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Strategies for Health Care Cost Containment (1980s–Present)

B. Rick Mayes

THE BIGGEST AND MOST INTENSE BATTLE IN the U.S. health care system during the past three decades has been over two interrelated questions: first, who will control the manner in which medical care is paid for, and, second, how much will it cost? Many health care experts believe that Medicare's efforts at cost control, primarily in the form of the program's seminal transition to and continual modification of prospective payment of health care providers, has both triggered and repeatedly intensified the economic restructuring of the U.S. health care system. Medicare is an almost \$600 billion public health insurance program for individuals sixty-five years of age and older; individuals under sixty-five with certain disabilities (with eligibility dependent on the severity of the disability and the resultant consequences for a person's ability to work), and those with end-stage renal disease). With regard to how the program reimburses for care, "Medicare sets prospectively the payment amount (rates) providers will receive for most covered products and services, and providers agree to accept them as payment in full," according to the Medicare Payment Advisory Commission. "Thus, in most instances, providers' payments are based on predetermined rates and are unaffected by their costs or posted charges."¹

MEDICARE'S VAST INFLUENCE

Medicare payment reforms have empowered the federal government's effort at cost control in ways that are similar to health care systems in other industrialized countries.² They have (1) given the U.S. government de facto control over the price of most medical care and (2) ended the era, dating back to the 1920s, in which doctors' and hospitals' authority over medical prices and decision making went virtually unquestioned.³ The key to Medicare's role as the leading catalyst for change in the U.S. health care system is the program's

immense size and influence.⁴ As the single largest individual buyer of health care and the "first mover" in the annual payment game between those who provide medical care and those who pay for it, Medicare invariably drives the behavior of both medical providers and private payers.

Medicare's revolutionary transition from traditional cost reimbursement (generally paying hospitals and physicians what they submitted in the way of costs) to a prospective payment model began in 1983. In that year, Congress changed the program's method of paying hospitals to a system of predetermined payment amounts for individual diagnosis-related groups (DRGs). In 1989, following the success of DRGs in restraining the rate of growth in Medicare's hospital expenditures, Congress enacted a similar program—a resource-based relative-value scale with a standardized fee schedule—for Medicare's reimbursement of physicians. The program went into effect in 1992. With the Balanced Budget Act of 1997, Congress reformed the reimbursement processes of the remaining cost-based components of Medicare, including outpatient ambulatory services and post-acute care (such as skilled nursing facilities and home health agencies). By 2003, twenty years after Medicare started the payment revolution in America's health care system, the program had become fully "prospective" in its reimbursement of all medical providers. Medicare also plays a significant role in supporting the education of health professionals, particularly medical school graduates training as residents in the nation's more than one thousand teaching hospitals. The program's direct and indirect financial support of medical training (direct in the form of paying the salaries of the residents and the supervising physicians' time, around \$3 billion, and indirect in the form of subsidizing other hospital expenses associated with running training programs, around \$6–\$7 billion) amounted to upwards of \$10 billion in 2012.

Each time Congress changed one part of Medicare from cost reimbursement to prospective rate-setting, the overall growth of the program's expenditures slowed. A significant, albeit temporary, measure of cost control was achieved. Yet these spending reductions have often come at the expense of health care providers compensating by increasing their revenues from private payers. "When Medicare slows its rate of expenditure growth," explains David Abernethy, former senior Medicare specialist and Staff Director of the House Ways and Means Health Subcommittee, "hospitals' overall rate of revenue growth slows and that, in the end, puts the final pressure on private payers."⁵ This increased use of cost shifting (or cross-subsidization or differential pricing) by medical providers, in which changes in administered prices of one payer lead to compensating changes in prices charged to other payers for care, propelled the growth of private sector efforts (namely, managed care in the 1990s) to achieve similar cost control.

Ultimately, the change in Medicare's reimbursement policy altered the balance of power between the federal government and medical providers. By increasing the scope and extent of Medicare's regulation through prospective payment, Congress for the first time gained the upper hand in its financial relationship with hospitals and then with physicians in terms of setting medical prices. Yet the federal government has done little to extend Medicare's success in controlling prices to controlling the volume of services provided.⁶ Therefore, although Medicare's Prospective Payment System (PPS) has been more influential than anything else in rationalizing health care prices in the United States, the program has never gained major and lasting control over utilization or total costs. Thus, Medicare's rate of expenditure growth and relatively meager results at cost containment in recent years remain issues of enormous political concern.⁷

Moreover, Medicare does not cover all health care costs for its beneficiaries. The program's Part A benefits cover inpatient hospital stays, skilled nursing facility stays, home health visits, and hospice care, but there is a deductible (\$1,156 in 2012) and coinsurance requirements. The program's Part B benefits cover physician visits, outpatient services, preventive services, and home health visits, but there is also a monthly premium that beneficiaries must pay (\$140 in 2012). Also, Part D, the voluntary, subsidized outpatient prescription drug benefit that George W. Bush (2001–2009) signed into law in 2003 and that went into effect in 2006, also includes deductibles and monthly premiums that vary by drug plan and beneficiary income.

