

Tennessee Bar Association

Health Care Rationing: Challenges for the Elder Law Attorney

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The Health Care Dilemma

1. Health care has always been rationed.

Implicit vs. explicit rationing.

With tension between the demand for health services and the cost of providing them, rationing is increasingly evident in all medical systems. Until recently, rationing was primarily through the ability to pay or achieved implicitly by doctors working within fixed budgets. Such forms of rationing are commonly alleged to be inequitable and inefficient and explicit rationing is advocated as more appropriate. Utilization management in the United States and quasi-markets separating purchasing from provision in the United Kingdom are seen as ways of using resources more efficiently and are increasingly explicit.

There is also advocacy to ration explicitly at the point of service. Explicit approaches are likely to focus conflict and dissatisfaction and be politically unstable. Explicit rationing is unlikely to be as equitable as its proponents argue and is likely to make dissatisfaction and perceived deprivation more salient. Despite its limitations, implicit rationing at the point of service is more sensitive to the complexity of medical decisions and the needs and personal and cultural preferences of patients. All systems use a mix of rationing devices, but the clinical allocation of services should substantially depend on the discretion of professionals informed by practice guidelines, outcomes research, and other informational aids.

David Mechanic, "Dilemmas in rationing health care services: the case for implicit rationing", *British Medical Journal* 310: 6995, 1655-9, June 24, 1995. See also David Mechanic, "Muddling Through Elegantly: Finding the Proper Balance in Rationing," *Health Affairs*, Sept./Oct. 1997, at 83.

2. Health care makes up one-seventh of the nation's Gross Domestic Product and is rising.

a. Government revenues are not keeping pace with the increased cost of health care and long term care.

b. The growth in costs of Medicare and Social Security is unsustainable, unless changes are made in benefits or revenue.

C. Eugene Steuerle, The Urban Institute, Excerpts from Statement before the Labor and Human Resources Committee's Subcommittee on Aging, U. S. Senate, May 14, 1996

(<http://www.urban.org/entitlements/aging.htm>):

What parts of the budget have grown the most in recent decades and are the greatest concern for the future? While health, retirement, and disability comprised less than 10 percent of the federal budget in 1950, they are now approaching one-half. The remaining half includes defense, interest on the debt, and everything else that the government does. Both retirement and health costs,

moreover, will rise significantly once baby boomers begin to retire early next century -- thus putting even more pressure on the rest of the budget.

It is vital to recognize that spending on retirement and health has been on a five-decade growth path that is not sustainable even if there were no demographic problem caused by declining birth rates and the upcoming retirement of the baby boom population. This demographic problem is highlighted by the movement of the baby boom hump through the age distribution. The budgetary problem, therefore, is really a dual one. No proposal for budget reform even in 1995 and 1996 dealt fully even with moving off of an unsustainable path, much less the second one related to demographics.

The push for larger and larger shares of our budget to be spent on additional years of retirement and greater amounts of health benefits increasingly makes our budget one oriented toward consumption. A larger share for retirement and health means a smaller share for everything else. It becomes difficult, in particular, to devote resources to promote productive activity among the young through programs of education, training, mentors, and after-school activities -- whatever it takes to move them away from the boredom, inactivity, isolation, and segregation that leads to so many of our social problems.

Built-in budget growth deters us from providing to our Presidents and Congresses the economic levers they must have to promote our interests as a world economic and political power. Even among the elderly, determining growth through past formulas has oriented increased resources less toward the needs of the poorer and older elderly and more toward additional years of retirement of relatively prosperous near elderly and younger elderly. In sum, we have taken from ourselves the freedom to allocate government resources by relying mainly upon past decisions and formulas to determine how today's expenditures should grow. This is reflected in part in the declining share of our budget which is discretionary -- going down to less than 30 percent by the end of the decade. As a consequence, our budget is increasingly likely to be oriented toward lower priorities and lesser needs.

Social Security and Medicare: Some Long-Term Patterns

One way to illustrate the full impact of Social Security and Medicare growth on the federal government's fiscal posture is to show how spending in these programs is expected to change as a percentage of the national economy or GDP. The assumptions here are based on the 1995 best estimates of the Social Security Administration and the Health Care Financing Administration, as well as some very conservative assumptions that growth in health costs will be brought under control almost immediately.

By 2030, the ratio of Old Age and Survivors (OASI) beneficiaries to workers is expected to rise by about 60 percent (see Figure 4). Partly for this reason, Old Age, Survivors, and Disability (OASDI) outlays (less income taxes on benefits) are expected to increase from 4.7 percent of GDP in 1996 to about 6.4 percent by 2030. Although projections of health spending are highly speculative, net Medicare spending would rise from 2.4 percent in 1996 to 6.4 percent in 2030 under intermediate projections of Social Security's trustees. Even under an extraordinarily optimistic assumption that Medicare costs per enrollee grow at the same rate as per capita GDP after 1996, health costs would still rise to approximately 3.8 percent of GDP by 2030. Demographic effects alone, therefore, imply that we will be spending close to 3.1 percent more of GDP on So-

cial Security and Medicare; in today's dollars, that is about \$227 billion more than if real spending merely kept pace with real growth in GDP. If we add current projections of inflation in real health costs, the additional amount to be spent rises to about 5.8 percent of GDP. These figures, moreover, do not take into account the growth in cost of Medicaid, including the substantial portion that goes for long-term care.

