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Legislative Initiatives on Medicare and Medicaid: Their Impact on Women, Children, and the Elderly

Martha Holstein

Congress's proposed changes to reduce the costs of both Medicare and Medicaid have emerged amidst a general restructuring of American health care. These proposed changes would transfer poor women and children from the varied sources of care now available to them into Medicaid managed care within a cost-constrained system. In this system, Congress would establish a cap on federal Medicaid spending. Older people, now covered principally by fee-for-service-dominated Medicare, will have the option of joining MedicarePlus managed-care plans or choosing other approaches, such as Medical Savings Accounts, to obtain their medical care. Medicare will also operate with new cost controls. In addition to reducing federal Medicare and Medicaid spending, a secondary goal of the proposed changes is to shift full control of Medicaid to the states, a process known as devolution.

The importance of the proposed changes cannot be overemphasized; once new structural arrangements are in place, they become almost impossible to dislodge. With rare exceptions, American policymakers usually modify existing programs rather than starting anew. According to political scientist A. S. Orloff, "Policy debates are regularly informed by ideas about how best to correct the perceived imperfections of past policy, rather than simply how best to respond to social conditions as such" (1988:42). As a result, choices made in the past inevitably structure and limit later policy options (Vladeck 1980). Vested interests develop and reduce the space within which reform can take place.

For this reason, we must pay close attention to potential problems as we develop new systems. Managed care, at this juncture in American history, will become the dominant delivery system for the foreseeable future. Some of the institutional and structural problems—tacit rationing, cumbersome appeals processes—that can arise in private managed care are already known. As public managed care becomes increasingly common, at least two questions emerge that are unique to the populations served: What special protections do more vulnerable populations require? How do

changes envisioned for these programs affect other medical and social services now available to the poor? Change does not occur in a vacuum: incremental changes, divorced from basic systemic reform, will inevitably affect other parts of the health care system.

While negative reactions to managed care are reported more often than positive reactions, a well-functioning managed care system *can* serve patients well. It can, for example, give patients a dedicated primary-care physician who is responsible for tracking them throughout the continuum. It can provide a framework for monitoring care and can encourage disease prevention. It *probably* can reduce costs without necessarily reducing quality of care. For Medicaid patients, managed care, in theory, offers specific advantages. Fee-for-service medicine has not, in most cases, served them well. In contrast, a managed-care organization (MCO) has a legal obligation to provide enrollees the services it has contracted for. It is also possible for state Medicaid agencies to achieve greater accountability than most have to date (Rosenbaum 1996), although there have been successes in some states. A 1995 Kaiser Family Foundation study reported mixed but not necessarily negative findings. For example, quality of care from Medicaid managed-care providers and fee-for-service providers was comparable—patient satisfaction was high for both. Evidence about cost savings was mixed (Kaiser Family Foundation 1995a).

This evidence, however, should not encourage sanguinity or eased vigilance. While it is possible that managed care can achieve desired ends, it will require the closest scrutiny (Armstead, Elstein, and Gorman 1995:29) and willingness to modify parts of the system that do not work. In this period of rapid and dramatic change in health care delivery systems, the Health Care Finance Administration (HCFA) and the states must track the effects of changes on patient groups. Careful oversight, monitoring, and enforcement of procedural safeguards must be built into the systems now being established. Yet the currently pervasive antiregulatory environment mitigates against strict scrutiny and oversight. For this reason we cannot forget the sad lessons from the past, especially those we learned from experiences with our nation's nursing homes. Even legislated oversight procedures and standards are often not enforced (Holstein and Cole, in press). Such lax enforce-

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ment is unacceptable, especially in this new, market-driven medical care environment, where the opportunities for profit and the likelihood of conflicts of interest abound.

In the past, neither insured patients nor their physicians felt the impact of costs; those "blank checks" are now gone. Cost containment is central to the new philosophy of care, and the realities of the marketplace—for example, competition and return on investment—increasingly frame and limit patients' actual choices. Hidden cost-containment strategies become ethically problematic. For example, financial incentives to physicians—such as paying bonuses from unspent capitated fees or withholding portions of their income until the year's-end cost-containment targets are met—can induce conflicts of interest and shape behaviors that control costs but potentially harm patients (Emanuel 1995; Christiansen 1995).

