

Following the passage of the Medicare Modernization Act (MMA) of 2003, the future of Medicare is less clear than at any time since its inception almost 40 years ago. Medicare policy regarding financing coverage and delivery mechanisms has been the object of intermittently fierce political debate and maneuvering since 1995 when a conservative Republican majority gained control of Congress and ended the political consensus that had guided Medicare policy for three decades. This consensus had supported Medicare as a single payer healthcare system—for most Americans aged 65 and older, persons with disabilities and end-stage renal disease—funded by the federal payroll tax and general revenues, as well as by beneficiary premiums and co-payments.

A new Republican Congressional majority in 1995 quickly challenged the Medicare policy consensus by pushing for large reductions in Medicare funding and incorporating market mechanisms designed to reduce costs by creating more competition among insurance plans and providers. These efforts eventually produced some relatively small reductions in projected Medicare spending and one major initiative, the Medicare+Choice program, to expand the role of managed care in Medicare. The results of the Medicare+Choice program, however, disappointed its backers as the percentage of beneficiaries who chose managed care reached a peak of only 15% in 1999 and then declined to 11% in 2003.

The fundamental character of Medicare has remained largely unchanged, even in the absence of a political consensus and continuing efforts, joined by the Bush Administration after 2001, to contain its growth and increase the role of the private sector through greater participation of managed care organizations. The recently passed MMA, however, contains several provisions that could dramatically change the Medicare program if fully implemented by substantially privatizing the program while adding a major new prescription drug benefit and increasing projected program costs by about $550 billion over 10 years. These provisions raise the stakes in the already hotly contested debate about the future of Medicare and insure its great saliency as a divisive political issue for years to come.

The Political Life of Medicare, by Jonathan Oberlander, is an insightful historical analysis of the politics of Medicare and a useful guide to understanding how events of the last 10 years led up to the struggle over the prescription drug bill and a return to the same kind of ideological confrontation from which Medicare emerged in the mid-1960s. Redesigning the Medicare Contract: Politics, Markets, and Agency, by Edward F. Lawlor, also includes a review of the politics and history of Medicare, though briefer and less detailed than Oberlander’s. Lawlor thinks Medicare can be made more efficient and achieve better healthcare outcomes by clarifying and strengthening Congress’ policy making role and the Centers for Medicare and Medicaid Services’ (CMS) administrative capacities, and by empowering Medicare beneficiaries.

Redesigning Medicare

The coherence and rationality of Lawlor’s proposals stand in stark contrast to the complicated, logic-challenged content of the MMA. It is just this glaring gap between Lawlor’s sensible ideas and the trajectory of Medicare politics and policy that will probably keep his proposals, which many policy analysts would support, from being seriously considered any time soon. His proposals would have been more consistent with the policy consensus of the pre-1995 period than the sharp partisanship of the present and foreseeable future.

Lawlor applies his concept of enhanced principal agent to what he considers to be the major Medicare realities in an effort to make the case for stronger contracting and regionalization within a Medicare program based on a well-defined purchasing model. The first reality he addresses is that Medicare is “big and complex,” requiring clear lines of responsibility and accountability, beginning with Congress. Lawlor thinks that Congress should establish the mission and goals of Medicare, funding levels, and major parameters such as eligibility criteria, benefits, and reimburse-
ment policy and not micro-manage program administration. In order to perform this policy role effectively and provide informed oversight of the program, Congress needs more analytical capacity including budget information, the results of health services and evaluation research, and routine information on Medicare beneficiaries, services, costs, and outcomes. The same could also be said for the analytical needs of CMS, which Lawlor argues is a substantially under-administered agency with only 49 senior-level executives to administer the largest healthcare program in the United States.

Lawlor’s second proposal is designed to help prevent administrative interference and clarify lines of responsibility by strengthening the administrative agency for Medicare. He would achieve this by carving Medicare out of CMS and making it a separate agency in CMS with the expectation that it would be given the authority and resources required to become a more aggressive purchaser and effective manager of health services.

