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THE BUDGET DEAL'S MEDICARE BENEFIT INFLATION

The Medicare provisions in the recent budget deal, though still lacking in detail, indicate clearly that the congressional and Administration leadership prefers damaging short-term program "fixes" to reforms aimed at improving Medicare and assuring its viability for future generations.

As the recent Medicare Trustees' report shows, the Medicare program is fiscally bankrupt and structurally unsound.[1] The hospital trust fund (Part A) is hopelessly out of balance, and the taxpayer portion of the physician payment part of the program (Part B) is rising at an unsustainable rate. Shifting money from Part A to Part B, as the budget deal would do, does nothing to address the underlying problem. It merely gives the taxpayer the runaway tab from a different account. Promised savings—if any—will come from reducing the availability and quality of care through tighter price controls rather than from encouraging greater efficiency. And incredibly, deal makers even propose to make new benefits available under the bankrupt program.

There are only two options for dealing with Medicare. Congress can resort to price controls and budget gimmicks, as the budget deal does. Or lawmakers can recognize that Medicare's fiscal crisis is a function of its structural flaws and start making changes today that will put the program on a better footing for future generations.

The issue of benefits design is one key element in the Medicare debate, and a graphic example of the two general choices facing Congress. Members of Congress can continue to play the role of medical experts, micromanaging the benefits the elderly and disabled may have—and subject to constant lobbying by provider organizations. Or they can establish an independent board to adjust benefits over time to reflect changing medical practice and the desires of patients, thereby depoliticizing the design of benefits. Unfortunately, the budget negotiators ignored the second option, and instead decided to win short-term kudos by adding new benefits to the cash-strapped program.

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1 See Stuart Butler, "Time is Running Out for Medicare Reform," Heritage Foundation *Backgrounder* No. 1112, April 30, 1997.

The budget decision builds on legislation introduced earlier this year by the chairman of the House Ways and Means Subcommittee on Health, Representative William Thomas (R–CA). The Medicare Preventative Benefit Act of 1997 (H.R. 15) would add new preventative health benefits like diabetic self-management training services and pelvic and prostate exams, as well as colorectal cancer screening. It also would increase benefits already offered by covering mammograms annually (currently, Medicare provides coverage every two years) and waiving deductible requirements for certain services in the Medicare program. This legislation is similar to the Medicare preventative health benefits package in President Clinton's 1998 budget proposal (the Administration's plan includes increased reimbursement for certain immunizations and a new respite benefit for family caregivers of Alzheimer's disease patients.) Some of or all these new benefits are likely to appear in the recently negotiated balanced budget agreement.

It is important to recall that two key issues drove the discussion regarding Medicare reforms during the last Congress. First, the urgent issue was that the Medicare Hospital Insurance (HI) Trust Fund was reported to be nearing insolvency much faster than previously predicted. The Medicare Trustees concluded that cost growth to the entire Medicare program was unsustainable. The second, and more significant, impetus for reforms was that the Medicare program, as it exists today, is an anachronism—out of date with modern medicine. Republicans in Congress made the convincing case that seniors are needlessly denied choice in health care by this bureaucratic, congressionally micromanaged program.

Expanding access for seniors to private health plans with a range of benefit options thus was the centerpiece of the 1995 Medicare Reform Act. With this proposal came the explicit recognition that neither Congress nor the President or the Health Care Financing Administration (HCFA) could both manage seniors' health care and control costs as well as the private sector had proven it could under the right conditions. Yet today, some of those same lawmakers who at great political risk advanced a reform agenda in the last Congress advocate adding new preventative benefits to the traditional Medicare program. The Thomas legislation and the budget deal would increase central management of the Medicare program by locking in statute new federally prescribed benefits.

Why would this be a mistake? For several reasons.

1. **New services, even preventative health services, can be very costly.** When assessing the benefits of preventative services, a distinction needs to be drawn between quality of life health benefits and actual cost-saving benefits. There undoubtedly are many good reasons for seniors and all Americans to receive certain preventative health screenings; there should be no argument regarding the importance of patient education on and access to such procedures. However, proponents of mandating coverage or waiving cost sharing for these services in Medicare should use caution when they attempt to sell their proposal as "saving" taxpayer dollars. The Congressional Budget Office (CBO) estimates, for example, that the Administration's proposed new preventative benefits "would increase Medicare spending—net of any savings attributable to avoided illness—by about $7.5 billion over the 1998–2002 period."[2]

2 Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 1998*, Chapter Three, March 1997, p. 29.