Other cost-containment strategies are aimed at patients rather than physicians. Because a healthy enrollee population supports a strong bottom line, MCOs adopt specific policies to weed out sicker patients (Luft 1996:26). Designing stringent protocols for referring patients to subspecialists is one strategy that discourages people with chronic and serious illnesses from joining or staying enrolled in particular plans. Such policies can wreak havoc with the broad risk sharing that has sustained Medicare for 30 years. Such market-type cost-control devices may not unduly affect people with modest medical needs, but they are potentially problematic for more vulnerable groups, like Medicare and Medicaid populations. This problem will not be solved easily.

Medicare: Past and Present

Enacted as Title XVIII of the Social Security Act in 1965, Medicare covers many medical expenses for the elderly and disabled. Medicare Part A, financed by payroll taxes, covers most acute-care services rendered in a hospital; the voluntary Part B, financed by beneficiary contributions and government general revenues, pays for inpatient and outpatient physician services. Today, beneficiaries may choose Medicare only; Medicare plus a Medigap or other supplemental insurance policy, for which they pay; or a managed-care plan that is government financed and privately run. A recent feature story in the *New York Times* (12 May 1996) called attention to the rapid and steep increases in the cost of Medigap plans, noting that the cost of these policies can "easily run into many thousands of dollars a year." Patients without supplemental insurance must pay out of pocket for deductibles and coinsurance for covered services. They must also pay the charges—known as balance billing—that reflect any difference between the Medicare reimbursement rate and their physicians' actual bills. Beneficiaries are also responsible for the Part B monthly premium. Because Medicare pays for almost no long-term nursing-home or home care and does not reimburse for prescription

drugs, eyeglasses, hearing aids, dental care, and "routine" care, it covers less than half of the total health care bill for most beneficiaries.

"In 1987 . . . Medicare paid for 69.7% of the elderly's expenses for hospital care, 60.6% of their expenses for physician services, only 1.7% of their nursing home costs, and 14.7% of their costs for other personal health care. Overall, it paid for 44.6% of the elderly's total personal health care expenditures" (Waldo et al. 1985, quoted in Scitovsky 1994:563). Yet, as health economist Rashi Fein pointed out a decade ago, "it does not negate Medicare's importance to acknowledge its limitations. . . . Medicare reduces but does not eliminate the financial problems of health care for the aged" (Fein 1986:76, 78).

Medicare quickly became an expensive program despite limitations in its coverage. Because the Medicare program subsidized demand and adopted a provider-driven payment system with no cost-control mechanisms, costs have increased annually by almost 14 percent (Bovbjerg, Griffin, and Carroll 1993). The Medicare Prospective Payment System known as DRGs (or Diagnostic Related Groups) was a targeted response to cost acceleration. Congress also enacted fee schedules for physicians and experimented with Medicare HMOs. The mélange of cost-containment efforts did not, however, lead to significant cost savings.

Any reform efforts can be evaluated most effectively when compared with what they replace. Medicare has at least three important features that give it its current strength—universality, broad risk sharing among a nonhomogeneous population, and related to that feature, significant income and health differentials among beneficiaries. Each of these features will influence the outcomes of reform and also Medicare's continuing viability—especially the second and third, which are the most at risk if the proposed changes divide (albeit unintentionally) the segments on the basis of health status and, to a lesser extent, income status. In the absence of overall health care reform that provides universal coverage to all Americans, Medicare's continued survival is essential. The program's strong popular support is based on its universality and its perceived intergenerational benefits (adult children do not have to worry about their parents' medical costs).

Clearly people with higher incomes and better health have an easier time meeting copayments, deductibles, and nonreimbursable costs than people who are poorer and sicker. They also have an easier time paying Medigap premiums. Given the press's attention to "affluent elders," it should be noted that 83 percent of Medicare beneficiaries have incomes under \$25,000; 18 percent have incomes between \$25,000 and \$50,000; and 4 percent have incomes greater than \$50,000. Accounting for assets does not alter the picture substantially; older people who have considerable assets also have high incomes. Medicare is predominantly a low-income insurance program (Armstead, Elstein, and Gorman 1995:29; Kaiser Family Foundation 1995a).

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Medicare: Reform Proposals

Congressional Republicans have proposed a \$270-billion reduction in Medicare spending over the next seven years. President Clinton's proposal would reduce expenditures by \$226 billion. Generally, the strategies for reducing expenditures include moving more Medicare beneficiaries into managed-care plans that will be constrained by specific growth targets, particularly a cap on total program costs, and restricting payments to fee-for-service providers and limiting the services provided. The congressional proposal includes a fail-safe mechanism that would penalize fee-for-service providers if growth rates exceeded targets, that is, if the expenses in this sector exceed an overall limit on Medicare spending by 2002. Congressional Republicans have proposed, while the president and most congressional Democrats have opposed, a new approach called Medical Savings Accounts (MSAs).

