Modern Healthcare

50

MEDICARE AND MEDICAID THE NEXT HALF-CENTURY

KEY PEOPLE WHO SHAPED THE PROGRAMS

POLITICAL AND POLICY ISSUES

PAST AND PRESENT

FUTURE FINANCING AND REFORM CHALLENGES
Happy anniversary, Medicare and Medicaid

Americans are living longer, more productive lives because of Medicare and Medicaid, signed into law by President Lyndon Johnson a half-century ago. Case in point: The father of a colleague recently passed away after reaching his 101st birthday. He was vigorous to the end—even mustering the curiosity to ask his daughter to explain Twitter and Facebook. Medicare helped ensure his longevity.

Medicaid also has made its mark. It has transformed the lives of the disabled and chronically ill; whether the wheelchair-bound grandmother with congestive heart failure or the single mom whose asthmatic child might die without Medicaid coverage.

But how can the healthcare industry achieve better outcomes for the poor, disabled and chronically ill? Good health requires quality education, a clean environment and the stability that comes from well-paid, full-time jobs. How can the industry help create the context for good health and positive outcomes?

The CMS is looking for ways to improve the healthcare system’s performance. Its Health Care Innovation Awards offer more than $1 billion to healthcare organizations that reduce costs and improve outcomes for Medicare and Medicaid patients. My personal hope is that this spirit of innovation and entrepreneurship will continue to mobilize and motivate every key player—whether clinicians, executives, consumers, politicians, educators, community leaders or the media.

Modern Healthcare has documented every Medicare and Medicaid milestone and challenge since Crain Communications purchased the magazine from McGraw-Hill in 1976. This section commemorates the programs’ 50th anniversary by providing some history and an overview of their challenges. Working together in the years ahead, I am sure we can rise to those challenges and realize the full potential of Medicare and Medicaid.

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Demands of an aging population will have Medicare and Medicaid fighting for dollars

By Merrill Goozner

From modest beginnings a half-century ago, Medicare and Medicaid grew and evolved in dramatically different ways. Medicare, which provides healthcare coverage for the nation’s seniors, became the third rail of American politics. Liberal politicians never proposed tampering with the program except to call for expanded benefits. Conservative politicians and think tanks with the temerity to suggest major structural changes, either to save money or limit financial support, invariably suggested a start date at least a decade away.

Medicaid, on the other hand, existed in a political netherworld. Because it was a state-based program that provided healthcare coverage for the poor, financial support was grudging and its payments to providers were woefully inadequate.

Moreover, Medicaid’s beneficiaries were largely politically invisible. Its supporters had little voice in day-to-day politics. Some labeled the program a burden on the nation’s hardworking, taxpaying public.

All that is about to change. Medicare over the next few decades will become a lot more like Medicaid.

The senior citizen healthcare program already has lost its untouchable status. It’s become the go-to source for funding everything from free-trade agreements to faster drug approvals.

Looking ahead, the demographic and fiscal realities facing the nation are such that Medicare will inevitably become a politically charged program whose underlying financing demands will be routinely scrutinized by the working-age, taxpaying public and the politicians who represent them.

**GEN XERS AND MILLENNIALS VS. BABY BOOMERS**

It’s not that Gen Xers and millennials are more likely to throw granny under the bus than the 77 million baby boomers born between 1946 and 1964, who are now entering retirement at a rate of 10,000 a day. Millennials, who were born between 1981 and 1997, tend to be politically more liberal than either of the two previous generations.

But, like the smaller and politically more conservative Gen X cohort just ahead of them, millennials are less likely to believe social programs like Medicare and Social Security will be there for them when they retire. That makes young adults more open to political messages that suggest major changes to those programs will be necessary to keep them available for future generations.

Whether changes are required—and whether those changes need to be dramatic—are questions that will be hotly debated in Washington over the next few decades as boomers move through their retirement years. We’re already seeing it in the nascent 2016 political campaign, where many of the candidates vying for the Republican nomination are willing to endorse changes like more extensive means-testing for wealthier seniors and turning Medicare into a defined-contribution program.

Many Democrats, no doubt, will continue to use the “Mediscare” tactics that have served them well in the past. But it’s doubtful they will be able to maintain the current Medicare program without at least some changes to its financing and benefit structure.

**OUR DEMOGRAPHIC DESTINY**

Raming the entire debate will be the underlying demographics. The long-expected graying of America is arriving right on schedule.