Passage of Medicare's Prospective Payment System Driven by the Need for Cost Containment

In the late 1970s and early 1980s, rampant medical inflation forced policymakers to search for ways to control Medicare's

rapidly escalating costs. With doctors and hospital executives in control of the U.S. health care system for decades, virtually unrestricted cost reimbursement had become the dominant model for financing public and private medical care. Independent not-for-profit hospitals and physicians practicing alone or in small groups dominated the medical landscape. Notes Bradford Gray,

Third-party payers (both private and public) played their financing role passively, reluctant to interfere with medical decision-making and the doctor-patient relationship. They paid for medical care by reimbursing for costs incurred or charges billed by health care providers and did little to control which services were provided or how much they cost.⁸

The medical inflation that grew directly out of these delivery structures and payment systems became unsustainable. In 1980, hospital spending grew 16.4 percent, as the nation's total health care expenditures reached \$230 billion, a threefold increase from \$69 billion in 1970.⁹ In Ronald Reagan's (1981–1989) first full year in office, hospital spending increased 17.5 percent.¹⁰ The following year the country slipped into the worst recession in half a century, with the unemployment rate reaching almost 11 percent.

Out of financial necessity, therefore, Congress and a handful of state governments commissioned experiments in alternative reimbursement systems. The most promising conceptual innovation, prospective payment with predetermined reimbursement rates, was the product of pioneering research at the University of Michigan and Yale University. Using data from Connecticut's hospitals, Yale professors John Thompson and Robert Fetter demonstrated that medical care could be standardized and measured. As a result, policymakers and administrators were able, for the first time, to compare prices across different hospitals for the same services. They found an enormous amount of unjustifiable variation, which called into question medical providers' authority to regulate their own affairs.

Rising Medical Costs

The deadly combination of inexorably rising medical inflation and deep economic deterioration forced elected leaders to pursue the radical reform of Medicare to keep the program from insolvency. Federal policymakers—led primarily by President Reagan's health and human services secretary, Richard Schweiker (in office 1981–1983)—eventually turned to the one alternative reimbursement system that analysts and academics had studied more than any other and even tested with apparent success in New Jersey: prospective payment with DRGs. Rather than simply reimbursing hospitals whatever costs they incurred in treating Medicare patients, the new model would pay hospitals a predetermined, set rate based on a patient's diagnosis. The

payment would be unrelated to any specific hospital's costs. Instead, it would be a national payment based on the costs of a general hospital. Thus, if a hospital could treat a patient for less than the standard DRG payment, it could keep the savings as a profit. If it cost the hospital more, it had to absorb the difference as a financial loss. Once Republican leaders became convinced that PPS could be used to reduce federal budget deficits, as well as create new profit and efficiency incentives for hospitals based on an increase in volume, the political obstacles to radically transforming Medicare finally dissolved.

Realigning Financial Incentives

Ironically, the most significant change in health policy since the passage of Medicare and Medicaid (the publicly financed, federal-state health insurance program for low-income Americans) in 1965 went virtually unnoticed by the general public. Nevertheless, the change was significant. For the first time in U.S. history, the federal government acquired a sizeable measure of power in its financial relationship with the hospital industry. Together with Congress's development and use of the budget reconciliation process, Medicare's new prospective payment system with DRGs infringed on the hospital industry's sovereignty and autonomy. Also, the new and vastly increased amount of government regulation that Medicare's PPS represented was paradoxical in that it purported to mimic the dynamic forces of the free market. By realigning financial incentives, policymakers designed the new system to bring Medicare's rate of cost growth under control.

Developing a new hospital reimbursement model was one thing; enacting it was another. A financial crisis affecting Social Security between 1982 and 1983 provided the Reagan administration and leading members of Congress with the necessary legislative opportunity to pass Medicare's prospective payment system as part of a larger and even more urgent package of welfare state reforms. Mushrooming budget deficits (stemming from President Reagan's major tax cuts passed in 1981), together with the highest unemployment rate and the worst recession in decades, created a sense of fiscal and economic crisis. When the Social Security boards of trustees released their annual reports on April 1, 1982, they noted that the Social Security system would be unable to pay cash benefits beginning in July 1983. Medicare's trust funds were in somewhat better shape, they reported, but the program still faced serious financial problems, including bankruptcy, by the late 1980s or early 1990s, unless changes were made.¹¹

Following a decade of development, experimentation, and analysis, the passage of Medicare's new prospective payment system with DRGs represented something of an administrative revolution. Key to policymakers' success was the strange political attraction of prospective payment.

Hospital industry representatives were already desperate for any alternative to the Tax Equity and Fiscal Responsibility Act (TEFRA), budget legislation that was primarily aimed at quickly increasing tax revenue to reduce deficits. However, congressional leaders of both parties and Reagan administration officials wanted increased control of Medicare to restrain the program's rate of growth, despite the fact that prospective payment required significantly increased government regulation and control of health care. Also, with Social Security literally on the verge of bankruptcy in 1983, policymakers finally had a legislative vehicle for comprehensive Medicare reform that was unstoppable.

CHALLENGES POSED BY CHANGES IN MEDICARE

Following the rapid passage of Medicare's reimbursement system, a new set of concerns arose: Would the system actually work? Would Medicare's rate of expenditure growth subside? How would hospitals respond to the new incentives? Would any particular set of hospitals be wiped out financially by the new system? How would patients be affected, if at all? The only thing policymakers did know for sure was that, with a program as immense as Medicare, it was impossible to change just one thing.¹² The ripple effects of moving to a prospective payment system were bound to be extensive.

