Law and the Public's Health

MEDICARE REFORM

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The 108th Congress is expected to address the question of Medicare reform, a topic that raises important issues of public health law and policy, and whose resolution can be expected to greatly influence the U.S. health system as a whole. In this issue, *Law and the Public's Health* summarizes the major policy options and identifies key law and public health practice questions.

OVERVIEW

Enacted in 1965, Medicare extends government-administered health insurance coverage to some 40 million beneficiaries, with total enrollment expected to exceed 60 million by 2020.[1] Medicare consists of Part A (hospital insurance), Part B (supplementary medical insurance, elected by virtually all Part A enrollees), and Part C (Medicare+Choice). Part A is funded by a 1.45% payroll tax, which covered 56% of total program costs in 2000;[1] Medicare program trustees project long-term shortfalls as the workforce fails to keep pace with the number of retirees. Part B is financed through both general revenues and out-of-pocket premium payments covering approximately 25% of total Part B spending.

Medicare is a "major medical" insurance plan that follows commercial insurance principles. Expansions since 1965 provide coverage of certain clinical preventive services (e.g., pneumococcal and influenza vaccines, screening mammography, and certain cancer screens). But the program lacks outpatient prescription drug coverage and long-term nursing facility and community based care. The program's definition of medical necessity tends to restrict coverage to interventions to aid recovery from acute illnesses rather than maintain functional status among individuals with long-term chronic conditions, despite their prevalence.[2]

Because Medicare benefits are limited, most beneficiaries supplement Medicare through Medicaid (11%), Medigap (24%), Medicare+Choice enrollment (17%), or retiree employment coverage (33%). However, retiree employment coverage is declining,[3] and Medicaid is deeply stressed by Medicare supplementation.[4] One in eight beneficiaries lacks supplemental coverage,[5] a problem linked to reduced health care access.[6]

The 1997 enactment of Medicare+Choice restructured the existing Medicare HMO benefit; in 2002, enrollment stood at 5 million.[5] Enrollment has declined considerably (from 346 plans in 1998 to 152 in 2002) as insurers have exited Medicare+Choice in response to payment reductions and increased federal performance standards.[5]

In 2001, total Medicare spending reached $246 billion, a 10.3% increase over 2000.[5] The Congressional Budget Office projects a 6.8% annual rate of increase between 2004 and 2013, far higher than the growth in the overall economy.[6]

PROGRAM REFORM AND THE SPECTRUM OF RESTRUCTURING PROPOSALS

As the 108th Congress commences, it will have several basic Medicare restructuring options, summarized in the accompanying figure.

The first approach—and one that remains the inevitable default in the face of irreconcilable differences—is to maintain current policy. There are two obvious problems with this approach: continued reliance by beneficiaries on eroding sources of supplemental coverage to ensure access to uncovered services (most notably, outpatient prescription drugs); and the enormous stress it puts on Medicaid.

The second and third approaches are in some ways strikingly similar, yet dramatically different. Both are incremental in that each addresses only the issue of prescription drug coverage. In approach #2, Medicare would be expanded to cover a government-administered prescription drug benefit. Under approach #3, Medicare would be expanded to provide an optional premium payment toward enrollment in a private prescription drug plan; the government's role would essentially be limited to overseeing the payments and certifying qualified plans under broad standards. Plans would define the benefit and set the payment rate.

Proposal #2 tends to be favored by policy makers who desire stronger legal controls over the nature of the benefit and the price to be paid. Proposal #3 tends to have the support of the prescription drug industry and policy makers who favor a legally deregulated, "market-based" approach to health care oversight.