In addition, it is questionable how these particular preventative health benefits will be effectively utilized in a fee-for-service, uncoordinated health care environment. Real health benefits from using preventative health services typically are associated with the appropriate case management by a physician. So it is by no means clear that the proposed new benefits will actually save taxpayer dollars. Most likely they will simply mean *more* services are used. When Medicare is financially strapped, adding questionable new benefits—especially without removing out-of-date and costly benefits—makes no sense.

2. **The benefits in H.R. 15 would shift cost-sharing burdens from Medigap insurers to the taxpayers.** H.R. 15 would exempt mammography screening and pelvic exams and pap smears for women from counting toward the $100 annual Part B deductible. Deductibles and co-insurance often are waived for certain benefits to encourage beneficiaries to use those services. Over 70 percent of Medicare-eligible seniors, however, currently have some form of private Medicare supplemental insurance coverage—either individually purchased or through a employer-sponsored retirement plan—to cover co-pays, co-insurance, and deductibles. Of those seniors participating in individually purchased Medicare Supplemental Insurance (Medigap) plans, almost 60 percent have full coverage for the Medicare Part B deductible. By exempting these services from applying toward a beneficiary's deductible (a deductible that is already significantly lower than those found in commercial fee-for-service health plans), this legislation simply forces the taxpayers to pick up the full cost of a benefit already covered in the Medicare supplemental policies of many beneficiaries.

3. **The legislation adds to the problem it attempts to solve.** The Medicare benefits package is not a particularly good one. Certain desired preventative health benefits are not covered or are covered only in a limited way. Medicare currently does not reimburse for outpatient prescription drugs, routine physical exams, or certain long-term care services in home- and community-based settings, and it does not protect enrollees from catastrophic medical costs.

   In addition, because the cost and type of physician services and benefits are all prescribed either in statute or regulations through the Physician Fee Schedule and Diagnostic Related Groups, changes to the program to control costs and keep up with medical innovation and practice changes often require an act of Congress (as in the case of preventative benefits) or lengthy regulatory review, thereby inviting active lobbying by physician or hospital groups that stand to gain by such changes. The result is an increasingly inefficient means of managing program costs and coverage decisions and a system that cannot adapt to consumer needs and medical innovation in a timely fashion. Indeed, the pace of change in the benefits package is so slow that new retirees joining Medicare enter a "time warp," giving up modern benefits they received when working.

   This happens because congressionally mandated Medicare benefits lock in statute a standard of care that soon can cease to be the most cost-effective or in the patient's best interest. As a result, low-cost and more effective alternatives to care often are not covered, even though higher-cost, less effective ones remain.

   Example. For many years, Medicare would reimburse for limb amputation of individuals with severe diabetes-related foot disease at a cost of up to $12,400 (in 1987

dollars) to the Medicare program but extracting a far greater cost to the patient in pain and suffering. It took an act of Congress in 1987 to allow Medicare to reimburse for a therapeutic shoe for diabetics which could, in many instances, help prevent the need for limb amputation altogether. The cost: $300 per pair.

Example. Because Medicare does not currently offer an outpatient prescription drug benefit, many doctors feel it necessary to hospitalize seniors in need of antibiotics to ensure that they get the care they need. Not only is this a huge and unnecessary cost burden on Medicare and the patient, but it also presents a health danger to the patient: In the hospital setting, patients often receive more powerful antibiotics than their illness requires, causing them to build immunities to antibiotics and putting them at greater risk for contracting deadlier infections.

The General Accounting Office (GAO) studied the internal regulatory process that the Health Care Financing Administration must undertake when making national decisions to change or update benefits and services that are already authorized for reimbursement in the Medicare program. While many local coverage decisions are made by contractors hired by HCFA to process claims, the GAO found that the national decision making process to change or update benefits is extremely burdensome. The report states:

> Decisions involving simple issues or expansions of existing coverage can be developed and implemented in 2 to 12 months. When complicated clinical issues are involved, however, the information needed to make coverage decisions can take several years to develop. Further, once HCFA decides to establish a new type of coverage or withdraw existing coverage, it publishes a proposed rule in the *Federal Register,* reviews and incorporates public comments, and then publishes a final notice. This can add another 9 to 12 months to the process. It took HCFA 4 to 5 years to decide to cover liver transplants and more than 10 years to withdraw coverage for thermography, a diagnostic technique that measures temperature variation on the body's surface.[3]

4. **To the most effective lobbyist goes the spoils: Congress's mandating benefit coverage politicizes health benefit decision making.** Not only is the current process for setting benefits unacceptably slow and cumbersome, but it is also unacceptably politicized. Since Medicare benefits are determined by statute or agency rules, the process invites heavy and protracted lobbying by interested parties wanting a piece of the Medicare pie. Consider the recent full-page newspaper ads sponsored by the American Diabetes Association stressing the importance of diabetes self-management education, a benefit reportedly included in the budget agreement and praised often in public forums by House Speaker Newt Gingrich. And, of course, no benefit coverage issue debated in recent history has been as politically charged (and distorted) as the issue of mammography coverage.

