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The Medicare Program: Ripe for Reform

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THE MEDICARE PROGRAM: RIPE FOR REFORM

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ABSTRACT

This thesis will evaluate several proposals to reform the Medicare system and how those proposals differ in terms of focus on either financial restructuring or care delivery redesign. This thesis proposes that an emphasis on managed care strategies will represent an effective way to reform the Medicare system.

The purpose of the study is to consider how a shift in focus from acute care treatment to illness prevention and chronic disease management would salvage the Medicare program. The thesis will further explore how an acute care focus has affected the Medicare program, turning a social policy into fuel that feeds spiraling of health care costs and enables a dysfunctional delivery system.

The Medicare program developed as a safety net to help the elderly and disabled pay for medically necessary medical care. Based on a fee-for-service model, the program quickly ran up costs and fueled the expansion of acute care in the health care delivery system. The naivete that supported a reimbursement system that rewarded overuse and dependency on acute

care persisted for nearly thirty years, despite little evidence supporting that the Medicare program has significantly improved the health of Medicare beneficiaries, the majority of whom suffer from illness have chronic disease.

Medicare reform became a political hot button for several presidencies. Spiraling costs caused tax payers to question the efficacy of the fee-for-service system. The desire for freedom of choice versus increasing costs made managed care alternatives more popular. Those parties guilty of fraud and abuse of the Medicare system found increased government initiatives to curb their profiteering.

This study reviews the classic fee-for-service Medicare program and attempts to discern whether managed care hybrids will improve the system in terms of financial solvency, improved health outcomes, and/or chronic disease management. Results of this study produced insufficient evidence to suggest that managed care alone could restore solvency to the Medicare trust fund and refocus providers on prevention and chronic disease management. A compromise of both financial restructuring over the short-term, and care delivery redesign focusing on chronic disease mangement and prevention over the long term, appears to represent the best hope for saving Medicare.

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Preface

The health care system is in need of reform. Popular media outlets have frequently reported on the spiraling costs of health care both in the public and private sector. In addition, many of the reports about health care relate to failures in the delivery system. Particularly, these reported failures relate to tragedies in the delivery of acute care; denied emergency service, shortened hospital stays, or restricted access to care, all allegedly related to profit motives, to name a few (Brink 60).

The silent tragedy, however, is more complex. The health care system in the United States was built around an acute care model. Diseases which can be quickly treated with surgery, antibiotics, or eradicated with vaccination have preoccupied the popular health care system for years. The reimbursement systems and rewards in health care, particularly in Medicare, have focused on the providers who deliver the "quick fix" to an easily identifiable health threat.

Chronic illness, which is more difficult to manage and is frequently incurable, has received much less attention, despite the fact that millions suffer.

Preventive care measures, which can delay or avoid the onset of chronic illness, have received little reward in the delivery systems and reimbursement arena. This is the underpinning of the current crisis in Medicare funding. Fighting the fire of acute illness has received far more prominence than clearing out the underbrush of chronic illness and disease prevention.

Managed care alternatives for Medicare recipients represent a step in the right direction of refocusing health care delivery in the United States. The attention goes where the money goes, and perhaps, at last, the provider community may be steered toward a logical approach to improving health, and thereby controlling health care costs.

Chapter I

INTRODUCTION

Medicare as a Safety Net

Medicare was established in 1965 under Title XVIII of the Social Security Act. Upon its enactment President Lyndon Johnson, quoted by Doug Bandow and Michael Tanner in USA Today, stated, "No longer will older Americans be denied the healing miracle of modern medicine" (40). Medicare would form a safety net to protect the savings of the elderly (those 65 and older) and disabled from the high costs of hospitalization and physician-directed health care (Bandow and Tanner 40-42).

On the way to good intentions however, something went terribly wrong with the program. The coverage was certainly comprehensive, covering thirty-six million disabled and elderly Americans in 1995 (Benning and Mishra 1F+). By 1997 Donna Shalala, Secretary of Health and Human Services, reported that the number had grown to thirty-eight million ("Press Conference" n.pag.). The problem reveals itself in analyzing the deficit trends in the Medicare hospital trust fund. From 1965 through 1994, and once in 1996, the hospital

trust fund ran a small surplus. In 1995 and 1997 the fund dipped into the deficit zone and was projected to be exhausted completely by the year 2002 ("Medicare" n.pag., Findlay and Welch n. pg.).

According to Congressman Greg Ganske of the fourth district of Iowa, third party payment is the source of the current funding crisis (Ganske n.pag.). Ganske states, "In providing...the elderly with generous health care benefits paid for by third parties, we have shielded (them)... from the true cost of the system" (n.pag.). Ganske further insists that insurers have become the true consumers of health care, and not the patients, leading to his stance that health insurance is in critical need of reform (Ganske n.pag.).

The root of the Medicare funding problem may be somewhat deeper. Medicare legislation was enacted to pay for the health care delivery system available to the United States public circa 1965. This delivery system may have already priced itself out of reach, considering only 56 percent of the elderly were insured in 1965, according to Shalala ("Reinventing Medicare" n. pag.). A review of the evolution of the United States health care system is necessary to explore the delivery system's role as a major contributor to Medicare's struggles and the financial burden placed on consumers and taxpayers today.

History of the United States Health Care System

Beginning with the reports of Abraham Flexner of the Carnegie Foundation in 1909, the groundwork was laid to create a medical system focused on acute care. Abraham Flexner, along with Dr. N.P. Colwell, secretary of the American Medical Association's (AMA) Council on Medical Education, undertook a survey of medical schools. Two of the criteria Flexner used to form his assessments of the programs revealed a great deal about what would become the cornerstones of American health care; adequacy of laboratories and clinical instructors and the programs' relationships with hospitals, particularly access to beds, hospital physicians, and surgeons as clinical instructors (Raffel and Raffel 9-12).

The Flexner survey supported the sponsoring reformers' drives to discredit programs found to be inadequate in their training, facilities, and personnel. The "reformers" however, consisted of the AMA, American Association of Medical Colleges, state medical societies, and state medical boards (Raffel and Raffel 12). These groups were dominated by medical physicians who focused their attentions on acute infectious diseases (Fox 30-31).

In time, physicians began to specialize, further fueling the focus on acute illness. The AMA took up

the debate of specialization in a meeting in 1866 in Baltimore. Quoted by Marshall W. and Norma K. Raffel, in The U.S. Health System: Origins and Functions, the proceedings of The Committee on Medical Ethics reported the following:

> The majority reported listed the advantages of specialization as including minuteness in observation, acuteness in study, wideness of observation, skill in diagnosis, multiplicity of invention and superior skill in manipulation. The disadvantages were a narrowness of view, a tendency to magnify unduly the diseases which the specialty covers, a tendency to undervalue the treatment of special diseases by general practitioners, some temptation to the employment of undue measures for gaining a popular reputation and a tendency to increased fees. The advantages far outweighed the disadvantages from the point of view of the patient and of the advancement of the specialty. The committee felt that these disadvantages could be overcome if the specialists would begin as a general practitioner and gradually grow into his specialty. (13)

The report, however, does not list how the patient's input was sought, but blatantly admits to the "advancement of the specialty" as a positive factor (Raffel and Raffel 13). Further, the report portends the problems which have contributed to runaway medical inflation resulting in a need to re-examine how the health care delivery system is organized in the United States.

Daniel M. Fox, writing in Power and Illness: The Failure and Future of American Health Policy in 1993, identifies a different perspective of the American people in the twentieth century:

> Although, as the century progressed, Americans had increasing cause for concern about sickness, disability, and death from chronic degenerative diseases - notably cancers, heart disease, stroke, and diabetes - health policy continued to give priority to research and public health programs that targeted infections and to hospital and medical services for acute, life-threatening episodes of infectious and degenerative disease. (31)

Fox recognized that practice and policy became inextricably entwined, and he further understood that the relationship between financing and delivery influenced policies for health care for years to come (32).

Medicare

Before Medicare, a variety of private sector initiatives established hospital insurance coverage plans. Sixteen state legislatures attempted to develop compulsory health insurance between 1916 and 1918, however, those efforts were thwarted by the AMA, private insurers, and business interests. The Blue Cross plans had their origins in a schoolteachers' insurance plan in Dallas, Texas in 1929 and by 1939,

Blue Shield plans had organized to provide benefits for surgical and medical expenses (Raffel and Raffel 211-212).

The problem with health care coverage pre-Medicare was that it was generally limited to the working classes (Fox 59). Those who were too old to work or disabled ended up doing without coverage and depleting their savings. When Medicare went into effect in 1966, coverage was provided for nineteen million elderly and disabled beneficiaries (HCFA n. pg.).

Simply stated, Medicare covers hospital and home care expenses under Part A and physician and other providers and outpatient expenses under Part B. The elderly qualify for Medicare if they qualify for Social Security retirement benefits. The disabled qualify if they have received disability benefits under Social Security for at least twenty-five months. There are some limited circumstances under which persons over age sixty-five who are not on Social Security may be covered; however, they must pay the premiums for the parts they desire. A person's income and assets are not assessed to determine eligibility (Goldfarb n. pg.).

For 1998, the premium for Part A Medicare coverage is $309 per month, and the premium for Part B is $43.80 per month. Enrollment for both parts is automatic on

enrollment, however, beneficiaries must pay for Part B unless they choose to reject the coverage. An inpatient hospital deductible of $764 applies annually, and a $191 a day copayment applies for the sixty-first through ninetieth day of hospital confinement, after which the copayment climbs to $382 per day (Goldfarb n. pg.).

Part B deductibles are $100 annually with payment to providers of 80 percent of allowed charges. The allowed charges may be less than providers actually charge, however, providers who "accept assignment" agree to accept the Medicare rates. Those who do not "accept assignment" are capped at limiting total fees to 115 percent of the Medicare rate (Goldfarb n. pg.).

Medicare Reimbursement

In 1990, 40 percent of hospital reimbursement came from Medicare (Raffel and Raffel 149). Medicare reimbursement to hospitals is based on payment for medically necessary services. Since 1965, the Medicare legislation required hospitals to perform peer review to ensure that beneficiaries were receiving medically necessary care (Raffel and Raffel, 159). This "fox guarding the chicken coop" process proved largely ineffective.

In 1971, amendments to the Social Security Act created Professional Standards Review Organizations (PSRO's). Made up of physicians, these organizations were charged with ensuring the medical necessity and quality of health care services. Through preadmission, concurrent, and retrospective review, 185 PSROs across the country hoped to rein in costs while safeguarding quality. A Department of Health, Education, and Welfare study in 1978 indicated, however, that the PSRO's did not significantly impact the quality or cost of care (Raffel and Raffel 159-160).

