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# Medicare as a National Debate in the U. S.: Policy Analysis of the Balanced Budget Act of 1997

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The current paper examined political and economic environments and key actors that affected and shaped the Medicare reform through the birth of the Balanced Budget Act (BBA) of 1997. As a social product, the BBA reflects various political and economic climates as well as the interactions with key actors and interest groups. Politically, there was a consensus that Medicare would be a public program operated by the federal government and that the politics of Medicare is bipartisan, supported by Republicans and Democrats. Economically, there was a shared opinion that an economic alternative to the inefficient and overspending health care system was to achieve a market-based health system, which encourages competition between insurers. At the same time, the legislation process in the United States showed why incremental changes are more politically feasible than comprehensive reforms.

**Key Words:** Medicare, Elderly Care, Balanced Budget Act, Medicare+Choice

## I. Introduction

One of the most serious problems with the U. S. health care system is how to control the skyrocketing health care costs without lowering quality of service. The federal government spent \$256 billion dollars on Medicare in fiscal year (hereafter FY) 2002 and that number will double in a decade (Congressional Budget Office 2002)<sup>1</sup>. Medicare is the largest domestic program in the federal budget other than social security (Newhouse, 1996: 159). The Balanced Budget Act (hereafter BBA) of 1997 resulted from the effort to control the Medicare costs. The BBA called for budget surplus by 2002 and reformed Medicare, creating Medicare + Choice program. The basic trust of these provisions was to offer Medicare beneficiaries more managed-care options and to subject the providers of skilled nursing facility and home health care to prospective payment via administered prices that would be determined by HFCA<sup>2</sup>) (Vogel, 1999:23).

The purpose of this paper is to explore the factors that affected the Medicare reform in the U. S. Firstly, it examines political and economic environments which shaped the birth of BBA. Secondly, it investigates the key actors such as health care providers, purchasers and interest groups- that affected and influenced the policy enactment. As a social product, the BBA reflects various political

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1) The federal government spent \$214.6 billion dollars on Medicare in fiscal year(FY) 1997 (HCFA, 1998), representing 12 percent of all federal spending.

2) Health Care Financing Administration

and economic climates, and will be operated and modified according to the interaction with various changing political and economic atmospheres. Looking at the various factors that affected the birth of BBA will provide us with much clearer ideas about the future direction of the Act and its impact on health care of the elderly. The legislation process in the United States also shows why incremental changes are more politically feasible than comprehensive reforms.

## II. Brief Description of the BBA

In 1997, Republicans and Democrats made an effort to reach a bipartisan budget agreement. The BBA of 1997 (H.R. 2015) was signed by President Clinton on August 1, 1997. The Act provided for a balanced budget by FY 2002 (a goal met in FY 1998), with the most of the program saving coming from Medicare. The BBA initiated a new era of expanded options for Medicare beneficiaries. It modernized Medicare by granting new health care options for seniors, while maintaining the traditional system, and more equitably distributed Medicare choice payments among geographic regions. It also extended the life of the Medicare trust fund by 10 years. The legislation also makes much needed changes in the Medicaid program, and extends health insurance to uninsured children providing \$24 billion (U. S. Senate Republican Policy Committee 1997). Under this law, health care insurers and providers are encouraged to provide services under several different arrangements that will dramatically

expand the scope of choice regarding health plan management for Medicare eligibles (Aaron, 1999: 39).

BBA establishes a new Medicare + Choice program. In addition to traditional Medicare and HMOs<sup>3</sup>), beneficiaries are able to enroll in preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans (United States Congressional Budget Office 1999). For now, only 61 percent of Medicare beneficiaries currently have the option of enrolling in a Medicare + Choice plan, down from 72 percent in 1999; only 5 percent of rural residents currently have such an option (Max, 2003). Medicare beneficiaries can continue to receive benefits as they currently do, or they may choose to change to a plan that gives them additional benefits. These choices are summarized in Table 1.

A Medicare Medical Saving Account (hereafter MSA) plan, a health insurance policy with high deductibles (up to \$6000 a year), is a test program for approximately 390,000 eligible Medicare beneficiaries. Medicare pays the premium for the MSA policy and makes a deposit to the MSA account that a beneficiary establishes. The MSA balances may be used to pay for medical expenses or, if the balance is less than 60 percent of the deductible a penalty tax will apply to withdrawals for nonmedical purpose.

