



Health Policy Reports

The Center for Health Services Research
The University of Tennessee

Health Policy Reports

summarize important issues in health policy. They are written by Associates of

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INCREMENTALISM — CLIMBING MOUNT EVEREST ONE STEP AT A TIME

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In the previous Health Policy Report (1), we examined some of the root causes of our apparent difficulty in making national health policy. These included features of the American public and government (including a tension between personal and societal responsibilities and a seemingly innate distrust of “government”) and of health and healthcare (such as the broad scope of “health”, the absence of a single “owner” of health policy, and the many ways to view and approach a single health problem). The net result is a sociopolitical conundrum that has, for almost a century, inhibited broadly based health policy development.

In its place, health policy has exhibited *incrementalism*, that is, the process by which decision makers “take what they are currently doing as a given, and make small, incremental, marginal adjustments in that current behavior” (2). The most common example of incrementalism is the budget process. We assume a base budget and make small increments to and from it without examining the entire budget.

In this Health Policy Report, we will examine some additional causes of incrementalism in policy making, describe some general consequences, and look more closely at one health-related example, that is, the evolution of policies related to dual (Medicare plus Medicaid) enrollees.

Why Small Steps?

The previous report gave reasons why broad health policies are difficult to develop. There are additional reasons why, even if developed, they are hard to implement. Two are particularly important. First, the broader the policy, the greater the number of interest groups that are affected and the greater the susceptibility to interest group opposition. Second, the broader the policy, the greater is the chance for unforeseen consequences.

Two recent examples illustrate these issues. The most notable is the Clinton health reform plan - a broad reform of the healthcare delivery and finance system that raised opposition from nearly every interest group representing the status quo. The second is the Balanced Budget Act of 1997 that seemingly “went too far” in reducing Medicare payments to hospitals as part of a broad effort to balance the federal budget that required significant revision this past year.

Thus, incrementalism appears to be an “endemic feature” of American political institutions (3). As summarized by Hecl (4), “Social policy reformers must struggle in an institutional system that tilts the survival odds in favor of the incremental action or inaction and against by new expression of public authority.... The result, spread across the historical record, is that major social reform efforts rarely succeed. It is the weaselly, piecemeal adjustments to social policy that make up the bulk of successful reforms”. Or as Lindbolm put it, it is “the science of muddling through” (5). Or put yet another way, policy without politics is like architecture without engineering.

What are the Consequences?

Incremental approaches to health (or other) public policy matters can be effective, even if slow. A series of small steps can get to the end result. Each small step causes little (political) objection but, once enacted, becomes part of the accepted base on which the next step more easily falls. One example is expanding health insurance only to children between certain ages as a step toward universal coverage - the “kiddie-in-the-door” approach of focusing on a target population for which sympathy and concern can be raised (6). Other examples include expanding coverage for end-stage renal disease and catastrophic illnesses.

Another value is that even small increments can signal a change, however subtle, in the direction of the debate on a larger issue. Oliver (3) argues, for example, that passage of the Health Insurance Portability and Accountability Act (HIPAA or the Kassebaum Kennedy Bill) did signal a shift away from the view that health insurance is a market commodity and toward the view that it is a right of citizenship.

But increments do not necessarily build. While they may catch on and lead to major changes, they may snag and be diverted or just fade away. Or the increments may be small enough to be passed but too small to attract sustained attention and support from the general public. Thus, the approach, while intended to lead to real change, is unlikely to impose substantial new restrictions on powerful industries.

One example is the very limited impact of the HIPAA. While marketed as a major move to expand insurance coverage, the actual impacts – on the insurance industry and the public – are quite small (7). Similarly, even though insurance reform was the one issue that received almost universal support in the Clinton plan, few of the intended reforms got support in the state level reforms that followed the demise of the national plan.

Also, incremental changes tend to treat healthcare as a balloon: the incremental steps push in one place (e.g., increasing access for one group) but the balloon puches out in another (e.g., reducing access for another group because of, for example, increasing insurance costs).