Phase-In Years of Medicare's New Hospital Cost Containment System

As it turned out, Medicare's new payment model had a major impact on hospital administration during its four-year phase-in period. During this time, the hospital industry's financial view of Medicare patients changed significantly. Instead of providing as much care as could be medically justified, hospitals shifted their focus to increasing efficiency and shortening Medicare patients' length of stay. In so doing, the PPS operated as a huge shock to the nation's hospital industry, because it completely reengineered the billing structure accounting for approximately 40 percent of every hospital's total revenue. The rate of growth in Medicare's hospital expenditures slowed considerably. Substantial cost control was accomplished with regard to Medicare hospital payment. No change in the private sector could ever have effected so much change in the U.S. health care system in so short a period of time. The Medicare payment reforms "were the most drastic and far-reaching changes in federal health policy since the passage of Medicare itself," notes David Smith. They were "remarkable for the comprehensiveness and sophistication of their design—indeed, the sheer technical achievement was astonishing."¹³

Medicare's transition to its new prospective payment system changed the focus of care. In fact, never had so much



change in hospital management transpired in so short a period of time. Previously, because Medicare paid hospitals whatever costs they incurred, hospitals had no incentive to control their operating expenses. Higher costs translated into increased payments from Medicare, which administrators could, and often did, use to expand their hospitals' programs and services.¹⁴ The PPS completely upended this status quo. By categorizing all hospital services and procedures, the new system allowed policymakers to know what medical care would cost *before* Medicare beneficiaries received it; the PPS established predetermined payment amounts for 467 different diagnosis-related groups. (In fact, the number of DRGs has increased over the years to approximately 536 to account for new procedures and services.) If the hospital managed to treat a Medicare patient for less than the DRG allotted, it kept the "savings" as profit. Conversely, if the hospital incurred more costs than the DRG allotted, it had to absorb the difference as a loss.¹⁵ As a result, the structure of Medicare's financial incentives flipped. By separating an individual hospital's level of reimbursement from its production costs, the PPS triggered a radical change in hospital administration. The focus shifted from providing as much care as possible to maximizing the overall profit from each Medicare patient.¹⁶

The initial success of Medicare's new reimbursement model encouraged a number of key congressional leaders and the staff of the Health Care Finance Administration (HCFA; the predecessor to the Centers for Medicare and Medicaid Services) to make a series of changes that, ironically, resulted in the PPS becoming *more* complex and political rather than less (as originally intended). The process began in the mid-1980s when senior congressional leaders turned to the PPS as a new and hugely effective deficit reduction device. By simply restraining the annual increases in Medicare's hospital payment rates, Congress was able to divert tremendous amounts of government revenue for reducing annual deficits and increasing spending in other areas of the federal budget. Congress repeatedly adjusted Medicare's payment rates at levels below annual increases in medical inflation, which would not have been enormously consequential had the hospital industry as a whole restrained its cost growth. However, it did not. In the late 1980s and early 1990s, hospitals' costs continued to increase at their pre-PPS levels.

Yet "squeezing" Medicare payments to all hospitals for larger fiscal objectives struck many policymakers as unfair, because some hospitals were in a much better position than others to absorb a decline in Medicare reimbursement. Therefore, Congress began selectively targeting increased payment rates to specific hospital groups (teaching, rural, inner-city). Along the way, the original goal of the PPS—to establish one set of national, wage-adjusted payment rates—became eclipsed by the

new goal of using the PPS to address major federal budget imbalances. In essence, as Medicare payment policy became increasingly subordinated to fiscal policy, Congress sought ways to try to ensure that the inevitable "rough justice" of moving to a national, standardized payment system would remain as financially fair as possible to the nation's hospital industry.

Medicare's PPS Triggers Private Sector Cost Containment with Managed Care

As Congress tightened Medicare's reimbursement policies, hospitals responded by increasing their charges to private payers. "Why it took private payers until the early 1990s before they began to marshal even a modicum of countervailing market power" is perplexing, notes Uwe Reinhardt.¹⁷ However, employers eventually found their paradigmatic response: managed care. Prepaid group practice, a form of managed care, did precede Medicare's PPS, but organized medicine's traditional opposition to any form of reimbursement other than the fee-for-service model associated with indemnity insurance kept managed care marginalized for decades. What ultimately made market incentives sufficient to induce a paradigm shift in the private sector away from indemnity insurance and toward managed care was the success of Medicare's PPS in controlling health care costs in the public sector. What is ironic about the rapid shift in the U.S. health care system from a predominantly not-for-profit ethos to a more corporate orientation is that it was largely the incidental byproduct of federal policy initiatives designed to control Medicare's costs.¹⁸ In other words, before business behavior triggered the managed care revolution, and the increased commercialization of health care that followed in its wake, it was largely a response to and an unintended consequence of government policymaking—in this instance, Medicare payment reforms.

By examining the connections between Medicare's subordination to budget policy and the rise of managed care, one finds that government policymakers in the late 1980s increasingly used the PPS as a powerful tool to address federal budget imbalances and increase spending on other government programs at the expense of health care providers (particularly hospitals but also physicians). Instead of increasing the payroll tax for Medicare (1.45 percent paid by workers and 1.45 percent by employers and deposited into Medicare's Part A Hospital Insurance Trust Fund) or making the program's beneficiaries pay more for their medical care, government leaders unintentionally increased less visible tax expenditures—tax revenue forgone—by precipitating a significant increase in health insurance costs for businesses.¹⁹ In short, Congress and the George H.W. Bush administration (1989–1993) made it clear that the government was only going to control Medicare's hospital costs; employers

were on their own.²⁰ The hospital industry responded to Congress's systematic reduction in Medicare's generosity by increasing the charges billed to their privately insured patients.²¹ By its very definition, this billing behavior (most commonly referred to as "cost shifting") was simply passed along the payment chain and contributed significantly to large annual increases in private health insurance premiums.

