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The Future of Medicare, Post Great Society and Post Plus-Choice: Legal and Policy Issues--Foreword

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The Future of Medicare, Post Great Society and Post Plus-Choice: Legal and Policy Issues

The 2002 Washington and Lee University Law Review Symposium Foreword

Timothy Stoltzfus Jost*

Medicare is many things to many people. To liberals, it is the great success story of the Great Society, a social insurance program that has brought health security to America's elderly and disabled. To conservatives, it is a bloated government program, verging on collapse and threatening the financial future of our children and grandchildren. To politicians, it is (with Social Security), the third rail of American politics, a tempting—but very dangerous—target for budget cuts or for contracting or expanding the role of government. For providers it is a vital source of income, but also a terrifyingly complex program where coding mistakes can result in substantial penalties. For beneficiaries, Medicare provides an essential safety net, but one that is far from secure and full of substantial gaps.

By any measure, however, Medicare is vitally important to Americans. Medicare covers thirty-five million elderly and six million disabled Americans.[1] Forty percent of these Medicare beneficiaries have incomes below 200% of the federal poverty level, and 40% have less than $12,000 in assets.[2] Medicare is the primary reason that many of these Americans have access to essential health care. Medicare is also very important to providers. Medicare accounts, for example, for nearly 30% of hospital and 29% of home health payments.[3] But, Medicare is also very costly. Medicare is expected to pay out $271 billion in

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1. KAISER FAMILY FOUND., MEDICARE AT A GLANCE, *at* http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14184 (Apr. 2003) (on file with the Washington and Lee Law Review).

2. *Id.*

3. Katharine Levit et al., *Trends in U.S. Health Care Spending, 2001*, HEALTH AFF., Jan./Feb. 2003, at 154, 158.

2003, accounting for 13% of the federal budget and 19% of total national personal health services spending.[4] Any serious attempt to control federal spending must, therefore, look carefully at the Medicare program.

To those of us in the Academy, however, Medicare is an endlessly fascinating subject for research and analysis. In the spring of 2003, a renowned group of scholars gathered at the Washington and Lee University Law School in Lexington, Virginia, to share their thoughts about Medicare. This distinguished group represented a wide variety of disciplinary perspectives—political scientists, policy experts, legal academics, and economists. It included faculty from law, public health, medical, and business and management schools, as well as scholars from independent research institutes. Among its members were a former Administrator of the Health Care Financing Administration (HCFA), which once administered the Medicare program; a former director of HCFA's Center for Health Plans and Providers; a former member of the Medicare Trust Fund Board of Trustees; and a former member of the Provider Reimbursement Review Board. This group represented the full range of political perspectives on the program.

This Symposium issue of the Washington and Lee Law Review represents the fruit of that conference. As this Issue goes to press in the winter of 2004, Congress has just adopted legislation making major changes in the Medicare program. This legislation partially fills one of the most significant gaps in the Medicare program: its lack of coverage for outpatient prescription drugs. But, these changes still leave many gaps in drug coverage and are certain to be a grave disappointment to many Medicare beneficiaries. Under the legislation, for example, a beneficiary is responsible for the first $250 of drug costs, twenty-five percent of the next $2000 in costs, and then must spend $2850 more out of pocket before catastrophic coverage becomes available.[5] This legislation includes broad changes to the Medicare Program that would greatly expand subsidies for the Medicare managed care program (renamed Medicare Advantage) and create a demonstration project that would put traditional Medicare in direct competition with managed care plans.[6] This legislation is

4. KAISER FAMILY FOUND., *supra* note 1. However, Medicare has been more successful in controlling the growth of its costs than the private sector. During 2002, Medicare spending per capita increased at an average annual rate of 7.8%, compared to an increase of 10.5% for premiums in employer plans. *Id.*

5. Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 1860D-2(b), 117 Stat. 2066 (to be codified at scattered sections of 42 U.S.C.).

