



## Tracing the Evolution of American Health Care through Medicare

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## Abstract

With President Obama's health care reform currently under intense partisan scrutiny in the United States, this article is an objective resource for understanding the ways in which Medicare has historically served as a weather vane for charting the changes to the American health care system. During its nearly fifty-year tenure as the standard for the provision of medical care in the U.S., Medicare has evolved in fits and spurts, with its core structure shifting over time in response to changes brought about by the economic and political climate of each decade. It is only by understanding these past revisions, both independently and in the context of the concurrent changes in other nations around the world, that we can fully comprehend the state of America's health care system today, and make the necessary allowances to ensure that our national health care program will survive to provide for its constituents in the years to come.

**Keywords:** *health; insurance; legislation; policy; risk management*

# Tracing the Evolution of American Health Care through Medicare

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## I. Before Medicare

Since its inception as a government sanctioned public health insurance program, Medicare has been both a bone of contention between political parties and a beacon from which to gauge the changes in American health care as a whole. Passed as part of the Social Security Amendments of 1965<sup>4</sup>, Medicare had as its focus individuals sixty-five years of age and older<sup>5</sup>, with a similar yet state-run program, Medicaid, addressing the medical needs of people with certain disabilities and low income families.<sup>6</sup> Over time, however, Medicare has grown to be the preeminent standard for our nation's health care in its entirety, with nearly every substantive change to its core foundation signaling a corresponding restructuring of our overall health care system.

The modifications imposed on Medicare, both by market forces and federal legislation, stand as a series of growing pains from which to mark the evolution of the American health care model. By charting these changes through the decades we can better understand the ways in which health care as a whole has morphed from a cost-based system to one of performance evaluation. In turn, this may provide us with a glimpse into health care's future if certain fundamental issues are not addressed in current reform legislation.

The rise of the government's role in providing health care to its citizens came relatively late in America's history. For much of its first two centuries the burden of caring for the sick and injured fell to neighbors, friends and relatives, with additional support from individual communities and religious groups. Visits by an actual doctor were generally limited to the home and dictated by local demographics. Almshouses and charity wards provided a certain degree of medical service, as hospitals were few and far between, and often existed solely upon the largess of the surrounding vicinities. Those who had the opportunity to visit a hospital prior to the twentieth century more than likely did so after an accident or as the result of an unfortunate designation of insanity.<sup>7</sup>

Founded in 1751 by Dr. Thomas Bond and Benjamin Franklin, Pennsylvania Hospital in Philadelphia is the self-declared first "hospital" in the United States. Funded solely by donations from the people in the community, its mission was "to care for the sick-poor and insane who were wandering the streets of Philadelphia." Its seal, borrowing from the words of the Good Samaritan from the Gospel of Luke, beseeches those within to "Take Care of Him and I will Repay Thee."<sup>8</sup> As early as 1736, however, the New York City Almshouse designated six bedrooms

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<sup>4</sup> *Social Security Amendments of 1965*, Pub. L. No. 89-97.

<sup>5</sup> 42 U.S.C. § 1395c.

<sup>6</sup> 42 U.S.C. § 1396a.

<sup>7</sup> Eaton, Leonard K., *New England Hospitals, 1790-1837* (University of Michigan Press, 1957).

<sup>8</sup> Morton, Thomas George, *The History of the Pennsylvania Hospital, 1751-1895* (Amo Press, 1973).

as a “ward” that would eventually grow to become Bellevue Hospital<sup>9</sup>, followed closely that same year by what would later be known as Charity Hospital in New Orleans, Louisiana.<sup>10</sup>

Through the 1800s the delivery of care rendered by the few hospitals in cities like New York, Boston and Philadelphia far exceeded the treatment one would expect from a local almshouse or charity ward, although service in these elite health care institutions went hand-in-hand with status in society.<sup>11</sup> As an example, the Constitution of the Philadelphia Lying-In Charity (the model of care preceding the maternity wards of today) stated as part of its mission to “discriminate between the deserving and the undeserving.”<sup>12</sup>

The need to provide health care for an entire nation was strong, however, and increased organization would play a crucial role by the turn of the twentieth century. With fewer than 200 hospitals in 1873, that number grew to nearly 5,000 by the 1920s, including mental institutions.<sup>13</sup> With this expansion, the hospital became a national institution in America. Medical facilities began to appear in towns across the country, bringing with them advances in technology and a dramatic growth in the number of able practitioners.<sup>14</sup> Understandably, such a shift in the practice of health care from home to hospital came with a price. Although the health insurance market had been expanding since the 1930s, hospitals found themselves with few limitations when it came to charging patients a “usual and customary” amount.<sup>15</sup> While collection of payment was not always guaranteed, there were minimal restrictions on the ways in which a hospital bill could be calculated.<sup>16</sup> Slowly, hospitals were beginning to find themselves not only places where the sick went to be treated, but burgeoning businesses where there was money to be made.<sup>17</sup>

As the shape of American hospitals began to change, the external influences governing their practices also evolved. A precursor to Medicare, in 1946 Congress sought to influence the distribution of health care nationwide through the Hospital Survey and Construction Act (the “Hill Burton Act”)<sup>18</sup> which disbursed approximately \$3.7 billion to hospitals so they could meet the needs of citizens across the country by expanding while incorporating advances in medicine. With the goal of creating 4.5 hospital beds per 1,000 people nationwide, the Hill Burton Act established specific criteria for states to meet in order to receive funding, such as non-discrimination as well as necessity and viability of the state’s health care systems (sometimes two very inconsistent ideas as the poorest, least sustainable areas in a state almost always were in dire need of such funding).<sup>19</sup> Eventually, Congress would come to require participation in Medicare and Medicaid as a condition to receive monies under the Hill Burton Act.<sup>20</sup>

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<sup>9</sup> Cooper, Page, *The Bellevue Story* (T.Y. Crowell Co., 1948).

<sup>10</sup> Salvaggio, John E., *New Orleans’ Charity Hospital: A Story of Physicians, Politics, and Poverty* (Louisiana State University Press, 1992).

