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How to Reform Medicare: A Reconciliation Checklist

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Introduction

As Congress works to reconcile the tax and entitlement bills passed by each house as part of the budget, lawmakers face important decisions about Medicare. Both the House and Senate bills contain major provisions that not only would save money over the next five years, but also would begin the crucial process of restructuring Medicare so that the program is modernized and made financially sound over the long term. Central to this restructuring are provisions in both bills that would permit retirees to obtain their care through a range of private plans. This would spur the consumer choice and competition that is the key to making Medicare much more efficient and innovative, and would do so in a way that empowers the elderly to decide which type of health care plan best serves their needs.

Even though the general thrust of each bill is toward choice and competition, specific provisions differ. Moreover, there are may provisions that would have consequences very different from those assumed by many lawmakers. Thus, if reconciliation is to achieve sound Medicare reform, it is important for conference negotiators and other Members of Congress to identify which provisions best serve the goal of reform.

The House and Senate Medicare Provisions on Medicare Choice Program and Administration

Creating a Demonstration Based on Congress's Own Health Plan

The most positive feature of the Medicare reform bills passed by the House and Senate is the Medicare demonstration program based on the Federal Employees Health Benefits Program (FEHBP) that Senators John Breaux (D–LA) and Connie Mack (R–FL) included in the measure passed by the Senate. More than any other feature in the House and Senate

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bills, this proposal introduces, on a limited basis, real choice and competition into the Medicare program—by freeing participating health plans from onerous payment formulas and participation limitations, and by giving seniors the same health plan options that Members of Congress and federal employees and retirees enjoy today. The legislation could be improved, however, by increasing the number of demonstration sites and by waiving the requirement that all health plans offer the core Medicare benefits in order to trigger greater innovation by allowing for more variation in benefits. In addition, Congress should reject language that would require health plans participating in the demonstration to comply with federally defined quality standards (see Quality Assurance below).

House Bill	Senate Bill	What Congress Should Do
No provision.	Creates a 13-site demonstration program modeled after the successful Federal Employee Health Benefits Program (FEHBP) that would: • Allow a variety of health plans meeting broad plan participation requirements, including union and association plans, to compete for seniors' business; • Create an Office of Competition to negotiate premiums and benefits with private insurers; • Avoid creating complicated formulas to determine premium rates, but instead set the government's contributions to health plans at 90 percent of the chosen plan's premium, up to a maximum of 90 percent of the weighted average of plans in the area or the average spent for fee-for-service care, whichever is lower; • Require health plans to offer the standard Medicare benefits package; • Require health plans to meet minimum quality standards established by the Office of Competition in order to compete.	Enact Senate demonstration *without* the federal quality standard requirements that would have the unintended effect of restricting quality-improving innovation by plans.

Choice of Plans

The payment and delivery structure of private health coverage has changed dramatically over the past 10 to 15 years. The Medicare program has been woefully slow in trying to catch up to these changes. If Medicare is to catch up with plans offered to working Americans, Congress should adopt the Senate language on choice of competing health plans, ensuring that the market remains open to different health care models in the future. Congress should ensure that only basic plan participation standards such as solvency and certain consumer protection requirements apply to all participating plans. It should avoid, however, inflexible statutory limits on the number or types of health coverage options, which would only inhibit competition and deny seniors a complete menu of choices similar to those Congress enjoys today.

House Bill	Senate Bill	What Congress Should Do
• Creates a new "Medicare Plus" program. • Expands seniors' choice of health plans to include preferred provider organizations (PPOs), provider sponsored organizations (PSOs), and a limited (500,000) number of Medicare medical savings accounts (MSAs).	• Creates a new "Medicare Choice" program. • Includes PPO, PSO, and a more limited MSA option (100,000), and adds private fee-for-service, point-of-service plans (POS), and "any other types of health plans" that meet required standards.	• Enact the Senate provision on choice of health plans. • Enact the House language on MSAs.

Payments to Plans

The current method of paying Medicare health maintenance organizations (HMOs) based on 95 percent of Medicare fee-for-service costs is irrational and does not save the government money. It has the effect of overpaying many HMOs while encouraging them to seek out more healthy enrollees. Ideally, Congress should cease to use formulas to pay for managed care plans. Tinkering with the formula, as the House and Senate bills do, may remove some irrationality but will introduce new distortions in the future. Congress should allow private health plans to offer bids to compete for seniors' business; to fine-tune the bids through negotiations (preferably through an expanded version of the proposed new Office of Competition); and to have Medicare agree to pay a portion of the premium up to a maximum. This is the system used by the FEHBP.