Ironically, federal tax revenue was forgone in this budgetary process, because private businesses simply absorbed the increased costs charged by hospitals. Over time, therefore, an increasing number of employers responded to the growing imperative for cost control by ditching more expensive indemnity insurance for their workers in favor of cheaper managed care alternatives. This linkage illustrates that nothing can transform an industry more quickly and profoundly than when the government—if it is an industry's single largest customer—dramatically alters how it pays for goods and services.

Managed Care

Managed care as a term hardly existed until the early 1990s. Yet employers' shifting of their workers away from fee-for-service health insurance was facilitated by the managed care industry's ability to quickly construct networks of participating providers.²² Between 1988 and 1993, managed care organizations responded to employers' demands for more cost control by consolidating and applying extensive utilization review and guideline development to their more traditional fee-for-service insurance offerings.²³ The traditional managed care organizations, such as staff- or group-model health maintenance organizations (HMOs)—for example, Kaiser Permanente—required significant expenditures in "bricks and mortar" when entering new markets. This served as a major barrier to entry because they were vertically integrated organizations that operated their own physical facilities in different geographic locations and whose physicians worked solely for the managed care organization.²⁴

Beginning in the late 1980s and early 1990s, however, many new for-profit HMOs experienced rapid growth because they were "virtual organizations" or "organizations without walls," built largely on contractual (paper) relationships with community providers.²⁵ These new HMOs began competing with the traditional prepaid group practices by contracting with networks of private physicians called independent practice associations (IPAs). In this newer type of HMO, physicians would provide care for HMO patients in their own offices, but not at a shared clinic. This model kept health plans from having to invest in "bricks and mortar" or hire their own personnel. The IPA approach also enabled HMOs to enter new markets more quickly and with much lower capital expenses than the traditional prepaid group practices.

The initial shift to managed care had a self-reinforcing quality to it that fed back into the momentum away from fee-for-service insurance. Managed care organizations initially attracted and enrolled low-risk individuals who were least likely to object to restrictions on utilization of services and physician choice.²⁶ Because these low-risk individuals also tended to be healthier than the general population, they did not increase operating costs; on the contrary, they increased the profitability of managed care organizations.²⁷ Meanwhile, by expanding their provider base and involving in their systems more physicians whose predominant practice was fee-for-service, managed care organizations developed to the point that employers took them more seriously and found them significantly more attractive.²⁸ Why? Because by increasing their number of affiliated medical providers, managed care organizations essentially became more effective "managed cost" plans, which could negotiate lower prices on behalf of larger numbers of patients and then pass the savings on to employers.²⁹ Before this balance of power shifted to payers in the early 1990s, providers had set prices and determined fees in most markets.³⁰ The advent of Medicare's PPS provided private payers with a critical benchmark for categorizing and comparing medical providers' prices.³¹

Cost Control or a Temporary Success?

During the mid-1990s, employers experienced minimal to no growth in their health insurance costs, largely because managed care clamped down on medical spending and decreased hospitals' ability to charge privately insured patients more. The United States spent almost \$120 billion less on health care in 1996 than the Congressional Budget Office had predicted in its 1993 forecast.³² With declining private payments from managed care, the hospital industry finally achieved significant cost control.

Ultimately, therefore, much of the (temporary) success in containing Medicare's cost growth came at the expense of hospitals increasing their revenue from privately insured patients. Exactly how much hospital cost shifting was specifically caused by Medicare's PPS is difficult, if not impossible, to determine. Nevertheless, employers simply bought into the cost shifting argument made by ProPAC, health policy journalists, and others, regardless of how much empirical support there was for it. This confounds the causation question, because if employers *believed* that cost shifting was driving the inflation in their health care costs (and then acted on this belief), then that belief was a powerful influence in its own right.

Moreover, causality comes in different forms.³³ With respect to prospective payment, explains David Smith, the image of a river and flooding rains is helpful. The rain comes down (cost drivers are continually raising the cost of medicine), and there are many tributaries—new medical

technology, rising prices, more elderly patients—filling the river. The PPS functioned, in part, as a diverting dam that helped to keep the flood away from Medicare. Yet the water was simply diverted back into the river. In other words, only Medicare was (temporarily) sheltered from ever-increasing medical inflation, and, after the PPS went into effect, the flooding problem became even worse because more water (cost drivers) was now moving down a smaller channel. In short, a huge part of the medical economy, Medicare, was no longer doing its part to absorb a significant portion of ever-increasing medical inflation because it was containing health care cost growth. This left employers in the private sector to make up the difference.³⁴

This cost-shifting phenomenon became a major motivation for businesses to begin moving their workers into various forms of cheaper managed care. The responsibility for either paying more for medical care or accepting increased rationing—which the government chose not to do—now fell squarely on employers and other purchasers in charge of health care spending.³⁵ They quickly moved many of their employees out of traditional indemnity insurance and into various forms of managed care.

