Chapter 3. Going Nowhere: The Politics of Benefits

- there are persistent gaps in Medicare coverage and Medicare pays for less than half of all health expenses incurred by the elderly
- Medicare benefits are not generous compared to international standards
- benefits in 1995 almost identical to benefits in 1965
- stability of Medicare benefits puzzling given the reputed political power of the elderly
- Medicare politics governed by a “negative consensus” on cost containment
- Puzzle 1: why Medicare benefits remained stable over time?
- Puzzle 2: why in 1988 catastrophic health insurance was added and then repealed?

The Development of Medicare Benefits

- Medicare Benefits, 1965
  - pay for hospital stays and physician services
  - coverage gaps, room for supplemental private insurance
  - balance billing allowed
  - no out-of-pocket maximum
  - limits on hospital coverage and mental health services
  - outpatient prescriptions drugs, medical physicals, hearing aids, eye-glasses, and dental care not covered at all
considerable cost sharing (deductibles and coinsurance)
no broad protection against the costs of chronic illness
restricted home health and nursing home coverage, no coverage for long-term care
limited benefits reflects (i) political feasibility and (ii) the standard private insurance package of the time without regard for the possibly differing healthcare needs of the elderly

• Medicare Benefits, 1966-86
  - few significant changes in benefits
  - 1972: addition of ESRD patients and SSDI recipients

• Why Medicare Benefits Did Not Expand
  - there was some expectation that Medicare benefits would expand similarly to expansions to Social Security
  - there were several sources of pressure for expansion:
    * popular appeal of the aged + public opinion
    * political power of organization representing the elderly
    * limited coverage
    * political strength of programmatic structure
  - forces against expansion:
    * fiscal concerns
    * availability of supplemental insurance (from previous employer or Medigap) and rapid expansion of this market
    * confusion about benefits among the elderly

Reversal of Fortunes: Catastrophic Health Insurance, 1986-89

• Medicare Catastrophic Coverage Act of 1988
• came during general Medicare cuts and deficit politics under a Republican administration intent on downsizing the welfare state
• largely a result of political entrepreneurship by Secretary of HHS Otis Bowen who succeeded over opposition from conservative cabinet members
• self-financing and income-related premiums
• Medicare catastrophic insurance collapsed 16 months after its adoption when opposition from the elderly led to its repeal
• wealthier elderly were opposed to the catastrophic health insurance expansion because they would have had to pay for poorer beneficiaries' benefits
Conclusion

- expansion of Medicare restrained by negative consensus about cost control over program coverage
- these same forces also caused the failure of catastrophic health insurance
- open puzzle: why income-related taxes for Social Security have succeeded and income-related taxes for Medicare expansion have failed

Chapter 4. Going Broke: The Politics of Financing

- during the 1990s there were increasing worries that Medicare is in crisis and is not sustainable
- Question 1: what explains the structure of Medicare financing arrangements?
- Question 2: How have these arrangements shaped Medicare’s financing politics?
- Question 3: What consequences have these arrangements had on the timing and substance of Medicare reform?
- trust fund crises of financing have received bipartisan response which made them less public events
- trust fund crises are not merely objective financial events but are political events with political responses
- the cycle of crisis and reform in Medicare financing is the single most important pattern in program politics which has driven program reform

The Origins and Structure of Medicare Financing

- Medicare in 1965 contained two difference financing systems:
  - Part A (hospitalization insurance): matching payroll taxes
  - Part B (physician services): premiums and general revenues
- payroll financing is regressive
- payroll financing based on experience with social insurance under the Social Security program
The Influence of Social Insurance

- idea of social insurance originated in non-voluntary welfare programs in Europe
- workers earn their right to benefits through mandatory payment of taxes (premiums)
- earned benefits maintain analogy to private insurance
- compulsion necessary so that higher-income people pay into the fund as well

The Social Security Connection

- Social Security started during the New Deal followed the social insurance model
- political advantages of reliance on payroll tax and trust fund financing:
  - workers have a moral claim to future benefits
  - intergenerational political alliance
  - notion of earned benefits can create buy-in from conservatives
  - payroll tax financing is compulsory and not limited to low-wage workers
- Social Security financed entirely from payroll taxes with no subsidy from general revenues