When Medicare was created a half-century ago, there were nine people in the under-65 population for every person drawing benefits from the new program, which was far less generous and far less effective than Medicare today. The average life expectancy then was 74.

Today, there are about five people for every adult in his or her retirement years. Beneficiaries enjoy a prescription drug benefit, access to artificial knee and hip surgery, and life-saving cardiovascular interventions that were undreamed of a half-century ago. The life expectancy of someone turning 65 today is 82, with the hope to extend life even further if the promise of genomic medicine, especially in fighting cancer, is realized.

To pay for these miracles over the next five decades, there will be relatively smaller working-age and youth populations, eventually reaching just 3½ people under 65 for every...
THE GRAY WAVE

Baby boomers—we’ve been hearing about them for over half a century
Now, they are turning 65—the age of Medicare eligibility—at a rate of 10,000 a day. How to finance the
baby boom’s healthcare expenses will dominate government fiscal discussions for at least the next two decades.

Medicare beneficiaries’ share of the total population will grow from 1 in 6
today to 1 in 4 by 2065; future retirees will have only two full-time workers supporting them,
compared with three today.

As the relative share of beneficiaries in the population grows, so will the share of overall
healthcare expenditures picked up by government. The CMS projects Medicare’s
share of the overall economy will nearly double over the next 50 years.

Projected Medicare expenses as a share of GDP (percentage)

2015 2025 2035 2045 2055 2065
3.32% 4.32% 5.22% 5.58% 5.75% 5.98%

Medicare beneficiaries will be competing with the poor
for tax dollars. Today we spend $1 trillion (or nearly 5% of the
economy) on both Medicare and Medicaid. Spending on those programs
will grow to 8% of the economy in the next quarter-century.

The good news is that Medicare cost per enrollee has slowed sharply in recent years

The projections are based on a
resumption of growth faster than the
rest of the economy. Keeping those
costs in check would make financing
Medicare much more affordable.

Source: Medicare board of trustees

Medicare cost per enrollee

2000 2005 2010 2013
$5,844 $12,210

The recent slowdown in spending . . .

Historical data
Average annual
cost per enrollee

2014 2016 2018 2020 2023
$12,243 $17,364

. . . will it last?

Current estimates
Medicare beneficiary. Demographers at the U.S. Census Bureau project average life expectancy will reach 85 in 2035 and 87 by 2060.

They also warn about the growing “dependency” ratio—which has huge implications for Medicaid funding. The relative number of children under age 18 will fall only slightly over the next half-century. Working-age adults will constitute just 57% of the population by 2060, down from 63% in 2012. They will be supporting an over-65 population that grew from 14% to 22% of the total, and a youth population that fell from 24% to 21% over that half-century.

Moreover, many more of America’s children will need public assistance given current economic trends. Already, over a third of the nation’s kids get their healthcare through Medicaid because of poverty and growing income inequality. That share is expected to reach 44% within a few decades.

When you factor in poor seniors needing nursing home assistance, which also comes out of Medicaid budgets, it adds up to well over half the government spending estimates all federal spending on Medicare and Medicaid expenses will reach 6.1% of GDP in 2035, up from 5.1% today. To reach that level of spending without adding to the deficit or crowding out other programs, the government tax take would have to grow at least 1 percentage point from current levels of around 18% of GDP. Over the next five decades, given the shifting demographics, government support for healthcare will require tax levels of anywhere from 21% to 23% of GDP. While not unprecedented, that is definitely higher than what most Americans are usually willing to vote for.

“More people living out their full lives is something we should celebrate and be willing to devote more of society’s resources to support,” said Stuart Guterman, vice president of Medicare and cost control at the Commonwealth Fund. It’s a sentiment typical of most people on the left side of the political spectrum.

To hold the required tax increases to a minimum, those in the more liberal camp are banking on the success of value-based healthcare payment and delivery reforms begun under the ACA. They also are calling for a single financing mechanism that combines Medicare’s hospital, physician and drug benefits (Parts A, B and D), which would make traditional Medicare more like private Medicare Advantage plans—a public option, if you will. Medicare Advantage plans have already captured nearly a third of the senior market and have proved popular with younger, healthier beneficiaries like the baby boomers who will be entering the system over the next two decades.

