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JAMES MADISON, RONALD REAGAN, AND THE FUTURE OF THE MEDICARE PROGRAM

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MR. GLENN M. HACKBARTH: James Madison, of course, was one of the founding fathers of our nation and, incidentally, this past March 16 was his 236th birthday. One of Madison's great accomplishments was to be the primary architect of the Constitution of the United States. Madison was largely responsible for devising this system of government. This system is known in the political world and the government world as a system of checks and balances. The genius of Madison's system was that no one branch of government was granted the authority to do what it wanted. We have three equal coordinate branches of government, each of which has very important powers. The three branches check and balance one another. This form of government was a byproduct of the time. Madison and the other founders of this nation had experienced tyranny. As a result they had begun to fear big government and consciously set out to devise a system of government that would be weak. It would be stronger than the system that preceded it (the so-called Articles of Confederation), but not nearly as strong as the system they were most familiar with -- the British Parliamentary System Constitutional Monarchy. The end result of Madison's handiwork is a system that is cumbersome in many ways -- sometimes quite frustrating. It is sometimes a system divided against itself. The end result of all that is that the Federal Government is a very difficult beast to manage.

We are not in eminent danger of being cited in one of Tom Peters' books about the pursuit of excellence in management, but that was a conscious goal. It is all too common today to think this is the result of incompetence in Washington. The fact is that we have a lot of highly competent people in Washington, both

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political leaders and career civil servants. The disorderly process we see is no accident; it is the planned result of our system of government. As Bill Roper, my boss, puts it: One of the nice things about the HCFA Administrator is that we have so many nice people willing to help us do our jobs.

That covers the James Madison part of my theme. Where does Ronald Reagan fit in? One of President Reagan's great strengths is that he understands the nature of the Beast. He understands that the Federal Government is constitutionally incapable of doing certain things. As a result, he would like to reduce the Federal role in making certain key decisions about the future of our country, and among those are decisions about certain elements of healthcare. In short, the President's philosophy is rooted in an understanding of the work of James Madison. So how are we trying to translate that understanding into action?

The Reagan Administration's Medicare policy can be reduced to five basic principles. First and foremost, we have the responsibility to assure that the nation's 31 million elderly and disabled citizens have access to high-quality healthcare services. Our second guiding principle is to reduce the Federal Government's direct role in decisions about how to pay for individual healthcare services -- services of individual physicians and hospitals, for example. And also to reduce government's role in deciding what constitutes appropriate medical practice. The third guiding principle is to increase choice for both Medicare beneficiaries and the healthcare providers that serve them. Fourth, we would like to increase competition among private healthcare organizations; and fifth, we would like to increase the economic incentives for efficiency.

Right now we are pursuing what is best characterized as a two-prong strategy for achieving those goals. One of the prongs of this strategy is the traditional Medicare program complemented by what we call Prudent Purchasing Reforms. The second prong of this strategy is what we call the Private Health Plan Option. I will describe each of these in more detail later. Right now I want to make a critical point -- that what we are trying to do is to set up a fair market test, if you will, between the traditional Medicare Program and what we call the Private Health Plan Option. It is our goal to give Medicare beneficiaries and healthcare providers the opportunity and responsibility to choose between the

two prongs of the strategy, and it will be they, not us, that ultimately decide which path the Medicare program takes.

Let me define more clearly the two prongs of that strategy.

Private Health Plan Option

Under the Private Health Plan Option, the government gives Medicare beneficiaries and healthcare providers the option of participating in the Medicare Program through private health plans. The Federal Government makes monthly lump sum payments to those health plans. In exchange, the private health plans assume both the financial and medical responsibility for assuring their enrollees, the Medicare beneficiaries, have access to medical services as necessary. Within fairly broad constraints, those private health plans are free to determine how they're organized as well as basic rules governing how individual physicians and hospitals are paid, decisions on utilization controls, and decisions on how to ensure quality of service. Some of you may recognize this idea under another name -- it's been called Medicare Vouchers or Medicare Capitation. We've been trying to use the term Private Health Plan Option because we think it's a clearer, more descriptive term.

