The Heritage Foundation Issue Bulletin

No. 220 | The Heritage Foundation • 214 Massachusetts Avenue, N.E. • Washington, D.C. 20002-4999 • (202) 546-4400 • http://www.heritage.org

November 9, 1995

REFORMING MEDICARE: COMPARING THE HOUSE AND SENATE LEGISLATION

INTRODUCTION

Congress is on the brink of enacting the most sweeping reform of the Medicare program since the program's inception. If enacted, the reform will take the first giant step toward a system that offers real choices to the elderly and, by slowing the rapid growth in costs, helps ensure that today's working Americans will have a health care program available to them when they retire.

The next action Congress must take to achieve this goal is to reconcile House and Senate versions of Medicare reform legislation. Certain key provisions in the bills passed by each chamber must be in the final conference package, and Members must focus on these. They must also bear in mind that failure to enact Medicare reforms will cause the whole tax and budget package to unravel.

House and Senate Members realize that failure to reform Medicare necessarily means the current program cannot be sustained financially, meaning huge future tax increases on America's working families[1] or deep cuts in future Medicare benefits for the elderly. Even the proposed reforms are only a stop-gap measure to ward off fiscal disaster when the "Baby Boom" generation qualifies for Medicare. The Democratic alternative would keep the hospital trust fund solvent until about 2006, just before the Baby Boomers begin to join the program. Even the Republican plan assures solvency of the Medicare hospitalization trust fund only until the year 2010. Failure to enact serious reforms now will just make that future task even more daunting.

1 For a discussion of the economic consequences of a failure to reform Medicare, see Stuart M. Butler, "The High Cost of Not Reforming Medicare," Heritage Foundation *F.Y.I.* No. 56, May 4, 1995; Robert E. Moffit, John C. Liu, and David H. Winston, "What Americans Will Pay If Congress Fails to Reform Medicare: The State and Congressional District Impact," Heritage Foundation *F.Y.I.* No. 62, September 19, 1995; and David H. Winston, Christine L. Olson, and Rea S. Hederman, "The Cost of No Medicare Reform: What Industry and Government Would Pass On to Consumers, Investors, Taxpayers, and Workers," Heritage Foundation *F.Y.I.* No. 67, October 16, 1995.

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

Medicare is plagued by structural problems and exploding costs, according to the program's own Board of Trustees.[2] There is a surprising consensus on how to deal with those structural problems.[3]

The legislation being considered by the House and Senate indicates that Congress is prepared to begin making those fundamental changes. The differing House and Senate Medicare proposals have been folded into their respective balanced budget reconciliation bills, H.R. 2491 and S. 1357. The key structural change in the House version is to create a new MedicarePlus Program, patterned after the successful Federal Employees Health Benefits Program (FEHBP), which has served Members of Congress and other federal employees and retirees for over 30 years. Under this arrangement, seniors could opt to use the value of their Medicare benefits as a payment toward a private health plan within a competitive market. Within this framework, seniors could pick plans offered in various ways, including plans offered through elderly organizations and physician- or hospital-organized plans (which would mean real competition to managed care plans). These plans also could include high-deductible insurance combined with Medical Savings Accounts (MSAs). The Senate's Balanced Budget Reconciliation Act proposal also offers seniors an alternative to traditional Medicare by creating a Medicare Choice Program that is also patterned after the FEHBP.[4] The FEHBP, which provides a wide-ranging list of competing health plans with varying benefit levels and prices, has held down premiums through the free-market forces of consumer choice and competition.[5]

While the legislation in both chambers makes significant improvements in the Medicare program, certain provisions, if not modified, could lead to unintended harmful consequences for the health care market and the elderly. Even more important, certain provisions are entirely counterproductive and contradict the leadership's stated goal of creating a consumer-driven market in Medicare.

Specifically:

- ✗ The government would standardize benefits packages in private Medicare plans;
- ✗ Price controls would be maintained in the traditional Medicare program according to the House bill;
- ✗ There would be premium caps on private-sector health plans in the House bill;
- ✗ Medical Savings Accounts have been removed as an option in the Senate Medicare Choice plan under the so-called Byrd Rule;

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2 The Medicare Board of Trustees is comprised of seven members, three of whom are Clinton Administration Cabinet Secretaries: Health and Human Services Secretary Donna Shalala, Treasury Secretary Robert Rubin, and Labor Secretary Robert Reich.

3 For a description of the various models for Medicare reform, see John C. Liu and Robert E. Moffit, "A Taxpayer's Guide to the Medicare Crisis," Heritage Foundation *Talking Points*, September 27, 1995.

4 On the use of the FEHBP as a model for Medicare reform, see Stuart M. Butler, Robert E. Moffit, and John C. Liu, "What To Do About Medicare," Heritage Foundation *Backgrounder* No. 1038, June 26, 1995; see also Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Winter 1995, forthcoming.

5 On cost control in the FEHBP, with particular relevance to the defined contribution option in Medicare, see Robert E. Moffit, "FEHBP Controls Costs Again: More Lessons for Medicare Reformers," Heritage Foundation *F.Y.I.* No. 64, September 25, 1995.

- ✗ The bills still do not allow private contracting arrangements between provider and patient;
- ✗ The House bill fails to permit union-sponsored plans as an option; and
- ✗ The bills do not create a balanced playing field in the clinical laboratory industry; they fail to link direct billing to the fail-safe budget mechanism.

If lawmakers do not come to terms with these and other issues, the legislation will not fully deal with the structural problems of today's Medicare program.

WHAT THE HOUSE AND SENATE BILLS DO

1. Both bills establish consumer choice of health plans.

Both bills seek to redress the absence of a health care market by expanding the choice of plans and benefits available to the elderly and disabled, using the value of their Medicare benefits as a contribution to the cost of their chosen plan. The elderly would be able to choose the package of benefits, beyond the current Medicare package, that they felt best met their needs. Enrollees would be able to choose traditional Medicare with certain changes (the non-MedicarePlus option) or a private plan as defined in the MedicarePlus/Medicare Choice Programs. The proposals thus expand the opportunities for individual choice of plans. To protect seniors from fraudulent sellers and ensure that confused seniors receive information with which to make a wise choice, the bills require private plans to meet certain minimum consumer protection requirements in order to qualify as MedicarePlus/Medicare Choice organizations.