<sup>11</sup> Morton, *The History of the Pennsylvania Hospital*.

<sup>12</sup> *Charter and By-Laws of the Philadelphia Lying-In Charity*, 1888.

<sup>13</sup> U.S. Bureau of the Census, *Historical Statistics of the United States: Colonial Times to 1970* (U.S. Dept. of Commerce, 1975).

<sup>14</sup> Wylie, Walker Gill, *Hospitals: Their History, Organization, and Construction* (D. Appleton and Company, 1877); Risse, Guenter B., *Mending Bodies, Saving Souls* (Oxford University Press, 1999).

<sup>15</sup> David, Michael M. and Rorem, C. Rufus, *The Crisis in Hospital Finance* (University of Chicago Press, 1932).

<sup>16</sup> *Id.*

<sup>17</sup> *Id.*; James, Marquis, *The Metropolitan Life: A Study in Business Growth* (Viking Press, 1947).

<sup>18</sup> Pub. L. 79-725.

<sup>19</sup> Lave, Judith R., *The Hospital Construction Act: 1948-1973* (American Enterprise Institute for Public Policy Research, 1974).

<sup>20</sup> *Health Planning and Resource Development Amendments of 1979*, Pub. L. 96-79.

As Federal funds flowed across the nation, the states found themselves attempting to make disbursements consistent with Congressional requirements while meeting their individual needs. In effect, the Hill Burton Act forced communities, and the hospitals existing within (many of which were doctor owned at the time), to work together, pooling these government grants as well as their own resources and equipment, in order to stay in business.<sup>21</sup> Providers viewed this infusion of capital in the context of communities, not individual hospitals. If a local hospital needed new equipment, its leadership went to other nearby facilities or the community as a whole to fill the gap, and collectively these institutions could share in the Federal funds disbursed under the aforementioned Act.<sup>22</sup>

### **Across the Atlantic**

Two years after Congress passed the Hill Burton Act, Britain's National Health Service ("NHS") joined the skills of all health care practitioners under a single agency.<sup>23</sup> Launched at Park Hospital in Manchester, the mission of NHS was to provide health care for the entire nation as a whole with funding entirely from tax revenue.<sup>24</sup> Another strong example of mid-twentieth century European health care was the compulsory health insurance system instituted by the Kingdom of Belgium dating back to 1945. Final codification occurred on August 9, 1963 with the passage of Leburton's Law and the creation of the National Institute for Health and Disability Insurance ("INAMI").<sup>25</sup>

## **II. Establishing a Foundation**

By the 1960s, America's health care system was at a crossroads.<sup>26</sup> While access to treatment had increased, so had the corresponding price tag, a fact which left many low and fixed income citizens, including a rising aging

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<sup>21</sup> Lave, *The Hospital Construction Act*; Hochban, Jacquelyn, *The Hill Burton Program and Changes in Health Services Delivery*, Inquiry 8 (Spring 1981).

<sup>22</sup> *Id.*

<sup>23</sup> Greener, Ian, *Healthcare in the UK* (Bristol, 2009).

<sup>24</sup> *See generally id.* By 1958, NHS had begun charging for certain services, including the procurement of prescription drugs. The initial £1 charge in 1958 had increased to £7.40 as of April 2011 (otherwise payable through a discounted monthly charge of £29.10 if more than three prescriptions were needed within a given month, or £104 annually if 15 or more prescriptions were needed over a twelve month period), although the NHS has faced recent scrutiny over the way in which it calculates the number of pills in each prescription. *See* Martin, Daniel, *Stealth Tax on the Sick*, The Daily Mail (Apr. 11, 2011). Today, the United Kingdom's publicly funded health care system is the largest and oldest in the world, in many ways financed through similar means as used by the United States and other European nations to maintain public emergency services such as fire, police, etc. While this "free at the point of use" method attempts to impose certain restrictions for hospitalizations and physician visits, there are no such restrictions for emergency services. *See generally* Greener, *Healthcare in the UK*.

<sup>25</sup> INAMI (which stands for "Institut National d'Assurance Maladie Invalidite") improved the delivery of health care throughout the Kingdom of Belgium, established a fee schedule, and set the parameters for that nation's health care system today. *See generally* Roemer, Ruth, *Health Manpower Policies in the Belgian Health Care System* (U.S. Dept. of Health, Education, and Welfare, 1977).

<sup>26</sup> Halfway around the world, in 1964 Australia reorganized its Department of Health to accommodate its ability to administer all or part of the nation's 22 health care, aged care, pension, and insurance acts. *See generally* Lewis, Milton, *The People's Health: Public Health in Australia, 1950 to the Present* (Praeger, 2003). In 1966, Australia provided financial incentives to include nursing accommodations in senior facilities, and by 1969, it was offering grants to those states that developed senior care plans outside of institutional facilities. *Id.* In many ways, Australia's response to treating the elderly by utilizing community care programs rather than hospital care was the polar opposite of actions taking place in the United States at the time.

population, out in the cold.<sup>27</sup> Though the earlier Social Security Act of 1935<sup>28</sup> had established a general welfare system for the elderly, it did not include health insurance. President Harry Truman had wanted to create a system of national health insurance during his tenure, but his efforts were continually stalled by the lobbying power of the American Medical Association (AMA), and the concept was finally abandoned once his administration was forced to focus its attention on the war in Korea.<sup>29</sup> Ultimately, a compromise of sorts was reached by diluting Truman's grand ambitions with an addition to the Social Security system created 30 years earlier. As President Johnson symbolically handed former President Truman the first Medicare card on July 30, 1965, America's commitment to government-sponsored health care became permanent.

In its fledgling form, Medicare<sup>30</sup> sought to provide coverage to all persons 65 years of age or older who could satisfy certain legal residency requirements. Within a year's time, nearly 19 million elderly Americans were enrolled in the program, with Medicaid<sup>31</sup> providing similar access to health care on a State level for qualifying low-income individuals, expanding the already-existing Federal and State welfare structure in the United States. That participation in the social security system was an early requirement for an individual to qualify for these health insurance benefits certainly did not stall the growth of Medicare.