This new agency with enhanced purchasing capacity would be in a better position to respond to the realities of geographic variations in healthcare needs, markets, and histories by creating regional administrative units equipped to carry out the purchasing agenda in a manner responsive to regional needs and opportunities. These new regional units would have more autonomy, responsibility, power, and resources than the current CMS regional offices. These regional Medicare sponsors could be existing nonprofit entities or new organizations selected through competitive bidding. They would have the authority to administer regional budgets, administer contracts let through competitive bidding, and coordinate coverage and delivery of services with public (Medicaid) and private (employer group) entities. The regional units would cover about one million Medicare beneficiaries each for a total of 40 or more units. Regional units covering substantially more than one million beneficiaries would be problematic in that they would begin to overlap healthcare markets and lose their regional distinctiveness.

I can see the advantages of Lawlor’s regionalization approach; but, as Lawlor anticipates, critics may be concerned about proliferating bureaucracy, fragmentation of authority, loss of policy uniformity, and the emergence of independent political agendas among regional units protected by Congressional delegations. For Lawlor, however, these risks are worth the effort to enhance Medicare’s administrative efficacy by creating regional capacities that would make Medicare a more efficacious purchaser/contractor at the service delivery level where regional differences really matter. In the absence of a uniform national health insurance program, I think Lawlor is right to support strong regionalization of Medicare. This approach probably would strengthen Medicare, make it more responsive to beneficiary needs and preferences, give it a stronger hand with providers, and achieve a better fit between resources (costs) and outcomes (quality of services). At this point, however, given the political realities described by Oberlander, any proposal designed to strengthen Medicare is not likely to gain majority support in Congress which, in the prescription drug bill, explicitly prohibited CMS from negotiating prices with pharmaceutical companies as is now done by the Veterans Administration.

Lawlor thinks that strong regional sponsors (units) would improve Medicare’s ability to deal with another Medicare reality, which is “nimble providers” with whom Medicare has difficulty in developing and monitoring sound contracts at a distance. Regional units would be in a better (more informed and responsive) position to write rigorous contracts with managed care organizations and other provider groups. Such contracts would be designed to achieve more than cost savings by emphasizing care coordination and management strategies, including disease management, by supporting domain integration (for both acute and long-term care), and by holding providers more effectively responsible for measurable healthcare outcomes. These contractual components and effective monitoring, based on well-designed and well-managed information systems, could make managed care better in providing the kind of care Medicare beneficiaries often need the most and that research indicates they provide even less effectively than the fee-for-services system—chronic care and management of comorbidities. These improvements would make managed care more appealing to beneficiaries and increase enrollments which are currently low.

This is also an attractive proposal that is not likely to gain much political support in the current environment. Congress is clearly committed to increasing managed care involvement in Medicare, mainly by increasing reimbursement rates as was done in the MMA bill. The rigorous contractual provisions recommended by Lawlor are not included.

Lawlor is at least as interested in strengthening the agency of beneficiaries (empowering them) as he is in the other Medicare principal agents. Beneficiaries should be able to gain efficient access to as much information as possible, including eligibility, cost, and performance quality data. Many beneficiaries are not able to access and use the bewildering array of vital information already available without considerable assistance. Lawlor suggests that one of the best ways to provide this assistance is for Medicare to create “one stop” centers staffed by counselors prepared to help beneficiaries gain access to and understand all of the information they need. This is a high priority function that the regional units would be expected to administer. CMS and the Administration on Aging have funded aging network efforts in 24 states to develop “one stop” centers called Aging and Disability Resource Centers that provide the kind of support and assistance Lawlor recommends. The need for more beneficiary information will be substantially greater after the complicated prescription drug benefit becomes available in 2006.

Lawlor notes that most of his proposals have gained the attention of the health policy community in the past but will require the hard work of creating new political
and administrative institutions to achieve. According to Lawlor, failure to build these institutions for the modernization of Medicare is caused by “a form of attention deficit disorder” among policy makers who have rather recklessly skittered from one idea to another without the staying power to actually get much done.