In 1981, the PSRO's were abolished and Congress replaced them with Peer Review Organizations (PRO's). The PRO's were less numerous and thus had less administrative overhead. Early PRO's were largely focused on cost and their sanctioning process for quality issues did not significantly impact the delivery system or outcomes (Raffel and Raffel 160).

Between 1965 and 1983, financial solvency concerns about the Medicare program continued to grow. Hospitals were paid on a cost base retrospective of the services rendered and costs incurred. Hospitals and physicians had no incentives to control costs, and had every financial incentive to provide more services, more tests, and any other billable services Medicare would allow (Raffel and Raffel 161).

Since the various peer review organization incarnations did not have the intended effect on spiraling health costs, Congress implemented the prospective payment system (PPS). This system reimbursed hospitals prospectively per discharge based on diagnosis related groups (DRG's) administered by the United States Social Security Administration's Health Care Financing Administration (HCFA) ("History of the Provisions" n. pg.). The program was phased in over four years and became fully based on the federal rates in 1988 (Raffel and Raffel 162).

DRG payments are determined by classifying inpatient hospitalization stays into groups utilizing similar resources based on primary and secondary diagnoses. These groupings are used for the purpose of calculating payment. Since extraordinary circumstances and catastrophic illnesses may push expenses way beyond what would normally be reimbursed in a DRG, outlier provisions also exist (Kongstvedt 992).

DRG's were supposed to reduce costs by providing incentives for hospitals to reduce their costs during inpatient stays. If the hospital could deliver care for less than the DRG reimbursement, they could keep the difference between their costs and the DRG reimbursement. If the hospital incurred higher costs than the DRG (before reaching outlier limits), they

were required to absorb the additional expense (Raffel and Raffel 162). This reimbursement mechanism remains in effect for most hospitals receiving payment under traditional Medicare.

After the implementation of DRG's, there was a decline in Medicare discharges and the average length of stay in the hospital decreased. By 1988, however, discharges were once again increasing (Raffel and Raffel 162-163). Hospitals are still paid for every discharge and there is no incentive to reduce admissions for acute care hospital services. Further, there are no financial penalties to physicians for prolonging the stays of hospitalized patients. Medical physicians continue to be paid for each hospital visit to every Medicare patient in the hospital under their care.

In addition, admissions to skilled nursing facilities and home care services rose. Skilled nursing facility and home care services are still reimbursed on a cost basis. The site shifting and reduced lengths of stay associated with the PPS system has been accused of adversely affecting the quality of care; however, according to Marshall W. and Norma N. Raffel, "there is no evidence that the quality of care declined" (163).

While hospitals learned to cope under DRG's, physicians continued to thrive under continued fee-for-service. Medicare Part B benefits per participant have climbed 27 percent between 1980 and 1992, according to the Medicare Board of Trustees (qtd. in Perot 104). Part B premiums climbed 30 percent. Physician payment reform in the United States was not begun until 1992, when some physicians begin getting reimbursement on a fee schedule ("History of the Provisions" n. pg.).

The fee schedule implemented for physicians is based on the resource-based relative value scale (RBRVS). RBRVS bases reimbursement on the value of the resources related to each procedure performed. The effect of RBRVS has been to decrease payment for procedural services, such as orthopedic surgeries, and raise reimbursement for cognitive services, such as visits to internists (Kongstvedt 1001). Howard Shapiro, Ph.D., Vice President for Public Policy of the American College of Physicians, has weighed in with an opinion in the online internet newsletter, the ACP Observer, maintaining that the methodology for updating the Medicare fee schedule should be revised to further increase payments for non-surgical, evaluation and management services (n. pg.).

According to the American Academy of Orthopaedic Surgeons (AAOS), HCFA has a mandate from Congress to

continue to implement RBRVS. The AAOS maintains that the data HCFA is using is not accurate, and Bruce Vladeck, HCFA Administrator, concedes that this may be true (qtd. in "HCFA proposes 1). The impact of the most recent proposal is as illustrated in Table 1.

Table 1

Reimbursement Impact to Specialty (Physician) Groups

Dermatology	+ 18%
Rheumatology	+ 15%
Family Practice	+ 12%
General Practice	+ 9%
Otolaryngology	+ 7%
Anesthesiology	+ 4%
Obstetrics/Gynecology	+ 4%
General Surgery	- 9%
Radiology	- 9%
Orthopaedic Surgery	- 11%
Ophthalmology	- 17%
Cardiology	- 20%
Gastroenterology	- 21%
Neurosurgery	- 21%
Thoracic Surgery	- 28%
Cardiac Surgery	- 32%
Podiatry	+ 24%
Optometry	+ 15%
Chiropractic	+ 14%

SOURCE: "HCFA proposes expense rule". Bulletin. The American Association of Orthopaedic Surgeons.

Although RBRVS has the net effect of reducing reimbursement to physicians, it does nothing to address the issue of increasing the volume of visits to offset decreasing per-visit reimbursement. Ross Perot, writing in Intensive Care: We Must Save Medicare and Medicaid Now, explains the situation clearly.

> Because of the capped Medicare fee schedule, doctors cannot raise prices. The only other way to increase revenue is to perform more tests and procedures that may only be marginally necessary. As a result, the government and patients have a larger health care bill to pay. (61)

The effect of increasing volume to offset decreasing pay is what Kongstvedt refers to as "churning" (989).

Trends

Many factors have conspired to drive health care costs upwards. Due to the size of the Medicare program, the government has a strong interest in bringing the growth of spending under control. According to Mark J. Roberts, writing in Your Money or Your Life: The Health Care Crisis Explained, "Health care spending...is the fastest-growing part of the federal budget and has emerged as the largest obstacle to deficit reduction" (11).

As a percentage of the gross national product, the health sector has grown from under 5 percent in the

late 1940s to over 14 percent in 1993 (Fuchs 67; Perot 29). According to Schieber and Poullier, in other countries with universal coverage, e.g. Canada and the United Kingdom, the health sector's portion of the gross national product is 7 and 9 percent respectively (qtd. in Fuchs 67). According to a publication by the United States government, if left unchecked, the amount spent on health care will exceed that provided for other social security expenses and defense by the year 2000 (qtd. in Perot 31).

According to HCFA, when the Medicare program was conceived in 1965, there were 4.5 workers contributing to support one Medicare beneficiary. According to HCFA, by 1995, that number had dropped to 3.9 and is further projected to drop to 2.1 by 2035 (Perot 33). This is largely attributed to the fact that the "baby boom" generation begins heading into retirement in the year 2010. In a speech to the Senate Finance Committee, HCFA Administrator Bruce Vladeck reports that "With a drop in the ratio of active workers to retirees, scheduled payroll tax cannot keep pace with the expected expenditure levels" ("Long-term future" n.pag.).

The inevitable bottom line looms; without reform, the Medicare Part A trust fund will go broke early in the next millennium. Testimony from Donna Shalala in

1996 citing the Trustees Reports for 1995 and 1996 put the estimated dates for the impending collapse at 2002 and 2001 respectively ("Medicare Trust Fund n.pag.; "HI and SMI Trust Fund" n.pag.).

Probably the most startling trend concerning Medicare expenditures is the comparison of actual spending from the Part A (hospital) trust fund against the original projections. In 1967, estimates for expenditures from the Part A trust fund were 2.3 billion, while the actual expenditures were 3.4 billion. By 1990, the actuarial projections deteriorated even further. According to the Actuarial Cost Estimates and Summary of the Hospital Insurance and Supplementary Medical Insurance System's 1993 Hospital Insurance Trustees Report, projected expenditures for 1990 were 9.1 billion and actual expenditures were 66.6 billion (qtd. in Perot, 7).

While the Medicare trust funds slumped under the weight of expense, the number of hospitals climbed. According to Dr. Marc J. Roberts, in 1993 there were an estimated 5,400 acute care community hospitals, 880 specialty hospitals, and 300 federal hospitals (60). There have been some hospital closures and the occupancy rates for those hospitals that have survived continue to be low. In 1990, hospitals with 500 or more beds had occupancy rates of 77 percent, while

their small (6 to 24 bed) rural counterparts had occupancy rates of 32 percent (Raffel and Raffel 156).

Roberts explains that Medicare reimbursement played a large part in the over-building of hospital facilities. Medicare reimburses a share of hospitals' costs associated with interest and depreciation. For new construction, hospital interest payments are very high in the early years of the loan. The interest and depreciation might be higher than the principal. Roberts illustrates his point as follows:

> Under this scheme depreciation payments could become a major source of hospital cash. Hence one way for a hospital to acquire cash was to build. And many shrewd hospital administrators did just that -- despite the fact that there already was excess capacity in many areas. Perversely then, the reimbursement system provided the most capital to hospitals with the newest and most expensive facilities. Eventually, as principal payments increased and interest payments decreased, the revenue from the reimbursement would be less than the hospital's cash outflow. But then the hospital could (and often did) either refinance its loan, or build another building. And unless the state had controls on hospital construction (controls which have become weaker and less prevalent in recent years), all this could occur without any real government review of the relative need for such investment. (59)

Physician specialists and physician supply also grew along with hospital beds in a symbiotic relationship. In 1990, there were 625,421 physicians in the United States, with only 40 percent in primary

care, defined as internal medicine, family practice, pediatrics, and obstetrics/gynecology. This translates into 244 physicians per 100,000 people (Raffel and Raffel 61-62). While the number of physicians grew, their average net income grew, in opposition to the usual laws of supply and demand. Between 1983 and 1991, this income increase was 6.1 percent.

According to Fox, due to the fact that the market for health care has failed and Medicare reimbursement subsidizes graduate medical education, the United States has too many specialists. Fox argues,

> The United States needs a medical equivalent of arms control in international affairs (or, in a more contentious metaphor, of birth control). The production of physicians who perform the most expensive diagnostic and therapeutic procedures, and who use the most expensive equipment, needs to decrease. Such a decrease would be particularly welcome among specialists who perform procedures that frequently turn out to be unnecessary or potentially harmful. At the same time, the number of physicians who assist their patients in managing chronic disabling illness and injury should increase. (128)

Over 25 percent of Medicare payments go to physicians and 60 percent goes to hospitals. As can be easily deduced, the supply follows the money (Roberts 52).

Both the private and public sector have made attempts at controlling costs. Reducing fees to physicians and hospitals has resulted in cost shifting to other payers (Kongstvedt 991). The variety of

managed care programs, e.g. health maintenance organizations (HMO's), preferred provider organizations (PPO's), point-of-service plans (POS's), and provider-sponsored organizations (PSO's) serve to redirect care to lower-cost settings. Managed care programs also monitor medical appropriateness as a means of controlling expense. According to Steffie Woolhandler and David U. Himmelstein, in an article in The New England Journal of Medicine excerpted by Consumers' Research, however, early managed care efforts that paid physicians on a fee-for-service basis, with only minor controls on utilization, have saved very little (Woolhandler and Himmelstein 16-18).