In its initial form, Medicare was to include an array of physician services as well as hospital care, but partisan struggles proved otherwise. To placate both sides, the program was divided into a series of sections, each of which was to reign over a specific aspect of health care. The program's cornerstone was "Part A", which provided health insurance coverage for qualified individuals requiring hospitalization.<sup>32</sup> As a concession to the demands of physician lobbying efforts and public fears, Congress created "Part B", a set of optional benefits addressing medically necessary services such as doctor services, outpatient care, and home health services.<sup>33</sup> Although Part B did provide limited coverage for physician and other similar services, it imposed no restrictions on what physicians could charge, thereby creating a fundamental rift between doctors and hospitals,<sup>34</sup> each now having different incentives in the way they approached the delivery of health care.<sup>35</sup>

A mere two years later, Medicare expanded the scope of its coverage under part B to include additional services such as durable medical equipment, podiatric care, and outpatient physical therapy.<sup>36</sup> At the same time, the number of days to which a Medicare beneficiary may be entitled under Part A was increased. Recognizing the many gaps inherent in its initial plan, in 1972 the Federal government extended Medicare eligibility to people under the

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<sup>27</sup> See, e.g., Oberlander, Jonathan, *The Political Life of Medicare* (The University of Chicago Press, 2003); Starr, Paul, *The Social Transformation of American Medicine* (Basic Books, 1982).

<sup>28</sup> Pub. L. 74-271.

<sup>29</sup> Poen, Monty M., *Harry S. Truman Versus the Medical Lobby* (University of Missouri Press, 1979).

<sup>30</sup> Originally Title 18 of the United States Code, as amended by Pub. L. 89-97.

<sup>31</sup> Originally Title 19 of the United States Code.

<sup>32</sup> Greenfield, Margaret, *Health Insurance For the Aged* (Institute of Governmental Studies, University of California, 1966).

<sup>33</sup> *Id.*

<sup>34</sup> This conflict of interest stands in contrast to the actual rift INAMI created in Belgium. To protest Leburton's Law, in 1964 Belgian physicians went on a one-year strike until reconciliations were reached and Leburton's Law was amended. See generally Roemer, *Health Manpower Policies in the Belgian Health Care System*.

<sup>35</sup> U.S. General Accounting Office, *History of the Rising Costs of Medicare and Medicaid* (1976). Ironically, almost 50 years later this rift will come together under certain provisions contained within the 2010 Patient Protection and Affordable Care Act, set to take effect in the next few years.

<sup>36</sup> 42 U.S.C. § 1395x.

age of 65 with certain long-term disabilities and others with chronic kidney disease<sup>37</sup> Concurrently, Medicaid eligibility for elderly, blind and disabled residents of an individual state became linked to the newly enacted Federal Supplemental Security Income program (SSI). This restructuring was intended to standardize not only the burgeoning ranks of eligibility, but the program's growing list of benefits as well. To monitor these program enhancements, the 1972 changes also established Professional Standards Review Organizations (PSROs), designed to keep an eye on quality and utilization within the Medicare program. Garnering limited success in monitoring utilization and even less in the area of quality, PSROs were abandoned by Congress just ten years later, although in hindsight this was in many ways a foreshadowing of things to come.

The early years of Medicare solidified a managed care infrastructure for the entire nation. Though the focus remained on the elderly, the net of coverage was quickly expanding to include other members of the general population. Such a dramatic step came at a price, however, and as a result of the swelling ranks of Medicare beneficiaries, escalating costs necessitated Congressional action. To address this issue, the legislative branch turned to Health Maintenance Organizations (HMOs) for help.

### III. How HMOs Changed the Rules

Historically, many in the medical field viewed HMOs with suspicion, concerned that such health plans compromised the ability of physicians to direct patient care. Since the mid-thirties, the HMO market in America was largely under the control of Henry J. Kaiser and his Kaiser network, which had made its name by providing health insurance to workers building the Grand Coulee Dam in 1938.<sup>38</sup>

HMOs grew slowly at first as they faced staunch opposition from the AMA, which contended that such health plans were tantamount to the beginning of socialized medicine. As a result, many physicians who worked within the HMO infrastructure were excluded from participation within medicine's mainstream.<sup>39</sup> Despite this resistance, HMOs endured, and began to win the support of those in favor of using standardization to reduce medical costs. By the 1960s, HMOs had begun to attract new money, new supporters, and new names. By 1970 there existed 37 HMOs in 14 states, with a total of 3 million enrollees and a tested work model that appealed to many who sought greater regulation over health providers. This change in conservative perception of HMOs opened the door for increased federal involvement.<sup>40</sup>

In 1973, Congress passed the Health Maintenance Organization Act<sup>41</sup>, creating a partnership of sorts between the Federal government and certain health care providers. The HMO Act offered government subsidies and loans to HMOs, helping these managed care entities to attain much needed financial stability, in part so they could carry Medicare's increasing burden. More significant, however, was a new power extended to HMO administrators that authorized their ability to challenge the medical judgment of licensed physicians, regardless of the clinical acumen (or lack thereof) held by these corporate executives. In doing so, the HMO Act represents the first instance of

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<sup>37</sup> Pub. L. 92-603.

<sup>38</sup> Adams, Stephen B., *Mr. Kaiser Goes to Washington* (University of North Carolina Press, 1997).

<sup>39</sup> Coombs, Jan, *The Rise and Fall of HMOs* (University of Wisconsin Press, 2005).

