Health Policy Report

The American Health Care System

Medicare

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WHEN Medicare was enacted in 1965 as the health care linchpin of President Lyndon Johnson's Great Society, its architects considered this insurance program for the elderly only an interim step toward the broader goal of universal health care coverage.[1] That goal has never been achieved, although Medicare is the nation's single largest source of payment for medical care, insuring 39 million beneficiaries against the financial consequences of acute illness. Since Congress established the program, the benefits covered by Medicare have remained largely unchanged, with the exception of a few added preventive services, and they are certainly inadequate by current medical standards. Medicare expended $214.6 billion in 1997 in two large funding streams: Part A, for hospital services, and Part B, for physicians' services. These two types of care are financed from four different sources, the most important of which is mandatory contributions by employers and employees. The other three are general tax revenues, premiums paid by beneficiaries, and deductibles and copayments.

Medicare is the subject of this report, the fourth in the current series on the American health care system.[2-4] Medicare's hospital-financing scheme, like that of the Social Security program, is grounded in the principle of social insurance, which requires all employers and employees to make payments to a trust fund. Some 151 million employees make mandatory contributions to Medicare's Part A Hospital Insurance Trust Fund during their working years, with the promise of receiving benefits after they retire. The money contributed by employees that finances Medicare's Hospital Insurance Trust Fund is not set aside to meet their own future health expenses. Rather, it is used to cover the medical bills of the people who are currently covered by Medicare. All eligible beneficiaries are automatically enrolled in Part A, which finances inpatient hospital services, continued treatment or rehabilitation in a skilled-nursing facility, and hospice care for the terminally ill.

Medicare's other major component, supplemental medical insurance (Part B), was modeled after traditional indemnity coverage and was initially created to win the support of Republicans for the program. Enrollment in Part B is voluntary, although the vast majority of beneficiaries sign on. Part B pays for physicians' services and outpatient hospital services, including emergency room visits, ambulatory surgery, diagnostic tests, laboratory services, and durable medical equipment. Under Part B, Medicare pays 80 percent of the approved amount (according to a fee schedule) for covered services in excess of an annual deductible of $100. Overall, 89 percent of Medicare's annual revenue now comes primarily from people who are less than 65 years old, through payroll taxes, income taxes, and interest on the trust fund, and 11 percent comes from the monthly premiums contributed by elderly beneficiaries.

THE CHALLENGE FACED BY THE HEALTH CARE FINANCING ADMINISTRATION

Medicare and Medicaid (which I will discuss in my next report) are administered by the Health Care Financing Administration (HCFA), a beleaguered federal agency that is criticized by observers on all sides as bureaucratic, rigid, and at times, overwhelmed by its administrative responsibilities, which have grown exponentially in the 1990s. In contrast to its vast charge, HCFA is a remarkably small agency, primarily as a consequence of "downsizing" that occurred during the administration of President Ronald Reagan. Since HCFA's creation, its spending on behalf of Medicare beneficiaries has increased by a factor of almost 10 (from $21.5 billion in 1977 to $214.6 billion in 1997) and the population eligible for Medicare has grown from 26 million to 38.6 million. But the full-time–equivalent staff of the agency has remained about the same, at roughly 4000 people. The performance of HCFA will come under closer scrutiny this year because the Republican-controlled Congress plans to conduct hearings on its performance. But in the view of 14 distinguished people from different parts of the political spectrum, including three former HCFA administrators (Dr. William L. Roper, Leonard D. Schaeffer, and Gail R. Wilensky), the agency's problems are not all of its own making. The 14 recently urged Congress and the administration to reexamine what they consider the inadequate resources at HCFA's command: "The signatories to this statement believe that many of the difficulties that threaten to cripple HCFA stem from an unwillingness of both Congress and the Clinton administration to provide the agency the resources and administrative flexibility necessary to carry out its mammoth assignment."[5]