Lawlor does not, however, offer any explanation for this chronic attention deficit, which is primarily a result of the political context of Medicare, especially since 1994. The healthcare corporate sector is fundamentally opposed to giving the Medicare administrative agency more power (authority and resources) to manage the Medicare program and exercise greater leverage over the insurance, pharmaceutical, and provider communities. The limited power Medicare has been able to exert in setting reimbursement rates for hospitals (Diagnostic Related Groups), physicians (Resource Based Relative Value Scale), and HMOs has been resisted by members of the provider community, many of whom have found ways of effectively circumventing rate adjustments—Lawlor’s nimble providers. The prescription drug bill may be their most successful effort so far to tilt the playing field toward their interests and further away from any chance that Lawlor’s proposals will receive serious attention.

**Forty Years of Medicare Politics**

Oberlander’s historical analysis of Medicare provides a comprehensive and nuanced description of the emergence and collapse of the “Medicare policy consensus” that prevailed from 1965 until the Republicans gained control of Congress in 1995. The consensus period was relatively uneventful except for two major initiatives to stabilize hospital and physician costs and one major effort to expand coverage (catastrophic care) in 1989 that was quickly repealed. The consensus ended in 1995 when Republican members of Congress under Newt Gingrich attempted to follow up the defeat of the Clinton comprehensive health care reform proposal by pushing for major Medicare cuts and incentives designed to increase enrollment in managed care organizations. These initiatives reflected the Republican priority on shrinking the public sector, and transformation of the Medicare program became the principal vehicle for achieving this priority. It was also a priority of the managed care community, which saw Medicare as the last frontier for managed care expansion.

The fiscal environment in 1995 was also conducive to efforts to reduce Medicare spending. Federal budget deficits were still high, the Medicare trust fund was projected to begin generating deficits in 2002, and the expansion of managed care in the private sector seemed to be containing healthcare costs. All of this changed between 1995 and 2000 when surpluses began to appear in the federal budget, trust fund deficits were projected to occur 20–25 years later than were projected in 1995, and private sector healthcare costs increased faster than Medicare costs.

The doubling of the population age 65 and older between 2000 and 2030, along with arguments for greater intergenerational equity, also became part of the rationale for Medicare reductions and privatization through a defined contributions approach that could be used to limit federal funding for Medicare by greatly increasing the share of healthcare costs borne by beneficiaries and gradually force migration of beneficiaries to managed care systems.

President Clinton’s threat to veto the Republican-supported Medicare reform bill, which included a $270 billion funding reduction, ended this first effort to transform Medicare. A second scaled back effort, the Balanced Budget Act (BBA) of 1997, passed with bipartisan support. The 1997 BBA included a $115 billion reduction in projected Medicare spending over five years and expanded opportunities for managed care Medicare participation by establishing the Medicare+Choice program. As noted above, however, managed care participation peaked at 16% in 1999 and then declined to 11% of beneficiaries by 2003. Two percent annual funding increases were not enough to maintain, much less increase, their participation. Medicare spending increases, however, did decline and actually fell by 1% in 2000.

Possibly the most interesting aspect of the 1997 BBA was the policy contradiction at the heart of the bill between efforts to legislate an infrastructure for managed competition designed to push/pull more beneficiaries into managed care and provisions that moved Medicare closer to the single-payer model. Oberlander notes that:

The 1997 legislation substantially increased the scope of Medicare subject to prospective budgeting by reining in payments for home health care and skilled nursing facilities. With the addition of these two sectors to prospective payment, Medicare was now closer than ever to having a program of global budget by default. The legislation also linked the growth in payments for physician services to changes in the gross domestic products, a potentially stronger brake on program expenditures that resembled cost control instruments used in other industrial democracies.

...The rhetoric was all about markets and competition. But the reality was that the savings were all from regulation. The secret of the BBA was that the move to competition was not projected to save Medicare any money..... In 1997, as in 1983, policymakers talked right, but ultimately moved left... Market and regulatory instruments now shared an uneasy co-existence within the same program. (pp. 182–183)

For all the rhetoric about markets and competition, the BBA 1997 really depended on expanded regulation to contain costs. As Oberlander points out, Congress talked right and moved left in the BBA 1997. In the MMA, Congress moved both left and right by adding an expensive new drug benefit and enhanced incentives for privatization.