Supporters of these changes must convince recipients (and their families) that the changes are better than the status quo. There are two primary ways to achieve that: raise the threat of Medicare bankruptcy and promise that the new Medicare will offer more choice. The annual Medicare trustees' report, although not containing any unfamiliar information, stressed the threat of bankruptcy. Although the second argument—that these changes will give beneficiaries greater choice among health plans—is, in theory, accurate, in practice, Congress has designed the reforms so that, in the end, Medicare beneficiaries may have fewer rather than more choices.

The Republican majority in Congress has also argued that their \$270-billion proposed reduction does not represent a true cut; rather, they say, it reflects a reduction in the rate of growth. This statement is true. Yet the projection of 5 percent annual growth is “two-thirds of that expected in the private insurance sector over the next seven years” (Moon 1996a:30) and about half of what the rate of growth was under Medicare in the past seven years. Controlling the rate of growth thus can be tantamount to a reduction as the elderly population grows and as new technologies emerge.

Managed Care Organizations

Clearly, Congress and the president anticipate that moving Medicare beneficiaries into MCOs will be an important long-run source of cost savings. In June of 1995, approximately 9 percent of Medicare recipients belonged to an MCO. By 2002, the Congressional Budget Office estimates that 24 percent of beneficiaries will have moved into private managed care; the Federation of American Health Systems suggests a 42 percent enrollment by the same date (Hiebert-White 1996:12). Currently, the 2.4 million Medicare beneficiaries who are in risk-contract HMOs are concentrated in just a few states; more than 42 percent are in California. (Under a risk contract, the HMO receives monthly capitated payments to provide Medicare-covered services to enrollees, thereby assuming the risk that the enrollees will require costly services [PPRC 1996:395].) About half of the enrollees in managed-care plans pay a modest premium to the HMO (with Medicare paying the more significant amount), which, on average, costs them less than the Medigap policies they once bought to supplement Medicare.

What then are the implications of this goal of moving more and more Medicare beneficiaries into MCOs? It could, in time, reduce the availability of the fee-for-service option. In particular, if Congress relaxes restrictions and limitations on private plans that may change the benefit package or increase an enrollee's premiums without coordinating MedicarePlus plans with private Medigap

policies, enrollees may have a difficult time leaving managed care to return to the fee-for-service system. Insurers who sell Medigap policies, which already have different enrollment periods, may also resist enrolling people who disenroll from managed-care plans, assuming that they have become unhealthy. Without guaranteed access to such policies, which most older people have relied on to assist with copayments, deductibles, and other uncovered expenses, they may feel compelled to stay in managed care. Thus, choice may quickly narrow.

Adverse or biased risk selection is a significant but unresolved problem that can, indirectly, also affect choice. MCOs specifically target marketing to healthier people—who are the best financial bet for them—while healthier people will find the MCO attractive because of its simplicity or the extra services it offers, such as payment for prescription drugs. To date, this payment system has cost Medicare 5.7 percent more than it would have had these enrollees remained in fee-for-service plans. The reason—and one that can be expected to continue—is that healthy enrollees use fewer Medicare-reimbursed services. The 95 percent of typical average Medicare expenses that Medicare pays the MCO is therefore in excess of what the typical enrollee would use in any given year. To achieve anticipated savings, Medicare would thus need to redesign the payment systems based on a more accurate assessment of disparate enrollees' health status (Kaiser Family Foundation 1995a). Such a move could reduce profits and make Medicare risk contracts less appealing to insurers.

If the sickest patients remain in the traditional Medicare program, such adverse risk selection will drive up costs in this sector. Such rising costs will trigger the fail-safe mechanism whereby HCFA would reduce payments to the fee-for-service portion of the program. Even without adverse selection, however, the fail-safe mechanism will most likely be required to generate nearly \$12 billion in savings that cannot be met otherwise (Moon 1996b). As a result, providers may choose to reduce their commitment to Medicare patients. Previous experience with Medicaid has tutored us about problems with access if reimbursement levels fall below the minimum that participating physicians consider acceptable. These same providers, who refuse Medicare patients on fee-for-service terms, could continue receiving Medicare reimbursement through their participation in private MCOs. By weakening the fee-for-service portion of Medicare, beneficiaries may be unwittingly driven into managed-care plans (Moon 1996b). The result again would be narrowed choice.