But for those on the political right, the tax-and-spend implications of the looming demographic realities are fueling their desire to make more sweeping changes in the financing and delivery system.

Distilled to their essence, their Medicare premium-support proposal would define an essential set of benefits for Medicare beneficiaries, provide a fixed amount to help purchase plans that include those benefits, and allow seniors who can afford it to purchase additional coverage on their own.

“Medicare reforms based on the principle of defined contribution can provide the financial work needed to slow program spending while preserving beneficiaries’ access to high-quality services and promoting continued medical innovation,” Joseph Antos of the American Enterprise Institute wrote.

THE STAKES FOR THE DELIVERY SYSTEM

The good news is that the recent slowdown in healthcare spending growth has created more breathing room before existing taxpayer sources become strained. Medicare and Medicaid projections for 2023 are now $1 trillion below where they were before the recent Great Recession and passage of the Affordable Care Act. Whether the economic downshift or delivery system changes account for the slowdown remains hotly debated.

But for the future of Medicare and Medicaid, only one thing matters. Will that cost slowdown continue?

CMS actuaries think not. They reported last year that government spending on Medicare (not including seniors’ out-of-pocket expenses) consumed 3.5% of the nation’s gross domestic product. By 2035 they expect that to grow to 5.4%. Medicaid—which both the federal and state shares—consumed 2.9% of GDP last year, and by 2023 is expected to grow to 3.4%, according to the Congressional Budget Office.

The CBO’s most recent budgetary update on government spending estimates all federal healthcare expenses will reach 6.1% of GDP in 2025, up from 5.1% today. To reach that level of spending without adding to the deficit or crowding out other programs, the government tax take would have to grow at least 1 percentage point from current levels of around 18% of GDP. Over the next five decades, given the shifting demographics, government support for healthcare will require tax levels of anywhere from 21% to 23% of GDP. While not unprecedented, that is definitely higher than what most Americans are usually willing to vote for.

“To the extent that we can bring the growth of healthcare spending under control overall, we will simultaneously improve the prospects of the Medicare trust fund, reduce the burdens that healthcare spending imposes on taxpayers and solve our long-term budget challenges,” Henry Aaron, Brookings Institution

People say traditional Medicare and Medicaid are broken. But people from Europe say the U.S. system is broken when, if you lose your job, you also lose your family’s health insurance.

The stakes in this debate for hospitals, physicians and the other providers who care for seniors and the poor couldn’t be higher. If the essential benefit package isn’t generous enough, who will pay for the care of those who can’t afford, but are equally deserving of, lifesaving treatments? If taxpayers balk at paying the higher level of taxation needed to finance healthcare programs, how will quality of care and access be maintained?

The CMS’ increasingly aggressive embrace of value-based payment programs is a gamble that physicians, hospitals and the broad array of ambulatory and post-acute-care providers can be weaned from the fee-for-service system that fueled their spectacular growth over the past half-century. The early experiments provide hope that such approaches can succeed, but they are hardly definitive.

The healthcare system has only begun to scratch the surface of eliminating wasteful or unnecessary care. Redefining end-of-life care in ways acceptable to older Americans, their families and society is a work in progress.
**MEDICAID: Caring for the Most Vulnerable**

Medicaid—state-run programs half financed by the federal government—didn’t reach every state until 1982. In 2013, the 50 state programs spent $438 billion providing services to nearly 70 million low-income Americans. For most state governments, it represents their second largest budget item—just behind education.

The nation is heading toward half its children being covered by Medicaid. The program’s 68 million beneficiaries in 2011 included 10 million developmentally and physically disabled children and adults. About 6 million Medicare beneficiaries are so poor they also qualify for Medicaid, which pays for nursing home care.

Despite many states turning their programs over to managed-care companies, forecasters still project problems with rising Medicaid expenditures in the years ahead.

The growth in Medicaid enrollment, after a sharp increase in this decade due to the Affordable Care Act, is projected to slow as we approach the 2020s.

The expansion had only a small impact on the long-term projections for Medicaid spending.

Despite many states turning their programs over to managed-care companies, forecasters still project problems with rising Medicaid expenditures in the years ahead.

“We need further steps to make the program sustainable,” said Dr. Mark McClellan, a former CMS administrator under the George W. Bush administration who is now at the Brookings Institution.

Ultimately, a system that is fiscally sustainable will need to deliver high-quality care within a fixed budget that grows no faster than the rest of the economy. Maryland is experimenting with such a model. Suppliers like the drug and device companies that set prices without regard to total healthcare spending will have to adapt.