Now consider the bind that government will find itself in when projected growth of Social Security and Medicare is combined with already potent deficit pressures. If average tax rates were to remain constant at 1996 levels, and spending other than OASDI and Medicare are also held constant as a percent of GDP, then the deficit would rise to 7.7 percent of GDP by 2040. If one were to focus solely on taxes as a correction, and I do not suggest such action, it would eventually require an increase in Social Security tax rates of about 4 to 5 percentage points as we move toward the middle of the next century simply to prevent OASI from spending more than it takes in revenues. An increase of even greater magnitude would be required to keep Medicare taxes and expenditures in balance.

Lifetime Benefits. Perhaps the most important budgetary decision we have made over the years in Social Security has been to provide more and more years of retirement support. Figure 7 shows one aspect of this: the increase in life expectancy at age 65. People, however, are also retiring much earlier and many more are living to receive retirement benefits. For a couple retiring at age 62 today, annuity payments can be expected to last for one-quarter of a century on average. That is, the longer living of the two -- Social Security operates like an insurance policy with a right of survivorship -- will on average receive 25 years worth of Social Security benefits.

The combination of real growth in annual benefits, combined with more years of retirement support, lead to a significant increase in lifetime benefits. For an average income one-earner couple retiring at age 65 in 1960, for instance, total Social Security cash benefits were worth about \$99,000 (in 1993 dollars). Today those benefits would cost \$223,000. In another 25 years, the Social Security pensions of new retired couple with average incomes will have a value of about \$313,000. Remember again that one reason these lifetime costs are this high is that benefits are scheduled to last for more than two decades.

When Social Security and Medicare benefits are added together, an average-income couple retiring today is promised benefits not far from 1/2 million dollars -- growing toward \$800,000 by the year 2030. For some high-income couples retiring in the future, the value of benefits will approach 1 million dollars.

The growth in future costs, of course, is unsustainable. The rise in value reflects what is promised, not what can be delivered. Based upon lifetime values, however, even today's benefits are not trivial. The difficulty is that we have given up control over how to allocate them. Rather than devoting them, for instance, toward keeping all the elderly out of poverty, we continue to provide substantial numbers of years in retirement and more and more in the way of health benefits. In the latter case, of course, some of the increased cost tends to go toward higher prices for health care rather than more services, and to support higher compensation levels among health care providers.

3. Federal, state and local government will ration health care.

a. It is inherent in any health care system. President Clinton, already facing formidable obstacles in reforming the health care system, denies that it will involve any rationing. This is politically understandable, but wrong. Infinite needs are rapidly overtaking finite resources. Most health providers recognize that the genius of modern medicine has outpaced our ability to pay. But the public still has unlimited expectations and a blind faith that everything can be provided to everyone by simply eliminating "waste, fraud, and abuse." Rationing is inherent in any health care system. As government undertakes to define what is "medically necessary or appropriate," it will unavoidably undertake a series of rationing decisions. Health care is being transformed from a private good to a public good. Government, when it reforms the health care system, must inevitably ask: How do we buy the most health for the public? R. D. Lamm, "Rationing and the Clinton health plan", *J Med. Philos.* 19: 5, 445-54, October 1994.

b. In any system of third party payment for health care, such care will be rationed. A clear policy agenda will be focused upon three questions: Who should ration? What mechanisms should exist for making and implementing rationing decisions? What are the criteria by which rationing should occur? S. Harrison, "A policy agenda for health care rationing", *British Medical Bulletin* 51: 4, 885-99, October 1995.

4. The elderly are heavily dependent upon Medicare and Medicaid payments for health care and long term care expenses.

The burden of cost shifting and reduction or elimination of services will be felt keenly by this group.

a. One criterion for rationing is the age of the benefits recipient. The U.S. has focused attention on the rising costs of health care coincident with the increasing age of the population. Arguments have been made to overtly ration care to older persons; however, general acceptance of the need to ration scarce resources, whether or not such a policy is actually formalized, can lead to covert rationing. Some overt rationing has already occurred, some of the data put forth to justify that rationing needs to be challenged, and ethical principles need to be applied to provide appropriate and perhaps less costly care. P. L. Blanchette, "Age-based rationing of health care", *Hawaii Med. Journal* 54: 4, 507-9, April 1995.

b. Cost-shifting will occur, for example, to the benefits recipient's family. In response to a demographic imperative, many countries have established policies to increase family involvement in the care of their dependent elderly relatives. Reflecting fiscal constraints and cultural norms, these policies are often designed to place the burden of care on family rather than government. Cost-shifting includes three approaches to increasing family care of elderly people: filial support legislation, incentives for family caregivers, and service rationing provisions. Policies that require or encourage relatives to provide care may have adverse consequences for elderly people and their families. Human services advocates should support policies and interventions that provide universal access to a continuum of care alternatives that facilitate rational health care decision making by families and that empower and sustain family members who choose to care for

elderly relatives. S. Barusch, "Programming for family care of elderly dependents: mandates, incentives, and service rationing", *Social Work* 40: 3, 315-22, May, 1995.

