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ONE CHEER FOR THE HOUSE MEDICARE PROPOSAL

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INTRODUCTION

The House of Representatives is considering legislation designed to breathe new life into Medicare. Although approval of changes by the Ways and Means Committee to stave off bankruptcy in Medicare's Hospital Insurance (HI) trust fund is at the center of the debate, serious structural reforms are necessary—and should represent more than a wink or a nudge at the overly bureaucratic nature of this ailing program. The fine print of the House Republican plan reveals that the legislation under consideration will stop short of the kinds of changes needed to shore up Medicare's long-term fiscal integrity. More important, the House proposal fails to establish a comprehensive framework for a consumer-driven program that includes a broad choice of health plans and benefits for senior citizens.

The House bill does take a few steps in the right direction. For example, it would expand the private choices available to seniors under a new "MedicarePlus" program; would allow certain forms of managed care, such as preferred provider organizations (PPOs) and provider sponsored organizations (PSOs), to compete with traditional Medicare; and would allow for a limited number of Medicare medical savings accounts (MSAs). It also would require, for the first time, that beneficiaries have access to necessary consumer information, much of it collected by the Health Care Financing Administration (HCFA) for years but never distributed to beneficiaries. This information should compare competing health plans in plain, non-bureaucratic language. Finally, the House bill would revise the irrational Medicare payment methodology that is used to determine the government's contribution to private managed care plans.

Other policies embodied in the bill, however, including a clear retreat from certain previously held positions outlined in the 1995 Balanced Budget Act,[1] cause it to fall short of the structural reforms that conservatives in Congress profess to want—and that the country's elderly desperately need.

There are several steps that Congress can take to save the House Medicare proposal from becoming merely one more stopgap measure designed to forestall the day on which Medicare's hemorrhaging costs require massive tax increases for working Americans in order to survive. Specifically, Congress should:

- **Offer** senior citizens a broad range of private health plans, benefits, and premium options—at least as many as Members of Congress, federal retirees, federal employees, and their families enjoy today in the Federal Employees Health Benefits Program (FEHBP);[2]
- **Allow** for choice and flexibility in the design of health plan benefits so that private insurers can offer different benefits or a combination of different benefits to meet the personal needs of patients;
- **Allow** senior citizens to keep the savings that result from choosing a lower-cost health plan;
- **Allow** patients to make private contracting arrangements with the doctor of choice in traditional Medicare;
- **Reject** the expansion of price controls like the hospital-based prospective payment systems (PPS) for home health care and skilled nursing facilities;
- **Halt** expansion of the HCFA Centers of Excellence program until further congressional review of its efficacy and standards can be conducted; and
- **Reject** the latest version of an earlier Clinton Administration proposal that would pay teaching hospitals *not* to train doctors.

THE NEED FOR MORE CHOICE AND COMPETITION

The proposed House legislation takes a limited step toward promoting consumer choice and competition in Medicare by allowing private health plans to contract with Medicare and compete directly for seniors' dollars. Currently, Medicare contracts with private plans are limited primarily to health maintenance organizations (HMOs); approximately 12 percent of eligible seniors are receiving their health care services through Medicare-contracted HMOs. The House bill would expand the options for senior citizens only by including other forms of managed care like preferred provider organizations; PSOs, which are increasingly popular with physicians looking to reclaim the autonomy they lost to managed care companies; and, on a very limited basis (500,000 out of a universe of 38.1 million), MSAs.

Although any expansion of seniors' choices would be welcome, the House proposal stops short of offering an open market for health care plans and services. Such a market would allow the entry and exit of plans sponsored by a variety of organizations and offering different benefits and options. Members of Congress need only look at the variety of plans currently available to them through the FEHBP to understand the value of allowing employee, union, and association plans to compete in Medicare. Congress recognized this

1 See John C. Liu and Robert E. Moffit, "Health Care," in Stuart M. Butler and Kim R. Holmes, eds., *Issues '96: The Candidate's Briefing Book* (Washington, D.C.: The Heritage Foundation, 1996), pp. 309–317.

2 See Stuart M. Butler and Robert E. Moffit, "Congress's Own Health Plan as a Model for Medicare Reform," Heritage Foundation *Backgrounder* No. 1123, June 12, 1997.

when it passed the 1995 Medicare Reform Act, which allowed for an FEHBP-style menu of health plans that would compete with one another based on price, quality, and (to a limited degree) benefits offered. The act was vetoed, however, by President Bill Clinton.