House Bill	Senate Bill	What Congress Should Do
Delinks payments to private Medicare health plans from current Medicare fee-for-service costs. **Ways and Means:** • Establishes a payment formula that combines a blending of national average per capita costs (50 percent) with area-specific average per capita costs (50 percent). • Establishes a payment floor of $350 per recipient per month. • Payments for Graduate Medical Education (GME) and Disproportionate Share Hospitals (DSH) are included in the payments to private health plans. • Payments to health plans would be capped at a growth rate of 2 percent annually. • Payments would be risk adjusted for age, sex, and disability status and the Secretary of Health and Human Services would be required to study and report to Congress on an appropriate method of risk adjustment by January 1, 2000. **Commerce:** • Similar to the Ways and Means plan but uses a different formula to blend local (70 percent) and national (30 percent) capitation rates; • Phases GME and DSH out of plan payments; • Allows for lower annual growth rates in the first two years.	Delinks payments to private Medicare health plans from current Medicare fee-for-service. • Uses the 50/50 blend of national and area-specific per capita costs to determine the new Medicare capitation rate; • Phases GME and DSH payments out of payments to private plans; • Establishes a minimum payment amount equal to up to 85 percent of the national average payment; • Allows an annual growth rate of gross domestic product plus 0.5 percent; • Risk adjusts for new enrollees, beginning at a 5 percent reduction in plan payments per new enrollee, phasing down 1 percentage point each year thereafter.	Because both the House and Senate bills keep a formula-based payment (essentially, price controls) they would maintain a flawed payment system. Each bill would do nothing more than make tiny improvements to this flawed system. Short of rejecting formulas outright and establishing a system in which health plans make bids and negotiate with the government for payments that actually reflect local market rates, it matters little which payment provision the conference adopts. Congress can and should take steps to reform DSH and GME, however. Specifically, Congress should: • Enact the Senate and House Commerce provision removing GME and DSH funds from payments to private plans.

Administration

The House and Senate Medicare bills do not propose to simplify the administration of traditional Medicare or the expanded Medicare choice program. In fact, the Senate bill complicates the Health Care Financing Administration (HCFA) mission further by placing the agency in charge of the proposed Part B means-testing program (see Part B Means testing below). Ideally, Congress should propose major changes in the administrative oversight of Medicare by creating a new, semi-independent board made up of private- and public-sector health care experts to operate the traditional fee-for-service program. The board would operate within an annual appropriated budget and would be charged with making determinations about new benefits, premium amounts, and other operational decisions. In this way, detailed decision making could occur in an expedited and depoliticized manner. Congress would continue to have authority to approve or reject board decisions by an up-or-down vote.

House Bill	Senate Bill	What Congress Should Do
• Currently, approximately 4.9 million of the 38 million Medicare-eligible seniors are enrolled in 336 Medicare HMOs nationwide. • The HCFA employs approximately 4100 full-time employees (FTEs) at an annual cost of $325 million, with 120 FTEs currently working on Medicare HMO contracts in its Office of Managed Care. • As under current law, the HCFA would continue to manage and regulate traditional Medicare and the private insurance contracting program with congressional oversight. • Updates in the government's prescribed physician fee schedule and most benefit changes would still require congressional action. • Private plans wishing to contract with the HCFA would be required to submit necessary information. If plans meet requirements for participation and provide the Medicare basic benefits package at no additional premium cost to the beneficiary and within the federally prescribed capitation rate, they may participate in the program.	Same as House bill.	Expand the mandate of the new Office of Competition established to operate the FEHBP demonstration and give it administrative authority for the entire Medicare private contracting program.

Enrollment

Seniors should be able to change health plans or return to traditional Medicare on the same basis that federal employees and retirees do in the FEHBP during an annual open season lasting four to six weeks. As the number of private health plans competing for seniors grows, the opportunities to game the system will also grow, with seniors enrolling in low-cost, low-coverage private plans when they are healthy and switching to more comprehensive coverage when they become ill. In the long run, allowing open and unlimited switching between private health plans, or back and forth between a private plan and traditional Medicare, will only increase costs, aggravate adverse selection problems, and prevent private health insurers from being able to negotiate fair premium rates for enrollees because they will not be able to measure their risk burdens accurately.

House Bill	Senate Bill	What Congress Should Do
• Medicare Plus participant may enroll and disenroll from a health plan at any time between 1998 and 2000. • Beginning in 2001, beneficiaries may switch between traditional Medicare and a Medicare Plus plan only once. • In 2002 and beyond, beneficiaries may disenroll only during the first three months of the year or during the required annual open enrollment period.	• As under current law, Medicare Choice participants may disenroll from a health plan and join another or switch to traditional Medicare at any time. • An annual coordinated enrollment must be held every November.	Enact the House provision.