The House Bill

A MedicarePlus product could be a physician-sponsored organization, a high-deductible policy combined with a Medical Savings Account, a private fee-for-service plan, a Taft-Hartley plan, or a plan offered through a church or other association. During an annual enrollment period, seniors would be able to enroll in a MedicarePlus health plan in their geographic area by filing a form indicating their preference. To ensure that seniors are making an informed choice, the Secretary of Health and Human Services would be required to provide information to future and current Medicare beneficiaries as to the coverage options available.

Notably absent from the eligible organizations in MedicarePlus are health plans sponsored by unions. While the original bill included unions as eligible sponsors of MedicarePlus plans, the substitute offered by Representatives William Archer (R-TX) and Thomas Bliley (R-VA) in their respective committees eliminated such opportunities.

The Senate Bill

In contrast, the Senate provision allows for union sponsorship of Medicare Choice plans and thus would provide even more choices to the elderly. The Senate bill allows unions to sponsor health plans for its members and their spouses. While this is an improvement over the House version, union plans should be allowed to market their health plans to seniors who are not affiliated with the unions, but who register as associate members. This would place unions on a par with other associations under the leg-

islation. In the FEHBP, individuals who are not affiliated with one of the federal employees' unions can join as an associate member for a nominal membership fee and avail themselves and their spouses of the program's health coverage. By not allowing the unions to sell MedicarePlus/Medicare Choice plans to the general senior population, the House and Senate plans restrict the market and the range of choices that could be available. One of the unintended effects of the bill as currently written would be to encourage many Americans to become full members of a union to gain access to union health coverage during retirement.

What Congress Should Do:

Congress should expand the options available to senior citizens to include union-sponsored plans. Any restriction on the supply of providers is a restriction on the free market and incompatible with personal consumer choice.

2. Both bills provide peace of mind to seniors by eliminating concerns about pre-existing medical conditions.

One of the conditions a plan or entity must satisfy to be certified as a MedicarePlus/Medicare Choice organization is to accept any individual electing to enroll regardless of health status.[6] This protection is needed for current and future Medicare beneficiaries who suffer from a pre-existing condition. Individuals who incur a serious illness after enrolling in a MedicarePlus/Medicare Choice plan could not be excluded from coverage in the future. Both bills guarantee the issuance and renewal of MedicarePlus/Medicare Choice policies to all future and current beneficiaries. Certain exceptions apply for Taft-Hartley organizations in which eligibility to enroll is restricted to members through an employment relationship, or to the spouses of such members.

3. Both bills impose a government-standardized benefits package.

MedicarePlus/Medicare Choice must guarantee that any package of health benefits it sells includes, at a minimum, the benefits and services currently available under traditional Medicare Parts A and B. While this is viewed by many in Congress and elsewhere as a guarantee that beneficiaries will not be "shortchanged" should they opt into the MedicarePlus/Medicare Choice programs, it undermines the principle of consumer choice. One of the many problems with a comprehensive minimum package is that the package is a political product, not a response to consumer demand. For example, the current Medicare program does not cover outpatient prescription drugs or long-term care, even though these are crucial to a growing number of elderly people. Yet, on the other hand, it includes:

- ✓ Major hospital inpatient services,
- ✓ Surgical-medical benefits,
- ✓ Mental care,
- ✓ Outpatient care, and

6 Both the House and Senate proposals contain one exception to this requirement, and that pertains to individuals qualifying for Medicare due to end-state renal disease (ESRD). Individuals who develop ESRD after enrolling in a non-Medicare plan may continue enrollment in that particular plan.

✓ Limited home health and hospice care.

Needless to say, federal workers and retirees have access to plans including drug benefits, long-term care coverage, and other benefits not available under Medicare. This happens because there is a consumer demand for these benefits, not because politicians support them. In the FEHBP, there is no comprehensive standardization of benefits.

A related problem is that specifying a minimum package of benefits undermines the cost control objective of the reform proposal. If a MedicarePlus/Medicare Choice plan were to offer such additional benefits, they could not be substituted for other benefits to keep the price down. Thus, beneficiaries normally would face higher premiums to get the benefits they really want. Furthermore, with the adoption of a standardized benefits package, Congress invites provider group pressures in future benefit setting. It can be expected that special interests will lobby Congress continually for additional mandated benefits and services, just as they do at the state level, where mandated benefits laws have driven up health care costs, and as they have throughout the history of Medicare. Members should recall their unpleasant experience with such lobbying practices the last time Congress reformed Medicare, during the adoption and later repeal of the Medicare Catastrophic Coverage Act of 1988.[7] As additional benefits and services were added to the original catastrophic package, the associated costs increased and required greater payments from beneficiaries. This is an inherently bad idea.

What Congress Should Do:

Instead of adopting a rigid framework, Congress should adopt the model of the FEHBP in which federal employees and retirees have access to a wide spectrum of benefits from health plans that are required only to offer catastrophic protection and meet certain solvency requirements and consumer protection standards.[8] Seniors would be given real choices in deciding which optional benefits were necessary or desirable. Like federal employees, the plans would have to protect seniors against the cost of catastrophic accidents or illnesses, but otherwise could offer a range of benefits.

4. Both bills establish a defined contribution for Medicare beneficiaries.

One of the key elements of reform, widely agreed upon by proponents of change in Medicare, is the defined contribution model. Regardless of the personal choice of a plan or option, Medicare benefits would be defined as a dollar amount, as opposed to today's open-ended entitlement to specified services. Both bills take the appropriate steps in determining how much of the federal budget will be allocated to the Medicare and MedicarePlus/Medicare Choice programs.

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7 For a detailed explanation of the downfalls of the standardized benefits package in Medicare, see Robert E. Moffit, "The Last Time Congress Reformed Health Care: A Lawmaker's Guide to the Medicare Catastrophic Debacle," Heritage Foundation *Backgrounder* No. 996, August 4, 1994.

8 Stuart M. Butler and Edmund F. Haislmaier, "The Consumer Choice Health Security Act," Heritage Foundation *Issue Bulletin* No. 186, December 23, 1993.

Under both bills the federal government would make monthly premium payments to the MedicarePlus/Medicare Choice plan chosen by the beneficiary. The payments reflect a refinement of the current Medicare risk contract, which reimburses HMOs that provide Medicare services for a single monthly capitated rate per beneficiary.[9] As opposed to the current government-regulated "fee for service" reimbursement system, which provides an open-ended subsidy, MedicarePlus/Medicare Choice would provide a defined contribution toward the purchase of a private plan in the beneficiary's geographic area. The contributions would vary among beneficiaries, depending on their age, gender, geographic area, welfare status, and other factors, to reflect the relative actuarial value of the benefits. To ensure stability in payments to MedicarePlus/Medicare Choice plans, the federal government's contribution levels would be adjusted to recognize legitimate variations in costs of doing business in different geographic locations. In general, contribution levels in rural and low service utilization markets would increase at a faster rate than those in high service utilization areas. The federal government's contribution level would be kept within the budget targets as outlined in the Balanced Budget Reconciliation Act of 1995.