Prospective payment systems (hereafter PPS) are planned for home health agencies, hospital based rehabilitation services, skilled nursing facilities, and ambulance services. Previously, skilled nursing facilities (hereafter SNFs) were paid the reasonable costs they incurred in providing Medicare-allowed services. There were limits on the costs that were reimbursed for the routine portion of care, that is, general

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3) Health Maintenance Organizations

nursing, room and board, and administrative overhead. Payments for capital costs and ancillary services, such as rehabilitation therapy, however, were virtually unlimited. Cost-based reimbursement is one of the main reasons the SNF benefit has grown faster than most components of the Medicare program. Because providing more services generally triggered higher payments, facilities have had no incentive to restrict services to those necessary or to improve their efficiency.

<Table 1> Medicare + Choice Program

Plan	Description
Fee-for-service	The beneficiary can visit any doctor. Medicare pays a set fee for each service. Most beneficiaries, however, purchase private supplemental insurance to pay for uncovered costs.
HMO	The beneficiary can use only the doctors and health facilities on a limited list, but often receives extra benefits. A gatekeeper oversees the patient's total care and makes referrals to specialists. Medicare pays the HMO a set fee in advance to cover all patient services for a period of time.
Point of service	In this special kind of HMO, the beneficiary can visit doctors outside the network but must pay an additional cost.
Preferred provider organization (PPO)	The beneficiary can visit any doctor in the health care network without a referral, or see doctors outside the network at an additional cost. Medicare pays a set fee in advance to cover all patient services for a period of time.
Provider-Sponsored Organization (PSO)	PSOs are new health plans that will be created, owned, and operated by doctors and hospitals. They will resemble managed care plans, in which Medicare pays the health plan a monthly fee for each recipient.
Medicare Saving Accounts (MSA)	Medicare provides catastrophic insurance coverage and advances a portion of the high deductible. At the end of the year, the beneficiary may keep any unused Medicare money.
Privately contracted fee-for-service	The beneficiary may visit any doctor or purchase any health plan but pay extra for noncovered or expensive services.

Source: Serafini, Marilyn W. "Brave New World." *National Journal* . Vol.29, No.33, 1997, p1637.

Prospective payment is intended to slow spending growth by controlling the increase in Medicare payments per day of SNF care. Facilities that can care for beneficiaries for less than the case-mix adjusted payment will benefit financially. The PPS for hospitals is credited with controlling outlays for inpatient hospital care. Similarly, the Congressional Budget Office (CBO) estimates that over 5 years the SNF, PPS could save \$9.5 billion compared with what Medicare would have paid for covered services (Aaron 1999: 13).

The goal of the BBA is a voluntary transformation of Medicare via the introduction of new plan options. Capitalizing on changes in the delivery of health care, these new options are intended to create a market in which different types of health plans compete to enroll and serve Medicare beneficiaries (General Accounting Office, 1998:6).

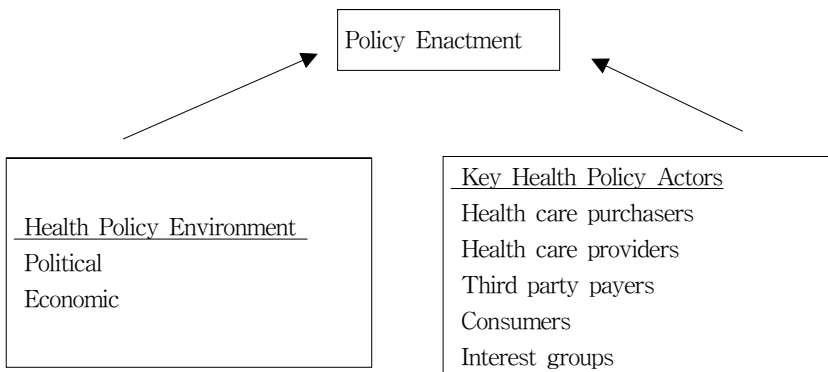
### III. Analytical Framework

In order to look at the factors that influenced the BBA enactment, this part introduces the analytical framework Patel and Rushefsky (1999) developed. They assume that health policy-making in the United States involves a complex web of decisions made by various institutions and political actors across a broad spectrum of public and private sectors. This perspective will help us understand what environments and key actors affected the birth of the BBA. Patel and Rushefsky's model and concepts are explained in the following part.