Traditional Medicare Program Complemented by Prudent Purchasing Reforms

Under this prong of the strategy, the Federal Government remains in its traditional role as insurer of healthcare services for the elderly and disabled. As the insurer, the Federal Government sets rules on how individual providers will be paid. Increasingly, the Federal Government is setting rules on what constitutes appropriate medical practice; for example, deciding whether an individual patient should be treated in the hospital or outside. Examples of our Prudent Purchasing effort include the prospective payment system for paying hospitals, what we call the inherent reasonable test for physician fees, the Peer Review Organization program, among others. Financial pressures are requiring the Federal Government to be more aggressive in its prudent purchasing activity. Fiscal pressures are requiring us to write ever more detailed rules governing how individual providers ought to be paid and about what constitutes appropriate medical practice. We are becoming more vigorous in exercising our purchasing power. The Medicare program is a huge program in excess of 75 billion dollars.

As a result of our ability to control that much money, we have substantial clout in dealing with healthcare providers. And, basically, we've been using that clout much more aggressively in recent years.

All of that is good for the Federal budget. Controlling Federal outlays and reducing the Federal budget deficit are obviously critical goals and among the highest priorities of President Reagan. But there are some problems. As we become ever more aggressive purchasers, we get ever more deeply involved in great detailed decisions about pricing services and about appropriate medical practice, and as I said earlier that is not our goal. The President would like to see us move out of those activities, not get more deeply involved. Unfortunately, so long as we are at financial risk for this huge expenditure, we have little recourse but to wade more deeply into these very complicated decisions. We are troubled by that prospect. We are concerned about our ability to make decisions in Washington, D.C. that are fair and equitable when applied across this huge and very diverse country in a very complicated healthcare system. In short, we are concerned that it is simply not possible to have national payment rules that are generally applicable across this country and at the same time generally fair. In short, we are not at all sure that we can have the same rules applied both in Sioux City and New York City and have them equally fair in both places.

Under the Private Health Plan Option, we take a fundamentally different approach. What we do is shift financial risk from the Federal Government to private healthcare organizations, and then delegate to those private organizations a fair amount of latitude to make decisions about how they pay for individuals services. In that sense, the Private Health Plan Option far better accomplishes the guiding principles, the goals, of the Reagan Administration's Medicare policy. It reduced the direct government influence over these decisions because different plans can have different rules; it increases the range of choice for both Medicare beneficiaries and healthcare providers; it increases competition since there will be multiple competing organizations seeking Medicare enrollees, and a byproduct of that competition is strong incentive for economic efficiency. Again, I should emphasize that it is not our goal to require Medicare beneficiaries to enroll in private health plans. That is one of the most common misconceptions about our policy. Instead, our goal is to assure the Private Health Plan Option receives a fair market test. Our goal is to assure that Medicare

beneficiaries and healthcare providers have a fair opportunity to choose between participating in a Private Health Plan Option and enrolling in private plans, or alternatively staying in the traditional Medicare program. The government should not push HMOs or any other single form of healthcare delivery. So far as possible we ought to be neutral. Beyond that we need to build a consensus in favor of this concept of the Private Health Plan Option -- a consensus that will endure well beyond the remaining two years of the Reagan Administration.

We recognize that this fair market test for the Private Option is going to take many years to run its course. The changes that we envision in the Medicare program are fairly fundamental changes; they are not changes that will happen overnight. And since we are giving beneficiaries and providers choices, as opposed to forcing them to change, we've got to allow time for people to become used to the new arrangements that are necessary under the Private Health Plan Option. We also recognize that we, the Federal Government, cannot lead the movement away from the sort of traditional insurance embodied in the Medicare program toward managed care, which we think is the sort of arrangement most likely to prosper under the Private Health Plan Option. We cannot ask Medicare beneficiaries to be the guinea pigs for managed care. Politically that is totally unacceptable. But what we do need to do is assure that Medicare beneficiaries have access to managed care systems that have proven their worth in the private marketplace by enrolling workers and other private individuals. So our goal is to follow development that we see occurring in the private sector, not to lead them.