Quality Assurance

Both the House and Senate Medicare bills include important provisions that would require all private contracting Medicare health plans to maintain ongoing quality assurance programs and to provide understandable comparative information regarding health plan options to seniors. In addition, the Senate added a provision to the FEHBP-style demonstration program that would require participating health plans to meet minimum federal quality standards.

Although the idea of requiring health plans to meet certain quality measures may seem reasonable, the provisions as written would lead to serious unintended consequences. It is reasonable to offer Medicare beneficiaries comparative information about health plans in a form that is easily understood. The problem concerns a requirement that health plans contracting with Medicare must meet federally established quality criteria as a condition of participation. Once the federal government takes on the role of setting rigid quality standards for private plans, there will be many cases in which these Washington standards do not reflect local health care service conditions. This will mean that in many areas, especially in rural states, good plans will be barred because they do not meet all national standards.

In addition, once federal standards are created it is likely that they will become a "ceiling" for quality, rather than a standard "floor" that health plans must meet. That is, the incentive for a health plan will be to satisfy plan participation standards—to gain a seal of approval—rather than go beyond the federal "minimum" standard. Moreover, plans will have no incentive to introduce innovations that actually improve quality if it means substituting these breakthroughs for now out of date, but federally required, standards.

The knowledge and understanding about what represents quality health care and how it should be measured is constantly evolving. At the very least, Congress should allow for flexibility and a process of negotiation with health plans regarding quality. In this way, health plans that do not meet standard federal quality criteria (due to some unique local circumstances or because they are very innovative) could appeal and be allowed to operate.

House Bill	Senate Bill	What Congress Should Do
• Private health plans contracting with Medicare are required to have ongoing quality assurance programs, which include collecting and reporting data measuring health outcomes. • In addition, each plan is required to have external quality review evaluations performed by an independent accrediting organization approved by the Secretary of Health and Human Services (HHS).	Similar to House bill. FEHBP-style demonstration includes provisions that would: • Require the Office of Competition to establish minimum federal standards for participating health plans and to make certain information available to beneficiaries. • Allow Medicare to pay 0.5 percent more for plans determined to have higher quality and less for those that do not.	Enact the House provisions and reject the Senate requirements on plans participating in the FEHBP demonstration.

THE HOUSE AND SENATE MEDICARE PROVISIONS ON MEDICARE BENEFICIARY RESPONSIBILITY

Means Test Part B Premium

Today, low-income wage earners just trying to make ends meet pay taxes that support Medicare Part B costs for seniors who have six-figure annual incomes. There is no reasonable or rational justification for this. The Senate took an important first step in correcting this gross inequity by requiring higher-income Medicare beneficiaries to pay a greater portion of their Part B premium costs. The means test should be administered by the Department of the Treasury, however, not the HCFA. The Internal Revenue Service (IRS) already has income data and the expertise to do this job, and there is no reason for any of this authority or the personal income records to be transferred to HHS.

Ideally, a means test should apply across the board for all Medicare beneficiaries so that some would pay more and some would pay less than the current requirement of 25 percent of Part B costs. Such a system would make more sense than the budget proposal to set aside $1.5 billion to provide assistance to non-Medicaid eligible low-income Medicare beneficiaries to pay Part B premiums. (The Senate bill would pay up to 150 percent of poverty, the House bill would cover full premiums up to 135 percent of poverty and make partial payments up to 175 percent of poverty.)

House Bill	Senate Bill	What Congress Should Do
No provision.	• Establishes an income-related Part B premium with the phase-out of federal subsidy payments to single beneficiaries with incomes of $50,000 ($75,000 for couples), and with phase-out completed at $100,000 ($125,000 for couples). • HHS would be responsible for administering the means test and determining eligibility.	Enact the Senate provision policy but put the Department of the Treasury in charge of program administration—to deny HHS access to IRS records.

Raising the Retirement Age

In 1983, Congress changed the age of Social Security eligibility from 65 to 67, to be phased in over a transition period from 2003 to 2027, while Medicare's retirement age remains 65. The average life expectancy has increased by almost seven years since Medicare was first enacted. The Senate bill would raise the Medicare eligibility age from 65 to 67, to be phased in between 2003 and 2027, in the same increments as Social Security. This change would have little to no effect on most middle-aged or older Americans, and have a full impact only on those currently under 35 years of age.

House Bill	Senate Bill	What Congress Should Do
No provision.	Conform the Medicare eligibility age to the Social Security eligibility age; beginning in 2003, age of Medicare eligibility will slowly increase to 67 by the year 2027.	Enact the Senate provision.

Home Health Copay

A significant portion of the double-digit growth in Medicare home health care costs can be attributed to overutilization of services. Providers have incentives to give more care because they are reimbursed on a "reasonable cost per visit" basis, and beneficiaries have no incentive to limit their own care because no cost-sharing is required of them. Medicare beneficiaries currently receive home health care services free of charge, regardless of income. Although a $5 copay per visit is low compared with home health program spending, it moves in the right direction by increasing beneficiaries' awareness of costs for services and may lead to more appropriate utilization of services.