Whether managed by insurance companies, provider-led accountable care organizations or a government program, care delivery systems under capped financing will begin to resemble those found in Western Europe and Canada (though not like the United Kingdom, where the National Health Service is government-run). The recent budget battles and resulting sequester cuts that slapped limits on Medicare funding are only the start of a decades-long war over how to finance healthcare during the baby boomers’ retirement years.

So here, finally, is where the new buzzwords like value-based reimbursement and population health management come into play. Changing payment policy to make the healthcare system deliver higher-quality, less wasteful and more cost-effective care is the least painful path to a financially sustainable future.

May 25, 2015 | Modern Healthcare 19
Will Medicare and Medicaid predict ACA’s future?

By Harris Meyer

While politicians debate the future of Medicare and Medicaid, few question that those programs are here to stay. It’s easy to forget how controversial the idea of government healthcare programs was for most of the 20th century, and how many decades it took to enact the programs.

Supporters of the Affordable Care Act, which arrived in a more polarized era, hope it will eventually receive similar public acceptance. The history of Medicare and Medicaid offers some reasons to think the ACA will become a fixture of the healthcare landscape—and some to think it won’t.

Starting with Theodore Roosevelt in 1912, political progressives, labor union activists and social reformers pushed for a national health insurance system. But after President Harry Truman’s 1948 bid for a universal, single-payer plan failed because of opposition from conservatives and organized medicine, supporters focused on expanding coverage for the elderly. They hoped to build on those gains to expand coverage to the rest of the population—never dreaming that their quest would continue well into the 21st century.

For Medicare proponents, starting with coverage for the elderly seemed like smart politics. “Everyone has parents,” noted Dr. David Blumenthal, president of the Commonwealth Fund, who has written about the history of Medicare and Medicaid. Seniors are widely seen as a “morally worthy” population, said Theda Skocpol, a Harvard University government professor who has written about healthcare reform.

Insuring the poor was an afterthought for President Lyndon Johnson, who focused on creating Medicare following the Democrats’ landslide election victory in 1964. Indeed, Rep. Wilbur Mills (D-Ark.), the House Ways & Means chairman who led the bill’s drafting, included Medicaid coverage for the poor at least partly as a way to blunt future pressure to expand coverage to everyone, which he opposed. When Johnson signed the Medicare and Medicaid legislation on July 30, 1965, he did not mention Medicaid by name, noted Theodore Marmor, a Yale University professor emeritus of public policy.

The political circumstances surrounding passage of the law and the ACA have many similarities. In both cases, a Democratic presidential candidate had campaigned on expanding healthcare and won a big election victory. Each candidate had campaigned on expanding healthcare and won a big election victory. Each

Congressional leaders also played strong roles.

Both President Johnson and President Barack Obama learned from their predecessors’ failed healthcare reform attempts. Liberals made major compromises to win passage. Both efforts avoided strict cost controls to avoid stirring up healthcare industry opposition.

But there also were important differences. Unlike the ACA’s coverage expansions, there was some GOP support in 1965 for extending coverage to seniors and the poor. Medicare built on the immensely popular Social Security program, and was available to everyone regardless of income.

In 1965, there was still broad public support for government social programs. Labor unions were far more powerful than they are today. By 2009, opposition to government healthcare programs had become much more central to the GOP, which had grown more ideologically conservative, Skocpol said.

For modern-day Republicans, the success of government-led healthcare reform threatens to undermine their core political message. In 1993, GOP strategist William Kristol famously warned that if President Bill Clinton won passage of his healthcare reform legislation, “its success would signal a rebirth of centralized welfare-state policy … and strike a punishing blow against Republican claims to defend the middle class by restraining government.”

“Republicans understand the long-term political stakes better than Democrats,” Skocpol said. “That’s why they have fought the ACA tooth and nail.”

One lesson Obama and fellow Democrats failed to learn from Johnson was the importance of getting the program off to a strong, fast start. That Obamacare weakness gave opponents ammunition Medicare’s foes never had. Medicare enrolled nearly all seniors within a year of the program’s creation and quickly became popular. In contrast, it was four years before the ACA’s coverage expansion took full effect, and the launch was rocky.