<sup>40</sup> *Id.*

<sup>41</sup> Pub. L. 93-222.

business concerns gaining the upper hand over medical judgment in the health care system, and marked the first step toward the discrepancy of power between the two that still exists today.<sup>42</sup>

Brandishing its new power, the HMO Act granted \$375 million to pilot HMOs, justified by the idea that their participation would contain health care expenses by implementing standardization. This funding expanded in 1975, and continued until 1981 through Federal grants and loans. Once invested in the success of the HMO model, Congress began to give HMOs more freedom of operation, including leeway to refuse to pay for certain treatments altogether.<sup>43</sup>

The HMO Act also mandated that any business employing more than 25 individuals offer HMO coverage as a health care option. In this way, the Federal government effectively guaranteed some semblance of health care to the vast majority of the working public, not just the elderly and disabled. From the perspective of the employer, managed care plans appeared to be less expensive than individual insurance packages, which often resulted in the elimination of plan choices for their employees.<sup>44</sup>

In theory, the HMO Act sought to create cheaper health coverage for working American by focusing almost exclusively on HMOs, which represented but a small portion of the health care sector in the early seventies. In fact, Kaiser Permanente was still the only significant HMO across the nation at the time, even though most of its members had joined through existing mandatory union requirements. By fostering the growth of HMOs around the nation, the HMO Act not only legitimized its model, but it spurred widespread corporate sponsorship from entities such as Prudential and several Blue Cross Blue Shield partners. Growth in the private sector continued, and by 1992 for profit HMOs surpassed their non-profit counterparts.<sup>45</sup>

Thanks to the consistency of government subsidies, the growth of this particular arm of health care has continued to be pronounced, with the HMO model expanding itself as the preeminent template for American health providers. 1978 saw 168 HMOs in operation, with 6 million enrolled. By 1990, there were 652 HMO plans, covering 34.7 million people. In 1996, the number of enrollees grew to 60 million. Last year there were an estimated 154 million people enrolled in managed care (109.7 million in preferred provider organizations, and 44.3 million in HMOs).<sup>46</sup>

Following Medicare's lead, managed care ruled the day as the preeminent means to contain the nation's health care costs, and the Federal Government made little change to this new structure other than to create a specific agency – the Health Care Financing Administration (HCFA) – to administer both Medicare and Medicaid.<sup>47</sup>

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<sup>42</sup> *Id.*; Falkson, Joseph, *HMOs and the Politics of Health System Reform* (American Hospital Association, 1980).

<sup>43</sup> Also in 1975, Australia unveiled its system of universal health coverage, initially called Medibank. The name was later changed to Medicare, which continues to provide universal coverage throughout the country today. See generally Lewis, *The People's Health*.

<sup>44</sup> What was at the time considered to be a seemingly insignificant interjection into the corporate world by the Federal government would eventually come to be one of the pillars of today's health care reform.

<sup>45</sup> Cunningham, Robert, III, *The Blues: A History of the Blue Cross and Blue Shield System* (Northern Illinois University Press, 1997).

<sup>46</sup> Coombs, *The Rise and Fall of HMOs*.

<sup>47</sup> Pub. L. 104-193.



## IV. A New Way to Pay – the DRG

The troubled economic climate of the late 1970s and early 1980s, combined with rising health care inflation and a continually expanding patient base, forced the Federal government to reevaluate and recalibrate Medicare's core structure in an attempt to keep the program afloat. It had become clear to Congress and the Reagan administration that Medicare's initial model was not nearly so streamlined as it should have been, allowing as it did too much freedom on the part of the provider, which created a discrepancy between treatment and funding.

Prior to 1983, most patients remained in the hospital until the doctor decided it was time for them to leave. Physicians had enormous discretion in determining the length of a patient's stay, which resulted in an inconsistent range of hospital days for treating similar conditions. To correct this issue, policymakers made dramatic changes to the program's payment system, scrapping Medicare's cost-based reimbursement policy in favor of a newly developed classification system designed to standardize patient care by devoting a set price to a given procedure.<sup>48</sup> Called the diagnosis-related group (DRG), this prospective payment system did away with reimbursing providers for the actual cost of their services, creating instead a predetermined rate per illness based on a patient's diagnosis.<sup>49</sup> In doing so, the burden now fell on hospitals to provide the necessary care for a set procedure that kept within the payment cap if they wished to see a profit. This shift away from Medicare's earlier "fee-for-services" policy was intended to curtail what many saw as the overuse of testing and treatments by doctors in a hospital setting who knew these patient expenses would be covered under Part A, the foundation of the Medicare system under which these physicians did not directly fall. By providing a set fee per diagnosis, proponents argued that providers would be motivated to become more efficient in their diagnosis and treatment.<sup>50</sup>

Furthermore, as an easily traceable classification system, DRGs made it simpler for health care administrators to keep an eye on their physicians and the extent of services rendered. Under the DRG structure, practice pattern information was generated, providing administrators with the necessary tools to govern staff more effectively and reduce costs across the board. This was significant in that it again marked a shift in the power structure between health care providers and their administrative counterparts, and pointed the way toward the Federal government's increasing ability to use its economic leverage as a means to direct medical policy.

Once the DRG plan was firmly in place and patient classification became more sophisticated, diagnosis-related units were assigned to almost every aspect of acute hospital care. As a sign that the new structure was here to stay, DRG regulation advanced in conjunction with modern medicine, and by 1991 the top ten most used DRGs alone constituted nearly 30 percent of all hospital Medicare discharges. Today, the top ten most used DRGs include: (1) heart failure and shock; (2) pneumonia; (3) certain cerebrovascular diseases; (4) psychoses; (5) pulmonary disease; (6) joint, limb and lower extremity procedures; (7) angina; (8) certain digestive disorders, such as

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<sup>48</sup> In 1982 the Kingdom of Belgium attempted to address this issue by focusing on the efficient use of hospital beds. The July 22, 1982, royal decree placed a moratorium on additional beds, and at the same time created specialized geriatric services in hospitals and provided incentives to convert acute care beds into geriatric beds. See generally Roemer, *Health Manpower Policies in the Belgian Health Care System*.

<sup>49</sup> Wilensky, Gail R., *The Economics of DRG-Based Physician Reimbursement* (Center for Health Affairs, 1985).