Once in managed care, beneficiaries would face other problems. Currently, Medicare promises older people set benefits; if costs climb, taxpayers bear the burden. In contrast, the congressional plan would establish a fixed rate of growth in payments to private plans on behalf of beneficiaries. This “defined contribution” guarantees general categories of services, not a specific set of benefits. It is unclear, at this point, whether Congress will modify or clarify the general services it now requires health plans to provide. Plans, for example, can refuse to provide or to pay for some services on the grounds that they are not “medically necessary or reasonable” (PPRC 1996:135). Plans have the option of selecting among acceptable alternate approaches to care. HCFA has not yet decided “how to define an acceptable latitude for . . . coverage choices by health plans” (PPRC 1996:138).

Medicare would pay the MCO a fixed sum, annually appropriated for each enrollee. As plans get strapped, they would have two choices—reduce the supplemental benefits they might have introduced to attract enrollees or raise the beneficiaries' premiums up to the \$100-a-month limit the congressional plan now permits. The burden of escalating cost would thus shift from the federal government to the plan or to the Medicare recipient. If the package of ser-

vices that the MCO provides is not satisfactory to the beneficiary, he or she could, theoretically, return to the fee-for-service option. But, as noted above, that option may become increasingly unavailable. In the end, this problem, exacerbated by difficulties in obtaining Medigap policies, may effectively lock the beneficiary into a managed-care plan (Moon 1996b).

Medical Savings Accounts

Medical Savings Accounts (MSAs) would allow beneficiaries to “exchange their traditional benefits for a [government-supported] high deductible insurance policy and a [federal] contribution to a dedicated savings account” (PPRC 1996:xxiv). Beneficiaries could draw on this account (or pay out of pocket) to cover their medical expenses up to the deductible amount (which could go as high as \$6,000). Under the congressional plan, called Medisave, Medicare would pay the premium for the high-deductible insurance plan; the difference between the cost of traditional Medicare benefits for one year and the cost of the annual premium would then be placed in the beneficiary’s MSA. Medicare pay-out would thus roughly equal the average spending per beneficiary in the traditional fee-for-service program. The insurance policy would pay for most or all costs of covered services once the beneficiary met the deductible (PPRC 1996:113, 121).

Theoretically, MSAs would encourage individuals to use fewer medical services. While presumably good for the individual, however, they may be very bad for the system. Adverse selection would, even more dramatically than in managed care, draw in the healthiest beneficiaries. MSAs therefore could also increase Medicare expenditures. These healthy beneficiaries would ordinarily cost Medicare very little in any given year. The PPRC estimates that for a person whose annual Medicare spending is \$1,000 per year, beneficiaries choosing MSAs would gain roughly \$2,400 by year’s end (PPRC 1996:117). The Congressional Budget Office estimates that Medicare outlays for every individual enrolled in an MSA “would exceed the amount that it would have spent in the traditional program by a sum equal to roughly one-third of its average per capita costs” (quoted in PPRC 1996:118). While there are several ways to reduce the problems of biased risk selection and overpayment to such plans (strategies that are not included in the current legislation), the potential and therefore the likelihood that MSAs would increase rather than decrease Medicare spending ought to be an important consideration. MSAs present other important problems as well. For example, lower-income individuals choosing this approach might not be able to manage an MSA’s financial risks, that is, payment of costs up to the deductible amount. Further, they might have difficulty finding a provider willing to offer care without a guaranteed source of payment (PPRC 1996:xxvi). MSAs would further fragment the Medicare population, thereby reducing risk sharing between the healthy and unhealthy and possibly driving up costs for the less healthy. MSAs are based on the assumption that individuals could and would make wise choices about when to seek medical treatment, but they might also cause individuals to delay seeking treatment or to not take advantage of preventive services (PPRC 1996:115). MSAs would place considerable public resources in private hands. Their consequences for the foundational notion of risk sharing and solidarity among diverse groups are also threatening. The implications of this approach, completely untested for a Medicare population, are serious enough to warrant delay, if not dismissal, of it as an option.

