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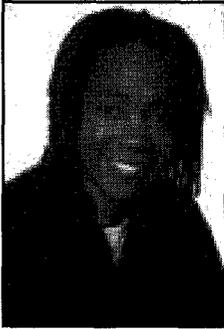
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Medicare: It's Time to Talk About Changing It

*Cynthia E. Boyd**



The Medicare Program was adopted in 1965, and except for some tinkering around the edges and the addition of a prescription drug benefit, it has remained virtually unchanged since its inception. While 2009 saw an unprecedented discussion on how to provide health insurance coverage to more Americans, there was very little conversation about the \$500 billion per year spent on Medicare and whether Medicare can be re-designed to save money, prepare for the onslaught of baby-boomer retirements, free-up health care providers from a nearly impossible landmine of rules and regulations—and importantly, encourage Medicare beneficiaries to live healthier lives. The debates on health care reform in 2009 overlooked that the largest health insurer in the country is operating on policies that are forty-five years old and designed for a health care system that had not yet developed mammograms.

Discussion on Medicare reform has been silent from a lethal combination of deeply vested interests, inertia and ignorance—but mainly ignorance. Most Americans do not understand how the Medicare Program works. There is little understanding how its design is not only outmoded, but discourages healthy living and requires wasteful resources in order to manage overly burdensome regulations. In order to improve the structure and function of Medicare, it is critical that more Americans, particularly physicians, become knowledgeable about its inner workings. From the perspective of a compliance officer, it will be difficult to achieve health care cost savings until Medicare is restructured.

While health care reform debates were mostly silent on Medicare, in a certain way that may have been a good thing for now. The framework of health care reform in 2009 was not the type of reform Medicare needs. The healthcare reform debate that captivated the country has been interesting at

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the least and theater, at best. As a physician, it is bothersome to see and hear career politicians designing systems of payment that assume what constitutes appropriate medical care for patients. While coverage of health care services does not technically control a physician's decision-making, it certainly controls a patient's decision about a course of treatment and there is little doubt that, in practice, it actually does control decisions made by the physician. The further away from the patient and physician decisions regarding appropriateness of care are made, the poorer the outcomes will be.

Medicine is in danger of losing its character as an art and becoming a mere functionary for carrying out clinical pathways cobbled together from politics and budget considerations rather than what a patient needs. Structures that establish boards and panels that design coverage based on hypothetical patients or merely from outcomes research miss the point of medicine: though the human body functions similarly, each individual is nevertheless unique. As I will discuss, there is much that could and should be limited in Medicare coverage to save costs, but importing a framework of coverage based on common denominator outcomes will not reduce costs or encourage public health. What Medicare reform needs is a paradigm shift in how resources are spent, not micromanagement of medical decision-making.

The reforms desperately needed in Medicare involve discussing disease prevention, disease management, pathophysiology and the long-term costs of chronic care. While there is indeed a strong argument for shaving back Medicare coverage at the outer limits of medicine, not paying for expensive state-of-the-art therapies that have dubious outcomes experience, and limiting coverage on highly-expensive multiple procedures (e.g., multiple liver transplants), these are limits on the edges. The goal should be to minimize the number of people who ever get to the point at which the edges of medicine must be considered. Medicare will pay for a person's dialysis for the rest of their life, despite their age, but the federal government has virtually no active programs to encourage and teach lifestyle changes that can prevent end-stage-renal disease or at least push back the day when dialysis becomes a permanent feature of a person's life. Focusing more resources on front-end prevention has the potential to save money and lives on the back-end.