Medicare and Payroll Tax Financing

- administrative experience with Social Security + ideology of social insurance
- intended to reproduce popularity of Social Security
- financing through payroll taxes makes recipients deserving claimants of benefits, instead of recipients of government welfare
- cross-generational and cross-class constituency
- from the conservative perspective, reliance on payroll taxes and reluctance of the public to accept tax increases constrained the future growth of the program
Insurance for Physicians’ Services

- Part B insurance for physician services was added at the last minute
- funded in equal parts by general revenues and beneficiary premiums
- response to criticism that Medicare Part A offered inadequate coverage which could have generated future demands of expansion
- lawmakers did not want to increase payroll taxes even further

The Political Consequences of Medicare Financing

- one of the nation’s most popular social programs
- popularity attributed partially to financing design: payroll tax created a sense of public entitlement (deserving claimants rather than recipients of government welfare)
- no evidence of difference in public attitude towards Part A (funded through payroll taxes) and Part B (funded primarily through general revenues)
- three periods of financial crises (1969-72, 1982-84, 1995-97)

Institutional Sources of Bankruptcy Crises

- other federal programs are usually not subject to bankruptcy rhetoric
- Social Security also had a bankruptcy crisis in 1977
- crises based on payroll tax and trust fund financing

Physician Insurance and Financing Politics

- in most years the annual rate of growth in physician outlays exceeded that of hospital outlays
- but Medicare Part B has never experienced a bankruptcy crisis
- this is because Part B is financed through premiums and general revenues

Timing

- Medicare’s long-range actuarial balance has been negative
- for most of Medicare’s existence, federal actuaries forecasted a long-range trust fund deficit
- there is no consistent relationship between the size of the long-range deficit and the onset of Medicare financial crises
- strong relationship between the number of years to trust fund exhaustion and the onset of Medicare crisis
The Privileged Position of Medicare Actuaries

- practice of reliance on actuarial estimates borrowed from Social Security
- principle of actuarial soundness
- long-range forecasts covered 25 years, expanded to 75 years in 1984
- actuarial estimates have had an unanticipated influence, less stabilizing than in Social Security
- forecasting medical costs has proven more difficult than predicting pension benefits in Social Security
- federal actuaries have frequently underestimated costs
- relatively unchallenged, privileged position

Are Medicare Crises Political Constructions?

- crises offer an opportunity to remake public policy
- large literature in political science and sociology argues that political crises are socially constructed
- Medicare financing crises are not merely political constructions: there is an undeniable relationship between objective financial conditions and the onset of Medicare financing crises
- but the relationship is not perfect and is based on subjective perceptions of objective actuarial forecasts

Managing Trust Fund Shortfalls: Financing as Political Choice

- actuaries define how much additional funding Medicare needs
- Congress and the President determine how additional funding is to be obtained
- there is no single, predetermined response required

General Revenues

- one potential response would be to augment program revenue from payroll taxes with general revenues from federal taxes
- periodic calls to restructure Medicare financing, proposals to move it to general revenue financing
- some evidence that the public supported greater reliance on general revenue financing
Payroll Taxes

- second potential response would be to increase the program’s income from payroll taxes
- two ways to do this: raising the tax rate or raising the amount of income subject to Medicare taxes
- 1972, 1986: tax rate increased
- 1993: ceiling on maximum income subject to the payroll tax removed
- “political limit” on the level of Medicare and Social Security taxes
- some survey results indicate that voters do not want to pay higher taxes but the validity of these surveys is questionable
- unclear whether the public or policymakers are the obstacle to raising taxes

Beneficiary Costs

- third potential response would be to increase the costs of hospitalization insurance to beneficiaries:
  - existing cost-sharing amounts could be raised
  - new cost-sharing measures could be introduced (e.g., monthly premiums)
  - retirement age for Medicare eligibility could be raised
- limited increase in beneficiary cost sharing reflected three main factors:
  - deductible for Medicare hospitalization insurances higher than deductible for most private health insurance plans
  - beneficiaries viewed in a more favorable light than hospitals and physicians
  - financing system of hospitalization insurance confers a sense of earned benefits
- significant public support for charging wealthier Medicare beneficiaries more or cutting their benefits