In pursuing a consumer choice policy, Members of Congress at least should allow senior citizens the range of choices they themselves enjoy through the FEHBP. This means that, in addition to HMOs, PPOs, PSOs, and MSAs, Congress should allow seniors to choose from other health care plans and options—such as union, Taft–Hartley, association, and private fee-for-service plans—so long as they meet prescribed solvency and plan participation requirements.

GOVERNMENT-STANDARDIZED BENEFITS: LIMITING CHOICE AND COMPETITION

The House Medicare proposal, like its 1995 predecessor, requires private contracting health plans to offer the same basic benefits as traditional Medicare. In other words, patients would have to have these benefits included their plans regardless of their specific medical needs; and if plans wanted to offer different combinations of benefits, they could do so only at a higher cost to patients.

The House bill would add expanded benefits, such as more frequent coverage for mammography and pap smears, to the traditional Medicare program. It also would add new benefits, such as screening for osteoporosis, prostate and colorectal cancer, and diabetes. In addition, if the government's premium contribution to a contracting health plan—reflecting a combination of national average per capita costs, regional average per capita costs, and such individual demographic characteristics as age, sex, and health status—was greater than the cost of providing health services to the beneficiary, the plan would have to offer additional benefits equal to the value of the difference, and these benefits would have to be uniform for all enrollees in that plan.

Requiring private plans to offer, at a minimum, the Medicare benefits package purportedly ensures that beneficiaries will receive a certain level of needed coverage. In practice, however, government benefit standardization limits the ability of private health plans to meet differing consumer needs. Standardized or one-size-fits-all benefit packages—so central to the ill-fated 1993 Clinton health plan—are antithetical to consumer choice precisely because consumers have different needs and insurers must have flexibility in meeting those needs.

In the consumer-driven FEHBP model, instead of a comprehensive standardized benefits package fixed by law, there is only a statutory requirement that plans offer a core set of benefits identified by category or type. Specific benefit levels, treatments, or procedures available to federal workers and retirees are left to a sensitive process of negotiation involving private-sector representatives, government officials, and the annual dictates of the market. Conversely, the Medicare benefits package, with its big gaps in coverage, is a rigidly prescribed political construct. It does not have the flexibility to expand or contract as individual needs and medical innovation constantly dictate.

Even worse, by trying to impose a specific standard of care or gauge which benefits are needed and desired most by consumers, policymakers exercise judgment beyond their professional competence and paralyze the practice of medicine with bureaucratic and imprecise decision making. A classic example of this tendency is a provision in the House

bill clarifying Medicare coverage for self-administered anti-nausea drugs approved by the Food and Drug Administration for cancer patients receiving chemotherapy. The provision stipulates that coverage would be provided only under specified conditions and "would have to be administered by or under the supervision of a physician for use immediately before, during, or after the administration of the chemotherapeutic agent."[3] Including this kind of detailed clinical protocol in federal law guarantees that even minor advancements or changes in the practice of medicine would require congressional action before being adapted for Medicare. Such inefficiency ensures that costs will continue to skyrocket and that consumer preference will remain hostage to a passionate but often scientifically ignorant political process.

The House Medicare proposal reflects Congress's increasing penchant for legislation governing the practice of medicine. It does so by prescribing new preventive health benefits. It is difficult to question the value of preventive health care, and such coverage may very well be warranted for senior citizens. But using the potential value of these services to justify mandating their coverage in Medicare misses a fundamental point: Each new benefit not only adds new costs to Medicare, but also imposes new and unpredictable costs on private plans contracting with it. New mandates restrict a health plan's ability to replace unwanted benefits with others the consumer may find more useful and desirable, such as prescription drugs or catastrophic benefits, neither of which is covered by Medicare. This, in turn, either creates disincentives for insurers to market supplemental benefits or imposes additional out-of-pocket costs on consumers trying to secure benefits that they want but that may not be part of the mandatory benefits package.

Finally, the 1995 Medicare reform bill included a provision allowing seniors to get a premium rebate equal to 75 percent of the difference between the Medicare payment to a health plan and the plan's actual costs after the cost of any additional benefits was taken into account, with the remaining 25 percent returned to the HI Trust Fund. Such a rebate provides a financial incentive for seniors to choose lower-cost plans and share in the savings resulting from such decisions.