Despite HCFA's problems, Medicare is a highly popular federal program, particularly among its beneficiaries, many of whom could not afford health insurance coverage if they had to pay its entire cost. Medicare beneficiaries include 34 million persons over

the age of 65, 5 million of all ages who are permanently disabled, and 284,000 with end-stage renal disease.[6] In 1993, almost three quarters of elderly people reported annual household incomes of less than $25,000, at a time when per capita Medicare expenditures averaged $4,083. In the estimation of a recently departed HCFA administrator, Bruce C. Vladeck, Medicare is "an extremely powerful weapon for reducing poverty for the elderly and disabled."[7] But not all its beneficiaries support the program's role as a redistributor of income. On July 1, 1988, when President Reagan signed into law the Medicare Catastrophic Coverage Act, its financing mechanism represented a formal acknowledgment by Congress of the disparities in economic status among the elderly. The law called for "an enormous increase in beneficiary contributions"[8] by elderly people with greater means to help finance the care of people with lower incomes. Less than two years later, on November 22, 1989, Congress repealed the law after coming under pressure from a vocal minority of relatively affluent elderly people, who resented paying higher premiums, and from the pharmaceutical industry, which was concerned that a new outpatient drug benefit would lead to federal price controls. Since the law's repeal, there has been no cap on beneficiaries' out-of-pocket liability.

Public-opinion polls show strong and consistent support for Medicare[9] and its intergenerational social compact; most beneficiaries who require medical care receive far more from the program than they contributed in payroll taxes, and far more than members of the baby-boom generation, the first of whom will turn 65 in 2010, are likely to receive. For example, a couple retiring in 1998, with one wage earner who paid average Medicare taxes since 1966, would have contributed a total of $16,790, with interest, not including the employer's equal contribution. The present value of future Part A benefits for such a couple is estimated at $109,000, more than six times the amount they paid into the trust fund (Foster RS, HCFA: personal communication).

Medicare is so popular that politicians who are seen as threatening it put themselves in jeopardy, as Republicans learned to their regret in 1995. After newly elected Republican majorities took control of the House and Senate and set out to cut the budget by trimming Medicare, their plan was vetoed by President Bill Clinton as too draconian and was strongly opposed by the elderly, who helped Clinton win reelection the next year. Whereas many billions of dollars separated what Republicans and Democrats were prepared in 1995 to excise from Medicare's future growth, Clinton focused on a figure that ordinary Americans could comprehend: the additional $264 that Republicans wanted an elderly couple to pay in annual Medicare premiums. As Charles N. Kahn III, a former Republican congressional staff member who was centrally involved in the issue, wrote recently, "President Clinton used the Part B premium issue to transform the debate."[10]

MEDICARE'S FINANCIAL PROBLEMS

In 1992, I reported that Medicare's trustees estimated that the program's Hospital Insurance Trust Fund would run out of money by 2001.[11] With bankruptcy looming, I concluded that Congress would have to soon decide how to close the gap between the program's income and its expenses. Its options were further paring payments to providers, raising taxes, reducing benefits, asking beneficiaries to pay more of the costs, or some combination of these options. Five years later, Congress followed a formula that it has applied consistently over the past two decades. In the Balanced Budget Act of 1997,[12] Congress extracted the vast bulk of savings to the Medicare program ($116.6 billion over the period from 1998 through 2002) from future payments to providers. To balance the budget and extend the solvency of the hospital trust fund to 2007, Congress took 56.5 percent of the government-wide savings contained in the Balanced Budget Act from Medicare's estimated future expenditures, although the program represents only 12 percent of federal spending.

In the process of shaping the Balanced Budget Act, Congress largely insulated beneficiaries from greater financial liability, but legislators also got a taste of the dilemma that looms ahead when the baby-boom population transforms Medicare's demographic characteristics[13] and health care costs nearly double over the next decade, as HCFA projects.[14] The Senate, whose members stand for election every six years, as compared with every two years for House members, showed a greater willingness to ask beneficiaries to shoulder more of the financial burden. The Senate voted to raise the age of initial eligibility for Medicare from 65 to 67 years,[15,16] to adjust a beneficiary's Part B premium on the basis of his or her income, and to require copayments for home health services. House members, always running for reelection and therefore more sensitive to the concerns of elderly voters, rejected all three of these ideas, relying instead on reductions in payments to providers.