Capitation of services involves paying providers (typically primary care providers) a set fee for the number of enrollees who sign up to them. This moves financial risk from the insurer to the provider of care (Pyenson 22). This shift in financial risk is presumed to alter approaches in practice from an acute care focus to one of promoting wellness and health maintenance. By promoting health maintenance and prevention, care can be delivered in less intense settings and can be less costly overall than the treatment of acute illnesses brought on by lack of judicious health management. Capitation can encourage physicians to take on unreasonable panel sizes in an

effort to increase their volume of PMPM (per member, per month) payments and has been cited as an incentive for causing physicians to consider withholding services they may have otherwise provided under fee-for-service (Easterbrook 64).

Overall, managed care alternatives have proven to save money over their fee-for-service alternatives. The difficulty lies in attracting membership when the managed care alternatives rely on some type of restricted access or choice. Of course, where choice is restricted, the question of quality will arise. The press has taken notice of such accused quality lapses, particularly as they relate to the potential to reduce financial risk exposure by withholding care (Brink 60).

Quality

Quality of health care is a source of pride for the United States, particularly in reference to the care of the elderly. From 1982 through 1994, the results of the National Long Term Care Survey sponsored by the federal government have shown annual declines in disability rates (Kolata A1+). Not only is quality health care a noble end unto itself, it also can result in decreased costs. Dr. Kenneth Manton from Duke University estimates that the decline in disability

rates from 1982 until 1995 have saved Medicare $200 billion (Kolata A1+).

In 1965, when Medicare was created, the life expectancy of the average American was a little over seventy years. In 1996, that figure rose to nearly seventy-six years. By 2025, the life expectancy projections for Americans is more than seventy-eight years. The fastest growing portion of Americans are those eighty-five and over. Half of all expenses for health care are experienced after age sixty-five (Bandow and Tanner 40-42).

A popular topic among consumers is the comparison of health care quality and cost in the United States to that experienced in other countries. In an analysis of what he refers to as "health care myths", Fred Barnes, writing in The New Republic, critiques a story by newscaster Peter Jennings about Japanese health care. Jennings reported that Japanese employers pay one fifth that of their United States counterparts for employee health care and the Japanese live longer. What Jennings failed to mention, according to Barnes, was that Japanese physicians, paid on a government established fee schedule for each procedure, seek to maximize their reimbursement by seeing an average of forty-nine patients per day, and that hospitals are antiquated by American standards. Admission to

Japanese hospitals is often facilitated by bribes, and incentives to maintain quality are lacking. Barnes further reflects that Jennings failed to attribute the longer life span of the Japanese to social factors such as better diet, avoidance of high-risk behavior, and less violent crime, drug abuse, and sexually transmitted disease (1C+).

Canadian and German health care is also seen as another potential benchmark for health delivery in the United States. Reporters have implied that patients in these countries where health care is subsidized by the government are enjoying a better delivery system. Fred Barnes, however, disagrees. Supporters of the Canadian health system fail to mention waits for elective surgeries for up to six months, with elective surgery including some heart surgeries, gallbladder surgery, major oral surgery, and tonsillectomies. At any given time, up to 250,000 Canadians may be waiting their turn for surgery (Barnes C1+).

In Germany, health care costs are soaring as well and technology is not on a par with the United States. German physicians get paid a fee set by the government for each visit. The patient pays nothing for the visit, so the German physicians keep bringing them back (nearly twice as often as in the United States) for more office visits (Barnes C1+).

Although the measurement of health outcomes and quality for Medicare beneficiaries is still in its infancy stages, HCFA is finally requiring all health plans that contract to provide Medicare services to collect and report HEDIS (Health Plan Employer Data and Information Set) data (Wingerson 121). Early comparisons of fee-for-service Medicare rates of influenza immunization, for example, to those of a large senior HMO, reflect immunization rates 62 percent better in the HMO setting (Wingerson 123).

In other areas of preventive care or chronic disease management, data is still lacking. In a General Accounting Office (GAO) report in 1997, the GAO noted that only 40 percent of diabetics in fee-for-service Medicare received an annual eye exam, and only about 20 percent received blood tests for monitoring diabetes control (Wingerson 166). Because Medicare, at the time of the study, did not require HMO's to submit HEDIS data, similar measures in the HMO setting could not be assessed by the GAO (qtd. in Wingerson 174).

Patient satisfaction is another aspect of quality of care important to consumers. A survey conducted by Towers Perrin in 1997 found that of 5,932 retirees, 68 percent were extremely or very satisfied with their coverage under a Medicare HMO. In addition, only 20 percent preferred their previous traditional (fee-for-

service) Medicare (Wingerson 158). Compared to commercial HMO members, Medicare HMO members' satisfaction scores were overall eight points higher (Wingerson 175). Typical satisfaction surveys include data on disenrollment, wait time for appointments, access, and general satisfaction with providers of care (Kongstvedt 487).

Medicare Reform

Considering all of the evidence pointing to a need to overhaul the Medicare system, it is heartening to know that the federal government has reacted with some attempts to improve the cost and quality of care delivery to the elderly and disabled served by Medicare. The Balanced Budget Act of 1997 has created some of the most sweeping opportunities for reform seen in many years of political infighting and special interests' influence. Changes in the way Medicare is administered will result in a savings of about $115 billion (Scott n. pg.; "Billions Cut" n. pg.).

All of these changes as a result of the Balanced Budget Act of 1997 have reportedly granted the Medicare Trust Fund another 10 years on its life expectancy and added more delivery and benefit options. Perhaps the most crucial component but frequently overlooked part of the Act was the formation of a Bipartisan

Commission on the Future of Medicare. According to Donna Shalala, this group will be charged with coming up with long term solutions to questions plaguing the Medicare program ("Reinventing Medicare" n. pg.).

In a speech to the AMA in March of 1997, Shalala referred to updates in the Medicare benefit package as "modernizing Medicare". Specifically, according to Shalala, Medicare will now pay for annual mammograms, colon cancer screenings, and diabetes monitoring and education ("Health Care Delivery" n. pg.). In addition, preventive measures such as osteoporosis bone mass screenings, prostate testing, and continued support for immunizations have also been added (Wingerson 536-538).

Member choice enjoyed by the commercial market has been expanded to include Medicare beneficiaries as well. According to Richard Smith, Vice President for Policy and Research for the American Association of Health Plans,

> Instead of having what is in essence a system that enrolls everyone in fee-for-service and then if you're lucky enough to find out about the managed care program, and lucky enough to pull together the information, you can switch to a managed care plan,...seniors are going to be given a real opportunity to make a choice with real information. (qtd. in Wingerson 2)

Medicare beneficiaries now have the choice of traditional fee-for-service Medicare, Medicare HMO's, Medicare PPO's, provider sponsored organizations (PSO's), private fee-for-service plans organized by physicians, and medical savings accounts (MSA's) (Wingerson 3).

In additional efforts to control costs, the Balanced Budget Act of 1997 allows for prospective payment to home care and nursing homes. According to economists Marilyn Moon, Barbara Gage, and Alison Evans, this change will result in $25.6 billion dollars in savings (Wingerson 3). Reduced payments to hospitals from DRG adjustments, reduced dis-proportionate share payments, and reductions in graduate medical education payments will result in an additional $33.3 billion dollars in Medicare savings (Wingerson 3).

No doubt, stepped up efforts to control fraud in the Medicare program will also result in savings. According to Michael F. Mangano, Principal Deputy Inspector General for the Department of Health and Human Services, the Office of Inspector General and the Department of Justice retrieved one billion dollars in settlements and sanctioned 980 fraudulent and abuse providers from the Medicare system in an eight month period (Mangano n. pg.).

Kathleen Buto, Deputy Director of the Center for Health Plans and Providers of HCFA, and Gary Kavanagh, Deputy Director, Bureau of Program Operations, described Operation Restore Trust as an initiative to integrate the activities of several agencies at the state and federal level to address Medicare fraud and abuse (Buto n. pg., Kavanagh n. pg.). Operation Restore Trust will enhance surveys of home health agencies, skilled nursing homes, outpatient physical therapy services, laboratories, and psychiatric services. An original demonstration project of Operation Restore Trust targeted home care, nursing homes, durable medical equipment suppliers, and hospices in states with a high concentration of Medicare and Medicaid beneficiaries (Buto n. pg.). Donna Shalala announced that the original Operation Restore Trust program had a twenty-three to one return on the dollar spent to implement the initiative (Wingerson 216).

Perils and Promise

Theodore R. Marmor and John C. Liu described the perils of the fee-for-service Medicare program and the naivete of the American people in their article in the Baltimore Sun. Marmor and Liu explain how this happened:

> All Medicare enthusiasts took for granted that the rhetoric of enactment should emphasize the expansion of access, not the regulation and overhaul of U.S. medicine. The clear aim was to reduce the risks of financial disaster for the elderly and their families, and the clear understanding was that Congress would demand a largely hands-off posture toward the doctors and the hospitals providing the care that Medicare would finance. Thirty years later, that vision seems odd. It is now taken for granted that how one pays for medical care affects the care given. But in the buildup to the enactment in 1965, no such presumption existed. (1F+)

The expansion of access described foreshadowed the bias toward acute hospital and physician care.

Daniel M. Fox, however, points out that deaths from chronic disease surpassed deaths from acute conditions nearly seventy-five years ago. The policy of the government in health care reimbursement has heretofore been obsolete. Ensuring coverage for chronic conditions and their preventable sequelae, could represent a step in the right direction (Fox 1).

Managed care, in its earliest incarnation via the HMO, addresses the maintenance of health. According to Peter D. Fox, consultant, this is achieved by placing a greater emphasis on prevention and wellness. Preventive care measures in managed care delivery systems are not only covered, but encouraged. Chronic disease management, through patient education or case

management, reduces the need for expensive acute care interventions (Kongstvedt 3).

Russel C. Coile, Jr., in his treatise on the future of health care delivery, The New Medicine: Reshaping Medical Practice and Health Care Management, acknowledges the insight of Rene Dubos, a research microbiologist in the 1960s. Dubos indicated that the work he and others performed in developing therapies such as antibiotics "had less to do with the real health of populations than a variety of economic, social, nutritional, and behavioral health factors" (qtd. in Coile 152). According to Coile, by 1987, more than one-third of acute care hospitals in the United States were catching on and were promoting some type of wellness initiatives, up from only 6 percent in 1983 (Coile 153).

HCFA reports indicate that managed care enrollees' cost are 12 to 14 percent lower than average, taking into account adjustments for demographics (Wingerson 117). There is some evidence, however, that Medicare HMO enrollees use less services even prior to enrollment, leading to the conclusion that they are healthier overall to begin with (Wolfe 81).