As a matter of policy, Congress should allow health plans the flexibility to compete on the basis of benefit design and price. Seniors should be able to choose from a wide range of benefit options that meet their individual needs and not be limited by options dictated by Congress. Health plans should be able to include incentives for seniors who make economical decisions when choosing a health plan by allowing rebates for the entire savings realized from these choices.

THE RIGHT TO CONTRACT PRIVATELY

Under current law, it is illegal for Medicare beneficiaries to visit their doctors and pay for the visit out of their own pockets. Medicare requires health care providers to complete and submit a claim for services rendered on behalf of beneficiaries. If patients wanted to receive a service at an agreed-upon fee, or possibly no fee at all, they could not do so.

3 Representative William Thomas (R–CA), *Coverage of Oral Anti-Nausea Drugs Under Chemotherapeutic Regimen*, Report by the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 105th Cong., 1st Sess., Sec. 10617, p. 125, as provided on facsimile, June 10, 1997, by the office of Representative Jim McCrery (R–LA).

Some ambiguity exists regarding the lawfulness of the HCFA's prohibition on private contracting with individual physicians. In at least one case, a federal judge has ruled that the HCFA had not articulated a clear policy against such action. During the 104th Congress, Senator Jon Kyl (R–AZ) introduced the Senior Citizen Health Care Freedom to Contract Act of 1995 (S. 1289) to clarify the government's policy and allow senior citizens this right.

As a matter of policy, Congress should allow health providers and all Medicare beneficiaries to enter into mutually agreed-upon service and billing arrangements through private contracts for health care services.

MORE PRICE CONTROLS: PROSPECTIVE PAYMENTS FOR HOME HEALTH AND SKILLED NURSING FACILITIES

Similar to the 1995 legislation, both the House Medicare bill and the Clinton Administration's Medicare proposal would establish prospective payment reimbursement for home health and skilled nursing facility services. Payments to home health agencies and skilled nursing facilities currently are made on a reasonable cost-per-visit basis. This, combined with the fact that Medicare beneficiaries have no copay or co-insurance requirements because the HI Trust Fund bears 100 percent of the costs, has caused these services to grow at unsustainable rates. Payments for home health services alone grew from $1.7 billion in 1983 to $16.2 billion in 1995—an average of 21 percent annually.

In an attempt to address the rapid growth of these programs, the House Medicare bill proposes moving to a prospective payment system similar to the system by which Medicare currently pays hospitals. Instead of paying the costs of care on a retrospective basis, the PPS would pay lump sums to a home health agency for defined periods of care.

Even though Congress must act to slow the growth of these program costs, experience with prospective payments made to hospitals based on Diagnostic Related Groups (DRGs) indicates that problems arise when it tries to contain cost growth by imposing price controls.[4] For example, some hospitals have responded to limits on their ability to bill for individual services under the PPS by moving patients to different settings for their care so that a new DRG can be applied and another payment secured. The most recent example of the legal manipulation of the Medicare PPS is the practice of moving patients who may require a protracted hospital stay into subacute care or skilled nursing facilities, which allows providers essentially to bill Medicare twice for the same patient.

Congress should reject efforts to expand the use of price controls and global budgeting to control Medicare's costs. Both have failed. A significant portion of the growth in home health and skilled nursing facilities can be attributed to overutilization of services. Therefore, the solution should fit the problem: One way to deal with overutilization, for example, would be by imposing a beneficiary copay of 20 percent.

4 For an excellent discussion of the inevitable consequences of price controls, including those in the Medicare program, see Edmund F. Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Care Costs," Heritage Foundation *Backgrounder* No. 929, March 8, 1993.

TIME TO QUESTION HCFA CENTERS OF EXCELLENCE

The House bill includes a provision to make permanent a HCFA demonstration called Participating Centers of Excellence. Under this program, the HCFA solicits health care providers and facilities specializing in a particular medical discipline to participate in a discount payment demonstration program. To date, the program has targeted cataract and coronary artery bypass graft surgery (CABG). In exchange for a negotiated "bundled" or capitated payment from Medicare, rather than individual payments for different services and providers involved in a particular procedure, an entity chosen to participate in the program is allowed to market itself to Medicare beneficiaries as a Center of Excellence in its particular discipline and waive the beneficiary cost-sharing requirements. This allows such entities potentially to increase the volume of care they provide.

