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# The Future of Medicare: Preserving a Structurally Sound Program for Tomorrow

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LEGISLATIVE WATCH

# *The Future of Medicare: Preserving a Structurally Sound Program for Tomorrow*

## *A Position Paper from the Undersigned Organizations**

*What are the ways the Medicare program can be preserved and its scope of services, payment mechanisms, and financial solvency guaranteed? Viability and solvency issues are discussed in this column, and various solutions proposed.*

**By Alfred J. Chiplin, Jr. and Brian W. Lindberg**

**Note**

What follows is an advocacy position paper for use in the emerging debate about the future of the Medicare program, the scope of services it is to provide, its payment mechanisms, and its financial solvency in the 21st century, particularly as the so-called baby-boom generation begins to use the Medicare program in large numbers.[1] The paper is written as a series of points for discussion and consideration with occasional annotation. It is not intended to be exhaustive in any way. Rather, it offers a framework for discussion and action.

This paper is a joint project of the Consumer Coalition for Quality Health Care, the Center for Medicare Advocacy, Inc., and the National Senior Citizens Law Center. It is annotated in this form by Alfred J. Chiplin, Jr., J.D., M. Div. and Brian W. Lindberg, M.M.H.S.

The Medicare Commission ended its work without agreement on March 16, 1999,[2] declaring itself unable to come to consensus on a set of recommendations. Its only proposal, a Premium Support-Voucher Program,[3] created concern among both current and future Medicare beneficiaries because it: (a) did not strengthen the financial health of the Medicare program for the future, particularly for those in the baby-boom generation; (b) did not set aside budget savings for Medicare solvency as requested by the president; (c) did not provide a stable and affordable premium structure for beneficiaries; (d) did not limit likely out-of-pocket expenses that beneficiaries would have to pay when premium support is not sufficient to buy necessary health coverage; and (e) did not guarantee a defined and dependable benefits package.

Over the years, most Medicare program growth and refinement, including the creation of new services and coverage options, have been through relatively modest legislative changes, technical corrections, and

court decisions that have tinkered at the margins of the Medicare program, with the creation of the Medicare+Choice Program[4] being a major exception. Examples include: providing a Medicare health maintenance organization (HMO) service option;[5] providing Medicare Part B beneficiaries with appeals rights that include administrative law judge (ALJ) review and access to the federal courts;[6] creating a prospective payment system (PPS) for the payment of hospital costs;[7] initiating physician payment reform, including the physician assignment program;[8] limiting what providers can charge their Medicare patients;[9] creating a PPS system for the payment of nursing home[10] and home health care costs;[11] improving notice and hearing rights for Medicare patients in HMOs;[12] and refining systems for monitoring and evaluating the quality of services provided by Medicare+Choice participating organizations (Medicare+Choice Organizations).[13]

## The Position Paper

### *Introduction*

The Medicare program is a success story. It reflects our national commitment to the concept of social insurance by providing one health insurance system with a defined set of benefits for our nation's elderly and disabled. Any discussion of reforms to the Medicare program, and responses to the Medicare Commission, must begin with understanding this important commitment.

As stated by Nancy-Ann Min DeParle, administrator of the Health Care Financing Administration (HCFA), United States Department of Health and Human Services:

> Medicare is clearly a success story, an achievement of social insurance. And yet, as the millennium approaches, the program faces challenges that cannot be ignored. While the Balanced Budget Act of 1997 extended the solvency of the Medicare Part A Trust Fund, the broader, longer term challenge of meeting the complex health needs of an aging society is not diminished. The number of elderly is growing and their life expectancy is lengthening. In addition, the traditional Medicare benefit package, reflective of average indemnity plans in 1965, is less generous than most large employer sponsored fee-for-service plans. Gaps in coverage contribute to high out of pocket expenses relative to income for many seniors, particularly those with low incomes. Indeed, only about half of the elderly's health care costs are paid for by Medicare.[14]

### *Basic Tenets and Principles That Must Be Observed*

- Medicare should continue to be a health care delivery and financing *program* provided and overseen by the United States government and not a mere set of payment mechanisms.
- The Medicare program *must* include a secure, guaranteed, defined set of benefits.
- Medicare should continue to provide one community of interests among the healthy and frail, rich and poor. It should *not* separate these beneficiaries into separate groups with distinct and varying interests by creating benefit options and delivery systems that differ depending upon the ability to pay or the beneficiary's health status.[15]
- The Medicare program must provide equal access to appropriate and high-quality services for all beneficiaries.
- The needs of beneficiaries who have chronic, long-term conditions and disabilities must be formally recognized by the Medicare program and must be met by its coverage and payment structures.
- The Medicare program must be administered fairly, efficiently, and consistently.
- The Medicare program must be comprehensible to beneficiaries. An appropriate, ongoing education campaign should be developed that makes Medicare understandable to the average beneficiary.[16]
- Organizations providing Medicare managed care services must be required to provide full and clear information regarding their plans, their benefits, all the rights of participants, and all the costs related to the care.
- The Medicare program must provide a full and fair appeals system that guarantees due process to beneficiaries if their health care services are denied, reduced, or terminated. The system must include access to the courts and an opportunity for attorneys' fees in order to ensure that

beneficiaries can obtain proper representation.[17]
- Medicare must provide an effective independent quality review system to ensure access and quality of care and services.