Nevertheless, observers agree that it’s hard to take back government benefits that millions of Americans have come to appreciate and that also help powerful healthcare industry groups. That’s what ACA supporters are counting on to give the law the same staying power as Medicare and Medicaid. “Congress doesn’t take things away from people,” Blumenthal said.
The people who built the programs

**THE PIONEERS**

HARRY S. TRUMAN was the first president to propose a national health insurance program, in 1945. **PRESIDENT LYNDON B. JOHNSON** credited Truman’s proposal as a big help in getting Medicare and Medicaid passed in 1965 and held the signing ceremony at Truman’s presidential library, presenting Truman with the very first Medicare card.

**SEN. ROBERT KERR** (D-Okla.) co-authored the Kerr-Mills Act which passed in 1960, which provided federal funding to states to cover medical costs for low-income seniors. It served as a model for Medicaid.

**SENS. TED KENNEDY** (D-Mass.) and **ORRIN HATCH** (R-Utah) in 1997 spearheaded creation of the Children’s Health Insurance Program, which built on Medicaid to expand children’s coverage.

**PRESIDENT JOHN F. KENNEDY** proposed universal health insurance for Americans 65 and older during the 1960 presidential campaign.

**U.S. REP. AIME FORAND** (D-R.I.), shown with Kennedy at left, introduced a bill in 1957 providing public coverage for seniors. The proposal is seen as a forerunner to Medicare.

**PRESIDENT BILL CLINTON** signed the bill.

**THE OPPONENTS**

**DR. EDWARD ANNIS**, president of the American Medical Association, led its opposition to Kennedy’s proposal for a public insurance program for seniors.

**RONALD REAGAN**, then a private citizen, was a prominent AMA spokesman in the early 1960s opposing a national health program for seniors.

**THE STRATEGISTS**

**ROBERT BALL**, commissioner of the Social Security Administration from 1962 to 1973, helped craft the political strategy for passing Medicare and Medicaid legislation and later was key in administering Medicare.

**WILBUR COHEN**, secretary of Health, Education and Welfare, was a key figure with Mills in crafting Medicare and Medicaid legislation and shaping the strategy to get it passed.

After Kennedy’s assassination in 1963, **PRESIDENT JOHNSON** took up the cause and pushed through passage of Medicare and Medicaid, signing the bill on July 30, 1965.

**THE LEGISLATORS**

**REP. CECIL KING** (D-Calif.) introduced a bill in 1961 and again in 1965 that provided a model for Medicare.

**REP. JOHN BYRNE** (R-Wis.) in 1965 drafted an alternative to Johnson’s Medicare bill to make coverage for physician services voluntary; it was incorporated into the final legislation as Medicare Part B.

**REP. WILBUR MILLS** (D-Ark.), chairman of the House Ways and Means Committee, above, led the complex political efforts to craft the Medicare and Medicaid compromise legislation in 1965 after opposing national health insurance for years.

**AP PHOTOS**
JOSEPH CALIFANO JR. helped launch Medicare and Medicaid as President Johnson's chief domestic policy aide from 1965 to 1969. Later, as Health, Education and Welfare secretary under President Jimmy Carter, he consolidated oversight of the two programs under the new Health Care Financing Administration (which became the CMS in 2001).

ROBERT FETTER and JOHN THOMPSON of Yale University, starting in 1967, developed the diagnosis-related group system, classifying medical conditions and treatments into bundled categories. It was used for the Medicare prospective payment system implemented in 1983.

PRESIDENT RICHARD NIXON signed legislation in 1972 extending Medicare to people receiving Social Security disability payments and to people under age 65 with end-stage renal disease.

PRESIDENT RONALD REAGAN signed legislation setting per-diem limits on Medicare hospital payments, paving the way for DRGs.

WILLIAM HSAIO of Harvard University published studies of resource-based relative values for medical services that were used in developing Medicare’s reformed physician payment system implemented in 1992.

CAROLYN DAVIS, HCFA administrator from 1981 to 1985, led the rollout of the hospital prospective payment system.

BRUCE VLADÉCK, HCFA administrator from 1993 to 1997, oversaw the introduction of Medicaid’s Section 1115 waiver program, expansion of the prospective payment system, and early experimentation with Medicare HMOs.

REPUBLICAN HOUSE SPEAKER John Boehner (R-Ohio) and DEMOCRATIC HOUSE MINORITY LEADER Nancy Pelosi (D-Calif.) crafted legislation in 2015 that reformed Medicare physician payment to move to a system of value-based payment.