To realize budget neutrality, the Secretary of Health and Human Services is required to compute per capita growth rates for a year so that the weighted average per capita growth rate for all areas in the country is equal to the national average per capita growth rate:

	House[10]	Senate[11]
1996	5.3%	8.7%
1997	3.8%	6.8%
1998	4.6%	6.3%
1999	4.3%	6.3%
2000	3.8%	6.8%
2001	5.5%	6.9%
2002	5.6%	7.0%

Note: The Senate bill includes no details on subsequent years. In the House bill, growth in each subsequent year is 5.0%

In both bills, the amount of assistance and rate of growth assigned to the defined contribution is a matter of explicit decision by political leaders. Beneficiaries who choose to be covered under MedicarePlus will know the amount of their benefit, and the federal government will know the amount of its obligation. Regardless of the type

9 The current Medicare risk contract payment is based on two factors: the adjusted average per capita cost (AAPCC) and the adjusted community rate (ACR). The AAPCC is an estimate of the average per capita amount Medicare would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who is not enrolled in an HMO and obtains services on the usual "fee for service" basis. The ACR is the estimated market price for the Medicare package and the average of the Medicare per capita payment rate.

10 H.R. 2454, The Medicare Preservation Act of 1995, Subtitle A, Part I, Sec. 15002, Part C, September 29, 1995, p. 25.

11 Percentage increases in the Senate bill reflect annual rates of growth allowed in the Medicare budget expenditure limit tool (BELT) as defined in "Budget Reconciliation Recommendations of the Committee on Finance," Committee on Finance, U.S. Senate, 104th Cong., 1st Sess., Committee Report 104-34, October 1995, p. 54.

of health plan a beneficiary chooses under MedicarePlus/Medicare Choice, the government's contribution remains fixed.

What Congress Should Do:

The defined contribution as drafted presents a step in the right direction of reducing the exploding rate of growth in Medicare but it does not go far enough and is not balanced. The bills apply the defined contribution requirement only to MedicarePlus/Medicare Choice plans, unintentionally placing private-sector plans at a disadvantage when attempting to compete against traditional Medicare.

Maintaining an open-ended subsidy to all enrollees choosing traditional Medicare (unlimited 80 percent copayments after reaching a $100 per year deductible for Part B) and retaining a heavily subsidized Part B premium (68.5 percent from the government) effectively precludes a level playing field between MedicarePlus/Medicare Choice plans and the existing Medicare program. While private-sector providers are required to design their various health plans in accordance with the size of the defined contribution, traditional Medicare is under no such constraint. Thus, the current draft would lead to a distortion of both choice and market by favoring traditional Medicare over the private sector in this regard.

The defined contribution should be applied universally so that a truly level playing field exists between traditional Medicare and MedicarePlus/Medicare Choice. Unfortunately, the fail-safe budget mechanism (price controls) created in the House version will force health care providers to be even more cost-conscious in providing services, which could lead eventually to rationing or a decline in participation by physicians in traditional Medicare. While the Senate attempted to create a similar mechanism—budget expenditure limit tool (BELT)—in its reform, it was stricken during floor debate as being extraneous under the Byrd Rule.

5. Both bills continue to rely on price controls for traditional Medicare.

Aside from the issue of fair competition between the federal government and the private sector, the lack of substantive changes in traditional Medicare means it is unlikely that the reforms as a whole will reach the targets required to help achieve a balanced budget by the year 2002. In that event, the House legislation would require Congress to trigger a last-resort fail-safe budget mechanism. (Depending on parliamentary procedures in the Senate, the equivalent procedure in the Senate version is called a budget expenditure limitation tool, or BELT.) This would automatically decrease the payments for items and services in the following sectors of traditional Medicare:[12]

- ✓ Inpatient hospital services;
- ✓ Home health services;
- ✓ Extended care services;
- ✓ Hospice care;

12 "Budget Reconciliation Recommendations of the Committee on Finance," p. 54. H.R. 2454, The Medicare Preservation Act of 1995, Subtitle H, Part 3, Sec. 15721, September 29, 1995, pp. 118-127.

- ✓ Physicians' services and other services of other health care professionals;
- ✓ Outpatient hospital services and ambulatory facility services;
- ✓ Durable medical equipment and supplies, including prosthetic devices and orthotics;
- ✓ Diagnostic tests; and
- ✓ Other items and services.

Should Congress implement the fail-safe mechanism as a last resort, providers of health care to Medicare beneficiaries would see a reduction in the scheduled reimbursement rate for services—in reality a tightening of existing price controls. But price controls in the past have failed to hold down Medicare costs, just as they have failed in other countries, leading to distortions, a decline in quality and availability of services, and widespread evasion.

What Congress Should Do:

Rather than require tighter price controls in a futile attempt to hold down costs, Congress should develop a market-based look-back mechanism, perhaps modeled after the reimbursement schedules developed by International Paper Company for its employee health insurance plan. These specify payment rates based on average market prices in different geographic areas, and then readjust the reimbursement rates for doctors, hospitals, and other health care providers in those areas based on market performance.[13] Even more important, International Paper's fixed reimbursement rate does not require the patient to pay a certain percentage of a physician's fee; instead, it allows the physician and patient to agree on a price, with the patient in effect receiving a voucher toward that fee (which may cover the full amount). Using this system, the company cut its costs 14.5 percent between 1991 and 1992. This equated to an average out-of-pocket savings of 5.7 percent per employee. International Paper, using the scheduled benefits plan, did not have increased medical costs in 1994 or 1995.[14]

6. Both bills raise Part B premiums in proportion to benefit costs.

The Medicare supplemental medical insurance (SMI) program, also known as Part B, is voluntary. All persons 65 or over may enroll by paying a monthly premium—$46.10 per month as of January 1, 1995. This amount is equivalent to just 29 percent of the actual average cost of Part B coverage. The remaining 71 percent is paid for by taxpayers out of the general revenue fund. When Congress created Medicare, the cost of Part B was divided evenly between the beneficiary and taxpayers. The original intent was to create a subsidy for the nation's elderly, but at a significantly lower rate than is being provided today.