<sup>50</sup> *Id.*; McClellan, Mark, *Medicare Reimbursement and Hospital Cost Growth* (National Bureau of Economic Research, Jan. 1996).

esophagitis and gastroenteritis; (9) gastrointestinal hemorrhage; and (10) nutritional and certain metabolic disorders.<sup>51</sup>

Perhaps the most important, if unexpected, outcome from the introduction of this system was the exodus of procedures that had traditionally been done in the hospital on an “inpatient” basis. Relying on advances in medical technology, many hospitals looked to the outpatient model (which included surgery centers) as a means to balance their bottom line and keep within the prearranged price caps. As a result, the years that followed the introduction of DRGs saw doctors and hospitals working together in outpatient facilities in an attempt to avoid whenever medically feasible the disparate reimbursement systems inherent in Parts A and B.<sup>52</sup>

## V. Congress Flexes Its Muscles

In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA).<sup>53</sup> Designed to counteract “patient dumping,” wherein hospitals refuse to treat people due to inability to pay or lack of insurance, EMTALA requires every hospital that receives federal funding to treat any patient with an emergency condition in such a way that, upon the patient’s release, no further deterioration of the condition is likely. No hospital may release a patient with an emergency medical condition without first determining that the patient has been stabilized, even if the hospital properly admitted the patient. Federal law defines an “emergency medical condition” as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in . . . placing the health of the individual . . . in serious jeopardy.”<sup>54</sup> Under EMTALA, patients requesting emergency treatment can only be discharged under their own informed consent or when their condition requires the services of another hospital better equipped to treat the patient’s concern.

Under this congressional act, the strength of EMTALA’s jurisdiction derives largely from the fact that it applies to all “participating hospitals,” namely those accepting payment from the Centers for Medicare and Medicaid Services (CMS, the successor to HCFA). In truth, however, as Medicare’s annual reimbursements add up to nearly 20% of medical expenditures in the U.S., most American hospitals have little choice but to participate in the interest of survival. Opponents of EMTALA cite this impossibility of refusing participation, when combined with the fact that the costs of its emergency health care requirements are not directly covered by the federal government, as yet another way in which the policymakers have attempted to establish greater control over America’s health care system through the use of government funds and ultimatums.<sup>55</sup>

While EMTALA does guarantee emergency medical assistance to everyone in need, regardless of insurance, citizenship, or economic status, it has been strongly criticized for overtaxing an already overburdened urgent care system.<sup>56</sup> As a result of its provisions, more than half of American emergency health care remains uncompensated,

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<sup>51</sup> Mayes, Rick, *Origins, Development, and Passage of Medicare’s Revolutionary Prospective Payment System*, *Journal of History of Medicine and Allied Sciences*, Vol. 61, No. 1 (Jan. 2007).

<sup>52</sup> *Id.*

<sup>53</sup> Pub. L. 99-272.

<sup>54</sup> See 42 U.S.C. § 1395dd.

<sup>55</sup> See, e.g., Trzeciak, S. and Rivers, E.P., *Emergency Department Overcrowding in the United States*, 20 *Emerg. Med. J.* 402-05 (2003); Fields, W. Wesley, *The Emergency Medical Treatment and Labor Act As a Federal Health Care Safety Net Program*, 8 *Acad. Emerg. Med.* 1064-69 (2008).

<sup>56</sup> *Id.*

causing some to claim that its passage is directly responsible for hospital consolidations and closures. Repercussions from the effects of EMTALA also include the suggestion that its passage has forced hospitals to participate in cost-shifting and led to higher rates for insured and economically sound patients, thus increasing medical inflation.<sup>57</sup>

1996<sup>58</sup> saw the Federal government take on increased regulatory responsibility with the passage of the Health Insurance Portability and Accountability Act (HIPAA).<sup>59</sup> This multifaceted bill was broad in its jurisdiction over both Medicare and American health care in general, as it sought to provide new Federal rules improving continuity or "portability" of coverage in the large group, small group, and individual health insurance markets, while reinforcing the need to protect the privacy of patient health records.

Combining a group of disparate issues, Title I of HIPAA amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986. In doing so, it strove to regulate the availability and scope of group health plans and many individual health insurance policies, including the protection of health coverage for workers and their families who have lost or changed jobs. Further provisions also limited a group health plan's ability to restrict coverage for preexisting conditions.

Title II, also known as the Administrative Simplification Provisions, focused on creating a set of national standards for electronic health care transactions and national identifiers for health insurance plans, providers, and employees alike. Recognizing the value of well-utilized electronic health records in increasing efficiency throughout the health care system, Title II tasked the Department of Health and Human Services (DHHS) with implementing national standards for the use and dissemination of electronic medical data.

Once accomplished, health providers were instructed to comply with HIPAA's Privacy and Security Acts by 2003 or risk severe financial penalties. As a result, many health care facilities sought help from a variety of for-profit HIPAA consultants who were familiar with the complexities of this far-reaching bill and capable of guaranteeing compliance for a price. This in turn added to the already extensive costs forced onto hospitals and medical practices as a result of HIPAA's passage, including the need to reorganize systems and infrastructure to comply with electronic health data privacy standards and an increase in staffing to address the myriad requirements of its legislation.

Congress quickly followed on the heels of HIPAA, enacting the Medicare+Choice program (now known as Medicare Advantage) in 1997.<sup>60</sup> Included in this bill were an array of new Medicare managed care and other private health plan choices for beneficiaries, all of which were offered through a coordinated open enrollment process.<sup>61</sup> The new regulations expanded education and information to help beneficiaries make informed choices, and created five new prospective payment systems (PPS) for Medicare services (inpatient rehabilitation hospital or unit services, skilled nursing facility (SNF) services, home health services, hospital outpatient department services, and outpatient

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<sup>57</sup> *Id.*

<sup>58</sup> This same year, on January 1, 1996, Switzerland's Law on Health Insurance of 1994 took effect. Funded by both public and private sectors (although with fewer public funds proportionally than seen in other European nations), the health care system in Switzerland now requires all residents to obtain basic health insurance, and likewise insurance companies must accept all applicants. See generally Leu, Robert E., Rutten, Frans, et al., *The Swiss and the Dutch Health Care Systems Compared: A Tale of Two Systems*, (Nomos Verlagsgesellschaft, 2008).