PRESIDENT GEORGE W. BUSH championed and signed into law in 2003 the Medicare Part D prescription drug benefit program.

TOM SCULLY, CMS administrator under President Bush, helped design and implement the Medicare Part D program.

REP. HENRY WAXMAN (D-Calif.) was a major architect of Medicaid expansion from the mid-1980s through the passage of the Affordable Care Act in 2010.

PRESIDENT BARACK OBAMA advocated for and signed the Affordable Care Act in 2010, which expanded Medicare benefits; extended Medicaid to low-income adults; cut Medicare spending; and established the CMS Innovation Center to test reforms to improve quality and reduce costs.

DR. DON BERWICK, acting CMS administrator from 2010 to 2011, oversaw the beginnings of the CMS Innovation Center and its many demonstration programs, including Medicare accountable care organizations.

KATHLEEN SEBELIUS, HHS secretary from 2009 to 2014, and MARILYN Tavenner, CMS administrator from 2011 to 2015, supervised implementation and administration of the ACA’s Medicare and Medicaid benefit expansions and changes.

For more information, contact MARY ANN HOLT, RN, MSN, Partner at 610-659-9530

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Uncapped programs fuel vast expansion of healthcare sector

By Steven Ross Johnson

Since their birth in 1965, Medicare and Medicaid have significantly influenced the size and shape of U.S. healthcare. The public insurance programs, initially blasted by critics as “socialized medicine,” have precipitated the vast expansion—and even the creation—of many profitable industry sectors including hospitals, physician groups, managed-care insurers, home health, drug manufacturers, device makers and others.

One big reason the two programs powerfully seeded healthcare expansion is that political forces—ideologically and economically motivated—blocked the government from establishing effective cost controls. That meant taxpayers essentially wrote providers, insurers, suppliers and beneficiaries a blank check. This quieted initial opposition to the establishment of Medicare and Medicaid by making the programs profitable for private-market players.

But the lack of cost controls, such as the global budgets used in other advanced countries, has created long-term financial headaches.

The two programs initially paid providers based on usual and customary fees. That led to “the vast enrichment” of providers, particularly physician specialists, Paul Starr, a Princeton University healthcare historian, wrote. The programs later moved to prospective payment models, but providers made up for that by boosting the volume of services for which they billed.

Over time, Congress has expanded Medicare and Medicaid to cover more services and products, including home healthcare, kidney dialysis, skilled nursing, rehabilitation, hospice, preventive services, and most recently, prescription drugs. That has led to a sharp rise in the number of for-profit providers. “You have this huge Medicare thing that is like a big barrel with money that flows out,” said Uwe Reinhardt, a Princeton University health economist. “It has all of these spigots—a hospital spigot, a physician spigot, etc. Every so often, a new spigot gets put into the barrel.”

That’s what happened with home healthcare, which at one time was dominated by not-for-profit providers. In 1980, Congress lifted the prohibition on Medicare participation by for-profit home-care providers. What followed was an increase in Medicare spending on home health, which grew about 31% a year from 1988 to 1996, according to market research firm Launch Factory.

Similarly, the dialysis industry took off after Congress expanded Medicare to cover people with end-stage renal disease in 1972. By 2012, Medicare was covering dialysis for about 370,000 ESRD patients receiving treatment at more than 5,800 facilities, at a cost of $10.7 billion.

Skilled-nursing facilities saw steady growth through the 1980s and 1990s as SNF providers received Medicare payments under a cost-based system that put no limits on how much providers could charge for occupational and physical therapists. Critics said that payment model led to abuse, with Medicare spending on SNFs averaging 30% annual growth between 1986 and 1998, according to a 2004 study in Health Services Research. Congress moved SNFs to a prospective payment model in 1997, resulting in estimated savings to Medicare of $3.4 billion in 1999. That year, nearly 10% of SNF facilities filed for bankruptcy.

Reinhardt said a rhythm has developed in the way a Medicare or Medicaid policy change first leads to rapid growth in a sleepy industry sector previously dominated by small operators. Companies rush in under the new, more favorable rules. After federal costs shoot up, Congress or HHS wakes up and tightens the rules. That’s typically followed by an economic decline in that industry sector.