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13 For a discussion of this idea, see Brenda Fitzgerald, M.D., "Reforming Medicare: What Congress Can Learn from the Health Plans of America's Corporations," Heritage Foundation *Backgrounder* No. 1059, October 30, 1995, p. 12.

14 Jerry Bowers, Director of Special Projects-Health Care, International Paper Company, Memphis, Tennessee, communication to Brenda Fitzgerald, M.D., September 1995.

Since the early 1980s, however, Congress has taken the politically safe path of setting premiums at a level which covers only 25 percent of program costs. This modest amount covers 80 percent of allowable charges with a deductible of only $100 per year.

Due to government miscalculations with respect to the cost of Part B, the 1995 premium paid by current beneficiaries is approximately 31.5 percent of program costs. Rather than allow it to fall back to 25 percent, which would mean actually cutting premiums, both bills would set the Part B premium permanently at 31.5 percent of costs beginning in 1996. But even this means a huge subsidy to seniors, regardless of income. And since this subsidy would continue in the traditional Part B program, private insurance alternatives in MedicarePlus would not be as attractive, even though their actual costs might be lower.

What Congress Should Do:

Taxpayers should not be subsidizing 68.5 percent of Part B. To reduce that subsidy, Congress should consider one of two options:

❶ **Raise the beneficiary premium to 50 percent of program costs, effective January 1, 1996.**

Such a change could yield net savings of up to $205.3 billion over the next seven years. Raising this premium immediately to its original proportion of 50 percent is not a tax increase, because Part B is entirely voluntary and subsidized by the general taxpayer, not paid for out of payroll taxes. Reducing this taxpayer-provided subsidy to the level specified in the original contract between the federal government and the American taxpayers will effectively reduce future Medicare outlays.

❷ **Increase the beneficiary premium in increments of 5 percent each year until it reaches 50 percent of program costs and then freeze it at that level.**

This more politically palatable option will not yield the same savings to taxpayers as the first option would in the first seven years. However, it will reduce outlays by $162.1 billion over this period. Each year thereafter, Medicare will realize significant savings while still providing a generous subsidy to enrollees.

7. Both bills reduce the subsidy based on income.

Under current law, all beneficiaries who choose to enroll in Medicare Part B, regardless of income, pay the same premium and receive the same subsidy from the taxpayers. The House bill reduces the subsidy to individuals with incomes over $75,000 and couples with incomes over $125,000 per year, effective January 1, 1996. The federal subsidy would be eliminated gradually for individuals with incomes of $100,000 and couples with incomes of $175,000 per year, also effective January 1, 1996. While policy analysts disagree on the level of income at which the Part B subsidy should be phased out, most agree that the bill takes a positive step in the right direction in this regard.

The Senate bill adopts a similar approach by reducing the subsidy for single individuals with incomes over $50,000 and couples with incomes over $75,000. The federal subsidy would be phased down and eventually eliminated for singles whose in-

comes are $100,000 and couples with incomes above $150,000, effective January 1, 1996.

Again, it must be emphasized that reducing taxpayer-subsidized services in a program that is entirely voluntary is not a tax increase. Medicare Part B costs are projected to increase at roughly 12 percent annually.[15] Because Part B is subsidized so heavily by the general Treasury, *all* taxpayers end up paying for the ever-increasing federal share of this program. It is ironic that, in an age when the working poor cannot afford to purchase even a minimum package of health benefits, they are forced to subsidize individuals who enjoy significantly higher savings and assets.

The Senate's Deductible Option. While the House made improvements in Part B, it did not change the Part B deductible. The Part B deductible was set up to serve two purposes: (1) to discourage unnecessary utilization of medical services and (2) to reduce the volume of small size claims, thereby producing not only savings in claim dollars, but also substantial savings in claim administration. It has to be set at an appropriate level to achieve these two purposes, but Congress has allowed it to fall sharply in real terms. From 1967 (the first full year of Part B experience) to 1996, typical service charges per enrollee will have increased more than 2,300 percent, while the deductible will have increased only 100 percent. For the deductible to keep up with per enrollee charges, it would have to be $1,203 in 1996.[16]

The Senate bill would automatically raise the Part B deductible to $150, effective January 1, 1996, and increase it in increments of $10 each January 1 thereafter, through 2002.

What Congress Should Do:

The conference should adopt the Senate policy on the Part B deductible.

Of the two options to adjust the premium according to income, the lower Senate threshold is preferable. An alternative would be to combine the lower threshold with a new provision to allow the premiums for lower-income elderly to fall to 25 percent of costs or less. This would mean a larger subsidy for poorer Americans, but no subsidy for more affluent seniors.

8. Both bills establish a new Medicare trust fund for Medicare savings.

Liberals in Congress have charged that the Republican Medicare reform proposals are nothing more than devastating cuts to fund tax cuts for the rich. While the fact remains that most of the tax relief provided in the Balanced Budget Reconciliation Act of 1995 goes to working families with children,[17] House and Senate Republicans have included provisions in their respective Medicare reform proposals to ensure that there will be "[a] lock box mechanism that places all savings from Part B into a Medicare Preservation Trust Fund and prohibits any transfers to pay for future tax cuts."[18]

15 "Budget Reconciliation Recommendations of the Committee on Finance," p. 40.

16 Guy King, former Chief Actuary of the Health Care Financing Administration, Washington, D.C., personal communication, November 1994.

17 Scott A. Hodge, "Senate $500 Per Child Tax Credit Frees 3.5 million Families from Income Tax Rolls," Heritage Foundation *F.Y.I.* October 26, 1995.

Savings from changes in Part B premiums thus will be used only to strengthen Medicare's financial status.[19] Under both the House and Senate versions, the Secretary of the Treasury, who serves as managing Trustee of the Medicare Trust Funds, is directed to estimate the savings to the federal government resulting from changes in the Part B premium on a yearly basis. The savings yielded from this reform will then be transferred from the general revenue fund of the U.S. Treasury to the Federal Hospital Insurance (Part A) Trust Fund in the form of public-debt obligations issued exclusively to the Federal Hospital Insurance Trust Fund. Money from the Federal Hospital Insurance Trust Fund may be used only for Medicare expenditures.[20]

HOW CONGRESS CAN IMPROVE MEDICARE REFORM

While the House and Senate bills significantly improve the existing Medicare program, there are several provisions which occur only in one of the bills. Other provisions should be strengthened, and still others should be changed or deleted.