Forms of Rationing

1. Denying or prioritizing services

A. The Oregon Health Plan

The author (Sipes-Metzler) of the following is affiliated with the Oregon Health Services Commission:

The Oregon Health Plan gained national attention by changing the focus of health care from who is covered to what is covered. This change was facilitated by insurance reforms in the areas of small market, employer mandates, high risk pooling and Medicaid. Most controversial of the reforms is the use by the legislature of a prioritized list of health services to determine benefit levels for the insurance programs. Significant debate has occurred over whether the use of such a list is rationing or reasoning. The Oregon Health Plan represents a thoughtful and deliberate blending of fact with public value for the purpose of responsible health policy. It is that unique blending of public values developed through community participation with fact that focused the attention of the world on Oregon. R. Sipes-Metzler, "Oregon Health Plan: ration or reason", *J. Med. Philos.* 19: 4, 305-14, August 1994.

Senate Bill 27 (1989) extended Medicaid coverage to every Oregonian with income below the federal poverty level (currently \$1300 per month for a family of four) and guaranteed them a basic benefit package (Standard Benefit Package) based on a prioritized list of health services. This expansion was contingent on receiving a waiver of federal law from the Health Care Financing Administration (HCFA). Where possible, SB27 requires that Medicaid deliver services through managed care plans to coordinate treatment and reduce costs. It also requires rates to Medicaid providers be reimbursed at reasonable rates to end the cost-shift due to Medicaid underpayment.

Basic Benefit Package: Senate Bill 27 created the Oregon Health Services Commission to rank medical services from most to least important to the entire population. The Legislature defines the Standard Benefit Package from this list. See the Oregon Health Plan Home Page at <http://www.oregon.gov/DHS/healthplan/index.shtml>.

The Oregon Health Plan has not been received with universal acclaim, however:

The goal of the Oregon Health Plan is to achieve universal coverage throughout the state. The first step under the plan is to expand Medicaid assistance to everyone below the poverty line. However, the plan is partly financed with a complex, bureaucratic, central planning, government rationing scheme under which the government -- rather than the patients and their chosen doctors -- decides which services and treatments patients should receive. This rationing scheme cannot be operated effectively as a practical matter and, as a matter of ethical principle, it unacceptably restricts the freedom of individuals to control the health related transactions they want, need and prefer.

Finally, the Oregon Health Plan will not only fail to reduce costs, but will increase them instead. The state now estimates that the plan will cost \$708 million in state funds over the 1995 - 1997 biennium, almost twice the estimated Medicaid cost over the 1993 - 1995 biennium without the Oregon Health Plan reforms, which was \$388.5 million. With federal funds, the total cost of the Oregon Health Plan over the 1995 - 1997 budget cycle would be \$1.9 billion, again almost double the total estimated 1993 - 1995 Medicaid cost without the reforms, which was just over \$1 billion. Moreover, these cost-increasing incentives in the Oregon Health Plan are just beginning to take effect.

The Oregon Health Plan includes some highly desirable goals. It seeks to end the drastic underpayment of doctors and hospitals typical of Medicaid across the country, which boils down to imposing back-door rationing on the poor and a hidden tax on the middle class through cost-shifting. Universal coverage and cost control are also highly desirable goals. But these goals need to be achieved through means that are not only effective but that maintain freedom of choice and control by patients and consumers over their own health care. P. J. Ferrara, "Power to the People--Positive Alternatives to the Oregon Health Plan", Cascade Policy Institute, *Health Care Policy Insight* #3, October 1994.

B. Tennessee's Moratorium on Nursing Home Beds

The General Assembly has sharply limited the number of nursing home beds that can be approved by the Tennessee Health Facilities Commission.

Currently, the state has about 38,000 licensed beds. Under the new legislation, a Tennessee county may have no more than 48 nursing home beds for every 1000 residents age 65 or over.

This still puts Tennessee about 9000 beds over the limit. Ninety-eight percent of all nursing home beds, however, are full.

The legislature hopes the new law will cap the growth of Medicaid expenditures for nursing home care. Although health care for the poor in Tennessee is now paid for by TennCare, Medicaid still pays 73 percent of nursing home bills in the state.

Because the law contains automatic renewal provisions, the moratorium on new nursing home beds, set to expire on June 30, 1997, will likely be renewed. The new law applies to all nursing home applications filed after April 15, 1996.

"Hopefully this [nursing home cap] will cause the industry to move toward the best alternative for long-term care versus the most expensive. We're not criticizing the industry; this is just our first step in moving long-term health care services along," Bill Corker, Tennessee's Commissioner of Finance, said when the bill was passed.

C. Raising the standard of medical necessity for nursing home bed space:

The state of Maine is likewise seeking ways to reduce the number of licensed beds by 50 percent, according to Portland, Maine, attorney Timothy M. Vogel. Maine currently limits access to long term care by heightening the standards for medical necessity required of a patient to receive Medicaid.

2. Cost shifting

A. To state and local governments

Under the 1995 Republican Medicaid reform proposal, vetoed by President Bill Clinton, Medicaid long term care financing would be changed from an entitlement program under federal law to a block grant program under state law. Due to differences in funding formulas, the shares of funds in block grants to certain states would be cut significantly, while other states would see an increase in funding.