### 1. The Health Policy Environment

**Political Environment** It includes a shared understanding among policy-makers about how policy decisions should be made and the underlying values, political feasibility, electoral cycles, influence of organized interest groups, and political ideologies.

<Figure 1> Analytical Framework



**Economic Environment** It consists of a network of institutions, law, and rules that deal with primary questions such as what goods and services to produce, how they should be produced, and, for whom they should be produced. The economic point of view is also rooted in three fundamental assumptions: (1) resources are limited or scarce in relation to human wants, (2) resources have alternative uses, and (3) people have different wants and do not attach the same importance to them.

## *2. Key Health Policy Actors*

**Health Care Purchaser** In 1996, federal, state, and local governments combined spent \$483.2 billion to fund health care services. This represents 46.7 percent of the total national health care expenditures of \$1,035 billion during the same year in the U. S. This alone makes the federal, state, and local governments key actors in the health care.

**Health Care Providers** The major health care providers include health care institutions such as hospitals, nursing homes, and pharmacies, as well as health care professionals such as physicians, nurses, and dentists. They are important actors in the health care system because they not only deliver health care services, but also influence the way in which services are delivered and types of services that are delivered.

**Third Party Payers** In a third party-payer system, a consumer pays predetermined monthly premiums to an insurance company. In 1995, out of a total United States population of 264.3 million, more than 223 million Americans, or 84.6 percent of the population, were covered by private or public health insurance plans.

**Consumers** The public can exert influence on health care policies not only as purchasers of health care but also by the perceptions, attitudes, and values they bring to the health care system as consumers. In 1996 consumers spent \$171.2 billion in out-of-pocket expenses for health services; 18.9 percent out of a total of \$907.2 billion of personal health care expenditures.



**Interest Groups** It is not too surprising that the number and variety of interest groups involved in health care politics and policy making is very large. One of major ways in which these groups try to influence the political process is through their political action committees (hereafter PACs). The largest donor among health PACs was the political action committee of the AMA(American Medical Association). Pharmaceutical and other health product manufacturers were the next largest segment, followed by hospitals and nursing homes.

## IV. The Birth of the BBA

### *1. Political Environment*

In the 1994 congressional election, Republicans gained control of both the House and Senate. The Republicans came up with a budget plan, and the Congress adopted a budget resolution for fiscal year 1996. It promised to balance the budget within seven years. It called for a \$245 billion tax cut. It advocated reducing projected spending on Medicare by \$270 billion and Medicaid spending by \$182 billion over the next seven years.

The larger political agenda of the 104th Congress, expressed in the so-called Contract with America, was structured by the following basic principles that have long been staples of conservative Republican ideology: government should pay a less intrusive role than it does in American society and in the lives of individuals (Binstock,

et al. 1996:218). It is seen that citizens and businesses can make more effective use of their money if it remains in their hands, as opposed to being confiscated through taxes to support governmental activities. In addition, Republicans and some Democrats adhere to the principle that the annual budget of the federal government should be brought into balance by sharply reducing expenditures. This last concern, to balance the budget, has weighted heavily in the proposals for large reductions in Medicare and medical expenditures that have been championed by the Republican leadership.

The Democrats went on the offensive and portrayed themselves as the savior of the elderly and the poor by being advocates for Medicare and the Medicaid, and argued that Republicans were willing to cut these programs to provide a tax cut for the wealthy. President Clinton refused to accept the Republican plan. The stalemate between the President and the Republican Congress led to two partial shutdown of the government. No action was taken on the proposed reduction in spending for Medicare and Medicaid.

Congressional Republicans passed a budget resolution in June 1995 designed to balance the budget by fiscal year 2002. The resolution called for \$938 billion in total deductions, without \$270 billion in reductions in spending over the 1996–2002 period. The plan included \$245 billion in tax cuts. Medicare was such a large program that Republicans would be unable to meet its goal without the Medicare reductions. Republicans were aided by an April 1995 report of the social security and Medicare trustees that estimated that the Medicare trust fund (Part A) would go bankrupt by 2002.

Senate Republicans focused on reducing benefits and provider payments. House Republicans had a more elaborate plan that

concentrated on beneficiaries: rising Part B premium, requiring higher payments by wealthier beneficiaries, allowing more choice of plans for beneficiaries, and permitting medical saving accounts (tax free saving accounts that could be used to pay for medical expenses). Clinton and House Democrats adamantly opposed Republican plans for Medicare and budget cuts, though the President eventually embraced the balanced budget goal. In 1997, Republicans and Democrats made an effort to reach a bipartisan budget agreement. Congress presented the President with a balanced budget (H. R. 2014), as certified by the Congressional Budget Office in 1995, but it was vetoed. The Senate passed its version of this bill (S. 947) on June 25, 1997, by a vote of 73-27 and the House passed H. R. 2015 the same day by a vote of 270-162 (U. S. Senate Republican Policy Committee 1997).