3 U. S. General Accounting Office, *Medicare: Technology Assessment and Medical Coverage Decisions*, GAO/HEHS 94–195FS, July 1994, p. 7.

In a recent opinion editorial in *The Washington Post,* Steven Woolf, Medical College of Virginia Professor of Family Practice Medicine, and Robert Lawrence, Johns Hopkins Professor of Health Policy, complained about the dangerous trend:

> Politicians, like all citizens, have a right to their opinions, and Congress does have purview over public health. But there are obvious dangers when lawmakers go beyond their role as advocates to become arbiters of scientific data: They are unqualified for the task, lacking training in either medicine or research design; and their views are influenced by ballot concerns and special interests.[4]

This is no way to be making such important and costly decisions regarding seniors' health care options.

A BETTER WAY TO DETERMINE MEDICARE BENEFITS

As Congress considers the specific Medicare policies it will pursue to meet the terms of the budget deal, it must focus on structural reforms, not phony fixes. This reform should be based on expanded private Medicare options for seniors (with a proposal to determine the federal government's contribution per enrollee), similar to the system Members of Congress and federal employees and retirees enjoy in the Federal Employees Health Benefits Program (FEHBP). This must be a non-negotiable condition of any final agreement. That approach would use the power of consumer choice and competition to achieve cost control with efficiency, rather than crude bureaucratic controls that undermine quality and availability.

With expanded choice, health plans would compete for Medicare beneficiaries' business based on the type and scope of additional benefits they can offer at reasonable prices. It is the desire for additional benefits, often at lower costs to the beneficiary, that has caused approximately 12 percent of Medicare beneficiaries to enroll in private Medicare HMOs where such coverage is available. Of the private managed care plans contracting with Medicare currently, 97 percent provide coverage for routine physicals, 88 percent provide coverage for immunizations, and 61 percent provide coverage for outpatient pharmaceuticals.[5]

Congress also must begin to rethink the manner in which the traditional Medicare program should be managed and benefits determined. The current process of determining benefits is a combination of politically driven benefit determinations and slow and inflexible HCFA regulatory micromanagement. The highly bureaucratic and outmoded fee-for-service program must be given the flexibility to adjust and modernize benefits so that it can deliver the highest quality care at the most reasonable price.

4 Steven Woolf and Robert Lawrence, "When Politicians Play Doctor," *The Washington Post,* May 4, 1997, p. C1.

5 Physician Payment Review Commission, *Medicare Risk Plan Participation and Enrollment: A Chart Book,* December 1996.

NEEDED: AN INDEPENDENT BOARD FOR MEDICARE

The problem today is that Medicare is run by both the Department of Health and Human Services and Congress. Benefit design and cost control could be managed more effectively if the operations of the traditional Medicare program were divorced from other HCFA operations. To do this, Congress should establish a semi-independent board to run the traditional fee-for-service program, leaving the HCFA to concentrate on general issues such as managing the trust funds, providing more help and information to beneficiaries, and setting the competition rules for plans.

- The board should be appointed by Congress and should include consumer representatives from seniors' groups. It should also receive expert advice from existing advisory bodies such as the Physician Payment Review Commission and the Prospective Payment Assessment Commission, which are already mandated by Congress to study cost and benefit issues in the Medicare program.
- The board would have authority to shape Medicare benefits and payment policies within annual budget limits established by Congress. Decisions would take into consideration all relevant information, such as health care quality and outcome data, service utilization rates, access to care, and beneficiary cost-sharing. Congress should be able to approve the board's decisions with an up-or-down vote.

After over two years of wrangling, Administration officials and congressional leaders finally have reached an agreement on balancing the budget with a broad outline for changes to Medicare needed to meet the budget savings target. This news, no doubt, brings great relief to a number of lawmakers still licking their wounds from the contentious 1995 Medicare reform debate and the subsequent thrashing they took during the 1996 political campaigns. These lawmakers, however, must beware of becoming complacent regarding their options for reforming Medicare. Certainly, the last Medicare battle was not all in vain. This is no time for policymakers to back away from principles that inspired them to pursue bold action only two years ago. Understanding that Medicare's financial crisis is a function of its structural flaws, lawmakers can and must make changes that open up new choices for seniors by expanding private coverage options and restructure the traditional program by allowing for benefit and cost decisions to occur outside the political and regulatory process. Only then will real changes occur in this troubled program.

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