### *Concerns and Cautions*

- In considering programmatic change, planners should learn from the recent experience of implementing the Medicare+ Choice program; beneficiaries were [ARE] confused by the Medicare+Choice program and unsure of its reliability as a set of health care delivery options.[18]
- Policymakers should remember that managed care plans have discontinued their Medicare managed care products in many markets, identifying lack of profitability and program uncertainty as reasons for leaving the Medicare market.
- Deliberations about Medicare reforms should take into consideration the realities of beneficiaries who have lost services (or who have been unable to obtain services) as a consequence of new, more restrictive Medicare payment systems such as the Interim Payment System (IPS) for Medicare-covered home health care.
- The Medicare program should be structured so that "Medigap" insurance policies are unnecessary. If Medigap insurance does continue to be necessary, the policies must provide comprehensive, affordable coverage.
- Policymakers should identify, address, and monitor the scope of services provided, and treatment options available, to women and racial and ethnic minorities, and assure that Medicare reform efforts address the special needs of these populations.
- Outpatient prescription drug coverage should be a Medicare benefit. This would not only provide for a critically needed benefit but would also give beneficiaries a better opportunity to choose between managed care plans and "original" Medicare, since many individuals join managed care to obtain prescription coverage. Careful attention must be paid, however, to what is required in order to obtain this benefit.

### *Ideas for Further Study and Exploration*

- Policymakers should explore some new cost-sharing provisions that do not adversely affect low- to moderate-income beneficiaries, and some new employer and/or employee contributions. New cost-sharing and contribution mechanisms may be necessary, and may well be acceptable to the public, if the public understands that the alternative is the loss of a Medicare program to which everyone contributes and from which everyone benefits.
- Policymakers should explore the advantage of combining Medicare Parts A and B, restructuring the Medicare premium, and *lowering the eligibility age* so that the risk pool includes individuals who will need less care and services while contributing premiums to the program. Similarly, efforts to raise the age of eligibility should be examined carefully to determine true cost savings, and to consider the likely impact these efforts would have on increasing the number of uninsured persons, decreasing access to services, and diminishing the good health and longevity of those who no longer qualify.[19]
- A significant portion of the budget surplus should be dedicated to help fund the Medicare program. If we have saved as a nation, we should use our savings for the nation's future; the health care needs of our increasingly aged population must be a priority.
- Medicare should explore strategies for incentive purchasing with providers who demonstrate a history of delivering appropriate access to high quality services.

## Conclusion

The public should be informed of the dramatic changes envisioned by the Medicare Commission and should be given an opportunity to consider seriously whether they want these changes. As we continue the dialogue about Medicare sol-

vency and reform, we must remember that the Medicare program is sound, and that it has served our nation's elderly and disabled well. Again, as HCFA administrator Nancy-Ann Min DeParle has stated:

> [F]ew programs in the history of the United States have brought as much benefit to society as Medicare. Since its enactment in 1965, Medicare has provided access to quality health care for those Americans least likely to be attractive to private insurers—those over age 65, disabled, or with end stage renal disease. Medicare has also prevented many Americans from slipping into poverty. The elderly's poverty rate has declined dramatically since Medicare was enacted—from 29 percent in 1966 to 10.5 percent in 1995. Medicare also provides security across generations: it has given American families assurance that they will not have to bear the full burden of health care costs of their elderly or disabled parents or relatives at the expense of their young families.[20]

Medicare must remain a strong and reliable program with specific benefits. It must be available to all eligible persons, irrespective of health or financial status. This must be our commitment. This must be our national goal.

*The following organizations join in this position paper:

*Center for Medicare Advocacy, Inc.*
*National Senior Citizens Law Center*
*Consumer Coalition for Quality Health Care*
*National Academy of Elder Law Attorneys (NAELA)*
*Alzheimers Association*
*American Federation of State, County and Municipal Employees (AFSCME)*
*National Council of Senior Citizens*
*Connecticut Association of Area Agencies on Aging, Inc.*
*Medicare Advocacy Project, Greater Boston Legal Services*
*Legal Assistance to the Elderly (San Francisco)*
*Tennessee Justice Center*
*Samuel Sadin Institute on Law, Brookdale Center on Aging, Hunter College (NY)*
*Vermont Senior Citizens Law Project*
*Vermont Medicare Advocacy Project*
*Council of Vermont Elders*
*Connecticut Legal Services*
*Greater Upstate Law Project, Inc. (NY)*
*Neighbor to Neighbor*
*Northern California Lawyers for Civil Justice*
*Coalition of Wisconsin Aging Groups/Elder Law Center*
*National Health Law Program*

## Endnotes

1. *See* Health Care Financing Administration (HCFA): A Profile of Medicare (May 1998), 7–15. It is anticipated that the baby boom generation will begin to use the Medicare program in significant numbers beginning in 2010 when they reach retirement age, with an anticipated 56.3 million beneficiaries in 2017.