RESTRUCTURING MEDICARE

With the enactment of the Balanced Budget Act of 1997, Congress and the Clinton administration approved the most far-reaching reforms in the 34-year history of Medicare — some 300 provisions that are certain to add more complexity to the program. In the process, Congress greatly expanded the responsibilities of HCFA and the Medicare Payment Advisory Commission, which Congress created to monitor the administration of the program.[17] The reforms were intended to expand the choices among private health plans that beneficiaries may select by

creating the new Medicare+Choice program and to strengthen Medicare's finances by including policies further constraining payments to providers in the traditional fee-for-service program and in managed-care plans.

Although news reports have focused on problems in the early implementation of Medicare+Choice, most beneficiaries are still covered under the program's traditional component — that is, indemnity insurance combined with fee-for-service payments to physicians, the model that prevailed when Medicare began. The program's original structure remains intact except for the imposition of administered prices through the prospective payment system for hospitals and the Medicare fee schedule for physicians' services. Under Medicare's traditional insurance program, all physicians and hospitals that meet Medicare's conditions of participation take part in the program without regard to whether they are affiliated with health plans or aggregated in medical groups. In 1997, 33 million Medicare beneficiaries were still in the traditional program, which cost an estimated $183 billion, representing 88 percent of total Medicare spending that year.

Most of the provisions of the Balanced Budget Act of 1997 that applied to traditional Medicare coverage reduced its growth instead of moving to upgrade it, as called for in a recent study by the National Academy of Social Insurance.[18] Congress directed HCFA to replace Medicare's cost-based reimbursement method with more restrictive prospective payment approaches that would apply to postdischarge services, the fastest-growing component of Medicare in the 1990s.[19] These services include care in skilled-nursing facilities, hospital outpatient services, inpatient rehabilitation services, and home health care. The growth of home health services, one of two major Medicare benefits for which there is no cost sharing by the beneficiary (the other is clinical laboratory services), has been particularly explosive; total expenditures increased from $2 billion in 1988 to more than $17 billion in 1997, largely because of increased rates of use. In 1988, about 5 percent of beneficiaries received home health care services, with the average user receiving 23 visits. In 1997, 1 in 10 beneficiaries received home care, and the average number of visits exceeded 80.[17]

MEDICARE+CHOICE

The Medicare-related provisions of the 1997 Balanced Budget Act to which Republicans attached the greatest ideological importance were those that expanded the array of insurance plan choices beyond fee-for-service indemnity coverage and health maintenance organizations (HMOs). Congress directed HCFA to offer options involving provider-sponsored organizations, preferred-provider organizations, private fee-for-service plans, and on a limited basis, medical savings accounts that combine high deductibles with a tax benefit. Congress also required the agency to develop a method of adjusting its payments to health plans so as to reflect more accurately the actual health status or recent medical experience of patients.[20-22] In the 18 months since the enactment of the law, the policy Congress designed and HCFA has set about implementing to broaden participation in the Medicare+Choice program has been fraught with problems.

As of last November, the date when HMOs in which Medicare beneficiaries were already enrolled were required to inform HCFA whether they planned to continue their participation in the program, 43 of the 347 plans announced their intention not to renew their contracts with Medicare for 1999, citing financial losses and other problems as the main reasons. Another 54 HMOs announced plans to reduce the number of geographic areas in which they were prepared to enroll Medicare beneficiaries. These changes affect the coverage of some 406,000 beneficiaries. Because almost all these enrollees live in areas where other HMOs operate, they have the option of switching to another such plan. Beneficiaries who do not live in areas with other HMOs will have to return to Medicare's traditional insurance program and, in all likelihood, to purchase supplemental coverage to pay for the additional benefits that HMOs offered elderly enrollees (coverage of outpatient prescription drugs is the most expensive of these). The plans cited several reasons for withdrawing from Medicare or from selected services areas. They considered HCFA's payment rates as reduced by the Balanced Budget Act too low and the law's new regulatory strictures as implemented by the agency too burdensome. An estimated 87 percent of all beneficiaries affected by the withdrawals of insurance plans were enrolled in for-profit plans (as compared with 68 percent of all Medicare beneficiaries enrolled in HMOs).[23]