The Dual Eligible - The Problem of Having Too Much

A potent example of the consequences of incremental approaches to policy problems is that of the “dual eligibles”. Dual eligible beneficiaries include Medicare enrollees who are also eligible, under law, for certain benefits under Medicaid programs. Many are eligible for Medicaid under standard income criteria. For others, Medicaid benefits were provided by federal law as a means to expand coverage to low income Medicare enrollees for whom the out-of-pocket costs for services not provided by Medicare were excessive. The number of Medicare enrollees with

low incomes is substantial; in 1997, 50% of all Medicare enrollees had incomes under twice the federal poverty level (FPL), while Medicare covered only 52% of the costs of needed care (8). For those at or near the federal poverty level, out-of-pocket costs may exceed 35% of total income (9).

The policy approach to this growing problem was incremental - based on expanding eligibility to selected benefits of Medicaid program to very specific Medicare cohorts. Thus, by 1999, seven distinct categories of dual eligibles (in addition to those entitled to Medicaid because of income) had been established, each with its own eligibility requirements *and* benefit packages. For example, Medicare beneficiaries with incomes under twice the FPL and assets under 200% of Supplemental Security Income eligibility level were entitled to receive payment for Medicare Part A and Part B premiums from Medicaid but were not eligible for direct Medical services (including pharmaceuticals - the major cause of high out-of-pocket costs). These with incomes of 100 to 120% of the FPL were entitled to receive Part B but not Part A premiums, while these with incomes of 135-175% of FPL were to receive a \$1.43 per month supplement to offset Part B premiums - substantial differences in benefits with small differences in needs.

Thus, a very structured and complex set of policy increments evolved to professional extend benefits to the poor elderly. What were the results? First, actual enrollment into Medicaid programs has been limited to under 50% of those eligible by ineffective outreach, the complexities of the enrollment requirements and regulations, etc.

Once enrolled, actual use of health care resources was *lower* than that of the general Medicare population (8). The percent of dual enrollees with problems paying medical bills and reporting difficulties with access to needed services remained higher than that of the general Medicare group. Fewer dually enrolled women have mammograms (45% vs. 51%) and fewer dually enrolled men have prostate exams (39% vs 59%) than do the corresponding general Medicare cohorts, and a larger proportion report no usual source of care (17%), delays in seeking care because of cost (12%) and no office visit within a year (24%).

Thus, incremental expansion of coverage, rather than having the intended effect of broadening coverage and enhancing health, was associated with lower access and more health-related problems. This counterintuitive result appears to be, in substantial part, the result of policy fragmentation. The health policy decisions determining the basket of services available to dually eligible beneficiaries was the sum of two uncoordinated plans, leaving gaps in needed services, providing different services to groups with substantially equivalent needs (e.g., with incomes of 100 to 120% of FPL and 120 to 135% of FPL), and for many providing minimal assistance (e.g. \$1.43/mo supplements that does little to obviate need. In addition, the complex eligibility and entitlement rules of the two systems leads to confusion by patients as well as providers as to what is covered, while regulations requiring that provide for dual-enrollees participate in Medicaid and, often, accept lower Medicaid fees rather than Medicare rates reduce the pool of available providers. States attempted to correct for the problems of federal policies by, for example, using different rules to compute asset value or simply extending full state Medicaid benefits to specific groups of Medicare beneficiaries, but these actions further increased the fragmentation of benefits that those with similar needs obtained in different states.

The Winner Is...

The net result of substitution of incrementalism for broad policy making is the fragmented and piecemeal health care system we work in and, hopefully, live in. The fragmentation is at many levels, between programs and between levels of government as well as between equally needy population groups. The fragmentation leads to greater administrative and direct care and reduced quality of care. The stress or fracture lines become critical to those most in need, such as

the poor elderly, while many of the widely agreed upon problems remain.

Does anyone win?

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