Means Testing

The congressional plan also calls for wealthier older people to pay higher premiums. Individuals earning \$110,000 and couples earn-

ing \$150,000 would pay about three times the standard Medicare Part B premium. Although this option is feasible, it raises several ethical and practical problems. Once means testing becomes acceptable, the income line can shift with the vagaries of each annual budget debate. Furthermore, experience with the Medicare Catastrophic Care Act (MCCA) suggests what might happen if one group is treated differently from those they consider their peers. One must remember that employer-based plans that we as consumers ultimately help support through higher costs of goods and services and through reduced corporate taxation do not ask the highly paid to contribute more to their health insurance than the least well paid do. This approach would single out older beneficiaries of Medicare for treatment different from that given to beneficiaries of other health insurance plans.

Medicaid: Past and Present

Medicaid, passed in 1965 as Title XIX of the Social Security Act, is a joint federal-state entitlement program that provides medical coverage to about 37 million low-income individuals. They are usually members of families with dependent children, mostly poor women and children, elderly residents of nursing homes (also mostly women) who have “spent down” their personal resources, and low-income people who are blind or disabled. Medicaid also assists low-income Medicare beneficiaries by providing assistance with copayments and deductibles. Federal matching payment to states comes from general revenues. There is currently no cap on expenditures. The costs of the program have escalated to the point that Medicaid accounts for 19.2 percent of state expenditures, second only to costs for elementary and secondary education (PPRC 1996:324). While broad federal guidelines establish some eligibility and service requirements, states have had considerable discretion in determining “eligibility standards, service coverage, utilization limits, provider payment policies, and use of managed care” (PPRC 1996:321). Relatively low reimbursement rates to physicians have made access problematic.

To conserve resources, many states have also lowered eligibility levels or sharply reduced services. Eligible women and children often have turned to emergency rooms or community clinics for care. In most communities, Medicaid lives down to the adage “programs for poor people are poor programs.”

Medicaid Reform: Proposals

Congress and the president propose to reduce Medicaid spending primarily by replacing matching federal funds with fixed-amount block grants to states and by limiting per capita expenditures. The congressional Medigap program would reduce federal spending by \$163 billion over seven years by capping the rate of growth. In perhaps the most troubling omission, for reasons that will become clear, the congressional plan does not “specify required quality-assurance mechanisms for managed care” (PPRC 1996:334).

The administration’s plan is more modest. Currently, under federal waivers, states have gained greater flexibility in designing their Medicaid programs. Most important, the section 1915 waiver permits states to mandate that its Medicaid-eligible populations enroll in managed care. It has also facilitated the development of home- and community-based services for Medicaid recipients. Section 1115 waivers encourage the development of unique ways to deliver and finance programs that meet Medicaid’s goals. The administration’s plan would allow states to mandate that covered groups be enrolled in managed-care plans—as long as they have

choices among plans or providers—without the necessity of obtaining a waiver. This proposal would repeal the current requirement that at least 25 percent of a managed-care plan's patients be commercial enrollees (that is, not Medicaid beneficiaries) and would set per capita limits on federal spending for different types of recipients (for example, the aged, the nondisabled young, persons with disabilities). The federal government would match state spending up to these amounts. Further, MCO providers "would have to demonstrate capacity to deliver services and would be required to have internal quality assurance programs that meet standards established by the Secretary [of Health and Human Services]" (PPRC 1996:335). The proposal would not require external review.

In an effort to restrain Medicaid costs, a number of states, using section 1915 and 1115 federal waivers, have tested different approaches to serving Medicare clients. The most common approach has been to move large numbers of women and children into managed-care plans. By 1995, states had forced 12–13 million people—mostly mothers and children receiving assistance under the Aid to Families with Dependent Children program—into MCOs, mostly HMOs.

Medicaid: Future Threats

There are two main difficulties in describing problems with the Medicaid program. First, the program varies greatly from state to state. Second, waiver arrangements in many states have already permitted rapid and relatively uncontrolled growth for the period that the waiver covered. Therefore, assessments of mandated Medicaid MCO programs are in their infancy.

Despite the number and variety of programs and the lack of data gathering and analysis done so far, some observations can be made. (A detailed analysis, unfortunately, is beyond this essay's scope.) We know that many new MCOs eagerly sought new patients; the larger the number of patients the greater the capitation payments. Investigative reporters Fred Schulte and Jenni Bergal uncovered serious problems in Broward County in south Florida. Hard sells, often accompanied by threats (for example, that people could be deported if they didn't sign up), were commonplace. In many cases, people did not know what they had signed up for; they were told outright lies (for example, that their doctor was in the plan or that all plan doctors were board certified). Monitoring was not enforced; the state did not look at the data it had collected; failed accreditation did not lead to closures. There was no regulation of who could open an HMO (Schulte and Bergal 1996).

