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Medicare Cures: Easy to Prescribe, Tricky to Predict

Bush, Congress Place Faith In Private-Sector Remedy; Echoes of Nixon HMO Push

By David Wessel

When Lyndon Johnson signed the law creating Medicare in 1965, the health-insurance program for the elderly was seen by those who favored it and those who fought it as the first step toward national health insurance for all. It wasn't.

Medicare began enrolling elderly Americans on July 1, 1966, and there were fears that no one would sign up, that doctors would strike and that hospitals would be inundated immediately. None of those fears were realized. The biggest early controversy was largely unforeseen: the forced racial integration of Southern hospitals.

For the past 37 years, Medicare has surprised those who created, changed and managed it. Predicting the speed

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and direction of medical progress has proved impossible, and it hasn't been much easier to predict how patients and the health-care industry will react to governmental fine-tuning. "It's policy wonks and politicians trying to pull levers that control things that they can't control," says Jonathan Skinner, a Dartmouth College health economist.

That's of more than passing importance as Congress moves toward making the biggest changes to Medicare in decades, a program that cost $253.7 billion last year, more than anyone imagined and bigger than the economy of Sweden. After years of partisan debate and false starts, the House and Senate last week each passed bills offering 40 million elderly and disabled Americans a prescription-drug benefit while trying to herd more of them into private-insurance plans.

Over the next several weeks or months, Congress must meld the two bills into a single plan to send to President Bush. Although different in significant respects, both bills rest on politicians' enduring confidence that patients and doctors, hospitals and insurers, pharmacies and drug makers will all respond predictably to a cleverly crafted subsidy here and a carefully specified requirement there. (Please see related story on page A2.)

Medicare today covers doctors, hospitals and many other forms of health care. But it has one big gap: funding outpatient prescription drugs, which were neither as potent nor as big a part of health care when Medicare benefits were crafted in the 1960s. The bills would offer the elderly government-subsidized drug insurance, either as an add-on provided by private insurers to the elderly who stick with traditional Medicare or integrated into coverage offered by private managed-care plans.

The underlying premise is that making government-run Medicare more like a private marketplace will save money and improve quality of care. Such transitions are always bumpy, as the deregulation of U.S. airlines demonstrated.

Among the most significant bets Con-

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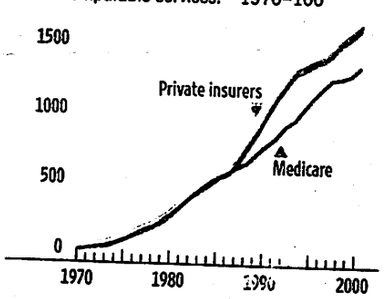
Comparing Costs

Cumulative growth in spending per enrollee for comparable services.* 1970=100



*Comparable services include hospitals, doctors, labs, medical equipment; excludes drugs which aren't routinely covered by Medicare.

Source: Urban Institute

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gress and President Bush are making are these:

- If the government shoulders enough risk, insurance companies or pharmaceutical-benefit managers who now run employers' drug plans will sell a product now unavailable: a stand-alone prescription-drug insurance policy for seniors who elect to remain in the traditional Medicare program. "It's 'Field of Dreams' public policy," quips Jonathan Oberlander, a University of North Carolina political scientist, recalling the mantra of a 1989 movie in which Kevin Costner builds a baseball field in an Iowa cornfield: "If you build it, they will come." The Senate bill calls for the government to provide drug coverage in regions where private companies won't; the House bill doesn't.
- If the government offers sufficient subsidies, private health plans will compete aggressively to lure the elderly away from the government-run, fee-for-service Medicare—even though the last major experiment with this is widely considered a flop. Bush administration actuaries predict more than 40% of the elderly would end up in private heath plans; the Congressional Budget Office says it's closer to 10%.
- If platoons of the elderly do enlist in these private plans—particularly preferred provider organizations, in which doctors and hospitals agree to discount fees—health care will be cheaper than in traditional Medicare. The administration says these organizations will cost less because they have financial incentives to be efficient. The Congressional Budget Office predicts preferred provider organizations will cost slightly more because the government effectively sets the prices traditional Medicare pays and because the government spends less on administration than any private insurer.
- If Congress writes the rules just right, employers will continue to provide drug insurance for many retired workers. If they don't, the elderly themselves or the government will have to pick up the tab. About one-third of the elderly have some employer-provided drug coverage. Under the House bill, the government would pay employers to continue this coverage; not so in the Senate bill.
- If the government provides a barebones prescription-drug benefit with lots of holes and complexity, elderly voters still will be grateful. Never mind that when Congress tried something like this in 1988, the elderly rebelled and the law was repealed before taking effect.

All these bets might pay off, but the history of American health care suggests otherwise. "As policy analysts and policy makers, we have an absolutely terrible record of prediction," says Mr. Oberlander, the University of North Carolina professor. "If you ask a researcher," he says, "the problem is that the politicians never listen. I don't think that's right. Researchers have far too much intellectual hubris."

The conventional wisdom on what's politically feasible is often wrong, too, as Republicans and Democrats showed this year by passing a prescription-drug bill so swiftly. "For years, neither side wanted to let the other side get credit for doing it," says Theodore Marmor, a Yale University political scientist. "Suddenly this year, each side fears being labeled the enemy for stopping it."

For all the "mis-prophecies," as Mr. Oberlander calls them, Medicare is hardly a failure. It allowed the elderly to get more health care, and they're much healthier as a result. Before Medicare, only about half the elderly had any health insurance. Many employers didn't cover retirees, and much of the available private insurance was lousy.

