed care has recently accelerated in newer “hybrid” forms of managed care plans such as point-of-service (POS) plans and in other network options such as preferred provider organizations (PPOs). The June 1997 report of the Prospective Payment Assessment Commission (PropAC) also notes that “a major reason managed care is not as widespread in Medicare as it is in the private sector is that beneficiaries can choose not to enroll. Employers, by contrast, often offer no indemnity alternatives.”⁴

Congress is considering several additional reforms.

Managed Care Options Although government legislators do not want to force Medicare beneficiaries into managed care plans the way some private employers have, they do want to reap some of the cost benefits apparent in the transformation of the private healthcare marketplace. A key tenet of the debate in Congress is that the new hybrids so popular today in the private insurance market would be expanded to include Medicare beneficiaries. For example, both House committee versions of Medicare reform would set up a “MedicarePlus” program that would allow PPOs, POS plans, and provider-sponsored organizations (PSOs), as well as traditional HMOs, to serve Medicare beneficiaries. The Senate Finance Committee version offers a similar plan with its “Medicare Choice” program.

Wilensky sees the expansion of choice in Medicare as an important reform that “moves the program closer to the FEHBP [Federal Employees Health Benefit Program] model.” She said, “This would be a different role for government, and one I think government can do better—to negotiate, provide oversight, and make sure plans don’t cheat, and make sure information is provided that is clear and honest.” But she also warns that “it shouldn’t be the role of government to push people into one plan or another.”

MSAs Another, more controversial, element of choice is the proposed demonstration to allow seniors to set up medical savings accounts (MSAs). The House versions of the plan set the limit on Medicare participants in MSAs at 500,000, while the Senate version is scaled back to 100,000. MSAs, tax-free accounts similar to individual retirement accounts, are controversial because many healthcare analysts believe they would attract only the healthiest seniors. Medicare would lose from \$1,000 to \$3,000 per person on this demonstration, warned Marilyn Moon, an economist at the Urban Institute and one of two public Medicare trustees.

Moon, in her remarks at the AHSR annual

meeting, said of the House version of the MSA proposal: "I don't think this is a commitment to just a demonstration; I think this is a commitment to a foot in the door" on allowing much broader use of MSAs. She called MSAs "a very bad idea . . . a natural risk-selection device." Wilensky, too, acknowledged that "there is more concern for risk selection in this area than in others." She would require those people who select MSAs to join for a four-year period, as a "crude" way to stop adverse risk selection. "We're asking for trouble on a one-year selection [limit] until we have better measures of clinical risk selection," she added.

Means Testing Another controversial reform element in the Senate Finance Committee Medicare proposal is one to charge wealthier seniors higher premiums. In the late 1980s, Congress approved an element of means testing as part of the Medicare Catastrophic Care Act, but later was forced to repeal the legislation under pressure from senior citizens' groups. Said Wilensky, "I don't think we need to protect higher income people at the same level [as lower income Medicare beneficiaries], but that is hard philosophically for this country to address."

Both Wilensky and Moon, representing relatively conservative and liberal views, respectively, agree as economists that the Medicare program will need to bring in more revenue to survive over the long term. The current proposals focus more on cutting expenses than on revenue raising. Wilensky believes that may be a prudent way to begin serious Medicare reform, however. "With the current unsustainable rate of spending [in Medicare] for the current population, I am reluctant to push for new money too early" in the reform process. "I don't think we have enough money to put in [to the Medicare trust fund] if we don't also restructure" Medicare to bring spending down, she added. Moon argued that "we're not going to solve the long-range problems [of Medicare] with privatization and increased beneficiary payments. To be honest, we have to put revenues on the table pretty soon."

Provider Cuts In general, about 90 percent of the \$115 billion in proposed Medicare savings would come from providers. CHA's Cox perceives a "sense on Capitol Hill that providers are overdue a large reduction, and government wants to benefit as well [as the private sector] from the downsizing in overcapacity in healthcare." CHA and other hospital groups are concerned because they "don't want savings attributed to hospitals to grow in relation to other sectors identified for cuts," said Cox.

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ficiaries, especially if the reforms "include an initial period of stable regulation," said Cox. The Senate Finance Committee proposal would let the federal government regulate PSOs for up to three years—a measure embraced by hospital groups but opposed by traditional insurers such as Blue Cross and Blue Shield Association and by HMOs. States currently have the responsibility of regulating the solvency of Medicare risk plans.

Other Reforms Other reforms on the table include the aforementioned Senate proposal to increase the eligibility age of seniors from 65 to 67, in tandem with changes set for Social Security eligibility. This shift alone could garner significant savings for Medicare, but is highly disputed and goes beyond what was agreed to in the balanced budget agreement.

Changes in how managed care plans would be paid are also under consideration. Analysts generally agree that the current payment methodology is exceedingly generous to some health plans. The reform proposals seek to implement better risk-adjustment mechanisms to target payments more accurately. Also under discussion is whether the government should continue to bundle higher payments for graduate medical education into the capitated payment to health plans or put such payments into a separate trust fund.

MEDICARE CHANGES ARE INEVITABLE

As the trend lines of Medicare spending and income increasingly diverge, producing unsustainable deficits, significant reform of the program is inevitable. Wilensky's message to lawmakers as they struggle with the current round of Medicare reforms is that they first need to "make sure we protect the lowest income [elderly]." But they also need to "alert people while they're still working (in their 40s and 50s) that they will need to take more responsibility for their health insurance. We need to tell them that the Medicare program when they retire will not be the same Medicare program" as today. The same message applies to hospitals that rely on Medicare income: Medicare is not going to stay the same. □

NOTES

1. Board of Trustees, Federal Hospital Insurance Trust Fund, "1997 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund," Washington, DC, April 24, 1997.
2. Jo Ann Lamphere, et al., "The Surge in Medicare Managed Care: An Update," *Health Affairs*, May/June 1997, pp. 127-133.
3. Lamphere, et al.
4. Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress*, Washington, DC, June 1997.