B. To the benefits recipient

i. Example: Medical Savings Accounts

Medical Savings Accounts (MSA) are included in the Health Coverage Availability and Affordability Act, sponsored by Senators Edward Kennedy, D-Mass., and Nancy Kassebaum, R-Kan.

No more than 750,000 MSAs could be established and only by people who are self-employed or work for businesses with fewer than 50 employees. The test would last for four years, and Congress would need to act in order to extend it.

Experts are sharply divided on the merits of Medical Savings Accounts.

Under a MSA, persons would pay for a catastrophic medical insurance policy with a high deductible. Money saved instead of buying a traditional health insurance policy or contributing to Medicare would be placed into a MSA. Medical expenses below the deductible could be paid for out of the MSA or the person's own funds.

The maximum deductible would be \$2250 for individual policies and \$4500 for family policies. Furthermore, the bill would limit "out of pocket" costs beyond the deductible amounts and the amount of money that could be sheltered from taxes.

"With workers paying for non-catastrophic expenses out of their own MSA funds, they would have normal market incentives to control costs," writes Peter J. Ferrara of the Cascade Policy Institute.

"They would avoid unnecessary care, and providers with excessive charges. They would be more likely to only consume health services where the benefits exceeded the costs. Probably more importantly, with this new consumer cost concern, doctors and hospitals would ethically compete to reduce costs as well as maintain quality instead of competing through the political process as another special interest group. Costs would consequently be controlled through incentives and competition, consistent with consumer preferences."

Republicans who have championed the measure stress that MSAs increase consumer choice and move the government away from market regulation of health care.

Critics of the MSA proposal argue that it suffers from an adverse selection problem. They argue that the MSAs would primarily be chosen only by the lower cost healthier retirees, not the higher cost sicker retirees. With the lower cost retirees opting out of Medicare along with their portion

of the funds, and the higher cost retirees staying, the result would actually be higher overall costs.

On this basis, the Congressional Budget Office estimated last fall that the MSA option would increase Medicare costs by \$2.3 billion over 7 years, figures disputed by the National Center for Policy Analysis.

Gail E. Shearer, a health policy analyst for Consumers Union, told the *New York Times* in July 1996 that rather than "pooling resources to take care of people when they get sick," MSAs "funnel money away from doctors' bills and into accounts that will help healthy people accumulate wealth."

John Burry, Jr., Chairman and CEO of Blue Cross Blue Shield of Ohio calls MSAs "a quick fix that will destroy the American health care system."

ii. Under the Republican Medicaid reform proposal, the Nursing Home Reform Act of 1987 would be repealed, and enforcement of nursing home standards left to the states.

iii. According to Leslie S. Madge, an elder law attorney in Littleton, Massachusetts, "For the last year or so, Massachusetts has been limiting the effective start date of benefits to the date of the medical screening [for eligibility for Medicaid long term care benefits]. And the screening agencies have been instructed not to do a screening until proof of the filing of a Medicaid application. This effectively eliminates all retroactive benefits." As a result, the patient pays.

C. To the benefits recipient's family

The Republican proposal last year to reform Medicaid long term care financing would have permitted the states to enact rules placing responsibility for payment for long term care on the children of benefits recipients. This is called filial responsibility.

Moreover, Federal rules that protect community spouses from impoverishment would be left to state discretion.

D. To health care providers

i. National Governors Association Proposal (Feb. 1996):

The governors have likewise proposed that Medicaid be turned over to the states in what is essentially a form of block grants. Each state would receive a lump sum of money. A package of benefits that must be offered would be specified.

But each state would be free to define the "amount, duration and scope of services." Moreover, each state would be free to set Medicaid payment rates for health plans, doctors, and hospitals.

Opponents of the plan are concerned about this discretion. Long-term care providers would have no means to seek reimbursement rates from the states because the Federal law guaranteeing "reasonable and adequate" compensation would be repealed.

"Without fair reimbursement rates," says the American Association of Homes and Services for the Aging, "access to quality nursing home care for Medicaid recipients will be limited."

ii. Health Maintenance Organizations (HMOs)

Approximately 12 percent of all Medicare-eligible persons are enrolled in Medicare HMOs. An avowed aim of the Clinton Administration is to increase the number of enrollees in Medicare managed care organizations.

In a speech to the AARP on May 23, 1996, Bruce C. Vladeck, HCFA Administrator, said, "Since 1993, we've experienced almost a 70% increase in Medicare managed care enrollment. On average, nearly 70,000 Medicare beneficiaries per month choose managed care. More than 4 million beneficiaries have elected to enroll in a Medicare managed care plan. Almost 300 organizations currently contract with HCFA to serve Medicare beneficiaries, including 208 that do so on a risk basis."

From: Social Security Handbook, Section 2423. Health maintenance organizations.

HEALTH MAINTENANCE ORGANIZATIONS. A Medicare beneficiary eligible for hospital insurance benefits and medical insurance benefits or only medical insurance benefits may choose to have covered health insurance services furnished through a health maintenance organization (HMO) or Competitive Medical Plan (CMP) by enrolling in an HMO or CMP that has a Medicare contract.