“Usually, after three of four years, as the cash flow through that spigot grows bigger and bigger, eventually Congress takes control of the spigot,” Reinhardt said.

Now there’s growing momentum to completely shift Medicare and Medicaid to a model in which the government pays private health plans a fixed monthly fee per beneficiary to manage patients’ care, establishes patient-outcome targets and lets the plans regulate provider behavior. Advocates hope that approach will end the cat-and-mouse game between the government and healthcare players. “You would get much better performance for taxpayers and much better performance for the programs,” said Tom Scully, CMS administrator under President George W. Bush, who is now a partner at private-equity firm Welsh, Carson, Anderson & Stowe.

But other experts warn that wholesale shift would merely change the identity of the cat and the mouse, not end the game. The danger is that private plans would “compete to enroll the healthy and avoid the sick,” leading to either higher costs or less access to care for chronically ill people, said Judy Feder, a professor of public policy at Georgetown University.
Celebrating programs that protect us from healthcare risks

By Judy Feder

The 50th anniversary of Medicare and Medicaid enactment calls for a celebration. Medicare provides health insurance protection to virtually all older Americans and many workers who become disabled. Medicaid is the nation’s invaluable long-term-care safety net, helping anyone who can’t afford services and support. Under the Affordable Care Act, states can rely on Medicaid to make healthcare available to all low-income Americans.

So what’s not to celebrate? To those philosophically opposed to government, program expenditures are fiscally daunting. But that spending growth now and for the foreseeable future is extraordinarily low, largely driven by growth in their eligible populations.

Critics propose to reduce government’s role and spending by radically restructuring both programs. They would replace Medicare’s public insurance with vouchers to buy private plans. They would replace federal Medicaid funding grants that match state spending with fixed-dollar block grants. Both “reforms” would shift healthcare and cost risks from taxpayers to beneficiaries.

Traditional Medicare has enormous clout in pricing services. And it avoids the risk selection that occurs when multiple private insurers compete to enroll the healthy and avoid the sick. Even in the regulated Medicare Advantage market, health plans benefit financially from serving less costly patients, and chronically ill patients report problems with access to and quality of care. With vouchers and less regulation, sicker patients would pay more or receive less care. Over time, all beneficiaries would bear the risk if voucher amounts failed to keep pace with healthcare costs.

Medicaid block grants would shift risks first to states, then to beneficiaries. Proponents say freeing states from federal rules would lead to efficiencies and savings. But recessions happen and health costs rise. With block grants, that risk would shift to the states. Then they would limit eligibility and benefits, and beneficiaries would bear the brunt.

Changes could be made in Medicare and Medicaid to better protect us—including a Medicare cap on out-of-pocket spending. Medicaid expansion in all states, better long-term-care protection, and better management of costs and overpayments. But that means managing the risk, not shifting it. That’s what government is supposed to do.

Judy Feder is a professor of public policy at Georgetown University who served as an HHS official during the Clinton administration.

Defined-contribution model would improve care

By Douglas Holtz-Eakin

Modernizing Medicare and Medicaid should be the highest domestic policy priority. These programs have an obligation to provide high-quality care to America’s seniors and low-income beneficiaries, and they must be made financially sustainable.

The first priority is to improve the quality of care. It is now widely recognized that fee-for-service medicine promotes the inappropriate use of services. Both programs should be moved away from siloed payments to providers and toward coordinated care that incorporates prevention and rewards quality outcomes.

For Medicare, that means building on the success of the Medicare Advantage program and improving its associated star-rating program for health plans. In Medicaid, it means greater reliance on managed care in the near term, and, ultimately, a move to portable private coverage enabling beneficiaries to keep the same plan and provider network as their circumstances change.

Ultimately, Medicare must be configured to take advantage of private market innovation, delivering a mix of medical and long-term-care services in the most cost-effective setting. By moving long-term care into Medicare, states will be relieved of the budgetary burden of nursing home coverage. Then Medicare can integrate the delivery of these services.

The second priority is to make the two programs financially sustainable. Medicare and Medicaid spending already accounts for over a quarter of total federal spending, and that will reach 30% in the next 10 years.

In both programs, increasing amounts of general revenue must be used to cover these commitments. Taking advantage of market-driven efficiencies can control excess spending and, ultimately, permit these entitlement programs to be transformed into defined-contribution models.