Although managed care does not represent a complete rejection of the acute care delivery model, its financial incentives reward the low tech care more

representative of chronic disease management and prevention. The Balanced Budget Act of 1997's endorsement of managed care options may mark a crucial turning point in the manner of health care delivery in the United States, by further stressing the need to maintain wellness and manage chronic disease.

Chapter II

LITERATURE REVIEW

The struggles facing the Medicare program today are not just issues of funding, but rather, those of the United States' total approach to health care. The focus on the quick fix of acute care medicine has been embedded in the psyche of the American public since the days of Abraham Flexner circa 1909. Some writers are discovering, however, that the allure of focusing the health care dollar on acute care medicine versus the prevention and management of chronic disease has been a costly and largely erroneous course for health care delivery and financing policies.

Although careful not to directly implicate the medical system in their text, Marshal W. and Norma K. Raffel concede,

> Shortcomings in our health system still exists, and change is occurring. As in the past, the change is usually a negotiated settlement, negotiated not because some do not want to act but because there are disagreements over how to best act. (34)

The literature reflects the persistence of these disagreements as they relate to salvaging the Medicare program. While some writers endorse financial

restructuring, eligibility changes, and tax manipulations to restore solvency to Medicare, others focus on the care delivery system.

The Balanced Budget Act of 1997 reflects the "negotiated settlement" approach as referenced by Raffel and Raffel (34). Its focus on managed care as the way to pull the program back from the brink is best described by Lois Wingerson, editor of the 1998 Managed Care Sourcebook, when she stated that, although the Act has been described as "a revolution for Medicare...it is more a revolution in the sense of turning on an axle rather than in the sense of explosion and reconstruction" (ix).

Daniel M. Fox, writing in Power and Illness: The Failure and Future of American Health Policy, provides the most comprehensive indictment of the American health system and its failure to recognize the prevention and management of chronic illness as a priority in health care financing or professional health provider education. Fox begins his challenge by examining the roots of health care delivery system in the late 1800s.

According to Fox, health policy in the 1800s spotlighted the problems of acute infectious diseases and chronic infections such as tuberculosis and syphilis. In addition, priorities for intervention

were targeted at research in the medical and bacterial sciences, care that was available in acute care hospitals, and a reformed medical education system. These priorities were congruent with the prevalence of disease at the time. Medical care for the indigent fell to the bottom of the priority list, as philanthropic or city and state budgets were expected to take up the charge. Since the economy was always expected to improve after the next election, middle and working class individuals were expected to be able to afford reasonable health care services (Fox 3-5).

In the 1900s-1950s, Fox highlights American health policy as a paradox. Public and private funds poured in to the health system; however Fox maintains that these efforts were largely misdirected. Although Americans were living longer, they were not necessarily enjoying healthier lives. More people were dying from chronic disease than acute illness. Health policy priorities were set on expanding access to acute care, when in fact, the occurrence of chronic illness and disability was increasing. There was a collective misconception on the part of policy makers that the system designed to address acute infectious diseases was going to be effective in addressing the chronic illness of cancer, stroke, diabetes, and heart disease (Fox 30 - 32).

With the exception of the discovery of Cortisone for rheumatoid arthritis, the acute care system did not generally provide much assistance for the management of chronic illness in the first half of the 1900s. The supply of Cortisone proved to be an issue that many extrapolated to other areas of health care access policy. Clinical trials in 1954 ended up proving that aspirin was nearly as effective in treating rheumatoid arthritis as Cortisone. Despite the eventual tarnishing of Cortisone's reputation however, the popular belief that a health system designed for treating acute illness would also be effective for treating chronic illness persisted in the minds of consumers and policy makers (Fox 54-55).

Fox suggests that the story of Cortisone sums up the problem with health delivery today when he proposes,

> Cortisone, in sum, is a metaphor for health policy that looked to the past for its priorities while the people who made it and those who gained the most personal income and prestige from it believed that they were using the best new science to create better health in the future. Cortisone also exemplifies the linkage of health power and illness. Government appropriations and the insurance premiums paid by employers and employees supported the grandest ambitions of medical scientists, specialist physicians, hospital managers, and the manufacturers of pharmaceutical drugs. Almost all of these powerful people also chose to give priority to the acute phase of chronic diseases that afflicted the people. The paradox of health

> policy rested on the disjunctions between belief and information. (55)

Fox believed that by 1950, health policy leaders still felt that a compromise between the reality of human illness and funding could be accommodated (56).

By the mid 1970s, Fox contends that economic growth and scientific progress were seen as the key to improving American health status. A hodge-podge of funding mechanisms, e.g., private contributions, public funds, taxes, and philanthropy were linked together to accommodate the varying interests' priorities. These interest groups included politicians, physicians, trade and labor unions, scientists, and managers of hospitals and health facilities, to name the majority (56-67).

It was through funding negotiations that the federal government ended up subsidizing medical research, with small assistance from disease-specific foundations and charities. Laboratory and hospital capital came from state and federal governments as well as private investors. States also were responsible for funding medical education faculty and facilities, mental health services, and public health. Through either Medicare or employer-sponsored private insurance, most working persons were insured against expenses for acute care and illness (Fox 57-59).

The "compromise", as Fox refers to the health policy prevailing at the later quarter of the 1900s, became a financial burden and a failure to patients, providers, and payers. Fox attributes the spiraling costs to the demand for new technology, the increasing number of elderly, and the increasing volume of physicians and health providers who were being well reimbursed by Medicare, Medicaid, and private insurance for acute care. In contrast, the cost for managing chronic illness continued to be borne predominantly by individuals and their families (Fox 59-60).

Fox claims that World War II also contributed to the acute care focus by increasing the number of specialist physicians. Certified physician specialists received higher rank and safer assignments. By the mid-1950s, specialists were in greater supply than generalists. Even the G.I. Bill provided payments to physicians who obtained specialty credentials after discharge. These specialists focused their work on treating the acute manifestations of chronic illness, rather than the underlying chronic disease (Fox 61).

Hospitals also supported interventional medicine; a preference skewed to favor acute versus chronic illness. Capital amortization payments from Blue Cross and Medicare served to fuel the demand for intensive care and surgical suites and equipment. The cost for

subsidizing the tools favoring acute interventions was passed on to payers, employers, employees, and taxpayers in the form of higher premiums and taxes (Fox 60-61).

With the exception of coverage under Medicare for End-Stage Renal Disease and Medicaid coverage for chronic disabling illness, social policy favoring acute care persisted. According to Fox, Medicaid appeared to be an acceptable way to cover chronic disease, in that it was seen as more of a welfare program rather than a health policy. Medicaid entitlements for long term care were extensive as long as financial neediness qualifications were met (Fox 76-78).

Fox cites several unique characteristics of American health policy. According to Fox, American citizens tend to dislike big government, remain optimistic about individual capacity for wealth and good health, and consider science and technology logical ways to solve social and health issues. Fox also posits that unlike Western European countries, United States health policy is controlled by special interest groups such as physicians and does not ensure access to health services to everyone via private or public funding (Fox 79).

Health care access in the United States is still contingent upon age, income, and/or employment. As for

a historical willingness to change this standard, Fox states, "In a country that makes new policy mainly in response to crises, moreover, we have not had a crisis in health service that stimulated more than incremental changes in policy" (78-79).

In the last quarter of the 1900s, Fox contends that the American people have begun to realize that their health care delivery system is a leader in expense, not necessarily a leader in quality or effectiveness (84). The cost of employee benefits for health care continues to gouge into corporate profits. The cost of public health benefits through Medicare and Medicaid have caused politically unpopular tax increases. The policy response to these concerns has just started to mobilize (Fox 86).

Fox notes that since the 1970s, several incremental changes have taken place in health policy. The government has attempted to control hospital expenditures for new buildings and equipment. HMO's have been promoted and insurance plans and providers have been negotiating discounts from providers. The Medicare program adopted the DRG system and has reduced fees to physicians in intervention-oriented specialties. Medical utilization review programs have sprung up to evaluate the appropriateness of ordered medical and surgical interventions. Medicaid dollars

have been increased to women and infants and reallocations have directed money from institutional budgets to individual providers and community agencies. Some states have begun to subsidize insurance for low income individuals who may not otherwise be able to obtain affordable coverage (Fox 86-87).

Acute care received the majority of the attention in terms of health policy changes, according to Fox, because that was where the budgets were hemorrhaging. Spending money on prevention was considered, but since the investment in education and behavior modification would probably not achieve short term results, if any results, it was not wholeheartedly endorsed by government payors. It seemed as though Americans were waiting for, in Fox's words, "Preventive services that could be delivered by injections or in tablet form..." (87-88).

Other important changes in health policy, according to Fox, came as patients became more cynical of their doctors. Citizens realized that the costs of health insurance benefits were going up, but better health was not necessarily the result of this investment. Businesses began to demand accountability for the dollars spent on employee health benefits and taxes to support public programs. Their skepticism became justified as they evaluated the results of

utilization review, in programs that even today, find approximately 50 percent of commercial and Medicare hospital days medically unnecessary (Axene et. al. 3-4). Also brought to light was the fact that some physicians had significant investment interests in surgical and diagnostic facilities from which they profited again by directing patient referrals to their holdings (Fox 97-99).

Fox concludes his treatise with advice on new priorities for health policy. Fox believes that dollars spent on unnecessary or infrequently used acute care services should be redirected to the management of chronic illness. As money is saved from the acute care side of the equation, Fox believes that money should be spent on efforts to prevent or postpone the effects of chronic illness, reduce preventable injuries, and prevent worsening of illness and accident sequelae (126 - 127).

Fox's work is thorough and well documented. He digs deep into American health policy history to come up with his conclusions. He thoroughly examines the lingering effects of special interest groups and connects the policy decisions they influenced long ago to the problems in health delivery and financing today.

Victor R. Fuchs, is the Henry J. Kaiser, Jr. Professor of Economics and of Health Research and

Policy at Stanford University and a Research Associate for the National Bureau of Economic Research. In his book, The Future of Health Policy, he takes more of an economist's dispassionate approach to analyzing American health policy. He is quick to point out the problems with current health policy as reflected against the health sector's increasing share of the gross national product (Fuchs 67).

Fuchs explores the relationships between poverty and educational level and health status. Studies quoted by Fuchs show that those with low incomes and less education have higher mortality rates. Fuchs points out that although England and Scandinavia have universal medical care coverage, age-standardized mortality differences persist between classes of workers, with those in higher paying professional roles experiencing longer lives (54-55).

Fuchs also cites studies showing that those with more education have a better understanding of how to access care and select better health habits. However, he contends that perhaps better health leads to additional time spent in the educational system (56).