1. **The Senate should consider carefully the House medical liability reform provisions.** Under current law, there are no uniform federal standards governing health care liability law. Unfortunately, the states generally have not introduced the reforms needed to curb unnecessary lawsuits and unreasonable damage awards. Thus, physicians often perform medically unnecessary and sometimes costly procedures to shield themselves from potential liability. The added costs of these procedures are paid for by the Medicare program and the private sector, as well as through higher premiums. The House bill would institute a number of crucial reforms in medical malpractice and health care liability law. The bill would apply certain limits on suits involving physicians, hospitals, pharmaceutical companies, medical device manufacturers, and other providers. Specifically, the bill would:

   ✓ **Allow** malpractice awards exceeding $50,000 to be paid in periodic increments;

   ✓ **Limit** noneconomic damages in medical malpractice cases to $250,000;

   ✓ **Make** each defendant liable only for the amount of noneconomic loss and punitive damages allocated in direct proportion to such defendant's percentage of responsibility; and

   ✓ **Grant** punitive damages only if the plaintiff establishes, by clear and convincing evidence, that the harm suffered was the result of conduct manifesting conscious, flagrant indifference to the health of the claimant or to the health of persons who might be harmed by the health care products. Punitive damages awarded would be determined by the court but could not exceed $250,000 or three times the amount of economic damages, whichever was greater.

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18 Representative John Boehner (R-OH), "H.R. 2425— Medicare Preservation Act," House Republican Conference *Legislative Digest*, FloorPrep, October 19, 1995, p. 1.

19 "Budget Reconciliation Recommendations of the Committee on Finance," p. 52.

20 *Ibid.*, p. 285, Sec. 7173. H.R. 2425 [Report No. 104-276, Parts I and II], 104th Congress, 1st Session, Union Calendar No. 145, October 16, 1995, pp. 967, 968, Sec. 15901.

The Senate version does not contain malpractice provisions.

While there are federalism concerns involved in any national legislation to reform malpractice, there is an urgent need to deal with the liability problem. The federal government funds approximately half the nation's health care expenditures through Medicare, Medicaid, and Veterans Administration programs, and medical malpractice and other liability costs, driven by pro-plaintiff state law, have contributed to the federal government's growing expenditures.

The case can be made for the federal government, under the Commerce Clause, preempting state liability law in those areas of the health care system where there is substantial interstate business such as pharmaceuticals and medical devices. Even here, Congress should move cautiously. There is a far weaker case, however, for preempting state liability law affecting economic activity entirely within a state (such as most physical or hospital services). So the conferees should resist incorporating federal preemption in these areas of the health care system, and instead urge the states to reform their own laws.

2. **Both the Senate and the House need to allow direct billing for clinical laboratory services.** Medicare Part B covers diagnostic clinical laboratory services performed in independent clinical laboratories, hospital-based laboratories, and physician office laboratories. Under current law, the provider of the clinical laboratory test must bill Medicare, not the beneficiary. In turn, Medicare reimburses the provider for services on the basis of "area wide fee schedules" which are updated periodically to account for inflation.[21] The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) included provisions that would slow the rate of growth in Medicare expenditures by eliminating the inflation update for 1994 and 1995, in addition to a "phased down" reduction in the national ceiling on payment amounts for clinical laboratory services.[22] OBRA 1993 set the national ceiling at 80 percent of the median of all fee schedules for the test, and 76 percent of the national median in 1996 and each year thereafter. Despite such measures, Medicare has achieved insignificant savings from the initial fee schedule rates originally established in 1986.

Medicare payment policy has rewarded inefficiency within the clinical laboratory industry. What is needed is a market-driven solution that will stimulate greater competition and substantially reduce the cost of laboratory services to all payers, public and private. The House and Senate bills both would reduce the Medicare fee schedule to 65 percent of the median, effective January 1, 1997. Reducing the national cap for each laboratory service to 65 percent of the national median fee during the base year for that service, and eliminating the CPI update factor through 2002, would effectively eliminate the cost shift to Medicare and force the clinical laboratory industry to compete on real costs. The savings to Medicare would be immediate, measurable, and significant.

21 Jennifer O'Sullivan, "Medicare: Payments for Clinical Laboratory Services," Congressional Research Service, CRS Report for Congress, 93-115 EPW, September 17, 1993, p. 2.

22 Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), P.L. 103-66.

The House bill does contain one advantage over the Senate proposal with regard to laboratory fees. This deals with the issue of direct billing. In general, clinical laboratories market their services to physicians, offering the physician a wholesale price for testing. The physician then can pass on the price of the test to the patient. Combining direct billing with the right of a patient to select a laboratory would remove the physician as the determinant of which laboratory to use. The House legislation would require the clinical laboratory to bill the patient or the health plan designated by the patient.[23]

What Congress Should Do:

The conference should include the House policy. Adopting this policy would help reduce Medicare spending by creating greater competition and consumer choice.

One technical and procedural problem remains, however: The current legislative language in the House bill contains technical problems that have prevented the Congressional Budget Office from "scoring" savings attributable to direct billing. Direct billing language appears to be used only as part of a separate fail-safe mechanism should Medicare not achieve its budgetary goals. The House bill can be corrected by linking the savings from direct billing to the overall fee schedule and CPI freeze contained in both the House and Senate versions. Applying the direct billing requirement to all services, both Medicare and non-Medicare, will end physicians' markups on tests they do not perform and lead to lower overall utilization and costs.

3. **Clarify the status and payment of skilled nursing facilities.** The Medicare SNF benefit covers post-hospital skilled nursing care in facilities certified to participate in the program. Currently, Medicare reimburses skilled nursing facilities on a per day basis for reasonable costs, subject to per diem cost limits. These limits are applied to per day routine service costs, which include nursing, room and board, administrative, and overhead expenses. Separate per diem limits are established for freestanding and hospital-based SNFs by urban or rural area. Freestanding skilled nursing facilities are set at 112 percent of the average per diem labor-related and non-labor-related costs. Hospital-based SNF limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding SNF limits and 112 percent of the average per diem routine service costs of hospital-based SNFs.

   Hospital-based and freestanding SNFs treat patients of similar acuity with almost identical outcomes. There is no difference in care. This finding is reported in a September 26, 1995, study by Abt Associates, Inc., using 1994-1995 data on over 20,000 rehabilitation patients.[24] This report concludes that the current reimbursement differential between freestanding and hospital SNFs is a waste of Medicare funds. The current reimbursement system contains an incentive for hospital-based SNFs to admit a patient for full Medicare reimbursement and then transfer that same patient down to the SNF unit and receive full cost reimbursement for SNF care at a higher level than a

23 H.R. 2425, "The Medicare Preservation Act of 1995," Report No. 104-276, Parts I and II, 104th Congress, 1st Session, Union Calendar No. 145, October 16, 1995, Subtitle G, Part 3, Sec. 15621, p. 859.