Researchers have reported comparable problems with marketing plans, access, and education in California and other states. For example, some states offered recipients no choice in plans or assigned mothers and children to different plans. Once enrolled in HMOs, individuals received little or no information about how the system worked. For this reason, many returned to their former "safety-net" providers or to emergency rooms for care. Yet managed care—Medicaid reimbursement, in particular—inevitably funnels resources away from these traditional safety-net providers, including public hospitals, undermining even further their financial viability, and thereby disrupting essential community services, just as the numbers of uninsured continue to grow (Andrulis et al. 1996). This problem is largely unexamined in the urgent rush to push Medicaid reform.

Medicaid abuse is familiar. Abuse can easily occur when money is limited, when minimal oversight takes place, and when the recipient population is often tacitly deemed the "nonworthy" poor. They are also mostly women and children. Medicaid managed care differs

from Medicare and commercial managed care in several important ways. Above all, it serves a client population that has historically had inadequate access to medical care. This access problem, when combined with homelessness, racism, violence, drug abuse, and other problems that plague poor Americans, "means that ethnic Americans [and other underserved populations] enter MCOs having poorer health status and needing more (not less) health care services" (Randall 1994:235). How well can they be served in a system intent on containing costs? There are other differences. For most Medicare enrollees, eligibility is permanent; for Medicaid recipients, enrollment is episodic. This makes it difficult to track quality; it also hinders the development of relationships between individual enrollees and primary-care providers. For Medicare beneficiaries, enrollment in MCOs is voluntary, and they have choices. For Medicaid recipients in a growing number of states, enrollment is mandatory, and they rarely have choice. Medicare patients are "mainstreamed," that is, they receive care in the same environments in which commercially insured patients receive care. Most Medicaid patients, however, are in MCOs that serve a high proportion of Medicaid enrollees, as high as 75 percent. In some cases the 75-percent rule is overridden, and they receive care in facilities that serve Medicaid patients only. Past experience with "Medicaid mills" should alert us to the problems of Medicaid-only MCOs.

Another difference that can emerge—and that was documented by the Florida experience—is variance in plans' ability to provide the services they are mandated to offer. In areas where there has been little experience with MCOs, competitive bidding may bring relatively inexperienced providers into the health care delivery business. Medicare beneficiaries can return to fee-for-service, as long as it exists as an option. They generally have had previous experience with a commercial plan and understand the system. Medicare has considerable public support among people of different ages and classes and will remain a federal program with national standards. These attributes are generally lacking for the Medicaid program (Hurley 1996).

It is thus essential to monitor access in the Medicaid program closely to "make certain the program is achieving the federal goals it was designed to meet. . . . With current legislative proposals recommending not only dramatic restructuring of Medicaid but also lower federal spending in the future, this monitoring activity is even more critical" (PPRC 1996:339). The Physician Payment Review Commission is equally emphatic in urging a comprehensive monitoring system. They recommend a short-term strategy that uses different measures—claims, encounters, hospital discharge abstracts, and surveys—to assess the Medicaid program. A longer-range strategy would involve a more comprehensive system that would permit comparisons across states and programs. The systemwide monitoring must also include analysis of how widespread Medicaid MCOs will affect traditional safety-net providers and traditional patterns of care seeking (Andrulis et al. 1996). Emergency use services may not decline, but payments for services will decline because those providers will not be reimbursed for services to individuals enrolled in Medicaid managed care.

Conclusion

We and our health care providers have created a difficult dilemma. Starting with the creation of the first health insurance plan in 1929, insured Americans and their physicians have had little reason to be cost conscious. Third-party payers covered most, if not all, of the costs of health care. Medicare followed the same formula. Insured Americans, young and old, came to expect "the best." We insisted that we had the best health care system in the world. It was also the

most expensive—without providing universal coverage. But demanding “the best” in a cost-unconscious system meant that health care, including Medicare, continued to inflate at double the rate of the consumer price index. Most Americans do not want to cover the costs of such a system, especially the most visible and publicly financed costs, which are Medicare and Medicaid. As a society, we are now confronting our own profligacy and, I would suggest, our own selfishness. Demands for the best services for ourselves has overridden efforts to provide even minimal services to all. Equality in access to care is a myth.