HMOs, however, sowed the seeds for future trouble by not fundamentally altering or improving the delivery of health care (as staff- and group-model HMOs such as Harvard Community Health, Kaiser Permanente, and Group Health had done for years in specific areas of the country, such as Boston, California, and Seattle, respectively). Instead, insurers simply employed the term HMO and focused on using contracting leverage to both negotiate discounts from medical providers and impose distant controls on them. The health care that resulted from these new arrangements was hardly more “managed” than it had been under traditional indemnity insurance. For these reasons, and others, managed care’s cost containment efforts in the private sector eventually proved enormously unpopular and acrimonious in the latter half of the 1990s.

Medicare’s Subsequent Cost Containment Success with Physician Expenditures

The cost-control success associated with Medicare’s DRGs for hospitals led policymakers to rationalize the program’s reimbursement of physicians. They adopted a resource-based relative-value scale (RBRVS) with a standardized fee schedule. One goal was to reduce payments to surgeons and specialists and increase them to internists and general practitioners. The main goal of the RBRVS and fee schedule, however, was to slow the rate of cost growth of Medicare Part B (which covers physician visits, outpatient services, preventive services, and home health visits and accounted for 20 percent of benefit spending in 2012); Part B benefits are subject to a deductible (\$140 in 2012), and cost-sharing generally applies for most Part B benefits. When the new

payment system went into effect in 1992, the growth in volume and intensity of Medicare’s spending on physician services slowed dramatically. Thus, the federal government succeeded in shifting another balance-of-power arrangement, in this instance, from physicians to Medicare.

Through most of the 1990s, Medicare’s RBRVS-based fee schedule was viewed as a significant success by most observers. A sign of its acceptance is the fact that, much more than is the case with DRGs, the RBRVS system that was adopted and maintained by Medicare became adopted by most private payers.³⁶ Before the RBRVS system, the private insurers that abandoned the inflationary “usual, customary, and reasonable” payment approach often used relative value scales that had been based on historic charges, thereby perpetuating the alleged distortions among the various categories of services.³⁷ Private payers now typically rely on the RBRVS relativities, even if they often use different conversion factors to reflect local market factors that dictate their ability to negotiate fees with physicians.³⁸ Perhaps because organized medicine was given a major role in maintaining and updating the RBRVS system through the Relative-Value Scale Update Committee, physicians generally accepted the resultant shift in relativities of different services, even if they continued to strenuously object to expenditure limits (cost containment).

An added benefit of the expenditure limitation mechanism was that it was formula-driven. Congress merely needed to tinker with some parts of the formula, based on recommendations from the Physician Payment Review Commission (PPRC) and HCFA could meet its obligations to make the necessary changes in the payment systems that the contractors administered without any disruption in the flow of dollars to physicians for services rendered.³⁹ With control over budgetary expenditures for Part B (physician services), Congress did not concern itself much with “winners and losers” among the medical profession. Congress and the HCFA were more than happy to let the American Medical Association preside over inevitable “food fights” within the profession when cutting the pie of physician expenditures. Already having control over physician expenditures, Congress subsequently did not need to include physician payment as a target of savings in the Balanced Budget Act of 1997.

Paying on the basis of input costs, however, ignores whether the services provide value for patients. The assumption had been that what professionals decide to do with their professional time is the best determinant of value. Yet even in the mid-1980s, some had argued that Medicare should set the relative values not just on how physicians combine inputs to produce services but also on what it gets as outputs of a fee schedule in terms of benefit to beneficiaries and the program.⁴⁰ That is, relative values should reflect relative value, not merely resource costs. Now, with more

POLITICS AND HEALTH CARE POLICY

President Clinton's and President Obama's Addresses to Congress

President William J. Clinton's (1993–2001) nationally televised address to a joint session of Congress on September 22, 1993, marked one of the high points of public support for health care reform during the effort that began during his campaign in 1991 and ended in failure in September 1994. It was the first presidential address ever to Congress solely devoted to health care reform (Lyndon Johnson [1963–1969] urged Congress to pass Medicare in honor of his martyred predecessor, John F. Kennedy [1961–1963], who had pushed for the program's enactment).

Early polls showed overwhelming margins of public support for President Clinton's plan. Four months later, in January 1994, Clinton reiterated his pledge to veto any health care reform legislation that emerged from Congress but fell short of universal coverage. However, support for the president's plan eroded over the course of spring 1994 and disintegrated entirely by the end of that summer. Democratic allies in Congress splintered into supporting different alternatives to Clinton's plan, Republicans united in total opposition, and the general public grew less supportive and more concerned about government efforts at reform in general.

Unless we do this [pass health care reform], . . . health care costs will devour more and more and more of our budget. Pretty soon all of you or the people who succeed you will be showing up here and writing out checks for health care and interest on the debt and worrying about whether we've got enough defense, and that will be it, unless we have the courage to achieve the savings that are plainly there before us.

President Barack Obama's (2009–) nationally televised health care reform address to a joint session of Congress on September 29, 2009, sixteen years after president Clinton's address, was delivered to a more partisan, divided audience. In contrast to Clinton's speech, Obama did not have a detailed presidential reform plan that he was promoting or trying to explain to the public. Instead, he listed a number of principles he argued were essential for any legislative proposal to receive his signature. In this way, he delegated far more power to congressional leaders in determining the details of the eventual Patient Protection and Affordable Care Act that he signed into law on March 23, 2010. Another key difference between the two presidents' efforts is that Democrats were the majority in both the House and the Senate for Obama, while Clinton had only a Democrat majority in the House during his effort.