6. *See id.* § 201 (creating the Medicare Advantage Program); *id.* § 211 (revising Medicare Advantage payment rates); *id.* § 222 (setting forth the framework for competition with managed care plans beginning in 2006).

likely to provoke further intense debate about the future of the Medicare program. Though it was too late to revise the articles in this Symposium by the time Congress finally took action on the prescription drug legislation, each author was given the opportunity to add a postscript to his or her article addressing this legislation and how it affects the topic of his or her article. The prescription drug legislation does not resolve the debates addressed by these articles, and, if anything, they become more timely in the wake of its adoption.

Jonathan Oberlander's paper, *The Politics of Medicare Reform*, introduces the Symposium by tracing nearly four decades of Medicare politics, from the founding of the program to the current drug benefit debate. Oberlander, a political scientist and professor at the North Carolina Medical School, who recently has published a book on the politics of the Medicare program, *The Political Life of Medicare*,[7] notes that at the outset of the Medicare program Congress considered two models: a subsidized private insurance model and a social insurance model. The social insurance model won out, the program became popular and successful, and for three decades a remarkable consensus reigned over Medicare politics. That changed in 1994, Oberlander observes, when conservative Republicans took control of Congress, and used the coincidence of a low Medicare Trust Fund balance to argue again for a defined contribution, privatized, approach to Medicare. The Republican vision proved very unpopular, contributing to President Clinton's re-election in 1996. But, the Balanced Budget Act of 1997 adopted a modified managed competition model for the future of Medicare. The 1997 compromise, however, does not seem to have reflected a true change in the consensus on Medicare, and the debate surrounding the recently adopted drug benefit reveals a continuing battle between the old Medicare consensus, based on social insurance, and the vision of a Medicare market, which harks back to the debates that preceded Medicare's founding.

The next contribution to the Symposium, authored by Ted Marmor, Professor at the Yale School of Management, Spencer Martin, and Jon Oberlander, who penned our opening article, is not so much about Medicare as it is about Medicare scholarship. The authors separate Medicare scholarship into three categories, which they characterize as the literature of omission, the literature of commendable commission, and the literature of regrettable misunderstanding. The first category consists of policy analysis that focuses on policy abstracted from political understanding; while the third category includes scholarship, primarily written by economists, which arrives at political understanding deductively, based on beliefs about the economics both of

7. JONATHAN OBERLANDER, THE POLITICAL LIFE OF MEDICARE (2003).

Medicare and of politics, rather than inductively through the study of actual political phenomena. The authors claim that valid political analysis (the second category of Medicare literature), though it can claim no monopoly on truth about Medicare, should form the basis of political claims about Medicare. They also assert that, given the high stakes involved in reforming Medicare, we cannot afford to attempt reform on the basis of "misunderstanding and mythology."

David Hyman's missive from hell introduces us to the seven deadly sins of Medicare: avarice, gluttony, envy, sloth, lust, anger, and vanity. Hyman (or the devil, whose amanuensis he claims to be—you decide) claims that avarice has overcome providers; gluttony drives beneficiaries; envy afflicts non-beneficiaries and beneficiaries disadvantaged by Medicare payment formulae; sloth incapacitates legislators and program administrators from addressing Medicare's serious faults; Democrats lust for program expansions; Republicans seethe with anger that the Democrats can tar them with being anti-Medicare; and health policy analysts are too vain to admit the deficits of the program. He also claims that the program undermines the traditional American virtues of thrift and honesty, and, indeed, threatens the Republic. In sum, Hyman, a professor at the University of Maryland School of Law, serves as the "devil's advocate" in a symposium otherwise generally at least sympathetic to the Medicare program.

Speaking of the devil, in Medicare, as elsewhere, the devil is in the details. Marilyn Moon's paper emphasizes the importance of the design features of Medicare's benefits package. Medicare is quite different from most contemporary private insurance programs because it has high and irrationally targeted cost-sharing, no stop loss provision for those with high medical costs, and, until now, no drug benefit. Unlike Medicaid, on the other hand, it covers both the wealthy and the poor, a feature that is particularly troublesome to those who believe that public programs should be limited to the needy. However, Moon, a long-time senior scholar at the Urban Institute who recently relocated to the American Institutes of Research, demonstrates that limiting Medicare to the poor would be administratively complex and might accomplish little in cost-savings. Fixing Medicare's defects, on the other hand, could be very costly if done wrong. Attending carefully to the details, Moon suggests how the Medicare program could be significantly improved without breaking the bank, and how a benefit package could provide two tiers of coverage without disadvantaging the poor.