Dr. Robert A. Berenson, director of HCFA's Center for Health Plans and Providers, said in an interview that Medicare had been overpaying health plans that operate in markets with high per capita rates and that HCFA had no plans to support rate increases, as sought by the industry:

> In 1999 payment rates will vary from almost $800 in Staten Island, New York, to about $380 in many rural areas. . . . What we are witnessing is that HMOs are eager to enroll Medicare beneficiaries in high-payment areas, but they are dropping out of marginal-payment areas. . . . Each decision to pull out of a service area makes sense as a narrow business decision. But when you add up all of these decisions, the HMO industry is losing a reputation for reliability and stability. And that is a very unfortunate trend for the industry and the Medicare population. Indeed, it casts in some doubt that a competitive market might be a solution to Medicare's long-term financial problems.

CONFLICTS AMONG PHYSICIANS

Medicare's schedule of physicians' fees, like the prospective payment system that pits different kinds of hospitals against each other, provokes conflict between medical generalists and specialists. These disputes have grown in prominence ever since 1989, when Congress directed HCFA to develop a schedule of physicians' fees.[24] In search of savings and greater equality in Medicare payments to generalists and specialists, Congress said the schedule should be based on a resource-based relative-value scale that would take into consideration three distinct types of cost that doctors incur: their time, energy, and skill (referred to as physicians' work); practice expenses such as medical equipment and office space; and premiums for malpractice insurance.[25] In 1992, the Physician Payment Review Commission estimated that by 1996, when the new payment schedule was due to be fully implemented, fees paid to generalist physicians would be 39 percent higher than they would have been under the previous payment method, whereas those paid to cardiothoracic surgeons and ophthalmologists would be 35 percent and 25 percent lower, respectively.[11]

How accurate was the commission's 1992 estimate? As Table 1 shows, family and general practitioners saw a cumulative increase of 36.1 percent in their average payments from Medicare between 1991 and 1997. But because Congress required separate but unequal relative-value–scale conversion factors for surgical and nonsurgical services, many specialist physicians fared better during this period than the commission had earlier estimated. For example, the cumulative reduction in Medicare payments from 1991 to 1997 for cardiothoracic surgeons was 9.3 percent and that for ophthalmologists was 18.4 percent. As Table 2 shows, Medicare has reduced payments for many of the procedures performed by cardiologists, gastroenterologists, and ophthalmologists. The Balanced Budget Act of 1997 directed HCFA to cease to apply different conversion factors and established a single conversion factor (payments to physicians are the product of the number of relative-value units established for each service in the fee schedule and the conversion factor). HCFA set this factor at $34.73 for 1999, a change that will most likely lead to further reductions in Medicare payments to surgeons.

Recently, what has provoked the most controversy among medical organizations in regard to Medicare's fee schedule is the way in which HCFA plans to phase practice expenses into the payment formula, as required by the Balanced Budget Act. The agency, believing it was following congressional intent, proposed to phase in practice expenses in a way that had the effect of granting generalist physicians higher payments and specialists lower payments. The dispute prompted 11 specialty societies (representing cardiologists, gastroenterologists, ophthalmologists, and different types of surgeons) to file suit last November 4 in U.S. District Court to halt the implementation of what they called HCFA's "unlawful transition formula."[26] The plan, scheduled to take effect January 1, 1999, would cost members of the 11 societies $495 million in Medicare payments over the next three years, the suit asserted. But a coalition of primary care medical groups, which formed the Practice Expense Fairness Coalition, disagreed, saying in a letter to HCFA, congressional committees, and others that if the plaintiffs won their court case, it would undo a compromise fashioned in the Balanced Budget Act that had settled a divisive debate within the medical profession.[26]