So the hallmarks of the President's Medicare policy are these:

1. Choice for Medicare beneficiaries and for healthcare providers.

2. We would like to decentralize decisions. Decisions about appropriate payment and appropriate medical practice. Take them out of Washington and instead have them made by local private organizations in competition with one another.

3. Breaking up the huge purchasing power represented currently by the Medicare program. We don't think that all that money should be kept in

one bundle so that any single purchaser of healthcare services should be in a position to economically coerce healthcare providers.

4. Following the lead of the private sector -- piggy backing on developments that are occurring there.

The Private Health Care Option is more than an abstract concept. In fact, it is underway already. Since April 1985, Medicare beneficiaries have had the option of enrolling in HMOs or what we call Competitive Medical Plans which are, in essence, a generic form of HMO. Right now we contract with over 150 HMOs and CMPs. Currently about 860,000 Medicare beneficiaries have exercised their option to receive their benefits through a private health plan. Roughly 10-1/2 million Medicare beneficiaries now have that option. The rate of increase in the number of Medicare beneficiaries electing the private option is anywhere from 3-5% per month. So over the last year the increase has been in excess of 60%, which is a reasonably healthy rate of growth. But at the same time, we recognize that 860,000 (the number of current enrollees) is a fairly small number compared with the 31 million entitled to Medicare benefits. Again, what we're talking about here is not revolution but evolution. We're talking about evolution because we recognize that this sort of fundamental change in a program can only unfold over a long period of time, and we are doing our best to build a bipartisan consensus in favor of this concept. There are critics of the Administration who say that the Reagan Administration doesn't have a Medicare policy, or alternatively, some say that our policy is a radical policy, one that is hell bent on privatizing the Medicare program -- privatization for its own sake. Needless to say, we don't think that's the case. Yes, it's true we do favor giving Medicare beneficiaries and healthcare providers more choice, and with that comes some responsibilities. Yes, we favor using market forces to a greater degree than some of our predecessors. Yes, we do favor decentralizing key decisions about appropriate medical practice and paying for services -- decisions that heretofore have been largely made in Washington. And yes, we do favor reducing the power of the Federal Government. But, again, we are committed to evolution, not revolution. We recognize the necessity of proceeding at a reasonable pace. The way that we see this policy is that it is a policy of vision -- it looks to the long-term future of the program, but it's a vision tempered by pragmatism, and in that sense it is characteristic of the President himself. I think that those characteristics of vision tempered by pragmatism are hallmarks

of the man. But in that same vain, vision tempered by pragmatism is a quintessentially American approach to public policy. It's consistent with basic American values. As I said at the outset, it's very consistent with James Madison's view of the world and the system that he established to bring life to that view. So that's where we're headed.

SPEAKER: What do you see happening in long-term care?

MR. HACKBARTH: In recent weeks and months there's been a lot of discussion of long-term care. Secretary Bowen and the President have proposed adding a catastrophic benefit to the Medicare program. However, that benefit would only cover acute care services, not long-term care services. I don't see any significant change anywhere on the near horizon. There is a lot of interest in long-term care and the very severe problems that it poses for the elderly, but the limits on our economic resources are such that I don't think it's a problem that the Federal Government can come to grips with soon. The President has asked, however, that we work with the Treasury Department to look at ways we might encourage the development of long-term care insurance in the private sector by using tax incentives or some other means. That study is underway now; I don't think there's a fixed schedule for completing it. I think that would be the limit of the Federal role -- some sort of tax inducement for long-term care insurance.

SPEAKER: You used the word "consistent." I've been told that the words "fair," as in fair market test, and "government" cannot be used consistently in the same sentence. Is there anything you can do to allay my fears?

MR. HACKBARTH: I've heard the same thing said myself. Obviously, it's one of the biggest problems we face. There's a lot of concern, for example, in the HMO industry about contracting with the Federal Government, the fear being that we won't keep our end of the bargain. I understand their point of view and their concerns, but on the other hand, I think there's a lot of outlandish rhetoric about how hospitals have been dis-served by the Medicare prospective payment system. The rhetoric is simply not consistent with the reality. By any reasonable measure, the Medicare prospective payment system has been an enormous boon to American hospitals. There are some important exceptions to this. I personally believe that we may be moving to a new phase with the prospective payment system, where the financial situation for hospitals is significantly

tighter. This rhetoric, however, has been going on since almost the first day of this system, and it's just not consistent with the facts. So, I'm not sure there's anything I could say right now to allay your fears, but I do suggest that everybody look very carefully at the reality and not just jump on the bandwagon.