Regulation

- fourth potential response would be the regulation of program payments to medical providers
- correlation between funding shortfalls and regulatory reforms
Conclusion

- the dominant issue in Medicare financing politics has been the causes, timing, and consequences of the financial crises
- the primary cause of these crises is the structure of Medicare financing
- Medicare financing structure copied from Social Security to emulate its political success
- political outcomes different in Medicare from Social Security
- Medicare politics fundamentally differ from Medicaid politics because Medicaid has a low-income constituency
- problems and solutions:

<table>
<thead>
<tr>
<th>Years</th>
<th>Problem</th>
<th>Solution</th>
<th>Policy Strategy</th>
</tr>
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<tbody>
<tr>
<td>1970-72</td>
<td>Over-utilization, fraud, and abuse</td>
<td>Professional self-regulation</td>
<td>Professional standard review organization</td>
</tr>
<tr>
<td>1982-84</td>
<td>Retrospective reimbursement</td>
<td>Prospective payment</td>
<td>Diagnostic-related groups</td>
</tr>
<tr>
<td>1995-97</td>
<td>Fee-for-service system</td>
<td>Managed care, competition</td>
<td>Medicare + Choice</td>
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</tbody>
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- reforms adopted in Medicare are products of the particular policy environment at the time of the crisis
- bipartisan responses to Medicare shortfalls did not contemplate program restructuring

Chapter 5. The State Rises: The Politics of Regulation

- Medicare regulatory policy has been a prominent battleground in program politics
- lot of money on the line and regulation has received more scholarly attention than benefits or financing
- Medicare is heavily regulated, similar to Canadian and Western European health programs
The Origins and Structure of Medicare Regulation

- initial character of Medicare regulation was permissive: hospitals and physicians essentially reimbursed for whatever they billed
- program designed to temper the hostility of the medical industry
- payment policies designed with the purpose of political conciliation towards hospitals and physicians
- reasonable-charges standards and fee-for-service payments
- minimized federal control of reimbursement and maximized physician income

Medicare Administration

- administrative structure reinforced tight connection between program regulation and prevailing practices in the healthcare market
- regulation mirrors private insurance
- much of the authority to administer program rested with the insurance industry
- federal Medicare administration placed in the Bureau of Health Insurance of the Social Security Administration: based on SSA officials’ role in developing Medicare and the linkages between Medicare and Social Security
- in practice, Medicare administration was contracted out to private organizations, Blue Cross and Blue Shield
- reasons for contracting out administration: political calculus to placate private insurance industry and the medical professions, as well as public opinion + missing federal administrative capacity
- policies were implemented to avoid conflict with medical providers

Developments in Medicare Regulation, 1966-94

- Professional Standard Review Organizations
  - fast-rising expenditures attracted attention and led to reforms
  - 1972 Social Security amendments created Professional Standard Review Organizations (PSROs)
  - Senate Finance Committee hearings and report blamed Medicare's overspending on widespread fraud and abuse
  - PSROs made sense politically but evaluations suggest that they cost more to operate than the money they saved
• The Prospective Payment System
  - healthcare spending accelerating at record rates in the 1980s
  - rapid rate of increase in Medicare expenditures, approaching bankruptcy of the trust fund, rise of federal budget deficit
  - private insurance still offered open-ended payments
  - in 1983, the prospective payment system (PPS) was adopted for hospital reimbursement
  - outcome of two processes:
    * technical development: prospective payment
    * political development: commitment to contain Medicare hospital costs
  - regulatory increase came during Republican administration that favored a “procompetitive”, market-based approach to reform
  - explanations for support for regulatory rather than market-based reform:
    * fiscal exigency
    * prospective payment favored by Secretary of HHS
    * DRG system evoked the symbolism of the market by providing incentives for efficiency
  - in 1977, Medicare administration was moved out from SSA and merged with Medicaid administration in the Health Care Financing Administration (HCFA)
  - HCFA meant that Medicare was transformed from a social insurance program into a health financing program