Followup studies, performed under HCFA contract and independently by the American Medical Association (AMA), report mixed and inconclusive results from the cataract and CABG demonstrations. For CABG surgery, the AMA reported cost reductions for hospitals from a more efficient use of staff, as well as consumer satisfaction as a result of shorter stays and the waiving of copayments. Questions remain, however, with regard to permanent administrative costs associated with the bundled payment and the impact this demonstration had on the volume of services. The cataract surgery demonstration reported less positive results: no clear volume and performance improvements and no significant savings.[5]

Recently, the HCFA proposed expanding this program to include knee and hip replacement surgery. The American Academy of Orthopedic Surgeons issued a memo strenuously objecting to this proposal and stating its concern that the HCFA's true goal is to establish exclusive contracts with certain low-cost providers of joint replacement surgery and thereby limit competition and consumers' choice of providers. In addition, the academy objected to the "marketing abuse" of the term "participating centers of excellence." According to its memorandum, "There is no evidence to support the contention that hospitals that will be chosen to participate are better providers than those facilities not selected for the project.... Rather, HCFA has designated these hospitals primarily because of their willingness to accept a discounted payment from the government."[6]

This program represents the classic health care conundrum facing policymakers today at both the state and federal levels—how to get more and better health care for consumers at lower costs and with increased regulation. But even though it may be possible to meet these competing demands in a competitive, efficient health care market, such conflicting goals cannot be realized effectively in a heavily regulated, price-controlled health care program like Medicare.

Congress should reject efforts to expand this program, or any similar government program, without clear and convincing evidence that the level of quality implied by its name is being met. Sound policy requires sound empirical evaluation.

5 Dr. P. John Seward, Chairman, AMA Board of Trustees, "Study of Medicare Coronary Artery Bypass Graft and Cataract Surgery Demonstrations," Board of Trustees Report No. 16, 1995.

6 American Academy of Orthopedic Surgeons, "Memorandum on the Medicare Joint Replacement Demonstration Project," Document No. 1128, September, 1996.

CORPORATE WELFARE FOR TEACHING HOSPITALS

Last—but far from least—the House Medicare proposal would create a program literally to pay teaching hospitals not to train physician residents, much as the federal crop subsidy program pays farmers not to produce food. The rationale for this program is that there are too many doctors today, and Congress can save graduate medical education money for Medicare by creating incentives for hospitals to train fewer physicians. Considering the large number of medical residents training in facilities and providing cheap labor for hospitals (but not for Medicare, which pays hospitals up to $100,000 each year in training subsidies for each resident), these incentive payments will allow hospitals to find alternate providers of care. So the argument goes.

Earlier this year, in the face of mounting criticism, the Clinton Administration approved a request made by the Greater New York Hospital Association to pay New York teaching hospitals $400 million in exchange for a reduction of 20 to 25 percent in the number of doctors they train over six years. Instead of condemning the New York program, House Ways and Means Committee spokesman Ari Fleischer noted that other hospitals around the country, eager to get more money for less teaching, were not included in this corporate welfare program: "In offering a special deal to New York, the administration may have created for themselves some non–New York headaches."[7]

If Members of Congress are convinced of the efficacy of national labor force planning and the wisdom of government set-asides, a proposal to pay hospitals not to train doctors probably makes perfect sense. It represents a major retreat, however, from the fundamental free-market principle that the demand for labor—not the dictates of government—best determines the supply of labor. Taxpayers should not be forced to subsidize such a policy.

CONCLUSION

The limited reach of the House Medicare reform proposal largely reflects the broader requirements of the budget agreement. A desire to accommodate the President, however, should not dissuade Congress from making the House proposal—which has many of the core elements of positive reform—into a better, more substantive, and effective Medicare reform policy. Members of Congress have invested too much in this effort to settle for second or third best, and there is too much at stake in its outcome.

By building on the popular theme of consumer choice and competition in health plan type and benefit options, and rejecting the failed policies that only would impose more price controls in health care or introduce counterproductive new federal set-asides, Congress can put Medicare reform back on the path to success.

7 Marybeth Rosenthal. "New York Incentive to Train Fewer Doctors Draws Attack," *The New York Times*, February 21, 1997, p. A1.