Mark Pauly's paper addresses the problem of the ever-expanding cost of the Medicare program. Dr. Pauly, a prominent health economist from Wharton, concludes that current rates in Medicare spending growth cannot be

accommodated without unacceptable, and inefficient, levels of increase in tax expenditures. Pauly finds that the main driver of Medicare spending growth is the cost of improvements in Medicare technology. He concludes that if Medicare is to remain affordable, the program must get control over coverage of new technologies by limiting access to new technologies for beneficiaries except to the extent that they choose to supplement public payments to obtain care in the private sector.

In his paper, Dean Harris, Professor of Public Health and Law from the University of North Carolina, addresses an important issue that rarely surfaces in the public debate over Medicare: the use of the Medicare program to pursue a number of policy goals unrelated to the purpose of providing Medicare coverage for the elderly and disabled. Harris notes that Medicare is used to regulate services such as Medigap coverage, or under recent Administration proposals, drug discount cards, sold privately to beneficiaries. Medicare further requires private hospitals that provide services to Medicare beneficiaries to also provide emergency medical services to the general population without regard for patients' ability to pay, and requires a variety of providers to give all of their patients information about advance directives and end of life care. Through its graduate medical education and disproportionate share payments, Medicare also subsidizes hospitals that care for poor people and that educate medical residents. Though Congress has been reluctant to admit the ways in which it is using the Medicare program to accomplish non-Medicare goals, the Supreme Court has recently acknowledged that the purposes of Medicare include "ensuring the availability of quality health care for the broader community."[8] Harris notes additional ways in which the use of the Medicare program could be usefully expanded, but his main message is that Congress and the Department of Health and Human Services should follow the lead of the Court in acknowledging that Medicare is being used not just to insure the elderly, but also to address important health needs of the American public

The contributions of Robert Berenson and Bruce Vladeck engage in a debate as to whether and how Medicare should pay for quality of care. Vladeck was the head of the Health Care Financing Administration, which then administered the Medicare program, from 1993 to 1997. Between 1998 and 2000, Berenson directed the Center for Health Plans and Providers in the Health Care Financing Administration, leading in the creation of the Medicare+Choice program, and then became Acting Deputy Director of the Agency itself. Both are long time health services researchers, and have subsequently returned to academia.

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8. Fischer v. United States, 529 U.S. 667, 680 (2000).

Both agree that the quality of health care in the United States leaves much to be desired, but they differ as in their opinion of the ability of Medicare to change this. Berenson argues that the quality deficits in American health care are in part attributable to the failure of insurers, and in particular of Medicare, to demand quality. He notes, however, that Medicare no longer simply pays for care, but instead attempts to be a purchaser of care in some instances, attending to what it is getting for its money. He notes the problems, both legal and technical, with Medicare aggressively seeking quality for its money, but believes that these problems can be surmounted. Most of the same problems, for example, would also limit Medicare's ability to provide information to consumers about providers, yet Medicare has already successfully accomplished this in some instances. A helpful approach, argues Berenson, might be to take into account a variety of quality measures in establishing payment incentives. He acknowledges that paying for quality might cost Medicare more in some instances but argues that it might save money in others, by, for example, avoiding the complications that result from poor quality care. In sum, while acknowledging the difficulties that face paying for quality, Berenson argues that the arguments for trying quality-based payments are powerful, and the technical problems that stand in the way are not insurmountable.

While Vladeck agrees that the quality of American health care could be improved, he is skeptical about the ability of Medicare to contribute to this task. He also believes that the problems that would accompany paying for quality are not merely technical, but are more profoundly conceptual. He argues, for example, that there is no necessary relationship between quality and cost, therefore paying more for quality might simply overpay high-quality, low-cost, providers. He also argues that the effects of financial incentives on behavior are difficult to predict, that the effect of particular incentives are often drowned out by all of the other tasks that the payment system is trying to accomplish (as well as by the absolute level of payment itself), and that quality can be measured in so many different ways that focusing on any of them might lead to suboptimal overall quality. Vladeck describes problems that will be encountered in paying for improved quality, including issues of where to set the threshold for paying for quality (and explains why providers who fall below this threshold should be participating in the program at all); the difficulty of accounting for the continuous improvement of quality that all aspire to in a payment system; the possibility of "tiering" of access to quality health care; and the problematic nature of replacing professionalism with financial incentives as the primary driver of quality improvement. Vladeck argues that these problems are not merely technical, but rather they are fundamentally ethical issues that

deal with distributional equity and the motivations of professionals in serving their patients.