The American Medical Association (AMA) has remained neutral on this matter, recognizing that its physician members are divided by it. But, on other matters related to Medicare, the association has carved out a unique relation with HCFA that holds both pluses and minuses for it. The AMA helped develop Medicare's fee schedule and also publishes *Current Procedural Terminology*, the widely used manual for coding physicians' services. Moreover, according to Vladeck, the agency has "largely delegated to [the AMA] responsibility for maintaining many of the system's technical aspects. This requires the increasingly disputatious specialty societies to go through an AMA process to achieve some of their objectives."[7] On the other hand, the AMA came in for sharp criticism over its role in the development of draft guidelines for documenting cognitive services (evaluation and

TABLE 1. CHANGE IN AVERAGE MEDICARE PAYMENT RATES, ACCORDING TO AREA OF PRACTICE, FROM 1991 TO 1997.*

GROUP OF PHYSICIANS AND AREA OF PRACTICE	ANNUAL CHANGE	CUMULATIVE CHANGE
	percent	
Generalist physicians		
Family and general practice	5.3	36.1
Internal medicine	2.6	16.5
Medical subspecialists		
Cardiology	−2.7	−15.0
Gastroenterology	−2.6	−14.4
Other	2.4	15.3
Surgeons		
General surgery	0.0	0.1
Dermatology	1.5	9.0
Ophthalmology	−3.3	−18.4
Orthopedic surgery	−0.3	−1.7
Cardiothoracic surgery	−1.6	−9.3
Urology	1.9	12.2
Other	0.7	4.1

*Data are from the analysis by the Medicare Payment Advisory Commission of claims for a sample consisting of 5 percent of beneficiaries in 1991 through 1997 (Hayes KJ, Medicare Payment Advisory Commission: personal communication). Values shown are average percent changes in payment rates.

TABLE 2. AVERAGE MEDICARE PAYMENTS FOR SELECTED HIGH-VOLUME PROCEDURES, ACCORDING TO SPECIALTY, IN 1991 AND 1997.*

SPECIALTY AND PROCEDURE	1991	1997	CHANGE
	dollars		%
Cardiology			
Echocardiography of heart	215.60	202.66	−6.00
Heart image (3D) multiple	531.91	469.16	−11.80
Cardiovascular stress test	131.43	109.56	−16.64
Complete electrocardiography	29.70	27.44	−7.60
Doppler color-flow ultrasonography	94.45	107.78	14.10
Report on electrocardiography	12.28	11.04	−10.10
Doppler echocardiography of heart	104.89	91.24	−13.01
Coronary-artery dilation	1,517.42	833.14	−45.10
Gastroenterology			
Colonoscopy and removal of lesion	567.40	406.67	−28.33
Diagnostic colonoscopy	352.01	264.64	−24.82
Upper gastrointestinal endoscopy and biopsy	347.45	207.36	−40.32
Ophthalmology			
Removal of cataract and insertion of lens	1,358.63	912.67	−32.81
Eye examination and treatment	44.06	53.10	20.54
Eye examination for established patient	35.00	36.39	3.96
Treatment of localized retinal lesion	702.75	740.98	5.44
Eye examination for new patient	50.33	74.51	48.05
Treatment of extensive or progressive retinopathy	733.29	868.88	18.49
Follow-up care after laser cataract surgery	517.50	247.00	−52.27
Ultrasound examination of eye	66.35	67.99	2.47

*Data are from the analysis by the Medicare Payment Advisory Commission of claims for a sample consisting of 5 percent of beneficiaries in 1991 through 1997 (Hayes KJ, Medicare Payment Advisory Commission: personal communication).

management) in the medical record.[27,28] On balance, Vladeck said, the relation between HCFA and the AMA is "functional for both parties, although the extent to which it protects the interests of practicing physicians, even that fraction that belong to the AMA, is subject to increasing question."[7]

GRADUATE MEDICAL EDUCATION

Underscoring the increasingly precarious nature of Medicare's status as the largest explicit financing source for graduate medical education, Congress took a first step in the Balanced Budget Act toward changing this policy by reducing the program's funding for this purpose.[29] Of the federal programs and agencies that support graduate medical education (Medicare, Medicaid, and the departments of Defense and Veterans Affairs), Medicare is by far the largest single source of such funds. Medicare recognizes the costs of education in two ways. It provides direct medical-education payments to hospitals that cover a share of residents' stipends, faculty salaries, and administrative expense, and it provides an indirect medical-education adjustment that reflects the added costs of patient care associated with the operation of teaching programs.[30]