The need to control medical care costs is not specious, especially if this country is ever to be able to guarantee that all Americans have access to health care. We seem to be unwilling to adopt a universal, single-payer system. Instead, we accept piecemeal reforms that *may* contain costs while preserving quality. If we are content with this possibility, then it behooves each of us to attend closely to the shifts now under way and the proposals that the president and Congress have made. They will probably affect us, our parents, and our children for some time to come. I think it is appropriate to worry about the enormous complexities of the system emerging and the many dangers from lack of foresight and lack of provision for oversight. I worry that the American health care system will develop even more tiers than it already has. The most vulnerable people are at greatest risk should this occur. I have noted the benefits that can accrue from proposed changes, including increased reliance on managed care, but I want to close by highlighting some special dangers.

For Medicare there are serious political concerns. Medicare’s broad constituency has given it support across the political spectrum and across age groups. By changing the options and incentives available to beneficiaries, the reform proposals that I have described threaten that fundamental political consensus and hence the continued viability of the Medicare program. Dissolving the Medicare program as it has existed for 30 years may also be an unspoken agenda item. Proposed reforms will change the nature of risk sharing that helped keep the program viable. Rather than preserving risk sharing among the oldest old, the younger old, and the younger disabled, between the sicker and the healthier, and between the more and less financially comfortable, the reform proposals are likely to segment these groups. The oldest and sickest will stay in fee-for-service plans, thus causing costs to continue to rise. Will we have the political will, and therefore the resources, to care for these beneficiaries? Will Medicare become a two-tiered health care financing system? Brookings Institution economists Henry Aaron and Robert Reischauer pessimistically note that “most likely, an already parsimonious system will be made even stingier, the need for supplemental insurance will grow, and the existing hybrid system will become even more complex and inequitable” (quoted in Hiebert-White 1996:13).

Medicaid changes pose different threats, which derive from the two issues I stressed above. If Congress enacts and the president signs the Medigiant program—in which the federal government’s Medicaid contributions to the states would consist of fixed-amount block grants at reduced funding levels—competition for resources among groups once eligible for Medicaid will increase substantially. The political strength of advocates representing poor women and children and low-income elders, especially those in nursing homes, can make a substantial difference in the design of different state plans.

State Medicaid plans already differ substantially; the cap on federal funding will exacerbate these fundamental discrepancies. Moreover, Congress would not require states to maintain their cur-

rent funding levels; it would mandate only that states spend at least 85 percent of what they had formerly spent for poor families, low-income elderly, and low-income people with disabilities (PPRC 1996:334). Reductions in expenditures at both the state and federal levels will substantially reduce the overall resources available for the Medicaid program. Low-income people will lose their entitlement status; states will decide whom to cover among people with incomes under 275 percent of the poverty line.

The reports from extant Medicaid care plans have been, with a few notable exceptions, mixed to negative. In the long run, poor quality, subtle rationing, or unavailable services will raise costs. We know too well by now that caring for a low-birth-weight baby is more expensive than providing its mother with prenatal care. As privately insured Americans are eager to keep their own physicians, so poorer Medicaid recipients are often eager to seek services from familiar providers who may share their ethnic background. Public hospitals, too, have been familiar sources of care as well as important training grounds for future physicians. What will the system do to protect ethnic providers and public hospitals?

Some states are responding imaginatively to the dangers that I have touched upon. Outside organizations like the National Health Law program have proposed sensible safeguards to protect Medicaid clients of MCOs. HCFA has developed a number of quality assessment instruments. It will be interesting to see just how diligent HCFA and states remain, over time, in collecting this data, analyzing it, and using it to respond to problem areas. We, as a society, are in quite a quandary. Costs are a serious problem; we ought not waste resources or provide excess treatments. Yet we also should not leap too quickly into a system that has not been tested adequately on people who are poor, chronically ill, or have multiple medical care needs. Whatever we create now will be ours to live with for a long time to come. Let us be sure it is what we want. Now is the time for a sustained dialogue about policy choices—ideally, removed from the heat of a political campaign. □

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Caring and Volunteerism

Robert Wuthnow, *Learning to Care: Elementary Kindness in an Age of Indifference* (New York: Oxford University Press, 1995), 287 pp.