The 1997 BBA established a Bipartisan Commission on the Future of Medicare, which met until 1999 without reaching the required super majority support...
on any policy recommendations. The co-chairmen, Democratic Senator John Breaux and Republican Representative Bill Thomas, pushed for a premium support approach patterned after the Federal Employees Health Benefits Program, which would pay some percentage (80–90%) of the premium cost of a private insurance plan with higher percentages for lower cost plans and participation in managed care programs. The Breaux–Thomas proposal was criticized by some Democratic members of the commission for putting sicker and poorer beneficiaries at greater risk of higher out-of-pocket spending, which already averages more than 20% of Medicare beneficiaries’ disposable income, and reduced access to necessary care.

During and after the 2000 presidential campaign, the Medicare debate was expanded to address the problem of prescription drugs and the most effective and efficient method of making them a Medicare benefit, which culminated, for the time being, in the November 2003 passage of the MMA. The addition of a prescription drug benefit to the Medicare policy agenda was largely a result of: 1) political pressure from beneficiaries for whom drug costs were increasing far faster than their incomes; and 2) the proposal by Breaux and Thomas and their supporters on the Bipartisan Commission to include a drug benefit designed to make their premium support approach more broadly attractive. The push for premium support, vouchers, and other privatization mechanisms as a cost-containment strategy was weakened by recent large increases in private sector insurance costs, including large increases in the Federal Employees and California Employees programs, which had been pointed to as models by privatization supporters in the past.

Although Oberlander’s book was completed before passage of the prescription drug bill, his concluding description of Medicare politics remains accurate:

Medicare politics is now transparently a battle of ideas about the role of markets and government in public policy. This is, in many respects, the same debate held in the 1950s and 1960s before Medicare’s enactment, replete with the same sharp partisan cleavages, high-visibility politics that reach into national elections, a broad scope of conflict, and an engaged public. The new politics of Medicare is an echo of the past.

As a consequence, after thirty-seven years of policy innovations, political upheaval, changing economic circumstances, and a radically altered health care system, Medicare politics is back where it started. (p. 196)

The prescription drug bill was fundamentally designed to achieve two purposes. First, the pressure for some coverage of drugs had reached the point that there was substantial bipartisan support for adding them as a benefit, however oddly constructed it would prove to be and despite the unhappiness of conservatives with its costs and expansion of the public sector. Liberal Democrats were also unhappy with the limitations of the benefit, especially the loss of coverage between $2,250 and $5,100 of beneficiary payments for drugs, and the prohibition on CMS negotiating prices with pharmaceuticals. They eventually supported the bill as a first step toward more comprehensive coverage and from fear of the political risks they might incur if they opposed the bill.

Many conservative Republicans also wanted to avoid the risks of opposition, and they were drawn to several privatization provisions in the bill, including private sector administration of the drug benefit, health savings accounts, more money for managed care, and six demonstration projects designed to test the relative cost effectiveness of managed care versus fee-for-service Medicare beginning in 2010. The bill went right to gain conservative support and left to pick up liberal support, which accounts for its schizoid character and reflects the current reality of Medicare politics as described by Oberlander. What MMA does not include is any plausible prospect of cost containment. All major components of the health care industry do well in the bill with pharmaceutical companies and HMOs set to make billions of dollars over the next five to 10 years and physicians and many hospitals receiving rate increases. It is difficult to see how Medicare costs will be contained by reimbursing HMOs at rates 5–20% above payment levels in the fee-for-service system.

With the exception of the health savings account program, which critics think may work for only a small percentage of beneficiaries who are healthy and more affluent, there is not much in the bill for premium support advocates. Some hope that once enough beneficiaries become members of HMOs, premium support can be resurrected and imposed on the fee-for-service system. The rationale seems to be that we will pay HMOs more now and then less later when they are dependent on retaining a large number of Medicare members and the government can exercise more leverage over them. If this is the rationale, I think it greatly underestimates the power of HMOs, which is likely to increase with greater Medicare participation. HMOs have shown an extraordinary capacity to expand and maintain or increase profits in the absence of cost containment or much popular support.

If Medicare costs are contained following implementation of the MMA, it is likely to occur as a result of increased beneficiary out-of-pocket spending, which is already three times the percentage spent by those under age 65. Without effective regulation, Medicare costs and beneficiary spending are both likely to increase. The MMA essentially leaves the struggle over the privatization of Medicare unresolved and guarantees that it will intensify in the future as health care costs continue to increase and the population aged 65 and older grows.