Fuchs' favorite variables are those of time preference and self-efficacy. According to Fuchs, those of lower educational status tend to have high rates of time preference, i.e., they discount

investments in the future requiring sacrifices today. Persons with self-efficacy believe that they have the ability to exercise control over their behavior and environment and are more likely to adopt better health habits (Fuchs 56-57).

Fuchs differs from Fox somewhat in his explanations for why current health policy is not an equitable solution to providing medical care for the poor and aged. Fuchs and Fox agree that one explanation for the resistance to federal or state solutions may relate to Americans' generalized distrust of the government. Fuchs further maintains that the average citizen believes that care for the poor and aged will somehow spontaneously occur without their individual sacrifice or effort. He supports this belief by relating it to what he maintains are general characteristics of United States society: a heterogenous population, the lack of generosity of the rich, and strong volunteerism (Fuchs 61).

Fuchs explores the Canadian health care delivery system and contrasts it to the health care delivery system available to most Americans. Canadians pay their physicians approximately 234 percent less than their United States counterparts (Fuchs 91). Despite popular opinion, Fuchs solidly refutes the idea that Canadian health care costs are lower overall than costs

in the United States because fewer services are being performed for Canadians (92-93). The United States, according to Fuchs, uses far more resources than Canada to deliver a given quantity of health services to its citizens, while Canada maintains a higher life expectancy and lower infant mortality rate (89,97).

Cost containment in health care is strongly advocated by Fuchs. Fuchs and Fox agree that citizens in the United States are not getting an adequate return on their financial investment in health care today. Unnecessary care and defensive medicine are two of the reasons cited by Fuchs for the poor return on the health care dollar (159).

Fuchs attributes the waste of resources as another area contributing to excess cost. Fuchs states that waste is concentrated in two main areas; administration (e.g., marketing, billing, collecting) and excess capacity (e.g., staff, buildings, and equipment). Fuchs, as an economist, identifies the need for a change in public policy to address resource use. Fuchs maintains that:

> Public policy is needed to reduce inefficiency because, unlike many industries, the markets for health insurance and health care are not self-correcting. For instance, in a typical industry, excess capacity has two dramatic effects. First, prices fall, and second, some firms go out of business.... In health care this adjustment process is slower and weaker, and is often nonexistent.

> In many U.S. cities hospital beds, high-tech equipment, and certain procedure-oriented specialists are all in excess supply, but charges and fees remain high and the excess capacity persists for decades. (160)

Fuchs cites evidence that even though there are many facilities providing complex procedures such as open heart surgery, many of the facilities are performing relatively few procedures per year. This raises costs and may contribute to worse outcomes in the low volume facilities (Fuchs 161).

Fuchs final rationale for cost containment is to "eliminate abnormally high returns to some producers of health care goods and services" (161). In particular, Fuchs targets drug companies as having a far higher rate of return than other manufacturing companies. Drug companies do this in part, via product differentiations and patent protections that allow them monopoly charges. Fuchs also points out that physicians in the United States have higher earnings relative to their peers in other countries. His data shows that United States' physicians earn about thirty-five percent more than their Canadian peers (162).

Fuchs believes that a "counterrevolution" is developing in terms of health care finance. He attributes this growing discontent to the unhappiness and unease among consumers, business interests, and providers alike. Fuchs believes that these groups will

seek a higher degree of federal involvement in health care and insurance, however, they will not come to an agreement on how that involvement will play out (184).

Fuchs discusses the potential for national health insurance; however he feels timing will be the major factor in when it might take hold (216-217). In summation, Fuchs states that,

> National health insurance will probably come to the United States in the wake of a major change in the political climate, the kind of change that often accompanies a war, a depression, or large-scale civil unrest. Short of that, we should expect modest attempts to increase coverage and contain costs, accompanied by an immodest amount of sound and fury. (217)

Fuchs' perspectives seem to be weighted more to the economic factors impacting health care than the structure of the delivery system itself. Fuchs' points well document the economic impact of the policy decisions that have been made, and the factors which have caused health policy to be such a difficult topic in this country.

Although Fuchs does not promote the idea that the United States is in a health care crisis, Marc J. Roberts, Ph.D., a professor of political economy and health policy at the Harvard School of Public Health and the John F. Kennedy School of Government definitely considers the system to be in peril. In Robert's book,

Your Money or Your Life: The Health Care Crisis Explained, he makes a compelling argument for the seriousness of the situation.

Roberts maintains, like Fox, that the ills of the current system are rooted in the way health care delivery developed in the United States. This delivery system developed out of the belief that the hospital and physician were infallible in matters pertaining to health. Although intuition and skill still play a large part in medical treatment, not many people realize that many patients, no matter how ill, will recover regardless of the treatment provided (Roberts 17-19).

Dr. Roberts also identifies that we are suffering from the "failures of success" in health care. Increased disability is the natural result of patients surviving acute episodes of illnesses or injuries to live long enough to suffer from the resulting disabilities or other age-related illnesses. Before the advent of effective acute care, many sick and injured died prematurely (Roberts 20-21).

As a result of people living long enough to develop chronic disease, Roberts has surmised that health care costs are becoming impossible to insure. Roberts maintains that insurance is designed to cover the unanticipated calamity, not the certain sequelae of

chronic illness. The result, in classical medical underwriting terms, is to charge high premiums to those who need the coverage the most (those who are already sick) and/or to spread the risk out over a larger group that will hopefully contain relatively healthy people (Roberts 21-22).

Roberts notes, however, that with advances in diagnostics and genetics, who is truly sick and who is not has been increasingly open to debate. This confusion has led some health care providers to expand the scope of what is in need of medical intervention. As a result, some providers have managed to carve out a profitable niche for themselves. Like Fuchs, Roberts also cites social problems and lack of access to ambulatory care as contributors to the poor being sicker and the sick being poorer (24-25).

Roberts also notes the death-defying attitude of Americans as another reason health care has reached a crisis. American fascination with technology, guilt surrounding the care of elderly relatives, and a competitive desire to beat death at the end of the game of life are all considered contributing factors as to why Americans are willing to spend high dollars on the terminally ill. Roberts, like Fox, concedes that Americans are still looking for a magic pill or therapy to help avoid illness and death, regardless of the bad

health habits to which many have subscribed (Roberts 24-25).

Roberts explores the concept of a "medical industrial complex", a play on words from the "military industrial complex" quote from President Dwight Eisenhower in the 1960s (qtd. in Roberts 33). The influence from this medical industrial complex, consisting of politicians who are willing to promise much and promise to tax little, and wealthy hospitals and physicians willing to commit support to candidates who favor their well being, has grown to dominate health policy. Roberts explains that whenever even a small group has a lot to lose (health providers versus health care reform), and the other affected parties have only a small amount to lose (gradually increasing premiums), the small organized group will mobilize the publicity and outcry to sway the outcome (34-35).

Roberts covers much of the same health policy ground as was explored by Fox. He thoroughly reviews how the American health system developed and the resulting financial and delivery system crisis. Roberts, like Fox, advocates preventive health services, and like Fuchs, feels a reduction in redundancy of facilities and overstaffing would go a long way to relieving financial burdens (95-97).

Like other writers, Roberts explores the pro's and con's of various health care reform proposals. He postulates seven areas that must be addressed in any practical reform plan: universality, equity, cost control, efficiency, access/quality, choice, and prevention (153-154). In addition, he summarizes his study with the identification of three obstacles that Americans must overcome in order to achieve true reform: 1) overcoming political inertia and special interest group influence, 2) unwillingness for individuals, businesses, or governments to get involved if there is not a direct impact on their economic self-interest; and 3) a lack of empathy for those in lower socioeconomic levels (155-156).

Since the impact of politics on health policy has been a common thread for all writers familiar with the need to address health care reform, it is interesting to note the writings of Ross Perot, a wealthy businessman and occasional presidential candidate. In Intensive Care: We Must Save Medicare and Medicaid Now, Perot attacks the issue of health care reform with his usual populist style and an abundance of graphs and charts.

Perot goes deep into Medicare financing history and notes that Medicare has seemed to be headed for trouble ever since its birth over thirty years ago.

Since its inception, Medicare has run far over budget estimates (Perot 6-7). Perot takes great delight in pointing out how Washington has done little to control these costs, and how fraud and waste have run rampant (6-7). Perot covers the usual territory, from the size of the gross domestic product devoted to health care, to the expanding number of eligibles, to the shrinking number of taxpayers trying to support the federally funded health care programs (28-31).

Perhaps due to his history as a businessman, Perot explores cost shifting more in depth than other writers. Perot correctly identifies that when payments from Medicare and Medicaid are reduced, providers merely shift costs on to the private sector. Although private insured citizens sometimes tend to think that health care is something paid for by someone else, Perot illustrates that workers pay for health care at least four times. The first payment comes through reduced wages or direct payment for premiums for employer sponsored health benefits. The second and third payments come through taxation to fund Medicare Part A and Part B, respectively. The fourth and final payment comes through income taxes for the needy who need Medicaid (Perot 31-33).

Perot's writing agrees with others in that federal government health care reform, particularly that

sponsored by President and Mrs. Clinton in 1994, succumbed partially due to the nation's mistrust of big government. Interestingly enough, in the same chapter, Perot proposes that the real cure lies in reforming the financing system, in a way, he states "that would not jeopardize the quality of health care" (39). In that sense, Perot departs from the other writers in that he appears to have an unshakable faith that the current health system represents the highest quality of health care that can be enjoyed.

Near the end of his work, Perot is ready to prescribe solutions to the problems faced by Medicare. He has the foresight to propose changes in two timeframes; short-term and long-term. His short-term fixes he describes as a "bridge" to a new system and his long-term option is to introduce the "new system" (109).

For short-term fixes, Perot proposes raising Part B deductibles, expanding coinsurance payments, reforming medigap policies, and raising premiums for Part B to reduce the amount the government must subsidize(111-114). Perot correctly illustrates that Part B premiums, which once covered 50 percent of the cost of the benefits, now cover only 28 percent of benefit costs. Perot estimates that, beginning in 1999, if new eligibles were required to pay $20 more in

Part B premiums for choosing Medicare fee-for-service over other managed care options, the program would save $3.8 billion over seven years (114).

In other more controversial proposals, Perot advocates raising the age of eligibility gradually to age sixty-eight. Perot cites life expectancy increases of eleven years since the Social Security retirement age was established, while the eligibility age for benefits for Medicare did not budge. No estimates of savings from this proposal were offered (115).

Perot also advocates means-testing for Part B premiums. Under this proposal, wealthier beneficiaries would pay a greater part of the portion of Part B costs through gradually increasing premiums. Cost savings associated with means testing based on the Perot proposal would reach $13.9 billion over five years (115-116).