An HMO or a CMP is an organization which provides to its members, who are also Medicare beneficiaries, either directly or through arrangement with others, at least all the Medicare covered services which are available to Medicare beneficiaries who are not enrolled in the organization who reside in the geographic area served by the organization. Some HMOs and CMPs also provide services not covered by Medicare, either "free" to the Medicare enrollee (that is, funded out of the payment Medicare makes to the organization), or for an additional charge. HMOs and CMPs typically charge a set monthly premium and nominal copayments for services instead of Medicare's coinsurance and deductibles.

How they work: Anyone enrolled in Part A and Part B Medicare is generally eligible (there are a few exceptions). The participant continues to pay his Part B Medicare premium. In return, he ordinarily receives more benefits for the same money. Participants often can pay additional premium to the HMO for even more coverage, such as for prescription drugs.

In addition to the monthly premium paid by each enrollee, HMOs make their money by receiving from the Health Care Financing Administration (HCFA) a fixed monthly amount per enrollee. HCFA claims to be the largest purchaser of managed care services in the country. (See <http://www.hcfa.gov/facts/mc0496.htm>.)

The enrollee is limited in the choice of hospitals and physicians he can use. The enrollee must select and see a primary care physician in his locality, who then recommends and refers the patient to a network physician or hospital for specialized care if necessary and approved by the HMO. For example, Health1·2·3 Platinum, a Vanderbilt health plan, requires that its enrollees reside in one of 18 counties in Middle Tennessee.

The HMO contracts with the health care providers and pays a flat monthly fee per patient to a health care provider in return for the provider's services. This arrangement, known as capitation payment, makes the primary care physician liable for any costs the patient incurs for specialty

care made at the referral of the primary care physician. Thus, the more referrals the physician makes, the lower payment the primary care physician retains. This leads to an incentive to minimize referrals. Because the physician is paid a fixed fee whether or not he sees the patient, it is likewise in the physician's best financial interest to limit his services to the patient.

This is the controversial aspect of Medicare HMOs. Critics charge that the fundamental structure of an HMO creates an irreconcilable conflict between the patient's health care needs and the provider's financial incentive to limit or ration those needs. No such financial incentives to limit care exist under traditional pay-as-you-go Medicare.

On March 27, 1996, the Department of Health and Human Services issued rules implementing the provisions of a 1990 budget reconciliation act requiring HHS to regulate physician incentive plans in prepaid plans with Medicare and Medicaid contracts. HHS issued a notice of proposed rulemaking on Dec. 14, 1992.

HHS Press Release (March 26, 1996):

In addition, the regulation outlines the requirements for managed care plans with physician incentive plans that put physicians at substantial financial risk for referral services. Such managed care plans will be required to put limits on financial losses for their physicians, as well as to conduct annual beneficiary surveys. "No patient should have to wonder if their doctor's decision is based on sound medicine or financial incentives," said HHS Secretary Donna E. Shalala. "This regulation should help put Americans' minds at rest."

"The final rule addresses some of the concerns of Congress and the public about the pressures and incentives HMOs create for physicians' care decisions," said HCFA Administrator Bruce C. Vladeck. The regulation applies to physicians providing medical care through health maintenance organizations, competitive medical plans and health insuring organizations. Under the regulation, HCFA may impose intermediate sanctions and HHS' Office of the Inspector General may impose civil monetary penalties upon Medicare or Medicaid managed care contractors who fail to comply.

The rules were scheduled to take effect in sixty days. Numerous HMOs objected, asserting that the rules would play havoc with their carefully negotiated contracts with health care providers. On May 28, 1996, HCFA mailed a memorandum to HMOs, saying "We realize this compliance date is unrealistic." The memo added that enforcement actions would not take place before January 1, 1997.

E. To employers

Beginning in 1997, the Oregon Health Plan imposes an employer mandate requiring all employers in the state to pay 75 percent of the cost of health coverage for their workers.

3. "Futile and Inappropriate Care"

"The difficulty is that elderly patients, simply because they are elderly, risk having their treatment considered futile when it is needed for a critical illness with an uncertain outcome. This seems particularly true when futility entails writing off procedures with a low probability of

benefit or only a short-term benefit. But the recent history of medical care for the elderly has shown a dramatic reversal of earlier patterns. There has been a decline in (but not a disappearance of) the age-based stereotyping by which the elderly were once dismissed as candidates for many forms of surgery and aggressive therapies.

"What seems clear now is that age as such is a poor predictor of medical outcome. Determining a priori that a certain form of care is futile or inappropriate is no more rational in the case of the elderly than in the case of any other age group." Callahan, Daniel, "Controlling the Costs of Health Care for the Elderly -- Fair Means and Foul," *New England Journal of Medicine* 1996; 335:744-746 -- September 5, 1996.

"The particular challenge for the elderly and disabled is the tendency to write off their medical problems because they are chronic and will never return to full health. We see it all the time in managed care denials of LTC services, home or facility-based, on the basis that the person is chronic, not improving, etc., even though there is a skilled need." Scott Severns, Attorney at Law, Indianapolis, Indiana (correspondence to the author).

The Challenge for Elder Law Attorneys

These examples can be multiplied manifold. Some, such as the Oregon Health Plan, do not apply strictly to the elderly (like Tennessee's TennCare program, the OHP does not replace Medicare or Medicaid long term care financing), but are merely indicative of which way the tide is flowing. In the end, the burden of health care rationing falls on the individual and his family. How should elder law attorneys respond?