Beyond Ideology and Special Interests

At some point policy makers may finally recognize that market mechanisms alone do not work to contain costs or ensure quality in health care and that Medicare’s regulatory practices have done more to
contain costs during the last 35 years than presumably competitive practices in the private sector. There is clearly a role for managed competition in Medicare as suggested by Lawlor, but not as a complete substitute for informed and flexible regulation.

A recent article by Nichols, Ginsburg, Berenson, Christianson, and Hurley (2004) indicates that private sector executives in every part of the health care economy are no longer confident that market mechanisms can generate savings (contain costs), increase quality of care, or efficiently expand access to care. At the same time, their support for regulation seems to be increasing out of a sense of disillusionment caused by market failures, which are rapidly increasing costs for employers and employees and leaving many without insurance. The study reports findings from nearly 1,000 interviews in 12 representative markets with health care officials in the public and predominantly private health care sectors. The feeling is pervasive among these executives that the creation of efficient health care systems is dependent on “wise policy intervention.” Market mechanisms have been compromised by the rapid growth of providers’ market power through the consolidation of hospitals and specialty medical groups and insufficient health plan competition. The authors note that in the case of managed care:

The vision was for tightly managed HMOs with distinct provider networks to compete on service delivery quality and price. But the managed care model is less conducive than the traditional indemnity business is to carrier competition because of its relatively higher fixed costs and barriers to entry. The fixed costs of systems to manage care, establish a brand name, and develop a network make it difficult for small plans to be viable. The substantial costs of creating a provider network mean that entry into a market requires a large investment of money and time. Thus, barriers to entry are higher, and the number of managed care plans any market can sustain will be fewer compared with those of traditional indemnity insurers. (p. 14)

Finally, employers have responded to their employees’ unhappiness with managed care restrictions by pushing plans to offer broader provider networks, direct access to specialists, and fewer authorization requirements. These changes have undermined managed care’s capacity to contain costs.

Policy makers should relinquish the illusion that privatization will fix all that ails a program that has essentially outperformed the private insurance market and focus on strengthening the traditional program by adopting many of Lawlor’s reform proposals and addressing several benefit and coverage deficiencies that have not received serious attention in years. Lawlor’s proposals are specifically designed to increase the efficiency of Medicare through systematic development of outcome measures and risk adjusters, with a focus on care of chronic conditions; strengthening Medicare’s administrative capacities at every level, including the capacities to conduct unfettered competitive bidding; development of rigorous contracts; empowerment of beneficiaries; improvement of linkages between Medicare and Medicaid and other insurance programs; and regionalized management of a global Medicare budget. These initiatives would probably increase Medicare’s cost-constraining influence on the private sector and its ability to guide the development of quality standards.

Lawlor’s strategies would also give policy makers some of the leverage required to address the most fundamental health care challenges, which are spiraling costs, declining insurance coverage, and inadequate quality of care, especially care for chronic conditions. Privatization of Medicare, at least as embodied in the MMA, would strip policy makers of the few tools they now have to meet these challenges.

The collapse of the Medicare policy consensus in the mid-1990s reflects and contributes to several trends in the larger U.S. health care system. Most fundamentally, it reflects the increasingly incoherent, even contradictory, nature of health financing and delivery. This trend toward growing incoherence is likely to continue for some time as the power of the expanding medical-industrial complex increases, the potentially countervailing influence of the public sector—declines, and employers curtail their participation in the private insurance market, leaving employees to fend for themselves with individual accounts or no insurance at all. These developments, in combination with longer-term deficits in the federal budget, the doubling of the aged 65 and older population over the next several decades, and the Medicaid fiscal crisis in most states, may constitute the incubus for a perfect storm in the U.S. health care system that could occur well in advance of the emergence of deficits in the Medicare Trust Fund. A crisis of this magnitude could qualitatively change the calculus of health care politics and shift the focus from Medicare privatization to the construction of greater regulatory leverage within the public sector.