• The Medicare Fee Schedule
  - after hospital payment reform, policymakers wanted to reform physician payments
  - physician expenditure was rising three times faster than hospital payments
  - reform of hospital regulation was partly responsible since incentivized providers to move care to outpatient settings not under PPS
  - policymakers worried about budgetary impact of rising spending + consequences for beneficiaries: rising premiums, copayments, and balance billing
  - 1984-1986: freeze on Medicare physician payments
  - 1986: creation of Physician Payment Review Commission which under William Hsiao assessed the viability of a resource-based relative value scale (RBRVS)
- RBRVS was designed to pay doctors based on objective measures of complexity, time, and resources involved in rendering services
- 1989: under Omnibus Budget Reconciliation Act, RBRVS was adopted as the basis of Medicare fee schedule
- over time there was some slowdown in Medicare spending

The Politics of Regulation
- theory of regulatory capture suggests that regulators will be captured by powerful industries and interest groups, therefore deregulation is better
- some think that symbolic benefits of regulation go to the public, while tangible benefits go to powerful industries
- in Medicare symbolic benefits went to medical providers and the government kept the tangible benefits (financial savings) for itself
- federal officials disregarded legislatively mandated reimbursement formulas
- Medicare regulation politics cannot be explained by theories of regulatory capture
- Congress which according to conventional wisdom is driven by interest group politics and lacks expertise recaptured Medicare regulation and implemented policies to save money
- some political scientists claimed that health politics had been moved to the bureaucracy with expertise (HCFA), but in reality Congress had the primary influence on regulation and payment policy

Conclusion
- Medicare regulation has gone through a series of shifts
- bipartisan consensus has governed Medicare policymaking
- Medicare moved towards budget-driven policymaking during the 1980s with the implementation of DRGs and RBRVS
- Medicare looked more and more like other national health systems in its forms of cost control
- key differences from other national health systems:
  - global budget, a ceiling on total expenditures was not adopted
  - technological diffusion is not controlled by the government
Chapter 7. The New Politics of Medicare

- 1965-94: politics of consensus
  - bipartisan policymaking
  - tacit acceptance of universal government program and single-payer system
- since 1994 the consensus around policymaking in benefits, regulation, and financing has broken down

Prelude to Change: The Clinton Administration and the 1994 Elections

- Democratic control of House, Senate, and White House before the midterms
- Clinton administration in 1993 wanted to fix the economy
- healthcare was second most prominent issue after economic revitalization
- by fall of 1994 there the administration had lot of political troubles (DADT, NAFTA, 1993 budget)
- greatest disappointment was healthcare reform
- Republicans took control of both the House and the Senate in 1994 midterms
- failure of healthcare reform, and the anti-government sentiment it generated were important in the defeat in the midterms

Medicare Politics in Flux: The End of Consensus

- 1994 congressional elections transformed the politics of Medicare
- 1995: high-profile, partisan, and highly ideological debates over Medicare
- reopening of the Medicare debate from the 1950s and 1960s
- movement from politics of management to politics of transformation

The Political Environment

- first time since 1954 that the Republicans controlled both the House and the Senate
- Congressional control of Medicare previously meant Democratic Party stewardship except for 1980-1986 when Republicans controlled the Senate
• Republicans led by Speaker of the House Newt Gingrich were advancing an assertively conservative agenda (Contract with America)

• Republicans aimed to cut back the federal government and reform Medicare, changing its liberal character

The Fiscal Environment
• Medicare was started in a period of economic growth and prosperity
• in previous funding crises, payroll tax increases were accepted by both sides and caused minimal controversy
• the fiscal environment started to change with stagflation in the 1970s and the rise of the federal budget deficit in the 1980s
• 1995 Republican budget called for a balanced budget in 7 years, proposed a $270 billion cut in Medicare spending (30% reduction in projected expenditures)
• deficit politics + Republican opposition to any tax increases