During this period, the political atmosphere that governed U. S. politics has been the new federalism policies which largely means cutting the federal budget rather than sharing responsibilities. Conservatives have placed great emphasis on devolution of authority and financial responsibility back to the states, without much concern for adequate access to health care for all segments of the society (Thompson, 665-66). More important, Medicare became a part of the battle over the budget between President Clinton and the Republican-controlled Congress after 1995 (Patel and Rushefsky 1999: 125).

The consensus that had existed from the beginning of the program about the contents of Medicare would be begun to dissolve. Some scholars argue that the politics of Medicare up to 1994 led to a consensus, first that Medicare would be a public program operated by the federal government. The other element of the consensus was

that the politics of Medicare was bipartisan, supported by Republicans and Democrats. The politics of Medicare subsequent to the November 1994 elections saw the unraveling of the consensus. Medicare was depicted by some as a failure, a throwback to the 1960s Great Society programs, and a program of intergenerational equity: younger people paying for older people (Patel and Rushefsky 1999: 131). Medicare+Choice was the result, with its medical savings accounts and private fee-for-service provisions.

## *2. Economic Environment*

The growing concern about the rapid increases in health care expenditure has been widespread in the economic sector. The first consensus widely mentioned by economists and policy-makers is that Americans spent over 13.5 percent of GDP on health care in 1997. In 1997, national health expenditures exceeded \$1.1 trillion, with per capita healthcare spending of nearly \$4,000 (HCFA, 1998). The amount is the biggest among OECD countries. For example, Canada spent 10 percent, and average country in OECD spent only 8 percent of GDP on health care. The sense that the United States spends too much on health care has led virtually every reform proposal to assert that there would be lower aggregate spending on medical care (Cutler, 1995:32).

In addition to the level of spending, the financing of health care also creates concern. The 1995 Trustees' Report assumed that the combined assets of the Old Age, Survivors, and Disability (OASDI) trust funds would go below the safety level in 2030. The assets of

the Medicare Hospitalization Insurance (HI) trust fund was projected to go below the safety level in 2002, a far more urgent situation (Gramlich, 1996). Over the past decade, Medicare program has grown 6 percent per year in real terms, about twice as fast as federal tax revenue, and the Congressional Budget Office baseline forecast is that growth will remain at almost that level between now and the year 2006(Newhouse 1996:159). As a result, the Part A Trust Fund balance is projected to change from a \$122 billion surplus in FY 1996 to a \$444 billion deficit in FY 1996 (CBO, 1996).

An economic alternative to the inefficient and overspending health care system is to achieve a market-based health system, which encourages competition between insurers. The economic explanation on the high spending is a lack of effective competition in insurance markets. Culter (1995:33) argues that introducing competition at the time of insurance purchase seems like a natural way to eliminate inappropriate care. By pointing out that insurer competition on the basis of price and service provision has been relatively weak, Culter (1995) stresses that creating more effective competition in insurance markets, through pooling small firms and limiting preexisting conditions restrictions, is therefore a second mechanism for reducing unnecessary care.

### *3. Key Actors*

#### 1) Public Opinions

A majority of Americans express very low satisfaction with the U. S. health care system and believe that increased health care

expenditures have not been matched by similar increases in the quality of treatment. It is not surprising, then, that by early 1990s, 60 percent of Americans had not been satisfied with the American health care system, while another 29 percent believed that the entire system needed to be rebuilt (Patel and Rushefsky 1999:26). Indeed, the fraction of people reporting themselves very or somewhat confident in Social Security is only around 40 percent.

According to National Journal (1993: 803), in 1992, a group started to mobilize young people in support of reducing the budget deficit held a protest rally in Washington not at the White House or the Capitol but in front of the downtown headquarters of the AARP. Because the elderly account for a relatively large share of federal spending, debates over the deficit have often carried an under current of hostility toward seniors. Now that deficit reduction has become a national cause, some advocates for the elderly expect the hostility to intensify. Surgeon General designates that the nation spent \$14 on the elderly for every \$1 spent on children. (Kosterlitz, 1993: 803).