The fourth proposal, set forth by President Bush in his State of the Union speech, would add a new Medicare premium support program that would purchase

Figure. Medicare reform: law and public health implications

Possible reform	*Elements*	*Public health-related questions*
Do nothing	Current structure remains, with limited coverage, high deductibles and coinsurance, and available options for enrollment in Medicare+Choice. Beneficiaries continue to supplement Medicare for benefits and cost-sharing purposes, if supplementary coverage is available.	Declining sources of alternative coverage for prescription drugs and chronic care services and management place pressures on state health programs, including Medicaid and other sources of supplemental funding. Medical management remains problematic for individuals without supplemental coverage. Exit from Medicare+Choice market is projected to continue. Structural shortfalls in health insurance trust fund remain unresolved.
Incremental reforms in current program	Retain current Medicare structure as a fee-for-service program, but add some coverage for prescription drugs. Beneficiaries continue to have a Medicare+Choice enrollment option. Beneficiaries continue to supplement Medicare for cost-sharing purposes if supplementary coverage is available.	Addresses in part the lack of prescription drug coverage; leaves chronic care management unaddressed, with continued pressure on Medicaid. Does not address loss of supplemental coverage options or exit from Medicare+Choice market. Leaves structural long-term health insurance funding problems unaddressed.
Major restructuring of Medicare	Create incentives to move from traditional Medicare into a private health plan purchased through Medicare, similar to the current Medicare+Choice program. Beneficiaries may elect to retain traditional benefits or secure enhanced benefits (including prescription drug coverage and greater preventive services) through enrollment in alternative plan. Beneficiaries who remain in the traditional program continue to supplement.	Impact on legal entitlement to defined benefits unclear. May improve coverage of preventive services and prescription drugs depending on regulatory scheme adopted. State vs. federal regulatory oversight of expanded private health insurance market not addressed.

not merely a prescription drug plan but an entire alternative private insurance arrangement. Beneficiaries would in effect be offered the incentive of expanded benefit design to forego Medicare's defined benefits in favor of enrollment into a subsidized private health insurance plan that includes, among other benefits, prescription drugs. As with the more limited prescription drug plan, this proposal would deregulate governmental oversight of the Medicare benefit in favor of an approach that relies on market competition among plans while shielding the government from excessive cost increases through premium controls.

PUBLIC HEALTH LAW AND POLICY CONSIDERATIONS

With the exception of the first approach, each proposal entails complex legal changes in Medicare. Each approach has its own strengths and limitations, as is the case with any undertaking of this sort.

1. Is coverage improved?

All three expansion proposals would provide additional prescription drug coverage, but only in the case of proposal #2 (defined benefit) would the exact parameters of the expanded prescription drug plan be

delineated as a matter of federal law. Under proposals #3 and #4, the power to make legal decisions over insurance design would effectively be given to the market. In the case of proposal #4, this power would be extended to the entire benefit, not solely prescription drugs. Proposals #3 and #4 also raise the inevitable question of what will happen to beneficiaries who lack any market for private plans in their communities, a current problem in Medicare+Choice. Finally, no proposal addresses preventive and chronic care coverage other than prescription drugs.

2. Deregulation vs. cost control

Proponents of #3 and #4 point out that the minuses of deregulating Medicare design are offset by the government's ability to better predict and curb long-term spending through premium controls. In turn, this ability to use the market to control long-term health costs will depend on whether safeguards are introduced to avert favorable selection, in which only the healthiest patients presenting the least actuarial risk enroll in private plans.

3. Regulating private health insurance products

Approaches #3 and #4 both raise issues related to the nexus of state and federal health law and the question of federal preemption of state insurance regulation authority. Medicare historically has been a federally regulated benefit. But the addition of Medicare+Choice managed care products has raised the issue of whether federal law will preempt state authority to regulate health insurance, a monumental legal matter raised by the Employee Retirement Income Security Act (ERISA).[7,8] The issue of federal preemption of state authority to regulate the design of Medicare+Choice plans has already been the subject of litigation, with courts ruling in favor of federal preemption based on the broad federal role in the current Medicare+Choice program.[9] However, to the extent that a broad premium support program is far more deregulated than the current Medicare+Choice system, new preemption questions can be expected.

CONCLUSION

From a public health standpoint, Medicare reform represents a critical legal development, both because of its potential impact on access to care and because of its implications for state regulation of health insurance. How the question ultimately is resolved will occupy much of the health agenda of the 108th Congress.

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