House Bill	Senate Bill	What Congress Should Do
No provision.	Establishes a beneficiary cost-sharing for Part B home health services at $5 per visit, billable on a monthly basis and capped at an amount equal to the annual hospital deductible (currently $760).	Enact the Senate provision.

Private Contracting

Incredibly, under current law, it is illegal for a Medicare beneficiary to visit a doctor and pay for the cost of the visit out of his or her own pocket. Medicare requires health care providers to complete and submit a claim for services rendered on behalf of the beneficiary. A patient wanting to receive a specific service at an agreed-upon fee, or possibly no fee at all, does not have the freedom to do so.

Some ambiguity exists regarding the lawfulness of the HCFA's prohibition on private contracting with individual physicians, with a federal judge ruling in at least one case that the HCFA had not articulated a sufficiently clear policy against such actions. Senator Jon Kyl (R–AZ) amended the Senate budget bill in order to clarify the government's policy to allow seniors this right.

House Bill	Senate Bill	What Congress Should Do
No provision.	Allows Medicare beneficiaries to contract directly for health services with their physician; payment for health services would not be subject to payment limitations, and no claims would need to be filed.	Enact the Senate provision.

THE HOUSE AND SENATE MEDICARE PROVISIONS: MISCELLANEOUS

Medicare Subvention

At a time in which the Medicare program is facing a fiscal crisis of monumental proportions, it makes little sense to create a program that would make additional demands on limited Medicare resources in order to fill in the gaps in the health systems of the Departments of Veterans Affairs (VA) and Defense (DOD), both of which currently face decreases in appropriated dollars reflecting their declining patient populations and resource utilization. Although supporters argue that transferring Medicare dollars to VA and DOD facilities for the care of dual-eligibles actually would save money, the Congressional Research Service reports[1] that this in not necessarily the case, and that the more generous Medicare benefit would encourage retirees and veterans to use more health services than they currently do.

If the VA and DOD face legitimate health care funding problems, those problems should be dealt with in the proper way: through the appropriations process. Allowing these programs to raid Medicare funds will serve only to encourage more Medicare spending to prop up inefficient and costly federal health systems and will not address veterans' and retirees' concerns about quality, choice, and access in their health care.

House Bill	Senate Bill	What Congress Should Do
No provisions.	Instructs the Secretaries of HHS, DOD, and VA to establish demonstration programs for the Medicare reimbursement of medical care provided to Medicare-eligible military retirees and veterans.	Reject the Senate provision.

Incentive Payment to Teaching Facilities

Similar to the justifiably maligned federal crop-subsidy program that pays farmers not to produce food, the House-passed Medicare bill includes a provision to pay hospitals *not* to train doctors. This provision builds on a Clinton Administration program that currently makes $400 million available to New York teaching hospitals to reduce their medical residency programs by 20 percent to 25 percent over six years.

1 David F. Burrelli and Tina Nunno, "Military Medicare Care and Medicare Subvention Funding," *CRS Report to Congress* (updated), Congressional Research Service, March 17, 1997, p. 11.

If conservatives in Congress believe in labor force planning and government set-asides, this policy makes perfect sense. This proposal, however, represents a major retreat from the fundamental free-market principle that demand for labor—not the government—will dictate the supply of labor. Therefore, the proposal should be rejected.

House Bill	Senate Bill	What Congress Should Do
Creates a new program that would make subsidy payments to teaching hospitals that develop a plan to reduce the number of residents trained in their facility.	No provision.	Reject the House provision.

"Centers of Excellence"

The HCFA has been conducting this program on a demonstration basis for approximately six years and has had questionable success. The program may not be living up to its name. Because the program seeks to contract with specialty providers and increase the volume of services at a discounted price, rather than actually focusing on excellence, some physician groups and hospitals have questioned whether the program is about quality or about the HCFA's interest in saving money. Their reasonable fear is that quality will be sacrificed to the lowest bidder for an exclusive Medicare contract.

House Bill	Senate Bill	What Congress Should Do
Makes permanent a HCFA demonstration called the "Participating Centers of Excellence" program. • The HCFA would solicit health care providers and facilities that specialize in a particular medical discipline (like orthopedic surgeons and hip replacement surgery) to participate in a discount payment demonstration program. • Participating providers would receive a negotiated "bundled" or capitated payment from Medicare (rather than individual payments for different services and providers involved in a particular procedure). • Providers chosen to participate in this program can market themselves to Medicare beneficiaries as a "Center of Excellence" in their particular discipline and waive beneficiary cost-sharing requirements.	No provision.	Reject the House provision.