In more administrative moves, Perot proposes the following changes: short-term savings to Medicare in the form of merging Part A and Part B administration to increase efficiency, rewards for whistle-blowers, elimination of unjustified disproportionate share payments to hospitals (payments designed to offset the cost of caring for the poor), elimination of bad debt payments, and a reduction in payments to highly reimbursed hospital-based physicians (117-118, 120).

Further, Perot proposes to eliminate payments through Medicare designed to subsidize direct and indirect education costs, although with a caution to monitor the effect carefully to avoid impacting the quality of providers (119-120). Perot does not address the issue that reducing the subsidies for education of physicians may in turn reduce the oversupply of specialists. This oversupply of specialist providers in some areas is cited by other writers as a contributing factor in increasing health care costs, but this fact is overlooked by Perot.

For a long-term solution, Perot advocates introducing additional choice in benefit packages to Medicare beneficiaries as the most noteworthy option (121). It is here that Perot acknowledges that lower cost plans come with some restrictions, but that restriction in choice does not necessarily equate to lower quality care (122).

In the final chapter, Perot touches on the role of public health initiatives in maintaining a healthy society. Perot cites clean water, effective indoor plumbing, and trash control as key early public health efforts (179). Beyond that, Perot trumpets an increasing life expectancy as a success of the health care advances made in the United States, ignoring, perhaps, the gains made by other countries under other

delivery systems (182). Perot, like Fuchs, places emphasis on the role of education in relation to personal health. Of course Perot also promotes personal responsibility as a way to maintain health and cautions people to avoid looking to big government to solve their problems (182-184).

What was glaringly absent from Perot's treatise was some indication of reforming the health care delivery system, not just reimbursement. Perot makes scarce mention of the role of prevention or chronic disease management as a means of controlling costs. Perhaps the key to Perot's perspective is best found in his closing acknowledgement:

> This book is dedicated to the men and women who have dedicated their lives to medical research. Our lives have been infinitely improved by their work, which goes largely unnoticed. Thank you for your dedication. (187)

Perot, unlike other writers, did not appear to go back in history to explore the root of the delivery system factors and special interests which have significantly influenced today's health policy and the resulting funding problems.

John R. Wolfe's book, The Coming Health Crisis: Who Will Pay for Care for the Aged in the 21st Century?, like the writings of Victor R. Fuchs, focuses on economic measures to save the health care delivery

system from crisis. Wolfe is an associate professor of economics at Michigan State University. Wolfe, like other writers, focuses on how changing demographics will affect income, wealth, and burden the health care system beyond what has ever been experienced in the United States (10-39). Wolfe, like the economists of his genre, and Ross Perot, believes that tinkering with the financing system represents the ultimate solution to the growing health care financing conundrum.

When discussing "gaps" in medical and long-term care, however, Wolfe is really describing gaps in health care financing instead (65). Wolf identifies these "gaps" as Medicare hospitalization cut-offs at 150 days, the absence of ceilings on copayments for physician services, and Medicaid coverage for long-term care only for the destitute (65). Wolfe believes, in his words, that "the best hope for improvements in quality of care and coverage is expanded self-financing" (65).

Near the end of Wolfe's book, he does explore what he refers to as "saving and insurance innovations" (117). In this section, Wolfe acknowledges the role of managed care and continuing care retirement communities in lessening "the need for long-term care through early detection and treatment of chronic illness" (118). Wolfe, like Perot, however, clings tightly to a faith

in physicians and the status quo of the current delivery system. Wolfe warns against lean treatment protocols "imposed by nonclinicians rather than professional management on the physician model" (118).

In proposing the usual financing adjustments to salvage Medicare (increasing taxes, covering social insurance programs for long-term care, increasing premiums, raising eligibility ages, reverse equity mortgages, etc.), Wolfe also acknowledges the role of decreasing demand for health care services by increasing taxes on cigarettes and alcohol (134-137). Wolfe states, however, that dampening the need for services alone will not be sufficient (134-135). Wolfe does not even consider the hypothesis that significantly restructuring the delivery system could provide a long-term solution to Medicare's woes.

In considering the popular literature relating to the need to reform the Medicare system, the writers seem to fall into one of two groups. Fox and Roberts advocate a restructuring of health policy to embrace an emphasis on the management and prevention of chronic diseases as a means to true reform. Others, such as Fuchs, Wolfe, and Perot emphasize financing adjustments and modest delivery system changes to restore solvency to the Medicare program.

It is certain that changing the priorities for health care allocations from an acute care focus to one that recognizes the need to better manage chronic illness will require public support. Public support for changing Medicare has not been overwhelming in the years since the program's inception. In good economic climates, public tolerance for financing changes would seem to be an easier option. However, ultimate Medicare reform will only come through fundamental changes in the funding priorities of heretofore competing aspects of the delivery system, acute versus chronic disease management and prevention.

Statement of Hypothesis

This thesis proposes that an emphasis on managed care strategies such as capitation, chronic disease management, and case management, will represent an effective way to reform the Medicare system. Financing manipulations to shore up the traditional fee-for-service program may provide some relief from the stresses facing the Medicare program in the short term. Both should be considered as part of a package reform that should also include an overall restructuring of the health care delivery system from one driven by excess profiteering to one better designed to meet real human needs.

Chapter III

SELECTIVE REVIEW AND EVALUATION OF RESEARCH

The writers examining the challenges facing health policy, particularly as it pertains to the elderly, identify both financing adjustments and delivery system allocation changes as a means to salvaging the Medicare program. The writers have employed a variety of study methodologies to come to their conclusions, most commonly citing available public information from the Medicare trust funds as support for their concerns. Some, such as Fox and Roberts, employ historical research to bolster their calls for a restructuring of the delivery system. Others, such as Wolfe, Fuchs, and Perot, heavily rely on economic data, both current and historical.

Daniel M. Fox relies on an extensive review of historical literature on the development of health policy and its relationship to the history of medicine in the United States (Fox 152-153). For the most part, he draws his conclusions by inferring that structure (the way the current health care delivery system is designed) drives consumption (the way available health funding resources are utilized).

When Fox examines what he calls the "paradox of health policy", that is, the inaccurate allocation of funds biased toward acute versus chronic health needs, he supports his thesis based on crude death-rate figures from the 1900s onward (30, 33). In this analysis, Fox notes that deaths attributable to chronic diseases increased 37 percent from 1900 to 1940. Fox then adjusts the death rate for age, to account for people living longer due to improved survival from childhood diseases. Based on this analysis, Fox found an increase of 36 percent from 1900 to 1948. When diagnostic coding guidelines changed, Fox acknowledged that comparability of data after 1948 was compromised, however, his estimated figures still show a 30 percent increase in deaths from chronic conditions overall from 1900 to 1960 (33).

Fox also supports his call for priority adjustments in health policy by citing data on disability and morbidity, not just mortality. Fox concedes that disability data was limited before the 1950s. Acknowledging the statistical limitations of studies from the Metropolitan Life Insurance Company, the United States Public Health Service, and the Milbank Memorial Fund, Fox nonetheless concludes that all of the studies pointed to the large and growing hardship associated with chronic disease and injury.

The National Health Survey of 1935-36 alone found that at least one of every six persons (in a study of 2.8 million) had a compromising chronic disease, vision or hearing impairment, or orthopedic disability. Despite this evidence, Fox notes that the United States Public Health Service was unable to marshall significant public support to make chronic disease a source of greater emphasis in public health programs (33-35).

Fox's historical data on death rates from chronic illness may be limited by the diagnostic capabilities available to physicians at the time of the recorded deaths. Another limiting factor may be that many people in the early 1900s died at home and the cause of death may have been that which was reported by family or friends to the undertaker.

Fox's disability data related to the National Health Survey of 1935-36 is significant in sample size and scope. The survey was conducted in eighty-three cities and twenty-three rural areas in nineteen states (Fox 24). The definition employed by the National Health Survey to describe the "handicapping condition"; as a "disabling illness which kept persons away from work, school, or other usual pursuits for seven consecutive days or longer during the twelve months preceding..." still functions as a general description of functional disability today (qtd. in Fox 34).

Dr. Marc Roberts, like Fox, uses historical data, economic data, and surveys to bolster his support for prevention and chronic disease management. In his opening chapter, Roberts cites an uncredited survey in revealing that "only one percent of the public felt that health care was the nation's most important problem" in 1991 (1). Roberts follows again with an uncited statement declaring that health care was the number two issue one year later in both congressional and presidential elections (1).

Throughout Robert's book, he mixes first person accounts of travails within the delivery and insurance systems with short facts and details such as the cost of health care relative to other industrialized nations and the percentages of employed uninsured (6-9). References to Medicare and Medicaid costs are factual and well supported in other literature. Roberts is also able to use data to support his cause and effect analysis of the way the structure of the delivery system has created a fiscal crisis today (11).

Roberts also shows a fondness for illustrations demonstrating economic principles. In several instances, Roberts shows a payoff function, with the "y" axis illustrating gain, and the "x" axis illustrating dollars spent. Roberts attempts to illustrate the difficulty in determining how much

should be spent, and when, to affect a cure or improvement for any given illness (22-24, 29-30). Roberts also uses the payoff function illustration to substantiate why biomedical researchers gain more by developing performance enhancing or new technologies, drugs, or devices, than those that merely reduce cost. According to Roberts, cost-savings technologies are limited in price by comparison to old technologies, not to mention that they bring less prestige to the developer than new breakthroughs (29).

Roberts makes the most compelling support for his contentions regarding health care reform in his chapter devoted to comparisons of the United States health system with that of other Western European nations and Canada. Roberts refers to the fact that the United States spends more and gets no more or less than other industrialized nations as a "central paradox" revealed by the data (78). Using the standard measure of percent of gross domestic (or similar, gross national) product, Roberts shows that the United States clearly overspends its peers (79).

Roberts then looks at life expectancy and infant mortality as outcome measures for assessing the efficacy of health systems in various countries. Accounting for all known variables in health habits and practices, the United States does not take a positive

leadership position in either life expectancy or infant mortality. In infant mortality in particular, Roberts illustrates differences between rates within United States ethnic groups such as whites, Asian-Americans, and African-Americans (80-82).

When evaluating quality of care, Roberts again turns to his payoff function illustrations. Acknowledging that oversupply of health care interventions can expose patients to risk through iatrogenic events, Roberts rightly proposes that appropriateness is the first consideration in terms of evaluating quality (84-85). He further explores the well-documented concept of capacity leading to increased utilization, as illustrated by several studies showing procedure frequency increasing where services suddenly become available (86-88).