24 Daniel Sherman, Ph.D., "Subacute Care at Freestanding Skilled Nursing Facilities: A Source of Quality Care for Medicare Patients," Abt Associates, Inc., September 26, 1995, p. 2.

freestanding SNF. Millions of Medicare patients require hospitalization each year for their particular ailments. However, it has become apparent that certain patients can be transferred to an SNF for subacute care with no detriment to the patient or sacrifice in quality of care.

Based on analysis of the cost of treating over 22,000 Medicare patients across the country representing across-the-board ailments (for example, stroke, orthopedic, heart failure, cancer, simple pneumonia), the Abt report concludes that the current Medicare program "could have saved an average of $455 for each day that subacute care at free-standing SNFs was substituted for hospital-based care. For Medicare to fully realize these savings, however, Medicare would need to first rebase the current hospital DRG payment system, dividing the DRG payment...between hospitals and SNFs based on the cost of providing care. In addition, Medicare would also need to eliminate the requirement that patients stay three or more days in a hospital before becoming eligible for Medicare coverage in a SNF."[25]

What Congress Should Do:

Congress should eliminate the routine cost limits (RCL) differential between free-standing and hospital-based skilled nursing facilities.

Congress should examine the cost-effectiveness that SNFs are able to provide and bring into play true competition among providers in this field of care by placing all SNFs under the same routine cost limit reimbursement formula. Based upon Congressional Budget Office projections for SNF spending over the next seven years, Medicare would save approximately $4.1 billion during this period if the routine cost limitation for all SNFs was set at 112 percent of the mean.

4. **Eliminate House-passed premium caps.** While MedicarePlus permits market forces to compete against one another, thereby promoting greater value and efficiency, the modified Chairman's Mark in both the House Ways and Means Committee and the House Commerce Committee contains a provision that exacerbates the imbalance between MedicarePlus and traditional Medicare.

   A new paragraph entitled "Relation of Premiums and Cost Sharing to Benefits" was added under Sec. 15002, MedicarePlus Program, as Sec. 1852(d)(5). The amendment would provide that in no case may the portion of a MedicarePlus organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments attributable to the minimum benefits exceed the actuarial value of the coinsurance and deductible applicable in the non-MedicarePlus option. Though price controls have been a failure within the current Medicare program, the House bill now proposes premium price controls for all private-sector plans. This provision would undercut the ability of private plans to compete with traditional Medicare. The danger is that few private plans will opt to participate in the new program if there are premium price controls. This could lead to a possible oligopoly in areas where well-financed insurance companies with high enrollment can take the financial risks inherent in a distorted health market. What is likely if the controls are included in the final legislation, par-

25 *Ibid.*, p. 1.

ticularly in underserved rural areas, is that virtually no private plans will be offered. Moreover, since MedicarePlus plans are required to offer the current Medicare Parts A and B package as a minimum benefits package, the ability to provide additional benefits within the limits on the rate of increase in capitation payments is hampered. The opportunity to provide greater value, choices, and efficiency would be severely reduced, since MedicarePlus plans opting to participate could be expected to offer limited options and seek out lower-cost providers.

Even if one accepts the notion that price controls are not harmful, they are not necessary in the bill because seniors are under no obligation to choose private plans. If a plan raises its prices, it must persuade customers that the extra cost is justified by extra value.

Under the House provision, it is the elderly and disabled who will be adversely affected, since lower-cost providers are not necessarily the more efficient or better quality providers. Plans will be effectively barred from offering superior services at a reasonable additional cost.

Thus, while the House bill is an attempt to provide the elderly with more choices and options in health plans through the private sector on the one hand, it simultaneously restricts private plans' ability to provide such services by imposing strict pricing caps and regulatory benefits requirements. By not allowing participating MedicarePlus plans to charge market-based premiums, it will severely limit beneficiaries' options in private health plans and prevent them from taking advantage of the wide range of health care delivery services available in a free and open private market.

What Congress Should Do:

The Senate bill wisely refrains from creating further distortions in the health market by allowing Medicare Choice plans to determine their premium prices and letting patients, not government, decide whether the higher-priced plans are good value. For Members of Congress serious about promoting rather than restraining market forces, the Senate policy is superior.

5. Both bills should allow patients to contract privately with doctors, hospitals, and other medical providers.

Noticeably absent from the House and Senate bills is an explicit provision to guarantee the right of every Medicare beneficiary to purchase health care services on a private basis. Under such an arrangement, also referred to as private contract, a Medicare beneficiary could receive a specified medical service for an agreed upon fee—or in some cases, for no fee at all, since Medicare regulators at the Health Care Financing Administration (HCFA) have threatened to impose $2,000 fines on providers who fail to charge any patient the Medicare Part B $100 deductible.[26] In private contracting arrangements, no Medicare reimbursement claims would be filed because no Medicare reimbursement claims would be sought by either provider or patient. This would occur at no cost to insurance companies or federal taxpayers.

26 Lois J. Copeland, M.D., "Please Do No Harm," *Policy Review*, Summer 1993, p. 8.

What Congress Should Do:

Congress should permit direct, private contracting among Medicare patients. While the House bill (like an earlier version of the Senate bill) allows for privately contracted services to enrollees in the Medical Savings Account option, Congress should allow all beneficiaries, regardless of the option they choose (traditional Medicare or MedicarePlus), to contract privately for health services. Many elderly and disabled persons, for varying reasons, have expressed to their physicians a desire to keep Medicare completely out of the picture. Sec. 1848(g)(4)(A)(i) of the Social Security Act requires health care providers to "[c]omplete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary."[27] However, the Department of Health and Human Services, which is responsible for implementing and enforcing this statute, has been inconsistent in this matter. In *Stewart v. Sullivan*, 816 F. Supp. 281 (1992), federal judge Nicholas Politan ruled that the Secretary of Health and Human Services had not articulated a clear policy against private contracting. Given the discrepancy between statutory law and existing case law, physicians are still uncertain as to which law prevails and fearful of possible reprisals from HCFA through the threat of sanctions.

Congress should end this confusion by supporting the principle of private contract. Any reform legislation should ensure that beneficiaries are not forced or required to receive their health care solely through Medicare and not prohibited from paying a provider on any basis as agreed to between the individual and the provider.