As a compliance officer with eight-year tenure in an academic medical center, it is amazing to hear what is not being discussed during this country's recent healthcare debate. It has seemed that the language used has been wrong. Debates often spoke about universal coverage as if merely having a health insurance policy is akin to good health care—it is not. Emergency care coverage and catastrophic coverage can help relieve an individual's financial burden, but are these the types of insurance policies

that should be encouraged for the public good? It is these types of insurance that give a false sense of health security and remove personal responsibility for keeping and staying healthy. Yet, that is how Medicare is structured. It seems as if the health care reform debates combined the worst of all worlds—a system focused on paying for health care when crisis hits and not focusing on prevention, yet still desiring to tinker with the medical decision-making when physicians will treat the very catastrophic situations there has been no encouragement to prevent.

In addition to prevention and self-responsibility, access is another issue that crosses both Medicare and the health care reform debates. Much has been made about ensuring “access” to health care, but this seems to dodge tougher issues not being faced. Access is not an issue in most areas of the country; access to health care is different from coverage for health care services and they are often confused. Access to medical care does not equal quality healthcare, nor does it mean that the patient is able to navigate his or her way through the rules. There can never be enough patient education about the health care system or patient options; but patient education resources are wasted if a system is too complex for the educators or even the regulators themselves to understand that system.

As I reflect on being a hospital administrator, a physician, a patient and citizen, my consternation rests with the fact that there is a deafening silence when it comes to discussion on how to change or reform Medicare—or even whether to reform it. Much has been said about health care reform legislation that fills the so-called “donut hole” or coverage gap in Medicare Part D, but those reforms are window-dressing. The most optimistic proposed legislation (at the time of this writing) covers the gap over the course of eight years, which seems to be such a span of time that hardly seems to be filling the gap at all. With that said, however, the coverage gap in Medicare Part D is not the crux of the problem with Medicare. It is a problem that helps patients, but it does nothing to change the framework of Medicare to think more about preventive care so that many of those patients will not need drug therapies that have costs that trigger the coverage gap.

Although I had been a practicing physician for thirteen years before I became a compliance officer, I knew very little about Medicare. My experiences with it have found it both intriguing and confusing. Medicare is the United States Government's health insurance program for people sixty-five years or older, for younger people with disabilities, and for individuals with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant). Medicare brought coverage to the elderly as health care costs began to increase and private insurance for the aged was at the verge of being utterly unaffordable. It is highly politically charged, with statutes and rules subject to every stripe of lobbyist and interest group. It has the largest budget of any federal program with massive unfunded

liabilities as the population ages and lives longer. It debits every employee's paycheck despite their age so that the largest bulk of its revenue comes from those who are currently working. It subsidizes the training of 100% of our country's doctors. It was instrumental in desegregating our country's hospitals. And it imposes over 130,000 pages of rules that have virtually nothing to do with patient care. In short, it is a mixed bag. For every point in its favor a negative can be easily thought of.

Despite the significant and far-reaching influence that Medicare has on the lives of Americans, it seems that Medicare is off limits, untouchable for criticism, almost sacrosanct when it comes to any substantive discussion of real reform. The rules are complex, often difficult to understand, and can change frequently. The Centers for Medicare and Medicaid Services (CMS) is structured to ensure the health of the elderly and others with specific chronic diseases. Any discussion of Medicare reform puts on the table the fact that coverage may need to be limited for some expensive, state-of-the-art therapies. This riles people up and consequently makes it a conversation politicians do not want to have. Yet the paradox is that there is nary a word raised about the endless administrative rules that pour forth out of CMS and the minutia of detail CMS can use on its rules for cholesterol tests, for example. At what cost does this conversation go unheeded? For the most part, Medicare does not provide coverage for preventive measures or services, but rather focuses coverage on chronic illnesses. The leading cause of death for all Americans is heart disease, yet CMS coverage does not address preventive measures such as blood pressure screening, screening urine for blood or protein (to look for early kidney disease) or cholesterol screening (to assess for early atherosclerosis). Surely these efforts, some not even needed to be performed by a physician, cost less than paying for a person's dialysis for the rest of their lives? If dialysis could be pushed off by even one year, how much does that save the public trust, let alone the patient's quality of living?