<sup>59</sup> Pub. L. 104-191.

<sup>60</sup> 42 U.S.C. § 1395w-21.

<sup>61</sup> *Id.*

rehabilitation services).<sup>62</sup> The idea behind this plan was to slow the rate of growth in Medicare spending by forcing providers to make deliberate decisions that reflected fiscal and clinical consideration. If successful, Congress anticipated this would extend the life of the Medicare trust fund.<sup>63</sup>

### **Raising the Question of Drugs**

Medicare reentered the spotlight in 2003 as it opened the door for prescription drug coverage in America. Targeted at seniors, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA)<sup>64</sup> established a voluntary outpatient prescription drug benefit for Medicare beneficiaries. Known as “Part D,” this prescription drug coverage was made available to all Medicare beneficiaries as of January 1, 2006, through a variety of plans that had been pre-approved by the federal government.

Laws governing the coverage of drugs had been a long time coming. Since the enactment of Medicare in 1965, the program had not generally paid for outpatient prescriptions, leaving them as the onus of the individual. In 1988, a prescription drug payment service was initially enacted as part of the Medicare Catastrophic Coverage Act (MCCA)<sup>65</sup> but this benefit was repealed along with other provisions of the Act in 1989. The Clinton Administration proposed adding a drug benefit to Medicare as part of the not-so-successful Health Security Act of 1993, and later that decade proposed to provide drug coverage under a new Medicare Part D. In both 2000 and 2002, the House of Representatives passed Medicare prescription drug legislation, but the Senate did not. When at last the new drug law was signed by President George W. Bush, a White House press release stated:

With the Medicare Act of 2003, our government is finally bringing prescription drug coverage to the seniors of America. With this law, we're giving older Americans better choices and more control over their health care, so they can receive the modern medical care they deserve. . . . Our nation has the best health care system in the world. And we want our seniors to share in the benefits of that system. Our nation has made a promise, a solemn promise to America's seniors. We have pledged to help our citizens find affordable medical care in the later years of life. Lyndon Johnson established that commitment by signing the Medicare Act of 1965. And today, by reforming and modernizing this vital program, we are honoring the commitments of Medicare to all our seniors.<sup>66</sup>

Through Part D, Medicare beneficiaries gain access to outpatient prescription drug coverage offered by private plans, which include both stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs) such as health maintenance organization (HMOs) that provide all Medicare-covered benefits including drugs. CMS has the authority to oversee all private plans that administer the drug benefit.<sup>67</sup>

MMA allows beneficiaries to enroll or switch plans during a given enrollment period. Its structure is such, however, that although enrollment in Part D plans is voluntary, there is a permanent premium penalty for those who

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<sup>62</sup> 42 U.S.C. § 1395w-22.

<sup>63</sup> See, e.g., Goodman, Harvey, *Money and Health: A Study of American Social Values, Volume I* (Dog Ear Publishing, 2005).

<sup>64</sup> Pub. L. 198-173.

<sup>65</sup> Pub. L. 100-360.

<sup>66</sup> The year before the United States embraced its victory with this new drug law, one European country experienced a celebration of a different kind. Reacting to increasing public acceptance of euthanasia, on April 1, 2002, the Kingdom of the Netherlands passed the “Euthanasia Act” so the Dutch parliament could oversee what had become a well-established practice. In point of fact the Euthanasia Act merely legalized the Netherland’s “status quo” where nearly everyone has accessible and affordable health insurance, yet a sizeable percentage of the population elects to die at home. See generally Leu, *The Swiss and the Dutch Health Care Systems Compared*.

<sup>67</sup> 42. U.S.C. § 1395w-101.

delay enrollment and do not have drug coverage that is at least comparable to the Part D standard benefit (known as “creditable coverage”). Once beneficiaries commit to a plan, they are generally locked into that plan until the following open enrollment period.<sup>68</sup>

By offering greater access to choice, the program relies on competition among private plans to limit drug prices and drug spending. Even so, the MMA explicitly prohibits the federal government from negotiating with drug manufacturers to reduce drug prices despite the view held by some that the government should use its purchasing power to leverage lower prices.<sup>69</sup>

## VI. Policing the Providers

Under the aegis of the MMA, Congress further expanded the federal government’s involvement in comprehensive health care regulation, directing the DHHS to conduct a three-year demonstration program using Recovery Audit Contractors (“RACs”) to detect and correct improper payments within Medicare. The original goal of the demonstration program was to determine whether the use of RACs would be a cost-effective way to maintain the integrity of Medicare by ensuring that provider payments were correct.<sup>70</sup>

By all government accounts, the original RAC demonstration program was successful, ending with more than \$1.03 billion recovered. According to CMS, approximately 96% of these payments were overpayments collected from providers (85% of which were collected from hospital providers) and the remaining 4% were underpayments. Emphasizing the need for hospital compliance with Medicare regulations in order to keep the program afloat, RACs further demonstrated the increasing shift from what was once a symbiotic relationship between administration and providers to one where governmental watchdogs held increasing power.<sup>71</sup>

For their part, health care providers were troubled by the fact that RACs were paid on a contingent-fee basis. Under MMA stipulations, RACs received a portion of the overpayments they discovered and recovered even if their determination was ultimately overruled. Additionally, RACs were not required to engage the services of a medical director when assessing medical necessity claims, could request an unlimited number of medical records from a particular provider, and were only required to do limited reporting on the problem areas they identified.

The Deficit Reduction Act of 2005 (DRA)<sup>72</sup> took the partnership between the CMS and the States to a new level. The Medicaid Integrity Program (MIP) offers a unique opportunity to identify, recover and prevent inappropriate Medicaid payments. Medicaid Integrity Contractors (“MICs”) work with CMS to carry out this program. It will also support the efforts of State Medicaid agencies through a combination of oversight and technical assistance.