6. **Make sure that the Administrator of the Health Care Financing Administration remains subject to Senate Confirmation.** The House bill contains a surprising provision that would eliminate the requirement that the Administrator of the Health Care Financing Administration, who is responsible for managing the huge Medicare Trust Funds, be subject to confirmation by the United States Senate.[28]

The Administrator of HCFA is an extremely important and senior official. The Administrator, among other things, is a member of the Medicare Board of Trustees with responsibility for administering an insurance system that covers close to 38 million Americans, and should be held to a higher level of accountability than a mere political appointee of the Secretary of Health and Human Services. The attachment of the Administrator's signature to the Hospital Insurance and Supplemental Medical Insurance Trust Fund Reports signifies an extraordinary degree of public accountability.

The Administrator of HCFA also is charged with overseeing both the Medicare and Medicaid programs and heads an agency that will have over 4,000 full-time employees and a budget of almost $250 billion this year. An official with these heavy responsibilities should be held accountable to the public through Senate confirmation.

27 *Compilation of the Social Security Laws, Including the Social Security Act, as Amended, and Related Enactments through January 1, 1993*, House Ways and Means Committee Print, 103rd Cong., 1st Sess., 103-5, 1993, p. 818.

28 H.R. 2425, The Medicare Preservation Act of 1995, Subtitle A, Part 5, Sec. 15033, September 29, 1995, p. 160.

What Congress Should Do:

Congress should retain Senate confirmation of the Administrator of HCFA and not allow the Secretary of Health and Human Services to appoint any individual to this powerful and influential position.

MAJOR PROBLEMS REMAINING IN MEDICARE REFORM

The Need for Medical Savings Accounts

During the floor debate on the Senate bill, the provision that created Medical Savings Accounts within Medicare was eliminated. A point of order against the provision was upheld on the grounds that it was extraneous and a violation of Sec. 313(d) of the Congressional Budget Act of 1974, the so-called Byrd Rule. The main explanation for the point of order was the alleged potential of MSAs to increase the deficit by $3.5 billion over the next seven years.

The House bill authorizes a beneficiary who chooses MedicarePlus to purchase a high-deductible insurance plan with an MSA. For individuals who choose the MSA option, the Secretary of Health and Human Services would make a defined contribution to the MedicarePlus MSA chosen by the beneficiary. Only contributions by the Secretary of HHS could be made to a MedicarePlus MSA, and such contributions would not be taxable income. The high-deductible policy would provide reimbursement for Medicare beneficiaries only after annual expenses equal to a deductible not to exceed $10,000. Interest earned on amounts held in the MedicarePlus MSA also would not be subject to income tax.

What Congress Should Do:

Conferees should redraft the MSA provision so that it does not conflict with the Byrd Rule.

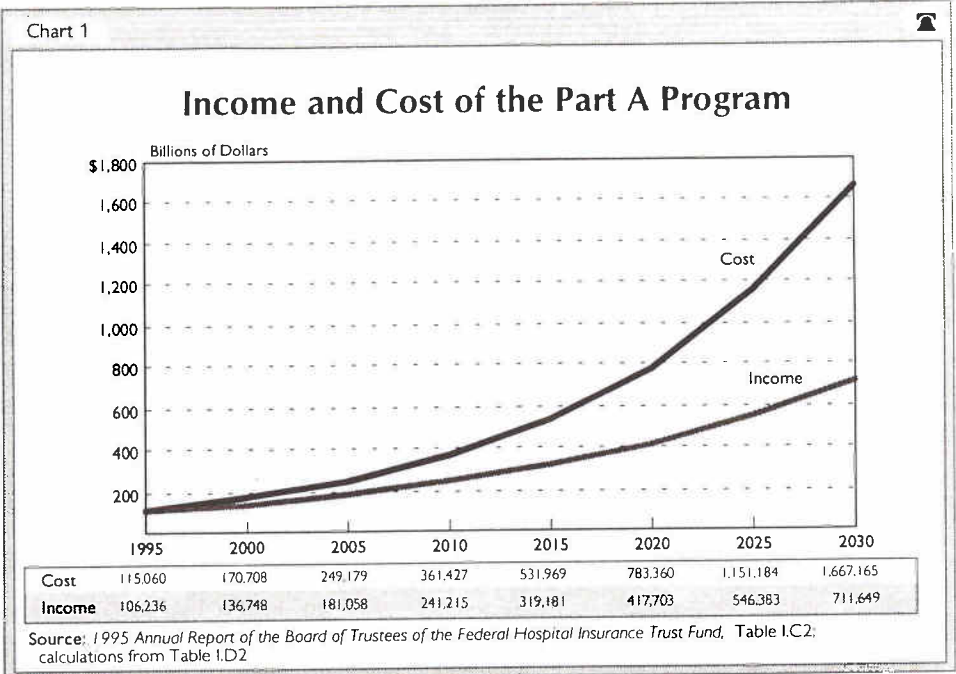
Medicare MSAs give the elderly who choose them complete control over most health care decisions and the flexibility to choose their own providers. Furthermore, they provide the security of catastrophic coverage, an element that is noticeably absent from the current Medicare program. Once an individual has reached his or her deductible level, the private plan, not the federal taxpayer, will cover all additional medical expenses.

The Need for Baby Boomer Guarantees

Baby Boomers must be assured that their payroll tax contribution will not be forfeited if Medicare ever defaults. The House and Senate Medicare reform legislation only partly addresses the troubled status of the Hospital Insurance (HI) Trust Fund. As Chart 1 indicates, the HI Trust Fund begins to pay out more money than it brings in (a negative cash flow) in 1996. Absent corrective legislative action, the Medicare Trustees say that assets will be depleted within the next 6 to 11 years.[29]