This example shows that public opinions do not support any extensions of Medicare coverage; instead, they are afraid of the burden of elderly caring. In general, public consensus on Medicare has not been focused on the quality of and access to care but on cost-containment. Indeed, this tendency is strongly affected by the media that have depicted excessive Medicare spending and imminent baby boom generation to be eligible for Medicare. Regardless of what negatively affected public opinion on Medicare, it is sure that the policy-makers have paid attention to the consensus when they enacted the BBA in 1997.

## 2) Federal Government

With the enactment of Medicaid and Medicare in the mid-1960s, the federal government became a major purchaser of health services in the health care market (Patel and Rushefsky 1999: 174). The burden on the federal health budget created the political environment for federal regulation of hospital costs. Over the years, the federal government has followed a middle road between the harsh realities of a private health care market place and a nationally planned and regulated health care system (ibid 167). During the late 1980s and particularly during the 1990s, the federal government particularly encouraged Medicare recipients to enroll in managed care organizations such as HMOs (ibid 173). However, while risk-contract enrollment increased at an average annual rate of more than 40 percent, fewer than 11 percent of Medicare beneficiaries are enrolled in HMOs (ibid 174). Thus, the overall impact of Medicare managed care on cost containment is likely to be very small.

A new way the federal government adopted for controlling Medicare costs is the Prospective Payment System (PPS) for Medicare reimbursement to hospitals. And the BBA called for extending the PPS to Skilled Nursing Home Facilities (SNF) and Home and Community Based Health Care.

## 3) Private Health Care Providers

Critics of the BBA claim that the burden and financial impact of changes lie disproportionately on the shoulders of the healthcare industry. Hospitals, health systems, and professional groups continue to argue for revision of several aspects of the BBA. Much of the outcry in funding, and hospital and health system leaders are

concerned about financial viability under the new budget. The American Hospital Association(AHA) issued a series of letters to Congress, updates to members, and position statements(HSCA, 1997). The following issues top the list of items increasing the intensity of the outcry: 1) HCFA capped reimbursement levels at the fiscal 1998 level, with steady reduction of payments over the next four years. In some cases, current payments are already less than hospital cost. 2) The interim payment system, designed to bridge the gap until implementation of home prospective payments, penalizes efficient providers and creates incentives for excessive utilization. The AHA and the Visiting Nursing Association of America are working toward revision of policy before the system is finalized. 3) Reduced funding for medical education payments may reduce the quality of training for medical students, with a long-range effect on the quality of care in the future. The HSCA argues that "the burden is now on the providers to find a way to deliver good care with reduced reimbursement. There is no more room for fat in the system, and that is generating an environment of fiscal Darwinism in the healthcare industry. "

#### 4) Interest Groups

In contemporary America, interest groups may well exercise significant influence over nonsalient issues related to the design of new government regulations. Representatives of the providers and insurers may successfully press congressional moderates to narrow the scope of health reform by drawing on public ambivalence over whether to increase taxation to fund the new plan. Thus, as the Health Insurance Association of America(hereafter HIAA) claims,



American's unwillingness to pay substantially higher taxes reveals that their support for reform is illusory: a wide-ranging reform that created a government-run health insurance system may well spark public opposition (Jajieh-Toch and Roper 1990). According to Jacob (1993: 390), in the battle over American health care reform, representatives of health care providers, health insurers, and small business are quite active in protecting their particular interests. Historically the American Medical Association (hereafter AMA) had advocated confining governmental involvement to those in "need" and creating needs-tested programs to handle low-income Americans. The very assumption that government has responsibility to ensure that all Americans have insurance coverage has been attacked for threatening the country's moral fiber and undermining individual and family responsibility. Indeed, one of the AMA's criticisms of Medicare was that it represented the "first step" to universal coverage (ibid: 390).

Private insurers, especially the Health Insurance Association of America (HIAA), were prior to the November 1992 elections adamantly opposed to universal insurance coverage, believing that protecting those not in need would invariably reduce their numbers and profits.