Intergenerational Equity
• change in the image of the elderly in American public life
• 1960s: elderly were the sympathetic social group - poorer, sicker, and less well-insured than younger Americans
• 1990s: intergenerational equity concerns, people becoming concerned that the federal government advantaged the elderly at the expense of other social groups
• criticism: some elderly are so well off, they don’t need government help
• coming retirement of baby boomers
• US proportion of healthcare spending on the elderly is actually in line with other countries

The Changing Health Care System
• managed care plans (HMOs, PPOs, POS) grew rapidly during the 1990s
• rapid rise in the number of physicians subject to capitation
• fall in conventional indemnity insurance
• Medicare was the only remaining large “unmanaged care” program
• unlike in other countries where public programs dominate, in the US the private insurance market puts pressures on Medicare:
  - performance
  - consistency
  - expansion

The Trust Fund Crisis
• previous trust fund shortfalls were noncontroversial, low-profile, and bipartisan
• 1995 trust fund crisis had different politics
• the 1995 trust fund crisis was political packaging to sell the Republican Medicare reform, framing it as a fiscal issue
• GOP lawmakers profited from trust fund shortfall + rise in Medicare spending rates
• Medicare was financially and politically vulnerable at the same time
• Republicans succeeded in passing Medicare reform in Congress
• President Clinton vetoed Medicare reform (using the same pen that President Johnson used to sign Medicare in 1965)
• the Medicare fight helped rehabilitate President Clinton in the 1996 election

Reform Rises from the Ashes: The 1997 Balanced Budget Act
• despite the Clinton veto and the failure of the reform, old program consensus was undermined
• after the 1996 election, Congress and the President agreed on the Balanced Budget Act (BBA)
• BBA mandated several policy changes, including a balanced budget by 2002
• BBA created the Medicare + Choice option that opened up Medicare to private insurance plans
• relatively little public attention on Medicare changes in 1996, because of the bipartisan agreement on the reform
• BBA changed several provisions that Democrats objected to during the 1995 reform attempt
• President Clinton and the Republican Congress actually agreed on a lot of things
• deficit pressures, and President Clinton’s push for a balanced budget were also important
• temporary reinstatement of political consensus around Medicare
• Republicans wanted to move towards defined contributions, but BBA only implemented managed competition with Medicare + Choice
• dual personality: embracing the market (Medicare + Choice), but also traditional component developing towards global budget
• new market vision did not replace traditional liberal consensus

The Bipartisan Commission
• National Bipartisan Commission on the Future of Medicare established by 1997 BBA
• mandate: comprehensive examination of Medicare’s future - financing, eligibility, benefits
• make recommendations to Congress by March 1999 on how to address challenges like baby boomers’ retirement beginning in 2010
• membership equally divided between the two parties and very diverse
• focused exclusively on managed competition and turning the program into premium support
• proposals:
  – raise eligibility age from 65 to 67
  – affluence test
  – reform Medicare into competitive market and premium support
• policymakers were frustrated with HCFA for being too bureaucratic and against private insurance
• both ideological and fiscal reasons for supporting the market-based reforms
• lack of consensus on some of the virtues of the market-based system and skepticism about its ability to both save money and expand benefits
• some fears that the reform would segment the market by income
• Republican Commission members ended up supporting proposals, at the end the President disavowed the Commission’s main proposals
The 2000 Elections: Surplus Politics and Prescription Drugs

- Medicare was a first order issue in the 2000 elections
- fiscal environment changed: budget surplus based on economic growth
- less deficit pressure on Medicare, improving trust fund position
- 1997 reforms also slowed down spending
- presidential candidates focused on prescription drug coverage
- drug benefit required to be in line with mainstream medical insurance
- Bush plan market-oriented, Gore plan more like social insurance but with voluntary enrollment

The Bush Administration and Medicare, 2001-2

- Bush came into office without any public mandate
- ambitious agenda on entitlements
- commission to study Social Security reform, wanted to introduce private accounts for Social Security
- political priority in Medicare was prescription drug coverage
- administration wanted market-based reform but it was constrained in what it could do

Conclusion

- the rise of the market in Medicare is not over
- 1995 ended the liberal consensus and reopened debate about the future of the program
- Bipartisan Commission illustrates lack of consensus
- Medicare's future is uncertain