1. HMO Appeals Process

Gail Edson writes:

"The [HMO payment] structure provides incentives for plans to keep utilization of services to a minimum. This focus on cost-containment often results in improper claim denials or over-restrictive plan practices. Recourse for claim denials and restrictions is available through an extensive set of federal laws and regulations. Both plan specific and administrative and judicial review are available to Medicare beneficiaries via federal appeals procedure. Some states also regulate the provision of managed care benefit plans. Actual utilization of such protections, however, is minimal. Beneficiaries do not pursue appeals for three reasons. First, many beneficiaries and advocates are unaware of appeal rights and procedures. Second, access denials usually occur when a beneficiary is ill and unlikely to be in a position to challenge the system. Additionally, the beneficiary may feel ill-equipped to establish the medical proof necessary to establish medical necessity determinations. Third, many beneficiaries choose to disenroll rather than challenge the system. Current law allows beneficiaries to leave Medicare managed care plans with only thirty days notice. Alternatively, beneficiaries may not appeal or disenroll because they fear losing an established physician-patient relationship. Therefore, many advocates feel that the most pressing need in the Medicare managed care system is a network of trained advocates able to explain and maneuver the complex managed care appeals process, as well as ensure that adequate due process mechanisms are in place."

Medicare, General: Statutes and Regulations

- Statute: Title XVIII of the Social Security Act: 42 United States Code 1395
- Regulations Promulgated by the Health Care Financing Administration: 42 Code of Federal Regulations Part 400
- Medicare Appeal Sections
- Appeal Regulations for Medicare Part A: 42 C.F.R. 405.701 et seq. oAppeal Authority for Medicare Part A Hospital Benefits: 42 U.S.C. 1320c-3(a) & (e)
- Appeal Statutory Authority and Regulations for Medicare Part B: 42 U.S.C. 1395u(b)(3)(c) and 42 C.F.R. 405.801 et seq.

Health Maintenance Organizations: Statutes and Regulations

Federal HMO Act:

- Authorizing Health Care prepayment plans: 42 U.S.C. 1833(a)(1)(A)
- Requiring existence of meaningful grievance procedures in all federally qualified HMOs: 42 U.S.C. 300e(c)(5)

Regulations:

- Concerning federally qualified HMOs: 42 C.F.R. 417.100 - 417.180
- Concerning cost and risk HMOs and CMPs: 42 C.F.R. 417.400 - 417.694

Medicare Managed Care: Statutes and Regulations

Statutes:

- 42 U.S.C. 1876(c)(3)(E)
- 42 U.S.C. 1876(g)(6)
- 42 U.S.C. 1876(i)(3)

Regulations: 42 C.F.R. Part 417 subparts A through F

2. Utilization of Advance Directives

Some practitioners are suggesting that advance directives will become a cost-saving tool, rather than an expression by a patient of the right to elect one's health care treatment.

Professor Thomas Wm. Mayo: Ezekiel Emanuel's latest study appears in the June 26, 1996, issue of the *Journal of the American Medical Association*. He reviews the results of three randomized trials to determine the extent of cost-savings that can be produced by hospice or advance directives in the last 12 months of life. The studies showed no savings, but he characterizes all of the

studies as flawed. The eight nonrandomized trials showed a wide range of savings, from 68% to none, but he identifies five methodological problems with these studies, too. For whatever reason, he concludes that the data suggest the cost savings from hospice care and/or advance directives will be in the range of 25 to 40% of health care costs in the last month of life, 10 to 17% over the last 6 months, and 0 to 10% over the last 12 months. In addition to recommending a more definitive study, he recommends increased use of hospice and advance directives "because they certainly do not cost more and they provide a means for patients to exercise their autonomy over end-of-life decisions." [Emanuel, E. J., "Cost Savings at the End of Life -- What Do the Data Show?", *Journal of the American Medical Association* 1996;275:1907-1914.] All in all, a very modest claim for cost savings. Prof. Thomas Wm. Mayo, SMU School of Law, tmayo@mail.smu.edu.

"The elderly often think of themselves as a burden to their families. Some dislike any form of dependence, whereas others worry that their dependence will be excessive and will drag their loved ones down with them. The temptation to play on this worry in order to talk an elderly person into signing an advance directive (or appointing a surrogate) is real. Seemingly, such a patient is merely expressing preexisting values. But the perversion of advance directives is possible if they are used in this way, building not on a person's strengths, which an expression of self-determination is meant to embody, but on anxieties and fears." Callahan, *op. cit.*

3. Antitrust

Prof. Frances Miller, Boston University School of Law, suggests that in the not-too-distant future antitrust law will become an important tool in regulating the business of delivering health care services in the United States. Address to the National Academy of Elder Law Attorneys 1996 Symposium on Elder Law, Cambridge, Massachusetts, May 17, 1996.