In 1997, Medicare's indirect medical-education adjustment totaled $4.6 billion. In the Balanced Budget Act, Congress reduced Medicare's indirect support for medical education by $5.6 billion over the next four years by changing the formula to make the payments less generous. Medicare's direct payments for graduate medical education totaled $2.2 billion in fiscal 1997. The budget legislation reduced Medicare's direct payments over the next five years by an estimated $700 million. The reductions in payments to teaching hospitals were partially offset by returning to the hospitals a portion of the premiums Medicare pays to managed-care plans. These funds, earmarked for education and amounting to some $4 billion, will be returned in annual installments of 20 percent over the five-year period from 1998 through 2002.

Although the Balanced Budget Act signaled the intention of Congress to cut back Medicare's commitment to financial support for teaching, several members of the National Bipartisan Commission on the Future of Medicare have urged more fundamental changes in federal policy as it applies to graduate medical education. Congress created the commission, a body whose deliberations have been contentious because some of its 17 members were appointed by Republicans and some by the Clinton administration. Its report to Congress is due March 1. Senator Phil Gramm (R-Tex.), who is a member of both the bipartisan commission and the Senate Finance Committee, which has jurisdiction over Medicare, has proposed that support for graduate medical education be subject to the greater scrutiny of the annual appropriations process rather than take the form of assistance to which teaching facilities are entitled according to a fixed payment formula. The Association of American Medical Colleges (AAMC) strongly opposes this proposal. With the departure of New York's two senators — the defeat last November of Republican Alfonse M. D'Amato and announcement by Democrat Daniel Patrick Moynihan that he will retire when his term expires in 2001 — proposed changes in federal policy on graduate medical education that are opposed by the AAMC must be taken more seriously. For many years, D'Amato and Moynihan used their positions on the Finance Committee essentially to veto any changes in Medicare's policy on support for teaching.

FUTURE DIRECTIONS

As the 21st century nears and the baby-boom population heads closer to retirement, the changes included in the Balanced Budget Act are strictly a down payment in terms of closing Medicare's funding gap. Economist Victor Fuchs estimates that "if the trends of the past decade or two continue until 2020, the elderly's health care consumption in that year will be approximately $25,000 per person (in 1995 dollars), compared with $9200 in 1995."[31] In

the short term, provoked by President Clinton's insistence that the current federal budget surplus be used to shore up the financial base of Social Security, Congress plans to consider replenishing the coffers of the Social Security program even though Medicare is slated to run out of money first. When it does focus on Medicare again, one proposal that may be considered seriously would make the government's financial obligation more predictable and shift more of the risk to beneficiaries. It has gained the support of Senator John B. Breaux (D-La.), chair of the National Bipartisan Commission on the Future of Medicare, a number of commission members,[32] and prominent economists of various persuasions.[33,34] The proposal would replace Medicare's commitment to provide a defined set of benefits to all eligible beneficiaries with a "premium support" system. All beneficiaries would receive a predetermined amount to be applied to the purchase of a health plan providing defined benefits. The amount would vary according to the beneficiary's age, sex, geographic area, health-risk status, income and assets, and use of services. If a beneficiary wanted benefits that went beyond those that could be purchased with the voucher, the amount of which would probably be related to income, he or she would be responsible for the additional cost. In many respects, the proposal resembles the Federal Employee Health Benefits Plan.

Beyond financial questions, Congress must consider how to improve Medicare's benefits package, which is based on a model of acute care that is wholly inadequate for the many elderly beneficiaries who have chronic illnesses.[35,36] A critical shortcoming is Medicare's failure to cover outpatient prescription drugs, particularly because most Medicare HMO enrollees do have such coverage.[37,38] Congress has taken note of this disparity and may well examine it this year. In any event, balancing the health care needs of the population eligible for Medicare with the available resources will be a continuing challenge well into the new millennium.

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