The American Association of Retired Persons (hereafter AARP) is the most significant organization for the elderly. It claims 35 million members and has 4,000 local chapters, 1,700 employees (New York Times, 1995), and revenues that totaled \$469 million in 1994 (Pear, 1995). The elderly have major anxieties, but also great expectations, about health reform. Many worry that change in the system will undermine the benefits they now receive under Medicare. But many see an opportunity to achieve a dream they are nurtured since

Medicare was created in 1965: Medicare coverage for long-term nursing-home care. (Kosterlitz, 1993: 800)

Hewitt (1993) says that the fear level of the AARP in Congress is incredible. Hilgenrath (1995) also adds that the AARP is one of Washington's most formidable lobbies. It would seem that the AARP does not even need many registered lobbyists in its Washington DC headquarters in order to achieve its members' goal of maximizing or maintaining their "public" income because the AARP mailing list has a political lobbying value (Vogel, 1999:131). For example, Vogel(1999:128-129) explains that the April 1995 issue of the AARP Bulletin carried the following headline on its front-page: "Hill Eyes Medicare Cuts: Two GOP leaders envision big reductions to balance the federal budget by 2002." This happened in March 1995 when the Senate majority leader, Bob Dole, publicly estimated that increases in Medicare expenditures balanced budget by the year 2002, and when Bob Packwood, then chairman of the Senate Finance Committee, estimated that growth savings would have to be even larger, at about \$250 billion.

However, Binstock(1996:228) points out that only limited political power is available to AARP and other aging-based interest groups. Organized demands of older persons have had little to do with the enactment and amendment of the major old-age policies such as Social Security and medical care. Rather such actions have been largely attributable to the initiatives of public officials in the White House, Congress, and the bureaucracy who have focused on their own agenda for social and economic policy. The impact of old-age-based interest groups has been largely confined to relatively minor policies that have distributed benefits to professionals and

practitioners in the field of aging rather than directly to older person themselves(Binstock, 1996).

Basically this organization opposed changes in any Medicare's defined benefit while the organization believes that there is a lot of room for true innovation and modernization of Medicare without resorting to a defined contribution system. At the same time, one of the agendas, the organization argues, is to strengthen Medicare fee-for-services. It is argued that original fee-for-service Medicare should be modernized and strengthened so that it remains a viable option for beneficiaries(AARP 1, 2000). This argument is strongly opposite to the direction where the Medicare reform is going.

## V. Implication for Policy

While Medicare remains a popular program among the population at large(Hochstein, 1997), problems remain in both the long and the short-term. Medicare has significant gaps in its coverage, particularly in long-term care, but also in areas such as prescription drugs. Pharmaceuticals take a particularly large bite out of elderly Americans' incomes. The elderly use roughly twice as many as prescription drugs as younger people, and Medicare offers no drug coverage, except for drugs used in conjunction with a hospital stay (Kosterlitz 1993: 802). Although relatively few elderly people require intensive long-term care, it looms as an even larger concern for them mainly because the costs are so high, averaging \$30,000 a year. The elderly are often forced to bankrupt themselves to qualify for

nursing-home coverage under Medicaid, a state-federal plan designed mainly for the poor.

In the short term, with robust economic growth, Clinton proposed in 1997 and 1998 expansion of Medicare by allowing those aged fifty-five to sixty-four who had no health insurance to buy into the program. While the proposal was attacked for expansion and for aggravating an already precarious financial status for Medicare, the proposal indicated a changed environment. A Medicare proposal by President Clinton includes 1) making Medicare more competitive and efficient; 2) modernizing and reforming Medicare benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protection for preventive benefits; and 3) making an unprecedented long-term financing commitment to the program that would extend the life of the Medicare Trust Fund until 2027. To strengthen Medicare's financing, Clinton proposed that the plan extends the life of the Trust Fund until at least 2027 and finances the new prescription drug benefit through saving and a modest amount from the surplus. The plan assumes that the savings from competition and efficiency would offset about 60 percent of the \$118 billion Federal cost of the new Medicare prescription drug benefit. Some of proposals to solve the federal budget deficit in the long-term have been suggested by Medicare experts.

It would be to increase the hospital insurance trust fund tax from 2.9 percent (half paid by employee, half by employer) to perhaps 4.5 percent.

It includes raising the eligibility age from sixty-five to sixty-seven (which would also save money, though it would run counter to proposals to expand Medicare to those below sixty-five) and means-

testing Part B premiums (higher premiums for wealthier beneficiaries).

A more radical proposal is to rely on vouchers. Under a voucher program, recipients would be able to purchase any plan they chose. This would bring competition and consumer choice into Medicare.