Then there's the problem of rising cost. We spend one and a half times more per person on health care than any other country, but we aren't any healthier for it. This is one of the reasons that insurance premiums have gone up three times faster than wages. It's why so many employers—especially small businesses—are forcing their employees to pay more for insurance, or are dropping their coverage entirely. It's why so many aspiring entrepreneurs cannot afford to open a business in the first place, and why American businesses that compete internationally are at a huge disadvantage. . . .

Finally, our health care system is placing an unsustainable burden on taxpayers. When health care costs grow at the rate they have, it puts greater pressure on programs like Medicare and Medicaid. If we do nothing to slow these skyrocketing costs, we will eventually be spending more on Medicare and Medicaid than every other government program combined. Put simply, our health care problem is our deficit problem. Nothing else even comes close. Nothing else. Now, these are the facts. Nobody disputes them. We know we must reform this system. The question is how.

than two decades of evidence that physician practice patterns and costs vary significantly without important differences in quality or patient satisfaction, there is increasing recognition that purchasers, including Medicare, may not be getting their money's worth for their major investment in physician services. More specifically, while the volume and intensity of physician services vary across the country, the variations seem to make no difference in either quality or patient satisfaction.⁴¹

The introduction of Medicare's new physician payment reform also further complicated the doctor-hospital relationship. Many specialist surgeons petitioned their hospitals to help them make up their income losses from Medicare, while hospital administrators increasingly pursued joint ventures with physicians for outpatient services in

order to enhance their institutions' revenues, which they increasingly needed to offset the declining generosity of Medicare's hospital payments.⁴²

Ultimately, though, the main problem with the Medicare physician fee schedule lies in the coupling of fixed budgets with fee-for-service reimbursements. First, the appropriate amount to be budgeted for physician services may be difficult to determine.⁴³ Using historic costs ignores the reality that technology changes, the population's burden of illness changes, and other factors may significantly alter how much should be allocated to any particular provider sector, such as physician services. The 1997 Balanced Budget Act (BBA) altered the calculation of the volume performance standard by tying spending-per-beneficiary on physician services to the rate of growth in



the national economy, as reflected in growth in the real gross domestic product; the new expenditure limitation was called the Sustainable Growth Rate (SGR).⁴⁴ Whatever the theoretical merits of tying Medicare beneficiary needs for physician services to how the national economy is doing, the new SGR approach has proved unworkable and is currently subject to intense attention by Congress and its advisory bodies.

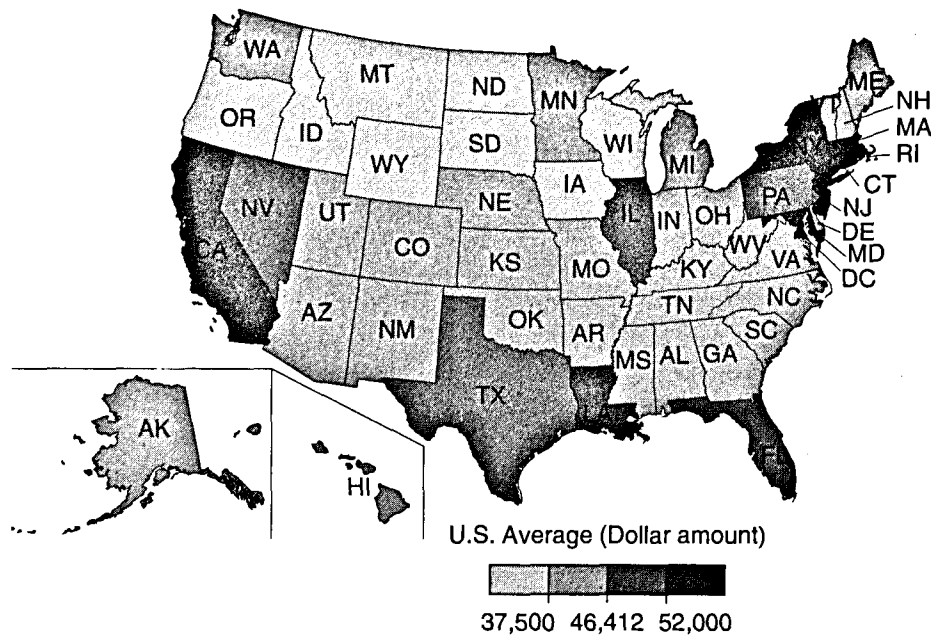
Second, in a fixed, national budget arrangement, all physicians have an incentive to overprovide, because gains from overprovision would typically exceed the losses from the pro rata reductions that the application of the expenditure limitation produces.⁴⁵ Under this system, prudent physicians are penalized financially, while profligate ones are rewarded. The PPRC had hoped that organized medicine would step up to the challenge of national expenditure limits by taking responsibility for rationalizing the volume of services through the establishment of clinical practice guidelines, enhanced peer review, and other professionally grounded approaches to reducing excessive volume and intensity of services.⁴⁶ It never happened, nor has Medicare ever achieved significant and sustained cost containment with regard to the program's physician expenditures.

Maintaining Health Care Cost Containment Proves Impossible

Following President Clinton's landslide reelection in fall 1996, representatives from both parties returned to using Medicare as a huge cost-containment mechanism in passing the Balanced Budget Act of 1997. The BBA constituted the ultimate subordination of Medicare to larger fiscal policy goals; it achieved approximately 73 percent of its total budgetary savings (\$224 billion) from reductions in Medicare spending.⁴⁷ The BBA also attempted to capitalize on the cost containment potential of managed care by encouraging millions of Medicare beneficiaries to enroll in private health plans as part of a new Medicare+Choice program.