Before Medicare, one in five seniors hadn't seen a doctor in the previous two years; after Medicare, that figure was one in 12. Columbia University economist Frank Lichtenberg estimates that the typical older American spends about 13% fewer sick days in bed because of Medicare and that the program has increased the odds that a 65-year-old will make it to age 70 by about 13%.

But Medicare is a leading example of the law of unintended consequences. It's a living laboratory in which science moves in unpredictable spurts, government-created incentives often do much more or much less than expected, profit-minded entrepreneurs exploit unintended loopholes and costs squeezed out of one place pop up elsewhere.

Not all the surprises are unhappy ones. In 1972, Congress expanded Medicare to people of all ages with severe kidney disease so they could get life-extending dialysis. Early estimates were that as many as 10,000 new patients would enroll each year and that the total caseload would level off at about 35,000. Dialysis was considered unwise for many older people and for anyone with diabetes. All that changed in the years that followed: Today, 45% of new dialysis patients have diabetes and a quarter are older than 75. At last count, there were 80,000 new patients a year enrolling in this part of Medicare, and 345,000 total. "Perhaps no other federal government program can lay claim to have saved as many lives," Paul Eggers, a researcher at the National Institute of Diabetes and Digestive and Kidney Diseases, wrote in a history published in 2000.

Few other expansions of Medicare have been enacted since. Instead, the government has concentrated on tweaking payment formulas to slow the program's inexorably rising costs. Occasionally, it has succeeded: Medicare spending actually fell in 1999 after Congress tightened the screws in a 1997 deficit-reduction law.

But more often, government overestimated its ability to set the dials precisely and underestimated the willingness and ability of patients and, particularly, of health-care providers to adapt to changed rules to continue to get Medicare money.

In 1984, for instance, the government made a major change aimed at making hospitals more efficient: Medicare would no longer pay a share of hospital costs or a per-day fee, and instead began paying a fixed sum per admission based on about 500 diagnoses. Some clever hospitals and software-wielding consultants learned to game the system, classifying as many patients as possible as having particularly complex cases to get extra payments. Medicare, for instance, paid $2,000 more to cover a case of high-risk pneumonia than low-risk pneumonia. A 1993 government study of 17,000 cases found only 3.3% were classified as low-risk, far lower than medical evidence suggested was likely.

To a significant extent, though, the change had the desired effect. Hospitals pushed people out sooner. The average hospital stay for Medicare beneficiaries fell by 27% between 1988 and 1997.

But as so often happens in health care, savings in one part of the system were offset by increased spending elsewhere. Hospitals and others quickly realized they could profit by caring for those same patients at skilled-nursing facilities and rehabilitation wards where Medicare was still basing reimbursement on costs. Relatively generous payment formulas led businesses, including HealthSouth Corp., which the government has accused of fraudulent accounting, to open many such facilities in the early 1990s. The number of hospital-owned nursing homes and rehab units grew rapidly, and hospital profit margins rose in the mid-1990s to the highest levels in more than a decade, according to economist Joseph Newhouse of Harvard University.

At about the same time, Medicare payments for home health care zoomed. Initially, Medicare limited home health care to people who had been discharged from a hospital stay of at least three days. After Congress lifted these and other restrictions in 1980 and hospitals began discharging Medicare patients sooner, analysts anticipated an increase in home health spending. That didn't happen.

Then a 1989 court decision forced Medicare to loosen some rules. Spending soared even faster than Medicare bureaucrats had feared, climbing 33% annually in the years that followed. In 1989, home health care amounted to $1 of every $40 in Medicare spending; by 1996, it was $1 of every $11.

Looking back, the auditing arm of Congress, the General Accounting Office, attributed the early 1990s surge, in part, to a largely unanticipated transformation of "the nature of home health care from primarily post-hospital care to more long-term care for chronic conditions" and the eruption of new for-profit home-care agencies in a market previously dominated by government and nonprofit agencies.

For-profit agencies, the GAO said, "consistently provide more home health visits in all areas of the country than nonprofit agencies." Patients with diabetes, for instance, were visited an average of 53 times a year if served by a for-profit agency; those served by a nonprofit or government agency were seen half as often. That helped drive spending up until Congress limited home-health payments in 1997.

But congressional faith remains strong that competition in health care is still the answer to Medicare cost problems. The pending legislation is just the latest attempt to wean Medicare beneficiaries from traditional, fee-for-service health insurance, which also has been gradually disappearing from plans employers offer workers.

Medicare has been flirting for decades with varying strains of managed care. None of them have worked as well as proponents hoped. In words that sound as if they were written by today's White House, Richard Nixon proposed giving each Medicare beneficiary a choice between enrolling in a health-maintenance organization or continuing to get hospital and doctor care in the traditional manner. "We must promote diversity, choice and healthy competition in American medicine if we are to escape from the grip of spiraling costs," President Nixon's secretary of health, education and welfare, Robert Finch, declared in March 1970. Congress changed the law accordingly in 1972, but few HMOs signed up.

With great fanfare, Congress in 1997 created Medicare+Choice, tinkering with payment formulas to encourage the spread of managed-care plans, especially to rural areas. The Congressional Budget Office projected that a third of Medicare beneficiaries would be in managed care by 2005. But the government set fees too low, doctors and hospitals in some places refused to participate and many plans were unable to control costs better than traditional Medicare. Dozens of private plans pulled out of the program in the past few years. After peaking at 16% of the Medicare population in 1998 through 2000, Medicare+Choice enrollment began falling. It now stands at only 11%.