Another proposal, based on European experience, is to use price controls through limits on spending (program controls), using such policy instruments as "fee schedules, volume controls, and spending caps."

These options have been proposed but attacked due to a variety of reasons. It is clear that a fundamental reform of Medicare is not economically and politically feasible under the pluralist American political systems. Thus, as done in the past, incremental reforms would be implemented. Nonetheless, the following principles must be implemented in the near future.

First, Medicare should cover outpatient prescription drugs based on means-tested principles. Second, for policy makers, financing the long-term care is undoubtedly challenging, especially if it is based on nursing home care, but the administration should try to keep costs down by initially offering benefits for home and community-based services. But it is noteworthy that most advocates for the elderly say that such assistance should be merely a first installment, a substitute, for coverage of more intensive care. Third, it is important to keep the fact that market based health care system limits utilization of service by the poor. Thus, it is necessary for policymakers to have mechanisms for regulating such a strict market rule. The proper mixture of private and public health care organizations might be needed. Fourth, the access to health care in rural areas should be extended not only to general service, but also to more specific needs. Fifth, technological advances in medicine are likely to continue at a

rapid pace and are one of the major contributors to increases in health care costs. Advances in medical technology have helped prolong life and have eased pain and suffering, but they cannot cure many major illnesses. Sixth, health care should be a right of all people, not a commodity available only to a particular population. As a result, the shape of public policy toward Medicare reform, especially its financing, may require a change in public attitudes toward the aged and the aging process. The roles of the media and policymakers are crucial to shape those values and attitudes.

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Summary

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## 국가적 논쟁으로서의 메디케어

-미국 1997년 국가예산안 균형을 위한 법률입안에 관한 분석-

이 은 주

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1997년 미국에서는 국가예산안 균형을 위한 법률이 미국의회에서 통과되어 연방정부에서 시행하는 주요 정책의 하나인 메디케어(노인의료보험)의 전폭적인 개정이 이루어졌다. 본 논문에서는 1997년 미국 국가예산안 균형을 위한 법률을 분석해 봄으로써 메디케어 개정에 영향을 준 정치적, 경제적 환경을 살펴보고, 보건소비자, 연방정부, 미국병원협회, 미국방문간호사협회, 의료보험협회, 미국의사협회, 미국은퇴인협회 등의 주요 보건관련 집단이 법안개정에 미친 영향을 고찰하였다.

메디케어 개정은 노인의료보험의 비용증가로 인하여 연방정부의 예산이 고갈되는 것을 막기 위해 메디케어의 비용을 효율적으로 관리하고 서비스의 질과 다양성을 높이는 의도로 진행되었고 1997년 미국의회에서 통과되어 시행되고 있다. 그 법안의 통과는 정치적인 측면에서 메디케어는 공화당과 민주당이 초당적인 차원에서 해결해야 하는 주요국가 정책 중의 하나라는 합의가 의회에서 존재하고 있다는 것을 입증하였고, 경제적인 측면에서 비효율적이고 과소비적인 기존의 보건체계에 대한 대안은 바로 보험시장의 경쟁을 강화에 기초한 보건체계의 변화라는 여론의 형성이 있었기 때문에 가능했다.

정책의 변화라는 측면에서 1997년 메디케어 개정은 정부의 정책이 전면적인 변화보다는 부분적인 변화를 피하였을 때 그 실행이 보다 현실적이었다는 점을 시사하였다.

개정된 메디케어가 앞으로 변화하여할 몇 가지 점을 지적하여 보면 다음과 같다. 1) 메디케어는 노인들의 경제적 자산의 평가를 통해 외래치료 처방약을 지불해야 한다. 2)기존의 시설보호가 아니라 재가보호와

지역사회보호를 통한 장기노인보호를 대책을 수립해야 한다. 3) 과도하게 시장에 의존한 보건체계는 빈곤층의 서비스 이용을 제한한다는 것을 명심해야 한다. 4) 일반치료와 전문치료를 포괄하는 의료서비스 다양화를 모색하여 서비스 이용의 지역적 편차를 줄여야 한다. 5) 의료기술의 진보가 생명연장에 기여하는 것은 사실이지만 보건비용 상승의 원인이 된다는 점을 감안해야 한다. 6) 상품으로서가 아닌 권리로서의 의료서비스에 맞는 정책 변화를 실행하기 위해서는 노인과 노화과정에 대한 여론의 형성과 태도변화에도 초점을 맞추어야 할 것이다.