A. Columbia/HCA Health Care

"Hospitals, surprisingly, have emerged as a prime growth industry attractive to entrepreneurs. Seemingly, a legacy of overbuilding combined with competitive cost-cutting pressures should reduce the earnings of nonprofit and for-profit hospitals alike, making them unattractive investment candidates. Yet in the 1990s, for-profit hospital chains on a buying binge have outpaced the stock market. Conversions of nonprofit to investor-owned hospitals have accelerated, reaching a level of 58 in 1995, up from 34 in 1994.

"This two-part article addresses the medical, ethical, and public-policy issues posed by the resurgence of for-profit chains and their acquisition of nonprofit community hospitals. The prime case in point is Columbia/HCA Healthcare Corporation, the largest and most aggressive of the for-profit chains, the product of three large and several smaller mergers. With 340 hospitals, 135 outpatient-surgery offices, and 200 home health care agencies in 38 states, Columbia/HCA now controls nearly half the for-profit beds, and 7 percent of all hospital beds, in the United States. The company's gross earnings exceed 20 percent of revenues, and its 1995 profits were just under \$1 billion, with \$20 billion in assets. It is now the nation's 10th largest employer, with 240,000 employees." Kuttner, Robert, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business," *New England Journal of Medicine* 1996; 335:362-367, 446-451, August 1 and 8, 1996.

B. Managed-Care Mergers and Acquisitions

"Hoping to cash in on the increasing number of Medicare recipients who are joining managed-care plans, Pacificare Health Systems, Inc. announced yesterday that it would buy the FHP International Corporation for \$35 a share--\$2.1 billion in cash and stock.

"The deal between the two companies, both based in Orange County, Calif., would form the nation's fourth-largest for-profit managed-care company, with about four million members in 15 states and \$8.6 billion in combined revenue.

"The merged company would also have nearly a million members on Medicare, the Federal program that guarantees health care for Americans 65 and older, making it to the largest provider of managed care to Medicare recipients.

"Medicare patients spend nearly four times as much on health care as do younger patients. They would represent about half the revenue of the new company, said Alan R. Hoops, Pacificare's president and chief executive.

"Reimbursements from Medicare are rising at a time when prices that health maintenance organizations charge commercial customers like large corporations have remained flat. In addition, the number of Medicare recipients choosing to join H.M.O.'s is gaining momentum, creating a strong opportunity for growth. 'This is really perhaps the heart of the opportunity of bringing the companies together,' said Mr. Hoops, who will run the combined company under the Pacificare name. . . .

"At \$2.1 billion, the price paid by Pacificare works out to approximately \$1,200 an H.M.O. subscriber, considerably less than the \$3,800 a patient the Aetna Life and Casualty Company paid earlier this year in its \$8.9 billion purchase of U.S. Healthcare, one of the country's largest managed-care concerns.

"Part of the reason for the lower price, according to Robert J. Hoehn, a Salomon Brothers analyst in New York, is the highly competitive California market.

"At time when many managed-care companies are being squeezed by higher costs and seem to have little ability to raise prices for their services, Pacificare will gain by swallowing its largest local competitor. As a bigger player, it will have more power when it negotiates contracts with doctors and employers." *New York Times*, August 6, 1996. (Note: The terms of the deal are subject to Federal and state regulatory review and approval of the shareholders of both companies.)

"Aetna Leaves Medicare Fee-For-Service

"Aetna Life Insurance Company is not renewing its contracts with HCFA to participate in the Medicare Part A and Part B fee-for-service program. Instead, Aetna plans to concentrate on its growing managed care business, including Medicare products offered through its affiliated health maintenance organizations (HMOs). Medicare managed care is one of the fastest-growing segments of Aetna's health business.

"In order to enable Medicare beneficiaries, physicians, and providers to make the transition to new contractors, Aetna agreed to extend its contracts through September 30, 1997.

"HCFA will negotiate agreements with other contractors over the next several months to administer the Medicare program for beneficiaries and providers in the jurisdictions served by Aetna. These areas include Alaska, Arizona, Georgia, Nevada, Oklahoma, Oregon, Hawaii, New Mexico, Washington, Guam, and the Northern Mariana Islands." *HCFA Health Watch*, September 1996.

4. Independent Standards for Managed Care Plans

July 16, 1996, Press Release:

NCQA ISSUES A DRAFT OF HEDIS 3.0

The national standard for measuring and comparing health plan performance is significantly enhanced

WASHINGTON -- The National Committee for Quality Assurance (NCQA) today released for public comment a new draft version of HEDIS, a measurement tool which helps consumers, corporations and public purchasers evaluate the quality of managed care plans.

This new version, HEDIS 3.0, contains: 1) measures that track how well health plans do at helping sick people get better; 2) indicators to assess how effectively plans address the nation's most pressing health problems, such as cancer, heart disease, smoking and diabetes; and 3) a survey to gauge how consumers view the care they receive.

HEDIS 3.0 was developed under the direction of the broad-based Committee on Performance Measurement (CPM). The 24-person CPM (see page 5) -- which includes public and private purchasers, consumers, labor unions, health plans and measurement experts - has endorsed HEDIS 3.0 as the national standard. HEDIS has been implemented by more than 330 plans nationwide, and underlies most employer and plan "report cards."

The HEDIS 3.0 "Reporting Set" -- those measures that plans will be expected to report in 1997 -- includes 75 measures (in contrast, HEDIS currently includes about 60 measures). Another 30 measures are included as a "Testing Set" for further evaluation; these measures will be moved into the Reporting Set at a future date if evidence establishes that they meet the CPM's criteria. . .