Temporary cost control by both Medicare and managed care in the private sector ultimately led to an economic reckoning that the U.S. health care system experienced in the late 1990s and the early 2000s. Health care reform by way of "managed competition" in the free market offered only a temporary solution to the nation's ongoing struggle with medical inflation.⁴⁸ Both the BBA's major Medicare cuts and the final death throes of restrictive managed care left medical providers in 1998 and 1999

MAP 17.1 Medicare Spending during the Last Two Years of Life for Chronically Ill Patients



The amount of Medicare spending on chronically ill patients varies by state, with New Jersey spending an average of almost \$60,000 per patient and North Dakota spending less than \$33,000 per patient. The spending associated with chronically ill and end-of-life patients continues to be a major factor in the government's and the health care community's work to control costs.

SOURCE: Adapted from the *Dartmouth Atlas of Health Care* by DWJ BOOKS LLC.

with declining payments from both public and private payers. Hospitals and home health agencies were particularly hard hit. When increasing cost pressures returned in the late 1990s, growing numbers of medical providers and managed care organizations found profitability difficult to achieve and bankruptcy a growing threat.

Eventually, renewed cost pressures, the BBA's significant Medicare cuts, and years of minimal (or nonexistent) payment increases from private payers left (1) the hospital industry with its lowest overall margins in a decade; (2) most physicians with increased workloads, less autonomy, and often reduced incomes; and (3) a slew of bankruptcies and near-bankruptcies among a wide variety of health care management and delivery organizations.⁴⁹ Yet medical providers were not alone. Even as managed care organizations experienced their own severe "profitability crisis," the consumer and physician backlash against them led to an aggressive legislative and legal assault on the industry. The general public came to view commercial managed care as responsible for turning doctors "into entrepreneurs who maximize profits by minimizing care."⁵⁰

The Managed Care Revolution Stalls

Medical providers hastened the demise of traditional, restrictive managed care by consolidating into larger networks and practice groups, which vastly improved their bargaining leverage. A roaring economy in the late 1990s aided their efforts, because it led employers to request more generous and less restrictive health plans. By the early 2000s, most hospitals and physicians were receiving sizeable payment increases. Private health plans followed suit and pursued their own consolidation strategy. Many managed care organizations and traditional health insurance companies either merged or exited the market altogether. The surviving plans, facing less competition and more employer willingness to pay higher costs, quickly restored their profitability by dropping money-losing patient populations and increasing premiums. Employers also shifted more and more of their employees out of low-cost HMOs into less restrictive preferred provider organizations, which allowed them to increase their employees' level of cost-sharing.⁵¹

The result is that the managed care revolution—which was principally about the private sector forcing medical providers (primarily hospitals and physicians) to provide discounts to health plans and

employers—stalled and surrendered. Managed care organizations dropped most of the business practices that had restrained (at least temporarily) health care inflation in the United States. Many of them also dropped their participation in Medicare+Choice, after years of overreaching for "easy" Medicare profits, which left millions of the program's beneficiaries scurrying to reestablish their coverage under the program's traditional fee-for-service arrangements.

This increased consolidation and the declining effectiveness of market forces triggered a return to rampant medical inflation in the 2000s. Health plans and hospitals successfully negotiated significant payment increases after years of minimal or no revenue growth, which restored the majority of them to solid financial health. However, skyrocketing health insurance costs and a sluggish economy left an additional five million Americans without health insurance coverage by 2003.⁵² Medical-related bankruptcies increased substantially, as did the costs of and enrollment in Medicaid.

In the midst of these and other deteriorating health care trends, President George W. Bush and Congress passed the largest expansion of Medicare since the program's enactment in 1965. The 2003 Medicare Prescription Drug, Improvement, and Modernization Act differed from the pattern established between the 1983 Social Security reforms and the 1997 BBA. It added a hugely expensive (almost \$550 billion between 2006 and 2015) drug benefit with major



The United States spends more on health care than any other nation in the world, about \$8,200 per person per year as of 2012. That figure is more than two-and-a-half times higher than most developed nations in the world, including relatively wealthy European countries such as Sweden, France, and the United Kingdom. U.S. health care now accounts for 18 percent of gross domestic product.

SOURCE: Brendan Smialowski/AFP/Getty Images.

coverage gaps for millions of people who spend moderate to high amounts on prescription drugs.⁵³ It injected the first elements of means-testing into Medicare, by which wealthier beneficiaries will pay more than poor beneficiaries for both their Part B (physician and outpatient) services and Part D drug benefits. It also pushed the program toward

increased privatization with a financial overcommitment to private health plans that enroll Medicare beneficiaries. These measures have not resulted in any noteworthy health care expenditure restraint.