The scale of Medicare and Medicaid make them the most powerful force for U.S. delivery-system reform. Unlike top-down regulatory models such as the Affordable Care Act, the use of bidding, decentralized coordinated-care plans and other competitive features permit success and failure on small scales to identify the most advantageous routes to the future.

Douglas Holtz-Eakin is president of the American Action Forum. He previously served as director of the Congressional Budget Office and chief economist of the President’s Council of Economic Advisers under George W. Bush.
By Virgil Dickson

Before Medicaid was established, low-income Americans had limited access to healthcare, relying heavily on charity care and public hospitals. What access they had came through a patchwork of community and religious organizations targeting the “deserving poor,” defined as sick or disabled children, pregnant women, infants, the blind and the elderly. If an “able-bodied” person needed healthcare, however, they generally were out of luck.

“Before (Medicaid), to be old and poor and sick was to suffer and to die prematurely,” said Trish Riley, executive director of the National Academy for State Health Policy.

The healthcare situation for low-income and disabled Americans improved significantly when President Lyndon Johnson signed legislation establishing Medicaid in 1965. Under the law, the federal government gave states matching funds for every dollar spent on the program. State participation was optional, and it wasn’t until 1972 that every state except Arizona had a Medicaid program. Arizona finally implemented Medicaid in 1982.

From the mid-1960s to the early 1990s, Congress incrementally expanded Medicaid eligibility. Lawmakers severed the link between Medicaid and welfare. By the start of the 1990s, all pregnant women, infants and children under age 6 who had family incomes below 133% of the federal poverty level had to be covered by the states. In 1997, Congress approved a separate program, the Children’s Health Insurance Program, to expand coverage to children 18 years of age and younger in families with incomes up to 200% of poverty.

Medicaid enrollment reached nearly 40 million by 1993, and there was a push from Washington to find ways to reduce program spending. States began to take advantage of demonstration waivers allowed under Section 1115 of the Social Security Act and shift parts of their Medicaid populations from fee-for-service to managed care. By 1995, roughly one-third of Medicaid recipients, or 11.6 million, were enrolled in managed-care plans, which were designed to cut costs and improve care.

While millions of people got healthcare coverage through Medicaid, up to that point millions of other low-income Americans—mostly non-disabled adults without dependent children—still found themselves with no affordable coverage options. Some states attempted to serve this population through waivers and state programs. Then, in 2010, the Affordable Care Act required states to expand Medicaid to all adults who were U.S. citizens or legal residents with incomes up to 138% of poverty, with an initial 100% federal contribution, eventually phasing down to 90%. There were about 17.1 million uninsured adults in that income range when the law passed, making up 37% of all uninsured Americans.

In 2012, the U.S. Supreme Court ruled that the federal government could not force states to expand Medicaid under the threat of losing all their federal Medicaid funding, making expansion optional. As of May 2015, 29 states and the District of Columbia had voluntarily adopted Medicaid expansion. A number of states with Republican governors or legislatures, including Arkansas, Iowa, Indiana and Michigan, have received Obama administration approval to implement their expansions with conservative-friendly features such as premium contributions from beneficiaries and reliance on private health plans. In the wake of the ACA expansion, the Medicaid program now provides coverage to nearly 70 million low-income and disabled Americans. For the rest of the Obama administration at least, there will be a continued push from the federal government to persuade the 21 holdout states to expand Medicaid. It’s estimated that 4 million more low-income adults could gain coverage if those states expanded their programs. Nearly 2 million of those people are in Florida and Texas. It’s likely that future state expansions will incorporate conservative principles of personal responsibility, which experts say will reduce the number of people covered.

But if Republicans win the White House and hold Congress in the 2016 elections, they are likely to push for eliminating Medicaid expansion, cutting Medicaid spending and giving states greater state flexibility in the program.

One area of bipartisan agreement, however, centers on the need for reform in Medicaid’s coverage policies for elderly and disabled people who need long-term-care services. There is broad support for shifting more care from institutional settings to home- and community-based settings. Medicaid currently pays for about two-thirds of all long-term nursing home residents’ care.

That shift is underway. “We are moving toward serving people based on the best way to serve them as opposed to saying, ‘If you need long-term care, you go into a nursing home,’” said Cindy Mann, who until recently served as the CMS’ Medicaid director and is now a partner at the law firm of Manatt, Phelps & Phillips. By the end of 2015, she said, 50% of Medicaid spending on long-term care will go toward community-based care.