Medicare is not wholly without preventive services, but they are extremely limited and must be added by Congress on a one-by-one basis to the Social Security Act—not an easy feat. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) expanded Medicare's menu of preventive benefits by covering an initial preventive physical examination. This benefit, also referred to as the "Welcome to Medicare" visit, is an excellent way for new Medicare beneficiaries to get up-to-date on important screenings and vaccinations, as well as to talk with their health care provider about their medical history and how to stay healthy.

The Welcome to Medicare visit enables the health care provider to comprehensively review his or her patient's health, to identify risk factors that may be associated with various diseases, and to detect diseases early when outcomes are best. The health care provider is also able to educate

his or her patient about the Medicare-covered services they need in order to prevent, detect, and manage disease, to counsel them on identified risk factors and possible lifestyle changes that could have a positive impact on their health, and to make referrals or follow-up appointments for necessary care. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made several important changes to this benefit, including, significantly, extending the time a beneficiary is eligible for this benefit to one year after enrollment in Medicare.

The Welcome to Medicare visit is a comprehensive examination consisting of the following seven components:

1. A review of an individual's medical and social history with attention to modifiable risk factors
2. A review of an individual's potential risk factors for depression
3. A review of the individual's functional ability and level of safety
4. A physical examination to include an individual's height, weight, blood pressure, visual acuity, and measurement of body mass index
5. End-of-life care planning (e.g., reviewing health care power of attorney provisions and living wills)
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five components
7. Education, counseling, and referral, including a brief written plan such as a checklist for obtaining the appropriate screening and/or other preventive services Medicare covers.¹

There is a major problem with this initiative, however. It is only a one-time benefit for Medicare beneficiaries and ends for most beneficiaries at age sixty-six. Rather than this current format, prevention and screening should be done on a regular, periodic basis consistent with the medical guidelines that exist for cardiovascular disease, cancer screening, and other diseases. Since Medicare will only cover a sub-set of what is considered to be "medically necessary," once this initial visit benefit is used, the beneficiary will need to wait until they are sick with symptoms before another physician visit is covered. This runs counter to the education and

1. Welcome to Medicare Visit, <http://www.cms.hhs.gov/WelcometoMedicareExam/> (last visited Jan. 28, 2010).

training of most health care professionals, and even runs counter to how most private insurance plans work. The number of retirees will soon be growing at a much faster rate than the number of new workers and the expected life span of these retirees is much longer than in years past. Government healthcare policy-makers need to reconsider the preventive measures outlined in the Welcome to Medicare package as part of the ongoing services provided to Medicare enrollees, rather than waiting for these individuals to get sick or develop symptoms. Disease does not, at first, always present itself with symptoms. The quality of life issues and cost savings associated with prevention, early detection and treatment are certainly worth considering.

Health care reform discussions need to begin addressing Medicare reform. I do not present in this reflection the concrete solutions to the coming Medicare crisis, but I will offer four suggestions that need to be discussed and debated:

1. The components of the Welcome to Medicare visit should not be a one-time event, but should be a regular annual benefit for Medicare enrollees.
2. The cost for certain screening services, such as annual mammograms, PSA testing, colon cancer screenings, diabetes screenings, and kidney and heart function tests, should be considered for extension earlier than age sixty-five in order to minimize the costs of chronic care after age sixty-five.
3. Serious discussion should be had about limiting coverage for state-of-the-art care without proven results. This needs to be an open and frank discussion so that people do not misconstrue it as withdrawing coverage for basic care.
4. A bi-partisan commission should be established to examine how to simplify Medicare's administrative rules in order to ease the regulatory burden and bureaucratic cost for the health care industry.

Half a trillion dollars per year is worth a debate or two.²

2. Medicare spending in 2009 was estimated to be around \$511 billion. See Henry J. Kaiser Family Foundation, *Highlights from the 2009 Medicare Trustees' Report*, available at <http://www.kff.org/medicare/upload/7905.pdf>. (Click on "chartpack").