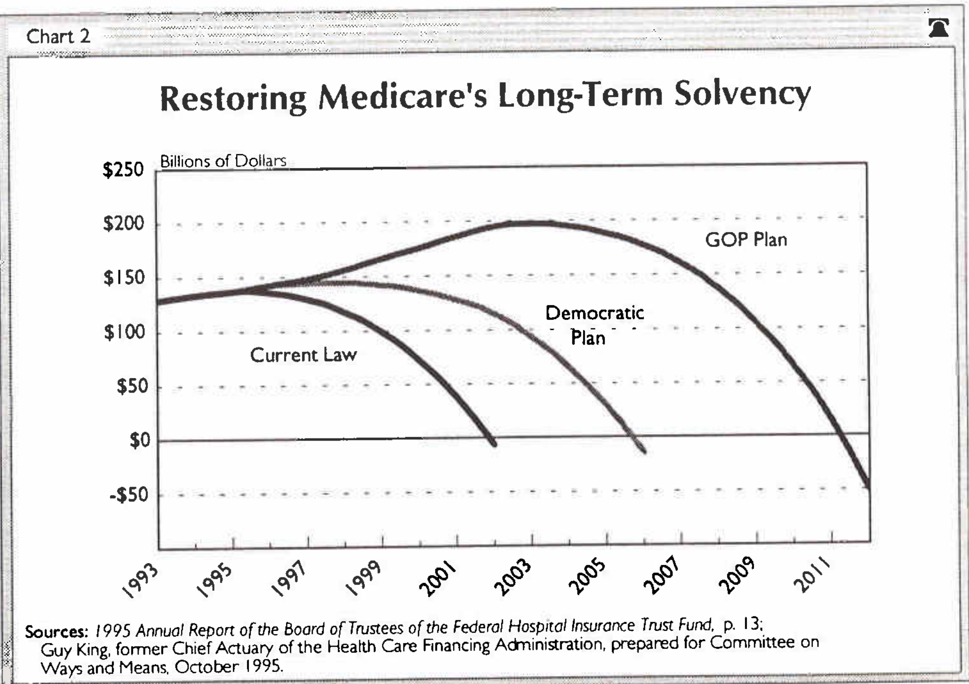
29 *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* April 3, 1995, p. 13.

In highlighting the critical need for the House and Senate to take corrective action, the Medicare Trustees state: "The fact that exhaustion would occur under a broad range of future economic conditions, and is expected to occur in the relatively near future, indicates the urgency of addressing the HI trust fund's financial imbalance."[30]



	1995	2000	2005	2010	2015	2020	2025	2030
Cost	115,060	170,708	249,179	361,427	531,969	783,360	1,151,184	1,667,165
Income	106,236	136,748	181,058	241,215	319,181	417,703	546,383	711,649

Source: *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* Table I.C2; calculations from Table I.D2



Sources: *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* p. 13; Guy King, former Chief Actuary of the Health Care Financing Administration, prepared for Committee on Ways and Means, October 1995.

The Medicare provisions of the reconciliation bill would address this near-term financial problem, extending the solvency of the HI trust fund through 2010. The White House proposal, like plans advanced by congressional Democrats, would not even keep the hospital program solvent beyond 2006. In other words, neither the reconciliation proposal nor the other proposals would guarantee members of the Baby Boomer generation (Americans born between 1945 and 1957) the current Medicare system when they are eligible to retire, starting in the years 2010 through 2022.

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30 *Ibid.*

The House bill does include a provision which creates a Commission on the Effect of the Baby Boom Generation on the Medicare Program. This commission is charged with reporting to Congress no later than May 1, 1997, its findings and recommendations on how to preserve Medicare in a financially solvent manner until 2030. The report is to include detailed recommendations for appropriate legislative initiatives specifying how this objective is to be accomplished.[31]

What Congress Should Do:

Congress should incorporate a provision in Medicare reform legislation to guarantee Americans born after 1945 that their contributions toward the Hospital Insurance Trust Fund will be paid back to them upon retirement if benefits are no longer available to them under Medicare.

As mentioned earlier, both the House and Senate reform proposals create a "lock box" trust fund which requires that Medicare savings be applied to the HI program. Since there is no certainty as to the longevity of this trust fund, Congress should make a commitment to the Baby Boomer generation that their mandatory contributions to the HI program will be paid back in kind. This can be accomplished through a provision that allows for a future tax reduction for individuals born between 1945 and 1962. If future income tax payments are pro-rated to reflect an individual's investment in the HI trust fund over the course of his working years, these working Americans will not be penalized should the commission fail to develop a concrete proposal ensuring the financial integrity of the HI trust fund.

The Need for Provider-Sponsored Networks

In trying to transform the current Medicare program into an open competitive system, both the House and Senate reform measures include provisions which create provider service networks/provider-sponsored networks (PSNs) in the MedicarePlus or Medicare Choice plans. In other words, both bills would enable doctors and hospitals in local areas to market health plans, giving the elderly yet another range of options from which to can choose.

Doctors and hospitals in local areas often may be better able than insurance companies to meet these needs, especially in many rural areas where managed care entities have found it difficult to create a network. By allowing doctors to form their own network, Congress would be giving the elderly a chance to buy health insurance coverage sponsored by a trusted physician in the community.

As passed by the House, PSNs would be regulated at the federal level. The Senate bill places regulation of PSNs at the state level while at the same time demonstrating an awareness of the current problem of overregulation of insurance at the state level, including mandated benefits and other restrictions incompatible with market-based reform. Under the Senate bill, therefore, a state has 90 days from the date of application from doctors and hospitals to issue a license. In the event the state fails to issue a license, the legislation creates an alternate avenue for certification via the Secretary of the U.S. Depart-

31 Based upon H.R. 2425, The Medicare Preservation Act of 1995, Subtitle A, Part 4, Sec. 15032(f), September 29, 1995, p. 159.

ment of Health and Human Services. This provision ensures that states are the regulators of first resort. Absent a fair and impartial judgment by a state regulator, the Secretary of Health and Human Services is authorized to grant temporary relief to provider-sponsored networks by issuing a federal license for no longer than 36 months. The PSN is still under an obligation to obtain state certification.

Over time, as PSNs become established, price and quality sensitive consumers will be able to make wise and informed decisions, comparing PSNs to all other options in the Medicares new consumer choice program. Moreover, the Senate bill, unlike the House version, recognizes that the federal licensure process should be applied only as a temporary measure to reflect necessary transition to a new competitive system. Thus, this alternative federal licensing program would expire on December 31, 2000.

What Congress Should Do:

As a matter of public policy, the Senate position on allowing PSNs is superior to the policy in the House bill. On the other hand, Congress should adopt the House antitrust policy that allows for creation of such provider-sponsored networks.

CONCLUSION

This Congress deserves enormous credit for its courage in tackling the tough and politically sensitive Medicare program. Typically, as with all those who try to deal with programs serving the elderly, Members seeking to save the Medicare program are being accused of wrecking it.

Medicare is in financial crisis. While liberals in Congress insist that the program remain unchanged—with its cumbersome bureaucracy, heavy regulation, price controls, and runaway costs—others should not hesitate to seize this historic opportunity to reform the program and give America's elderly more control over the ownership and selection of health care benefits. The House and Senate bills have many deficiencies. But by introducing consumer choice and competition, this Congress can take a giant step toward assuring that Medicare will still be available, at reasonable cost, to future generations.

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