Roberts sums up his quality analysis in the following statement:

> In sum, our national quality record is mixed. We do great on amenities and reasonably well on skill. Care among socioeconomic groups is uneven. And on appropriateness there are reasons to be concerned. (89-90)

Roberts' data on outcomes and total utilization support his contention that the poor receive less care due to reduced access to ambulatory care and the presence of conditions related to behaviors such as alcohol and

drug abuse (91-92). Roberts call for "a fundamental restructuring of the system necessary to resolve our most pressing problems" appears well supported by his data (128).

Victor R. Fuchs, an economics professor, relies heavily on economic data to propose financing changes as one source of resolving the vexing issue of health care financing. Fuchs devotes a great deal of his work to examining questions relating poverty and health, without coming to any solid conclusions (64). In addition, Fuchs also conducts an extensive comparison and contrast of the Canadian and United States health systems, the conclusion of which is that Canada more efficiently uses personnel and resources and uses a higher ratio of outpatient care, as compared to the United States (120).

In his final analysis, Fuchs holds out little hope for reform in the shape of a national health insurance program due to lack of public support, although the bulk of his data would indicate that it might represent an effective financing measure (217). He explores the role of managed competition as a cost control measure, and concludes, based on presidential economic reports, that increasing competition in health care has done little overall to control expenditures (172-174).

Although he relies heavily on outside data from a variety of sources, Fuchs use of data fully supports his multi-pronged hypothesis that, in order to be effective, health care must not be related to employment status, new technologies must be thoroughly evaluated for overall effectiveness in improving health with an acceptable cost-benefit, and that strategies must be devised to cope with the growth of the aging segment of the population (12-15).

John R. Wolfe, an economist like Victor R. Fuchs, uses economic data to support his contention that a combination of funding changes (savings programs and taxation strategies) and delivery system changes (social programs) must be made to salvage the Medicare program. Wolfe definitely leans toward the funding changes as being able to affect the most positive opportunities for change (134-138) Age distribution curves, life expectancy and survival curves, projected annual per capita growth rate tables, and hospital insurance trust fund taxes and ratio tables all serve to support Wolfe's points (13,21,23,35,48).

Wolfe's projected annual per capita growth rate of various measures of sought after medical resources includes physician visits, short hospital stays, nursing home residency, and number of patients with reduced capacity in their activities of daily living

(35). Wolfe uses his illustration, based on figures from HCFA actuaries and projections from other experts, to predict that demographic changes alone will not cause an increase in the health sector's portion of the gross national product (36-37). Wolfe predicts that the primary drivers of growth in the health sector will be the increasing intensity of medical care per encounter, medical inflation, the growth in number of aged women without spouses, and an increasing number of aged disabled married persons (37-38).

It is Wolfe's reliance on sociological trends that brings him to conclude that "intergenerational transfers"; i.e. increasing taxes to support care for the elderly, will be unpopular with voters. Wolfe cites the fact that more elderly are living independently as creating a loosening of family bonds. This loosening of the intergenerational family structure will cause workers to feel that the aged have less right to the worker's incomes (38). It is also these concepts that drive Wolfe to conclude that mechanisms should be devised to support social health maintenance organizations by integrating financing for long-term and acute care into a seamless continuum (117).

Wolfe's call for increasing taxes to support current programs, increasing eligibility ages,

increasing age-weighted taxes to support existing programs, and taxes to support new programs for long term care costs are solidly based in a study of well published trends regarding the future of the Medicare trust funds. Wolfe briefly touches on prevention as a strategy by proposing taxes on cigarettes and alcohol, but does not provide data to support the effect of these taxes on reducing consumption or reducing health effects (134-137).

Although the concept of reverse mortgages and individual retirement accounts are also offered as funding vehicles to provide for long-term care, Wolfe fails to illustrate how this will help the poor elderly (129-133). As many have illustrated before, the poor tend to be sicker. Wolfe does not provide data to illustrate that perhaps the large number of elderly who own their own homes (75 percent) might subsidize their non-home owning peers (131).

Ross Perot, the businessman and politician, uses an abundance of government data to support his recommendations for funding changes to save Medicare. He speaks of managed care as an unproven alternative, however, he provides no data on quality, access, and member satisfaction and maintains that the jury is still out on the workability of HMO's (161-166).

Perot's only support for managed care comes in a

1993 illustration from Aetna Health Plans showing 64 percent of private employees enrolled in some form of managed care, i.e. HMO, PPO, or POS plan and a 1994 Statistical Abstract of the United States showing 41 percent of all insureds enrolled in HMO's in 1992, up 22 percent since 1985 (158,164). The only financial data Perot can offer in terms of HMO experience is that of the Tennessee Medicaid sector's TennCare program, which ran $99 million in the red in its first year (156).

To reform the current system in the short term, Perot's proposals include the following: increasing the Part B deductible, expanding coinsurance, reforming medigap insurance, increasing Part B premiums, increasing eligibility age, means testing Part B, merging administrative functions for Part A and B, rewarding whistle blowers, reducing disproportionate share payments, reducing direct and indirect education costs, and reducing fees to hospital-based physicians. For the majority of his proposals, Perot has federal government data and congressional budget office estimates to support his cost savings figures. Notably absent, however, is data showing the financial results of increasing eligibility age, merging administrative functions for Part A and B, and whistleblower initiatives. Although these initiatives make logical

sense, a lack of data to support their impact makes prioritization among these three initiatives impossible (111-120).

All of the aforementioned writers are able to support their conclusions with the best available data. From a broad perspective, it appears that both sociologic and financial issues alike will be key obstacles to reform. Neither financial manipulations such as taxation or savings plans, managed care alternatives, or a fundamental restructuring of the health care delivery system will succeed without strong public support.

Chapter IV

RESULTS

Although the data showing the Medicare system is in need of reform is overwhelming, sociologic and financial issues alike will challenge any attempts to reform both the structure and financing of the present system. Health care sector special interest groups will challenge fundamental reforms driving funding to preventive care and chronic disease management programs. Anti- big government citizens will reject broad reforms and tax increases. Citizen special interest groups will oppose reductions in benefits.

Federal health care spending in the United States has skyrocketed. In billions of dollars, government health care spending is projected to exceed that spent on defense by 1995, and sail past social security expenditures near the year 2000 if growth remains unchecked (Perot 31). The taxes that support these programs will come from a shrinking pool of workers. The 4.5 workers per beneficiary of Medicare in 1965 will be reduced to 2.1 workers by 2035, if demographic trends persist (Perot 33). Clearly, each worker will have to pay an increasing burden of the tax required to support the Medicare program.

In 1995, federal spending on the health sector reached 17.4 percent of the total budget. Table 2 below illustrates this in relation to other federal spending initiatives.

Table 2

1995 Federal Spending by Categories

Rank	Percentage	Category
1	21.8	Social Security
2	17.7	Defense
3	17.4	Medicare & Medicaid
4	16.7	Domestic
5	15.4	Interest
6	9.5	Other Entitlements
7	1.4	International

Source: Representative Chris Shays, qtd. in Perot, p. 25.

The government, and the citizens that make up the United States, are not likely to support the continuing drain on the overall economy represented by health care spending growth. However in the thirty years since the advent of Medicare, there have been no substantial lasting changes in the program (Perot 107).

The United States government is a significant payer of health services (Raffel and Raffel 210). Table 3 indicates total expenditures for health

services in 1990 and the percentage covered by the government.

Table 3

Government Health Care Expenditures

Category of Expenditure	Total Dollar Expenditures in Billions	Percent Paid for by the Government
All Personal Health	585.3	41.3
Hospital Care	256.0	54.7
Physician Services	125.7	34.9
Dentist Services	34.0	2.6
Other Professional Services	31.6	20.3
Drugs and Medical Sundries	54.6	11.2
Eyeglasses and Appliances	12.1	22.3
Nursing Home Care	53.1	52.2
Home Health Care	6.9	73.9
Other Health Services	11.3	80.5

Source: K.R. Levit, et. al., "Health Care Finance Review", Fall 1991, qtd. in Raffel and Raffel, p 210.

The government has the overall largest single stake in the issue of health care financing and will need to take the lead in reforming the delivery system to maintain solvency in the Medicare program.

According to the Congressional Budget Office, Perot and Wolfe are correct in assuming that the growth

in Medicare spending between 1995 and 1999 will not be related to merely to a shift in demographics related to an aging populace. The Congressional Budget Office indicates that 64.7 percent of Medicare spending growth will occur as a result of increased services and technology, while 24.4 percent will be tied to price inflation, and the smallest percentage, 10.9, will be due to increasing caseload (Perot 59).

Demographic shifts, nonetheless, will push more people into the ranks of those covered by Medicare. When Medicare was passed by Congress, there were 18.5 million people age sixty-five and over. By 1990, this number had grown 60 percent to 31 million and 3 million of these people were over eighty-five, according to the Census Bureau (Perot 56-57). Perot reports that persons over age eighty-five consume at least twice as many health care dollars as those age sixty-five (57).

According to Russell C. Coile, Jr., a noted health care futurist and author, over 80 percent of America's seniors have at least one chronic health problem, with the average being 4.4 conditions each (77). Chronic care is the cause of the majority of hospital and physician visits for the elderly (Coile 77). According to researchers Daniel R. Waldo and Helen C. Lazenby, 75 percent of days where the elderly cannot complete their usual activity are related to chronic disease (Coile

77). Coile notes, "Despite the heavy preponderance of older health care users, health care plans orient reimbursement toward cure rather than care; yet the chronically ill need the latter, not the former" (77).

Based on a review of resource consumption data, the conclusion that funding mechanisms and increased taxation have not effectively served to curb Medicare's growth is apparent. When DRG's were introduced in 1983, hospital costs (Medicare Part A) were slowed from annual increases of 15 percent to 6 percent between 1983 and 1985. After 1985, however, costs again increased by 10 percent annually (Raffel and Raffel 163).

On the physician payment side (Medicare Part B), the resource based relative value scale (RBRVS) was introduced in 1989 to instill equity in physician payment between interventional physicians (predominantly surgery and procedure oriented specialists) and internists, general practitioners, and other non-interventional physicians. The RBRVS system was supposed to reduce payments overall by setting predetermined fees that were generally lower than the usual and customary fees previously charged. In response, physicians quickly made up the difference by performing more procedures, and Part B expenditures grew (Perot 60). Medicare Trustees' data shows that

Part B spending increased 25 percent between 1988 and 1992 (Perot 104).

Managed care is one way of controlling Medicare spending growth, contends health care writer Julie Boyle (Wingerson 29). As of April, 1997, 13 percent of Medicare beneficiaries were enrolled in HMO plans (Wingerson 45). According to the Physician Payment Review Commission, Medicare HMO's have shown 25 to 35 percent increases in enrollment since 1993. HCFA and the Congressional Budget Office project that HMO risk plan enrollment will be 22 and 29 percent respectively by 2005 (Wingerson 21). Donna Shalala, in a presentation to the American Association of Health Plans Policy Conference in February of 1997, related that Medicare's independent actuary predicted that 23 percent of Medicare beneficiaries would be participating in managed care plans by 2002 ("Future" n. pg.).