One last point about HMOs in particular: I've talked to a lot of folks in the HMO world about their fears of contracting with Medicare. In fact, my former employer is also in the HMO business. The point I make to my former employer and all the other HMO folks I know is that eventually you're going to be doing business with us. Those 25 year olds that you have in your plan are someday going to be 65 year olds. If you're successful in the private market, and you eventually want to keep those people, you're going to have to do business with us. Demographics are on our side, guys. So it's in your interest that you not just listen to the rhetoric and say, "I'm scared of Medicare, I'm not going to get involved." It's in your interest to get involved with the program and do everything you can to make it a better program, a fair program, because in the long run that's where things are headed. That is my advice for now.

Conclusion

Despite all of the rhetoric about Medicare (and there's a whole lot of it in Washington), the fact is very little happens in the Medicare program that is not the result of a bipartisan consensus. Even from the beginning of the Reagan Administration, one house of Congress has been controlled by the Democrats. As a result, it simply was not possible for the Administration to make major changes in the program without the support of leading Democrats. As a result, the Medicare prospective payment system, the Private Health Plan Option both were passed with overwhelming bipartisan support. There are disagreements at the margin, but I think there's a clear consensus about the basic strategy that is being pursued -- this two-prong strategy that I mentioned. So, even if we were to have a Democratic president next time around, I don't think there would be dramatic changes. I think there would be possible changes in emphasis, but I don't see any revolutionary change there either.

One of the reasons that the prudent purchasing strategy is so difficult is that it's incredibly difficult to deal with 400,000 physicians on a nationwide basis.

It's very difficult to even reform physician payment. What we did with hospitals was very easy by comparison. We deal with 6,000 hospitals as opposed to 400,000 physicians, and we had great detailed data on hospital costs that we could use in developing a payment system that created strong incentive for efficiency. We had the advantage of a history of mandatory assignment on hospital bills, which meant that we were in a position to be fairly aggressive with hospitals. We had the advantage of having 40% on average of the typical hospital's business and a lot of financial leverage. We don't have any of those advantages on the physician side. Everything we do with physicians therefore must be at a much slower, much more cautious pace or we can provoke very severe ill effects. Our approach on physician reform is not to go the route of comprehensive reform; not to try to do something analogous to what we did with hospitals, but rather to tinker at the margin using what we call "inherent reasonableness authority." For example, last year we proposed more stringent limits on the amount we would pay for cataract surgery, and Congress ultimately decided to go along with that. What we will do is pick particular targets of opportunity and reduce fees for those particular services. But unfortunately, that approach does not get at your primary point, which is controlling utilization of services. Indeed, it seems to me there is relatively little we can do under the traditional Medicare program to control physician utilization of services -- the number of visits outside the hospital, or even in the hospital for that matter. We think the most important route to controlling utilization on the physician side is through capitated systems, and that's the way we hope the system will move.

We are vehemently opposed, however, to mandatory assignment. We do not think that's an appropriate course for the program to take. We do disagree on this, however, with some of our colleagues in Congress. At the same time, we support the idea of a participating physician program, which I think is one of the reasons we've seen an increase in the assignment rate in recent years. We think great strides have been made. The assignment rate has gone up by roughly 20 percentage points in the last four years or so. Real progress has been made in that regard. We do think Medicare beneficiaries ought to be told that certain physicians are willing to accept assignment on 100% of all claims. Then they can decide for themselves whether to go to those physicians or not. By the same token, physicians who are willing to accept assignment on 100% of all claims, become participating physicians. We think they deserve some publicity for that

fact. So that's the policy we would like to pursue. Sign up the doctors that are willing to become participating physicians, let beneficiaries know that there are physicians who are willing to accept assignment, and then let the two parties decide for themselves and not coerce anyone into mandatory assignment.