Wuthnow's book asks whether and how caring, which he identifies with kindness, can flourish when society's transactions, including the provision of help to people in need, take place primarily through institutions. His specific focus of concern is the fate of caring attitudes and behaviors among young people as these are (or are not) revealed in their participation in and reflection on volunteer activities. Wuthnow's exploration and his conclusions are based primarily on personal interviews with youthful volunteers.

Wuthnow believes that volunteerism is a significant bridge between the kind of caring that most of us learn in our families of origin and the more complex, impersonal, and limited forms of care that we experience in the institutions that shape both our work and our nonwork lives. If volunteering can help the young learn something about the transformations that care may and must undergo in the institutional context, the future of kindness may stand on firmer footing than social pessimists imagine.

Thus Wuthnow's exploration encompasses not only the future of volunteerism in America but also the educational and transformative impact that volunteer experiences have on the young. He concludes that, while volunteering can indeed help young people attain "more mature" understandings of kindness, it takes more than the volunteer experience alone to achieve them or secure a future commitment to such kindness in attitude and behavior. "Frameworks of understanding," ranging from humanitarianism to self-realization to religiously inspired idealism, are needed to help young people interpret the meaning of their volunteer experience and construct a rationale for continued participation. The development of stories that capture the experience and the availability of role models also contribute to the growth of such kindness.

The volunteer's maturation in kindness may never find expression in a service vocation, and it seldom appears as a sweeping change of perspective or commitment. But Wuthnow's interviews do suggest that volunteering—especially when accompanied by sound interpretive aids—usually makes a modest difference on both counts, and sometimes a dramatic one.

What Wuthnow is exploring, as one chapter makes explicit, can be encompassed under the heading of virtue. If virtue as a quality of "rugged individualists" seems in short supply, perhaps it has been largely absorbed by the societal institutions created to mediate compassion. Nevertheless Wuthnow is cautiously optimistic about the potential of volunteer experience to further the virtuous actions of the young in institutional environments which seem less than hospitable to virtue's development. Some of these young people will undoubtedly enter service professions, including those in health and human services. Others will be led by the richness of previous volunteer experience to volunteer again, sooner or later, in adulthood. Still others will find in their volunteer repertoire clues for the creative incorporation of kindness into institutionalized work contexts. Last, but not least, Wuthnow finds that volunteers are likely to see a need for compassion as an ingredient in formulating public policy.

Wuthnow's arguments could be made more briskly, and I have some reservations about his equation of caring with kindness.

Nevertheless, *Learning to Care* offers a suggestive analysis of the meaning of virtue today and the importance of appropriate social supports to its development. The facilitation of personal kindness in a society highly dependent on its institutions is a subject that deserves sustained study. □

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Setting Priorities for Public Mental Health Services

Philip J. Boyle and Daniel Callahan, eds., *What Price Mental Health? The Ethics and Politics of Setting Priorities* (Washington, D.C.: Georgetown University Press, 1995), 256 pp.

This book is an outgrowth of a Hastings Center interdisciplinary working group that explored the issue of setting priorities for providing mental health services. For those who doubt whether priorities can or should be set, the book makes a strong argument that the explicit setting of priorities can only improve the present state of affairs. Through presentation of historical accounts, social context, conceptual papers, and the experiences of decision-making groups in Oregon and New York, the complexity and nuances of priority setting are revealed. This background provides evidence that substantive ethical guidance is needed in these processes because "priority setting is not and cannot be a 'rational objective' process, but is ultimately concerned with power relations and value judgments" (p. 181).

Part 1 of the book considers influences on priority setting. Prominent here are the roles of intergovernmental relationships, the American political system, interest groups within the mental health community, the rule of law, and the private health insurance system, as well as the stereotypes and prejudices associated with mental illness. The narratives of case examples from Oregon and New York that make up Part 2 provide a rich look at the actual process of priority setting. These examples greatly advance the reader's understanding of the process and are particularly helpful because states are likely to be the units for priority setting in the future. Part 3 explores ethical issues in priority setting. Daniel Callahan's paper, while acknowledging the problems, expresses optimism and maps out a practical approach to priority setting not limited to mental health.

On balance, *What Price Mental Health?* is a useful tool for anyone interested in the issue of priority setting in health policy. (The reader can expect some redundancy among the papers, however, and some make a less useful contribution than others.) It is also a timely book, especially in view of recent attempts in Congress to incorporate mental health into the mainstream of American health. Finally, it establishes priority setting as desirable "not just because of scarce resources but also as a way of cutting through some of the chaos of the present way" (p. 183). □

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