The enrollment trends in Medicare are significant for several reasons. Care delivered in HMO managed care settings is paid for on a capitated basis. Providers receiving payment under capitation have an incentive to control costs because they are paid a set fee per member per month. In addition, capitation payments can be processed with less paperwork and are less costly to administer (Kongstvedt 135).

For Medicare, enrollment in managed care via HMO's also predictably reduces cost because of the way the capitation is calculated. Medicare capitation is paid based on 95 percent of an average adjusted per capita cost (AAPCC). The AAPCC is calculated by estimating the cost of providing care to beneficiaries in traditional Medicare fee-for-service plans (Kongstvedt 988). According to Shalala, in the year 2000 HCFA is proposing that Medicare HMO payments be reduced to 90 percent of the AAPCC ("Future" n. pg.). As HCFA imposes additional cuts to Medicare providers in the fee-for-service sector, $33.3, $25.6 billion over five years to hospitals and home health/nursing home providers respectively, this will drive down the fee-for-service equivalent on which the AAPCC is based (Wingerson 3).

Data available to date shows that the reduction in payments under the AAPCC system to Medicare HMO's is probably a fair approach in light of the fact that Medicare HMO's enjoy a favorable selection bias by enrollees. That is, Medicare beneficiaries, according to Bryan Dowd and Roger Feldman, tend to have less chronic diseases and be younger (Wolfe 81). Edgers and Prihoda also note that Medicare HMO enrollees have had lower health service utilization rates even prior to HMO sign-up (Wolfe 81).

All of the Balanced Budget Act of 1997 initiatives together are designed to save enough money to keep the Part A trust fund from going bankrupt until at least the year 2007. Nonetheless, the baby boom generational wave will be hitting the shores of Medicare in the year 2010. Without additional creative measures on the part of the seventeen member bipartisan commission chartered by Congress and the President (The National Bipartisan Commission on the Future of Medicare), the budget will be back in trouble again early in the next millennium. The Commission's report is due March 1, 1999 and is supposed to contain recommendations for long-term change (Wingerson 1, "Billions Cut" n. pg.).

Chapter V

DISCUSSION

Summary

Overwhelming data illustrates that the Medicare system is in dire need of reform (Perot 31). In 1965, when Medicare was established under Title XVIII of the Social Security Act, the American public apparently never dreamed that the system would fuel what Marc J. Roberts refers to as a "medical industrial complex" of profiteering special interest groups (Bandow and Tanner 40-42, Roberts 33).

Despite efforts to control costs, Medicare expenditures have risen at an alarming rate. Efforts such as means-testing and raising the eligibility age have been forced out of reform proposals by special interest groups ("Billions Cut" n. pg.). Of course, tax and premium increases are also never popular with voters. True reform is a bitter pill that few are willing to swallow.

Attempts have been made to control hospital costs. In 1983, DRG's (also known as prospective payments) were introduced to encourage hospital providers to control costs within the hospital stay. After a brief

correction curbing the growth of annual hospital cost increases (a drop of 15 percent to 6 percent), hospitals once again adapted and responded with 10 percent annual increases by 1985 (Raffel and Raffel 163). Hospitals also diversified, adding prospective payment-exempt services such as home care and skilled nursing facilities (Coile 85, 89).

Attempts at controlling physician payments have also fallen dismally short of their goals. RBRVS, the physician payment reform system that was supposed to bring physician reimbursement under control and curb Medicare Part B expenditures, was introduced in 1989. Between 1988 and 1992, Medicare Part B spending had instead, increased by 25 percent (Perot 104). Clearly, physicians had learned to adapt. Coile sums it up best:

> The reality is that medical fee increases cannot cover rising costs. In the future, physicians can only improve their net incomes by cutting overhead costs or increasing service volume. The alternatives are just that simple. (23)

The whole fee-for-service concept on which Medicare was based was beginning to appear ill conceived. Periodically, issues of medical necessity were raised, such as when utilization review committees and peer review organizations were required. The medical experts, invariably physicians, on whom these

programs relied, ironically, were the same ones benefiting from the generous reimbursement status quo. Medical necessity justification could be found for nearly any procedure, hospitalization, or test that was not overtly harmful.

With over 31 million persons covered by Medicare today, a program designed to help the uninsured elderly and disabled has turned into a subsidy for those health care providers who typically occupy the highest socio-economic levels of society (Perot 56-57). The average net income for physicians in 1987 was $116,440, with ranges from $271,550 for cardiovascular surgeons down to $79,910 for general practitioners (Coile 23). Even under a single-payer government system, the American Medical Association estimates that physicians would lose only 10 to 15 percent of their income (378).

The Balanced Budget Act of 1997 has been proposed as one way to control the runaway costs of Medicare. Politicians have been slapping each other on the back on the bipartisan nature of the agreement and bragging about a estimated $100 plus billion dollars in savings to the program. According to Donna Shalala, this savings is projected to prolong the life of the Medicare trust fund until 2007 ("Future" n. pg.). This "savings" actually equates to less than $33 per

beneficiary, less than the cost of a typical single prescription patented drug.

Paul Ginsburg, an economist involved in the Physician Payment Review Commission responsible for the recommendation to implement RBRVS, spoke with Elizabeth Austin in an interview for Advances. When asked for his views on how to preserve Medicare, Ginsburg responded:

> First of all, the costs of the program have to be cut; at least, cost increases need to be slowed. Savings can be achieved through payment cuts for hospitals, physicians and other providers. The skilled nursing and home health benefits of the program also need to be addressed; right now, those costs appear to be out of control. We also need to move more beneficiaries into private managed care plans, and to have the Medicare program fix up the method of paying those plans. My feeling is that strictly demographic issues such as how many people are getting benefits in relation to the people that support them, can be solved if we get started early, by delaying retirement age, increasing contributions and trimming benefits somewhat. That will get us through it. (3)

Ginsberg's opinions echo those of other health care economists such as John R. Wolfe and Victor R. Fuchs. Ross Perot, the businessman and politician, also lines up with the economists. Tinkering with financing and eligibility seems to be the preferred way to address the issue of Medicare reform. It makes sense to those who hold the Medicare program sacred and dare not doubt the medical experts. In the short term, financing and

eligibility machinations may be all that is feasible from an administrative and societal acceptance perspective.

Some of that tinkering that the economists advocate comes in the way of supporting managed care as a way to salvage a government-administered program for health care targeted at the elderly and disabled. The addition of managed care is designed to achieve at least two objectives for Medicare: to give Medicare beneficiaries the same choices as their peers in the commercial insurance market and to save money. On the first count, the objective is logically met.

As for managed care saving money, Ginsburg maintains that managed care is actually costing Medicare more money than it should. Ginsburg believes that the government would be better served by letting market competition set the reimbursement level. Since Medicare beneficiaries are healthier compared to their fee-for-service counterparts on whom the AAPCC is based, Ginsburg alleges that Medicare really pays 5.7 percent more for Medicare HMO enrollees care than they should, based on their actual resource utilization (Wolfe 81, qtd. in Austin 1).

In the whole discussion regarding the redemption of Medicare, the minority voice of those who would advocate for a redesign of how American health policy

would shape the health care delivery system is almost drowned out. Marc J. Roberts and Daniel M. Fox recognized that the United States' health care delivery system was created with acute care in mind. The dramatic recovery from acute illness is what gave birth to the hospital- and physician- based delivery system put in place nearly a century ago. That acute-care oriented system received the public's attention, and therefore, the money, when a government managed health plan, Medicare, was conceived. All of this took place despite the compelling evidence regarding the impact of chronic disease.

In practical terms, the results of study show that the best process for reforming Medicare relies not exclusively on financial tinkering or on managed care strategies as they are practiced today. In the short term, financial restructuring will be necessary to buy time to lay the groundwork for new health policy. Even in the current economic upswing, however, increased taxes and reduced benefits are not popular with voters. Providers, instead, will take a financial hit.

Managed care, with its emphasis on wellness and prevention, appears to be a step in the right direction. However, without incentives to keep members from switching plans, long term outcomes of care delivered in managed care plans will be difficult to

measure. Managed care also faces the challenges of bad press which serves to highlight the occasional sensational incident involving the withholding of acute care services and the ever-present reality of restricted choice. This may cause beneficiaries to hesitate to join managed care plans, thereby further reducing the opportunity to see if managed care continues to hold promise from an economic as well as delivery system standpoint with the Medicare population.

Limitations

During the analysis of data relating to how best to reform the Medicare system, several difficulties were encountered. Primarily, there appeared to be a lack of consensus around the ultimate effect of promoting prevention and managing chronic illness. Although there was data to support that chronic illness is a prevalent problem in the senior population, since there has been a scarcity of large-scale attempts to demonstrate the financial effects of focusing resources on chronic care and prevention in the Medicare system, there is no solid evidence to support that this emphasis would be financially sustainable.

There was consensus, at least in the short term, that some reanalysis of how Medicare providers are

reimbursed for care must be entertained. Although managed care was touted as a potential salvation and Medicare beneficiary migration to HMO's has been taking place, there are still only yet-to-be realized predications about a dramatic increase in enrollment (Wingerson 39). Further, since managed care for Medicare beneficiaries must include at least, the basic benefits allowed under Medicare, there is no way to predict or control the overall rate of medical inflation.

Some evaluator bias was evident in the writings. Those who wrote from the standpoint of economists believed that all data pointed to a need to financially restructure how Medicare is supported and accessed in terms of eligibility. Those who wrote from a sociologic standpoint viewed the data and concluded that the underlying problem was in the structure of the delivery system. Like the ancient blind men of India examining different parts of an elephant, the health care delivery and financing theorists served in their own way to describe very different and valid parts of the same complex beast.

Suggestions for Future Research

To determine the effectiveness of managed care as a strategy for addressing the ills of the Medicare

financing system and the health care delivery system, further research will be required. In particular, it will be important to analyze the ongoing health status of Medicare beneficiaries as they migrate into managed care plans. It will also be important to evaluate whether or not the managed care plans can care for the sicker Medicare beneficiaries with better cost effectiveness and outcomes than their fee-for-service peers.

An improved analysis of delivery systems focusing on chronic disease management is also warranted. When sufficient data from their effectiveness on the management of chronic disease becomes available, their delivery system models should be considered as part of any long-term efforts to reform the health care delivery system.

The effect of the Balanced Budget Act of 1997 on the fiscal solvency of the Medicare program will also warrant further research. The dramatic cost savings portended by the politicians will need to be examined compared to reality. If the financial effects are not achieved as predicted, the timeline for proposing long-term changes will need to be accelerated.

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