Currently, while about thirty-three million Medicare beneficiaries voluntarily enroll in the program's Part D

KEY DECISIONS: HEALTH CARE CRISES AND SOLUTIONS

Section 3403 of the Patient Protection and Affordable Care Act: The Independent Medicare Advisory Board (also known as the Independent Payment Advisory Board)

This section of the Patient Protection and Affordable Care Act establishes specific target growth rates for Medicare and charges the Independent Payment Advisory Board (IPAB) with ensuring that Medicare expenditures stay within these limits. The IPAB must also make recommendations to Congress as to how to control health care costs more generally. As noted by Bruce Vladeck in 1999 in *Health Affairs*, the IPAB

will have significant authority to curb rising Medicare spending if per beneficiary growth in that spending exceeds target growth rates. In a process that began in 2013, recommendations made by the 15-member board will go to Congress for rapid consideration; Congress must adopt these or enact savings of similar size in Medicare. If Congress doesn't act within a specified timetable, the secretary of health and human services (HHS) must implement the board's recommendations. The board is not allowed by law to recommend changes in premiums, benefits, eligibility, or taxes, or other changes that would result in "rationing" of care to Medicare beneficiaries.

SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

(a) BOARD.—(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:

INDEPENDENT MEDICARE ADVISORY BOARD

SEC. 1899A. (a) ESTABLISHMENT.—There is established an independent board to be known as the "Independent Medicare Advisory Board."

(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as "a determination year") the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as "an implementation year");

(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as "a proposal year") a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

(c) BOARD PROPOSALS.—

(1) DEVELOPMENT.—

(A) IN GENERAL.—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

(B) ADVISORY REPORTS.—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board's recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).

pharmaceutical program, it was designed (and continues to operate) largely on financing from general revenues, which are 80 percent of the program's total cost. Many leading Republicans in Congress were hopeful that forcing the new benefit to be financed from general revenues would make its total cost more transparent and, thus, of greater concern in annual budget negotiations. On the individual level, policy-makers also tried to restrain the new benefit's cost growth by including a "donut hole," whereby once a Medicare beneficiary reaches \$2,930 of Part D spending on pharmaceuticals in a calendar year, he or she becomes responsible for any additional drug costs accrued up to \$4,800, at which point Part D coverage reengages. Part of the 2010 Patient Protection and Affordable Care Act includes a gradual phasing out of the donut hole until its closure by 2020. Part D has been less costly than originally predicted, largely due to the fact that only about 77 percent of Medicare beneficiaries have enrolled in the benefit (rather than the original estimate of 93 percent). Yet monthly premiums have increased each year of operation by approximately 10 percent and are predicted to continue increasing by the same annual rate. Additionally, total Part D expenditures will increase from roughly \$85 billion in 2013 to around \$150 billion by 2020.

THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON HEALTH CARE COSTS

The need for health care cost containment has only become more urgent in recent years. The landmark passage of the Patient Protection and Affordable Care Act (PPACA) in March 2010, along with its constitutional upholding by a slim 5–4 Supreme Court vote and President Obama's reelection in November 2012, will dramatically increase the number of insured people with access to more health care. Roughly thirty million currently uninsured individuals were expected to gain insurance coverage starting in 2014, which will cost hundreds of billions of dollars by the end of the decade. Also, as a demographic tidal wave (the baby boom generation) began retiring in 2010, the government's longtime use of Medicare as a fiscal "cash cow" for other budgetary purposes has become much more problematic despite the fact that the PPACA depends on hundreds of billions of dollars in reduced future Medicare payments to health care providers—mostly hospitals and physicians—to finance expansions in health insurance coverage. Furthermore, with health care expenditures constituting 18 percent of gross domestic product and on course to reach expenditures of 20 percent by 2020, employers and government leaders are hoping that alternative reimbursement models such as bundled episode payments and capitation to medical homes and Accountable Care Organizations will engender better quality and slow cost growth.⁵⁴ To date,

TABLE 17.1 **Federal Government Spending on and Financial Support of Health Care in the United States**

Program	Approximate Amount of Federal Spending (2011)
Tax expenditure on employer-provided health insurance	\$260 billion
Medicare	\$550 billion
Medicaid (federal portion)	\$275 billion
Children's Health Insurance Program (federal portion)	\$8 billion
Department of Veterans Affairs	\$90 billion
Indian Health Service	\$4 billion
National Institutes of Health	\$31 billion
TOTAL	\$1.3 trillion

SOURCES: Department of Health and Human Services, Office of Management and Budget, Congressional Budget Office.

unfortunately, preliminary pilot studies have given little reason for observers to be overly optimistic about any major health care cost containment in the near future.

Ultimately, as health economist Victor Fuchs observes,

It is difficult to see how the health sector can continue to expand rapidly at the expense of the rest of the economy, but every past prediction of a sustained slowing of the growth of health expenditures has been proved wrong. Rapid growth may continue as a result of political gridlock regarding the form that curbs on expenditures should take. There is no public consensus about how much care should be provided for the poor and sick or how it should be done. Similarly, there's no public consensus regarding efforts to increase the efficiency of care. A rational approach to the financing, organization, and delivery of care seems politically impossible. However, the observation by [Alexis] de Tocqueville [the French political thinker who toured the United States in the 1830s] that in the United States "events can move from the impossible to the inevitable without ever stopping at the probable" may prove to be prescient.⁵⁵

See also Chapter 13: Government Financing of Health Care (1940s–Present); Chapter 14: Biomedical Research Policy and Innovation (1940s–Present); Chapter 16: Promoting Health Care Quality and Safety (1960s–Present); Chapter 18: Health and Health Care Policy: Ethical Perspectives (1970s–Present); Chapter 20: Women's Issues and American Health Care Policy (1960s–Present); Chapter 21: Minorities, Immigrants, and Health Care Policy: Disparities and Solutions (1960s–Present); Chapter 26: Interest Groups, Think Tanks, and Health Care Policy (1960s–Present).



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