Though Medicare's $250 billion annual budget exceeds the gross domestic product of most of the world's nations, the staff of the Centers for Medicare and Medicaid Services (CMS), which administers the equally large Medicaid program as well, has fewer than 4500 staff. Thomas Stanton's article focuses on the formidable problems faced by this small group in administering the massive program. It examines problems that CMS faces: inadequacy of administrative staff, funding, and information systems; mandated reliance on third parties for carrying out many of its administrative responsibilities; legislative constraints on personnel, contracting, and budgeting policies which greatly constrain its flexibility; micromanagement by an almost hostile Congress; and life cycle problems based in the original design of the program, the culture of the agency, and the aging of the agency's staff. Stanton, who served on the National Academy of Social Insurance's Medicare Governance Study Panel and teaches at the Johns Hopkins Center for the Study of American Government, notes that the problems CMS faces are not unique, as the United States has generally undergone a "disinvestment in government" over the past few decades. Stanton argues that all of Medicare's constituencies face serious consequences if we do not decide to "reinvest" in the administration of Medicare.

Phyllis E. Bernard's contribution to this Issue deals more directly with the concerns of Medicare beneficiaries than do the other articles. Professor Bernard, Director of the Center on Alternative Dispute Resolution at the Oklahoma City University School of Law and a former member of the Medicare Provider Reimbursement Review Board, notes that the beneficiary is often marginalized because of all of the attention focused on Medicare providers. She asserts that the Medicare program should be refocused, through the use of mediation, to reorient Medicare from a provider to a beneficiary orientation through the use of collaborative medical treatment plans. She reviews the problems with "mass justice" as it is currently provided through the Medicare appeals system and the limitations of mediation when power is imbalanced (as it is between Medicare and beneficiaries), and describes the growing use of mediation in Medicare. She proceeds to address the problem of power imbalance and specifically advocates the use of mediation to empower patients. She concludes by describing the mediated medical treatment plan as a means of empowering patients, and argues that Medicare should fund services provided under such plans as a means to encourage them.

Finally, Eleanor D. Kinney explores the vital question of Medicare coverage determinations and appeals. One of the major factors driving the

growth in cost of the Medicare program over the past three decades (as Mark Pauly notes in his paper) has been the expansion of medical technology. For much of its existence, however, Medicare had only very informal processes for making coverage decisions. Professor Kinney describes the history of these processes. In 1999, Medicare adopted a four step plan to create an "open, accountable, and dependable" coverage decision-making process, which Kinney describes. The next year brought Congress's adoption of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)[9], which established a new beneficiary appeal process and coverage determination appeal process. Kinney describes these new processes, and then proceeds to analyze them under the tripartite calculus established for defining due process under *Mathews v. Eldridge*,[10] considering the interest of various participants in the Medicare program, the risk of erroneous deprivation of rights and probable value of substitute procedures, and the interest of the government.

Though this Symposium showcases the work of an extraordinary group of scholars, it would not have been possible without the contributions of others whose work is not so visible. First, I am grateful for the generous support of the Frances Lewis Law Center, and of its benefactors Frances and Sydney Lewis, who funded this effort. I also thank Blake Morant, the director of the Center, who supported us from the outset, and Terry Evans, his omnicompetent administrative assistant. President Thomas Burish of Washington and Lee University and Dean David Partlett of its law school also offered encouragement. Bridget Blinn, Ben Brown, and their staff at the Washington and Lee Law Review did a superlative job of editing these papers, introducing a number of academics from nonlaw settings to the conventions of law reviews. It was a pleasure working with them all.

9. Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, 42 U.S.C § 1395y.

10. Mathews v. Eldridge, 424 U.S. 319, 335 (1976).