2. The Balanced Budget Act of 1997 (BBA '97), signed into law on August 5, 1997, created the National Bipartisan Commission on the Future of Medicare [Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4021 (1997)]. The commission began its work in January 1998 and was to submit its report to Congress and to the president by March 1, 1999 [*see id.* § 4021(f)]. Findings, conclusions, and recommendations that had the support of at least 11 of the 17 commissioners were to be reported to the president and the Congress. It was not able to reach consensus on its only proposal, the Breaux-Thomas proposal, known as premium support or a voucher program.

3. *See The Breaux-Thomas Proposal: What Will It Mean for Medicare Beneficiaries?* (A Families USA Analysis of Ten Important Questions, March 12, 1999); Marilyn Moon, *Restructuring Medicare: Impacts on Beneficiaries,* URB. INST., Jan. 1999; Brian Biles et al., *Issue Brief: The Future of Medicare,* COMMONWEALTH FUND, Nov. 1998; Robert B. Doherty, *How Can Medicare Be Saved? A Look at What's on the Table,* ACP-ASIM OBSERVER, Mar. 15, 1999. See also Preliminary Staff Estimate and Discussion of the Premium Support Proposal, Medicare Commission Staff Report (Feb. 17, 1999).

4. The Balanced Budget Act Section 4001 adds new sections [42 U.S.C. § 1395w-21 *et seq.*]. The implemented regula-

tions, as they become available, are being codified at Title 42 of the Code of Federal Regulations, Part 422. The Medicare+Choice program, also known as New Medicare Part C, creates a number of options for the delivery of Medicare-covered services. It retains the original Medicare fee-for-service program as an option while adding a series of coordinated care or managed care options.

5. *See generally* 42 C.F.R. § 417.101 *et seq.* (coupled with new Medicare+Choice options, *supra* note 2).

6. *See* 42 U.S.C. § 1395ff.

7. *See* 42 U.S.C. § 1395g.

8. *See* 42 U.S.C. § 1395u(b)(4).

9. *See* 42 U.S.C. § 1395w-4(g).

10. *See* Balanced Budget Act § 4432 (prospective payment for nursing facility services).

11. *See id.* § 4603 (prospective payment for home health services).

12. *See* Grijalva v. Shalala, 152 F.3d 1115 (9th Cir. 1998) (establishing notice and appeal rights for HMO managed care beneficiaries, drawing into question the sufficiency of current Medicare+Choice efforts to provide Medicare managed care beneficiaries with appropriate due process protections when services are denied, reduced or terminated); *see* Grijalva v. Shalala, 119 S.Ct. 1573 (1999) (remanding case to the 9th Circuit Court of Appeals for consideration of the grievance and appeals provisions of the Balanced Budget Act of 1997, Pub. L. 105-33, §§ 1852 (f) and (g) of the Social Security Act, and whether Medicare participating HMO decisions are governmental decisions in light of American Mfrs. Mut. Ins. Co. v. Sullivan, 199 S. Ct. 977 (1999).

13. *See* 42 U.S.C. § 1395w-22(e)(2)(A) *et seq.*; 42 C.F.R. § 422.152.

14. Nancy-Ann Min DeParle, HEALTH CARE FINANCING ADMINISTRATION: A PROFILE OF MEDICARE (May 1998), preface.

15. The Medicare program may very well not be amenable to large-scale reform. This point is raised most recently in a *New York Times* article [Robert Pear, *Changing Medicare*, N.Y. TIMES, Mar. 18, 1999, at A20]. In describing the Medicare program as "complex and political," he suggests that large-scale reform is likely to give way to incremental change [*Id.*].

16. Beneficiary education has been a major focus of federal efforts with respect to the Medicare+Choice program. This federal focus, linked with efforts from the private sector, including the beneficiary advocacy community, holds promise. The task is always one of translating complicated information into usable formats and segments for consumer use. A joint project of The League of Women Voters Education Fund and the Henry J. Kaiser Family Foundation, "A Public Dialogue on Health Care: The Future of Medicare" (Fall 1998), is illustrative of this important work. Focus group work by this joint project shows dramatically the need for more precise beneficiary education about Medicare and patients rights. For copies of the Kaiser information packet outlining its work, call the Kaiser Family Foundation at 1-800-656-4533 and ask for information packet No. 1427.

17. *See* Grijalva, *supra* note 12; *see also* George J. Annas, J.D., M.P.H., *Patients' Rights in Managed Care: Exit, Voice, and Choice,* NEW ENG. J. MED. 210 (July 17, 1997).

18. The Kaiser Foundation and Harvard School of Public Health have conducted a national survey on Medicare, looking at what beneficiaries understand about the program, focusing on national policy options and what seniors would like, including financing options and greater reliance on managed care. For a copy of this survey, contact the Kaiser Foundation's publications request line at 1-800-656-4533 and ask for publication No. 1442.

19. *See* Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777. Kaplan argues for Medicare reform in three principal areas, prescription drugs, nursing home care, and preventive care. He also argues for a more cohesive Medicare program with simpler rules.

20. DeParle, *supra* note 14.