The joining together of public and private reporting requirements is not only more efficient, but provides a common yardstick for assessment. Bruce Vladeck, Administrator of the Health Care Financing Administration (HCFA), said, "The inclusion of measures related to Medicaid and Medicare into HEDIS 3.0 is a significant step toward obtaining comparable plan performance data, which will allow both HCFA and its beneficiaries to hold plans accountable for the quality of care they deliver. In particular, HCFA is gratified by the inclusion of a functional status measure for its Medicare population."

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"The National Committee for Quality Assurance, NCQA, is an independent, nonprofit organization that assesses and reports on health plan quality. Through accreditation reviews and standardized measures of health plan performance, NCQA holds health plans accountable for the quality

of care and service they deliver. We provide health plan information to consumers free of charge. NCQA does not, however, represent consumers or intervene with health plans on their behalf." [[http://www.ncqa.org/.](http://www.ncqa.org/)]

5. Long Term Care Insurance

Less than five percent of the long-term care custodial care expenses in the United States are paid by long-term care insurance companies. With the passage of the Kennedy-Kassebaum bill (Health Coverage Availability and Affordability Act) and the criminalization of asset transfers in order to qualify for Medicaid long-term care benefits, LTC insurance should become more important in the asset protection plans of the elderly (those that are healthy, that is), particularly since the bill grants tax breaks to policyholders. Earlier in this paper we discussed cost-shifting; purchasing LTC insurance is simply another form of shifting the cost of long-term care to another.

6. Housing and Care Alternatives

As the states continue to be squeezed in Medicaid dollars that are available for payment of LTC expenses, the criteria for medical eligibility for nursing home care will continue to become more restrictive. We are not serving our clients if we insist on preparing them for financial eligibility and yet find that in the end they cannot obtain Medicaid benefits because of medical ineligibility. A client who is not medically eligible still needs our help in identifying alternatives to single-family, independent living. Among the most common of these alternatives are:

Shared Living Residences

These are homes in which unrelated people live together. Bedrooms are private; bathrooms may be private or shared; all other living spaces are shared. A manager is usually responsible for overall maintenance, housekeeping, shopping, and dinner preparation. In states that license boarding homes, a group residence may be licensed as Class B or Class C boarding homes.

Foster Care

Similar to foster care programs for children, this service places an older person in need of a modest amount of assistance into a family environment.

Boarding Homes

Many states classify and license these facilities. In New Jersey, for example, Class A boarding homes provide rooms and baths, but no other services. Class B and C boarding homes provide rooms, baths, linens, and meals. Class C homes, in addition, provide 24-hour supervision, financial and personal services, including medication monitoring.

Assisted Living Residences

"Assisted Living" means a coordinated array of supportive personal and health services, available 24 hours per day, to residents who have been assessed to need these services, including residents who require formal long-term care.

These are residences licensed by the Tennessee Health Department to provide apartment-style housing, congregate dining, and to assure that assisted living services (as defined above) are available when needed. At a minimum, apartment units offer one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance.

Comprehensive Personal Care Homes

These are facilities provide room and board and assure that assisted living services (as defined above) are available when needed.

Board and Care Homes

A study by Congress found that there were over 225 different titles that various states used to describe board and care homes. In Tennessee they are called "homes for the aged." These facilities are just below the level of nursing home care. They should not be confused with boarding homes, which often offer nothing more than a bed and room for an elderly resident.

Board and care homes may provide two levels of care. One level of care is assisted-living in which room, meals, personal assistance, 24-hour security, and recreational activities, medication supervision and limited health services are provided. The second level of care offers intermediate and/or skilled nursing care.

Residential Health Care Facilities

These are licensed facilities that provide: health maintenance and monitoring services under the direction of a professional nurse, room, meals, linens, housekeeping, personal assistance, laundry, 24-hour security, financial management, and recreation activities, medication supervision and limited health services.

Continuing Care Retirement Communities (CCRCs)

Continuing care retirement communities (CCRCs) offer seniors long-term contracts that guarantee lifelong shelter and access to specified health care services. In return, residents usually pay a lump-sum entrance fee and regular monthly payments. Depending on the contract, the entrance fee may be nonrefundable, refundable on a declining basis over time, partially refundable, or fully refundable. CCRC residents enjoy an independent lifestyle with the knowledge that if they become sick or frail, their needs will continue to be met.

These communities provide a continuum of care from independent housing through skilled nursing care.

Senior Housing

These are apartment buildings for the elderly and disabled, which may have some subsidized units; construction or rental costs may be financed by the state or federal government. Sponsors include non-profit, limited profit organizations or public housing authorities.

7. Nursing Home Reform Act

It is important that our clients and the relatives of our clients be counseled on their rights under the federal Nursing Home Reform Act (OBRA 1987, 42 U.S.C. §§ 1395I-3 and 1396r, et seq.). Under the Act (which was subject to be repealed in 1995 under the House and Senate majority Medicaid reform proposals), the care provided to residents must be "in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident."

Practitioners must assist their clients in identifying long-term care that does not meet their rights to quality care and in learning how to advocate for those rights.