In a subsequent effort to improve patient safety and rein in health care costs, CMS announced in August 2007 that Medicare and Medicaid would no longer cover the treatment costs of “conditions that could reasonably have been prevented.” Instead, hospitals and physicians would bear responsibility for these errors and cover their own

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<sup>68</sup> *Id.*; 42 U.S.C. § 1395w-103.

<sup>69</sup> 42 U.S.C. § 1395w-104.

<sup>70</sup> Pub. L. 108-173.

<sup>71</sup> Centers for Medicare & Medicaid Services, *Status Report On Use of Recovery Audit Contractors (RACs) In the Medicare Program* (2007).

<sup>72</sup> Pub. L. 109-171.

costs in instances when they were liable. This decision was based in part on research previously done by a national coalition of health care safety and quality experts. These experts had assembled a list of complications so egregious that they called them “never events,” meaning they should never occur in a hospital setting. “Never events” included such examples as complications stemming from operating on the wrong side of the body to leaving instruments in a patient after a procedure.<sup>73</sup>

While the CMS’s list has always included several of the original “never events,” it has since grown to include complications that were never before mentioned by the health care experts. For example, in 2007 CMS stated that patients develop 1.7 million infections in hospitals each year, and claimed that those infections cause or contribute to the death of 99,000 people a year — about 270 a day. Regardless of the health of a patient’s immune system at the time of admittance, hospitals suddenly found themselves responsible for any and all hospital acquired illnesses. Over time, this was followed by other insurers adopting similar practices of refusing to pay for treatment costs of certain complications, creating a private sector version of “never events,” which placed an even greater strain on the bottom line of the American hospital.<sup>74</sup>

## VII. Health Care Goes HITECH

With the passage of the American Recovery and Reinvestment Act of 2009 (ARRA)<sup>75</sup> certain standards governing electronic health care transactions under HIPAA were strengthened and fine-tuned under the Health Information Technology for Economic and Clinical Health Act (HITECH). Seeking to protect patient privacy and tighten the rules of accountability for the sharing of a patient’s medical information, HITECH will undoubtedly have a dramatic effect on the ways in which medical files are shared in the years to come.

Under HIPAA, a covered entity was able to disclose protected health information (PHI) to a business associate without a patient's authorization if the business associate provided the covered entity with satisfactory assurance that it would appropriately safeguard the information. These assurances were to be documented in a written contract often referred to as a business associate agreement (BAA) that met certain regulatory requirements. Prior to HITECH, although a covered entity was required to impose certain requirements on its business associates via contract, business associates were not regulated directly by the DHHS or its Office of Civil Rights (OCR).

But HITECH changed these rules. With an eye toward expanding liability, HITECH makes most of the HIPAA Security Rule requirements directly applicable to business associates as well, including direct regulation by the OCR and enhanced penalties for HIPAA violations. Among other things, after February 17, 2010, HITECH required a business associate to:

- Implement reasonable and appropriate written policies and procedures
- Develop a system for identifying breaches and notify covered entities following discovery of a breach of unsecured PHI
- Mitigate any harms from the inappropriate use or disclosure of PHI

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<sup>73</sup> Wachter, Robert M., *Medicare’s Decision to Withhold Payment For Hospital Errors*, Joint Commission Journal on Quality and Patient Safety (Feb. 2008).

<sup>74</sup> *Id.*; Michaels, Robert K., *Achieving the National Quality Forum’s “Never Events”*, 245 *Annals of Surg.* (Apr. 2007).

<sup>75</sup> Pub. L. 111-5.

- Train its workforce
- Develop a sanctions policy
- Establish safeguards
- Develop and implement a complaint system<sup>76</sup>

On January 13, 2010, CMS proposed the adoption of a more specific definition of what was to constitute “meaningful use” of electronic health records (EHRs), while also implementing financial incentive programs through Medicare and Medicaid that would reward or penalize hospitals and physicians for their ability to institute certified EHRs within an established time frame. Such a proposal drew on the strength of the newly passed HITECH Act, which required the Secretary of DHHS to establish such a definition.<sup>77</sup>

CMS proposed that hospitals adopt this new ruling on “meaningful use” in three stages of increasingly technological sophistication. Although most hospitals will only need to meet Stage One requirements for a 90 day contiguous period during the first year to receive incentive payments, they will in future need to continue to enhance their EHR capability in order to continue to receive incentive payments and avoid penalties beginning in 2015. These stages include:

Stage One “meaningful use” criteria focuses on electronically capturing health information in a coded format; using that information to track key clinical conditions and communicating that information for care coordination purposes; implementing clinical decision support tools to facilitate disease and medication management, consistent with other provisions of Medicare and Medicaid law; and reporting clinical quality measures and public health information.

Stage Two will encourage the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders entered using computerized provider order entry (CPOE) and the electronic transmission of diagnostic test results such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, pulmonary function tests and other such data needed to diagnose and treat disease.

Stage Three will focus on promoting improvements in quality, safety and efficiency, as well as decision support for national high-priority conditions, patient access to self-management tools, access to comprehensive patient data and improving population health.<sup>78</sup>

While many praise this bold step to protect patient privacy, the reality is that the burdens placed on health care facilities as a result of mandated HITECH compliance are a great cause for concern for America’s hospitals. From a financial standpoint, by requiring compliance to the Privacy and Security Provisions the federal government has in effect forced most medical centers to change their methods of operation and taxed their resources to include additional staff, technology, and infrastructure. Additionally, concomitant regulations have placed greater barriers for medical research and development by disallowing retrospective chart-based surveys and follow-up evaluations. Furthermore, the heavy price for non-compliance has naturally made many medical facilities wary of sharing patient

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<sup>76</sup> 42 C.F.R. §§ 412, 413, 422, and 495.

<sup>77</sup> 42 C.F.R. § 495.4.