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References


At the beginning of Sociological Analysis of Aging: The Gay Male Perspective, J. Michael Cruz reflects on his own introduction to the study of aging and poses a disquieting comment:

On the first day of class, professors would ask what the life stages in the aging process are... and follow up with questions about the experiences we go through as we age (e.g., dating, college, marriage, family). Time after time, in each class, I thought about how my life was different from the information provided. (p. xi)

In social gerontology, empirical studies of aging have yielded a widespread consciousness of the expected “life course” and a better understanding of the social worlds of the old. This life course perspective is supposed to help account for the trajectories of individuals moving through time while connected to specific others, contexts, and the accompanying cultural meanings of one’s generation, gender, regional or geographic location, and religious, economic, political, and racial/ethnic identities. But as Cruz poses, does it?

The fact is, our appreciation of the life course and the aging experience were developed without conscious consideration of sexualities or much consideration of gender. Consequently, over time we have come to take for granted a lifespan development perspective that is what Judith Baker terms “heteronormative,” in her chapter in Gay and Lesbian Aging: Research and Future Directions, edited by Gilbert Herdt and Brian de Vries. For example, marriage and grandparenting are regarded as normative activities and meaningful stages within healthy adulthood, yet gay men and lesbians most often negotiate and maintain partnerships in ways quite distinct from those of spousal relationships, and most are not natal parents. Our general cultural illiteracy about sexual minorities makes Cruz’s musing important: The custom of framing issues of aging and old age from the conventional “life course” perspective effectively erases sexual minorities—whether gay men, lesbians, bisexuals, or the transgender—from discourses in social gerontology. When one adds long-established cultural prejudices about sexual minorities (Berger 1982/1996) and “a policy of nonrecognition, delegitimization, and overt hostility toward GBLT [gay, bisexual, lesbian, transgender] cultural and social needs articulated by conservative American politicians” (E. Michael Gorman and Keith Nelson, in Herdt & de Vries, p. 78), heterosexism has kept gay and lesbian older adults a much ignored population.

The heterosexism eraser also effectively helps hide the complicated and nuanced relationships between aging and masculinities and femininities. The field of gerontology in the post-Parsons and Bales (1955) era has been slow to abandon the single definition of masculinity that stresses how socialization shapes the predispositions and temperaments of men within a culture, whether during their childhood or in late life (Calasanti & Slevin, 2001). The theorized developmental trajectories for both men and women are toward a normative (and normal or healthy) masculinity and femininity (e.g., Gutmann, 1987). Nature is organized socially; hence there are “sex roles.”

Because this perspective twists the range of heterosexual masculinities into a single standard and converts the behavioral norm of heterosexuality into normal or healthy manhood, gay men are not identified as a sexual minority, but as sexual deviants. In addition, whenever gerontologists elect to ignore sexualities and presume that everyone is heterosexual, or assume that differences in sexualities have little or no consequence on aging, the field contributes to the maintenance of a hegemonic version of masculinity as much as it homogenizes the sexualities among older adults. Researchers of aging sustain, as Goffman (1963) noted in Stigma, the image that “[i]n an important sense there is only one complete unblushing male in America: a young, married, white, urban, northern, heterosexual, Protestant, father, of college education, fully employed, of good complexion, weight, and height, and a recent record in sports” (p. 128).

It is a basic proposition of men’s studies that there are different kinds of masculinities evident in society, and we ought not to speak of “masculinity” as a singular term. In the introduction to Men’s Lives, Kimmel and Messner (2003) tell us that, in contemporary Western societies, masculinities are organized differently by generation, age, class, race, and ethnicity, and sexual preference and orientation, and “each of these axes of masculinity modifies the other” (p. xvi). This results in a matrix of masculinities that are visibly “out there” in the culture, embedded in institutions and in social relationships at all levels. Each masculinity is a symbol naming a configuration of gender practice (Connell, 1995). It is also understood within gender studies that masculinity is what men do in interaction with others. It was West and Zimmerman (1987), in their article titled “Doing Gender,” who conceptualized gender as a routine accomplishment. Stoller (2001) noted that these actions are seen as routine and relatively unreflective. Thus, the masculinities we witness heterosexual and gay men doing as gender performances reflect and reproduce the multiple, contemporaneous, poignant social contexts of being a man.