<sup>78</sup> 42 C.F.R. § 495.6.

information, regardless of their right to do so, which in turn leads to restricted access to legally shared, anonymous data. It seems the price for privacy is high when it comes to health care.<sup>79</sup>

## VIII. Reform, Restructure, Review

Today's health care climate is one of flux, and it is too soon to tell whether the dramatic policies implemented in 2010 by President Barack Obama's Patient Protection and Affordable Care Act (PPACA, also known as Health Care Reform) will be successful in their attempt to provide health care to the estimated 50 million uninsured Americans, while simultaneously decreasing the United States budget deficit. There is little doubt, however, that the corresponding changes will impact both the ways in which Americans receive care and the means by which it will be provided.

Enacted on March 23, 2010, PPACA<sup>80</sup> is a comprehensive plan embracing a multitude of revisions to the structure of the American health care system that will take effect over a four-year period, including prohibiting health insurers from denying coverage or refusing claims based on pre-existing conditions, expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, and increasing support for medical research. Through the resultant growing pains from such sweeping legislation have yet to be fully understood, parts of the 2,700-page bill are beginning to take shape, just as the bill in its entirety is currently facing challenges of constitutionality.<sup>81</sup>

One of the major policy changes brought about by Health Care Reform is the creation of the "health insurance exchange," a marketplace designed to offer affordable high-quality health insurance options. The exchange was initiated to assist families who have no insurance or do not get adequate insurance at work and cannot afford to buy coverage in the costly individual or small group market. It is also applicable for small businesses that cannot afford small group health insurance.

By 2014, state-based health insurance exchanges are expected to provide consumers with a variety of private health insurance plans to consider. This would include comparisons of covered services, premiums, co-pays and deductibles, as well as out-of-pocket limits on expenses. Each exchange will focus on individuals and small employers with 50 to 100 employees. In 2017, states will have the opportunity to opt out of the federal requirements establishing an insurance exchange if they can demonstrate the ability to provide coverage comparable to the new Federal law.

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<sup>79</sup> *Electronic Personal Health Information Exchange*, United States Government Accountability Office (Feb. 2010).

<sup>80</sup> Pub. L. 111-148.

<sup>81</sup> *See, e.g., Thomas More Law Center v. Barack Obama*, 651 F.3d 529 (6<sup>th</sup> Cir. 2011); *Virginia v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010). Seven months later across the Atlantic Ocean, the United Kingdom championed its dedication to the delivery of health care for the elderly. In saving a substantial portion of health care funding for the elderly, the UK was quick to target the typically abrupt, transitional care from hospital to hospice. By focusing on a smoother transition for elderly patients, the UK anticipates a reduction in hospital readmissions, resulting in substantial savings. *See MacDonald, Alistair, U.K. To Protect Social Care for the Elderly*, Wall St. J. (Europe) (Oct. 17, 2010). These changes, however, have not ameliorated NHS' increasingly poor reputation when it comes to providing health care for the elderly. Critics claim that NHS provides neither dignity nor nutrition for elderly patients, although since 2011 this debate has become increasingly mired in politics. *See Denis Campbell, NHS Falling in Basic Care for Some Elderly Patients*, The Guardian (May 27, 2011); *Report of the Care Quality Commission* (May 26, 2011).



## Medicare's New Standard: Performance

At its core, America's new reform favors performance as a means to save money and increase efficiency, rather than the cost-based initiatives that had traditionally been the hallmark of American health care, and as such marks a dramatic shift in government policy as it relates to both regulation and funding.<sup>82</sup> While performance measures in health care have historically focused on individual clinicians, not systems, PPACA legislation now encourages the formation of accountable care organizations (ACOs), a concept designed to overhaul the nation's health care system by implementing structures that monitor the quality and efficiency of entire groups of medical practitioners in an effort to assess performance and create standards for compensation.<sup>83</sup> This Hospital Value-Based Purchasing Program is another step toward shifting the reimbursement infrastructure from the cost of services to improvements in patient health and performance.<sup>84</sup>

An integral part of implementing ACOs will include measuring processes and outcomes across the health care continuum to support improvement and accountability, while at the same time reducing the burdens associated with such performance measurements. Experts wait cautiously to gauge the success of ACOs as they monitor just how CMS, private payers, physicians, and health system leaders work together to establish the necessary criteria and maintain the integrity of the mission behind ACOs (advance accountability to patients and payers while supporting broad dissemination of successful innovations).<sup>85</sup>

The rules governing ACOs go into effect in October 2012. In the program's first year, hospitals will be entitled to share bonus money from an \$850 million fund based upon their performance. CMS will also evaluate patient satisfaction during hospital stays. Quality measures will weigh in at 70%, while patient satisfaction results will constitute the remaining 30%.<sup>86</sup>

Come fiscal year 2013 (starting October 2012), hospitals will face a 1% reduction overall on Medicare payments under the Inpatient Prospective Payment System (IPPS), as these funds will be used to pay for the performance bonuses. By 2015, hospitals that continue to show poor performance ratings will not only be excluded from the bonus pool, they will also face additional cuts in reimbursement.<sup>87</sup>

While providers join together under Congress' ACO model (which some critics argue may trigger antitrust issues), they must also contend with the trial stage of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey, the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS (pronounced "H-caps"), also known as the CAHPS® Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience.<sup>88</sup> While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there

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<sup>82</sup> PPACA, § 3022; 42 C.F.R. § 425 (proposed rules as of April 7, 2011).

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*; see also Berwick, Donald M., M.D., *Launching Accountable Care Organizations -- The Proposed Rule for the Medicare Shared Savings Program*, *New Engl. J. of Med.* (Mar. 31, 2011).

<sup>85</sup> PPACA, § 3022; 42 C.F.R. § 425 (proposed rules as of April 7, 2011).

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> In May 2005, the National Quality Forum (NQF), an organization established to standardize health care quality measurement and reporting, formally endorsed the CAHPS® Hospital Survey. The NQF endorsement represented the consensus of many health care providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality organizations.

was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally.

In theory, HCAHPS will enable valid comparisons to be made across the nation's hospitals by relying upon three conceptual premises. First, the survey is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons to be made between hospitals on domains that are important to consumers. Second, public reporting of survey results is designed to create incentives for hospitals to improve their quality of care. Third, public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey is credible, useful, and practical. It is important to note that both its methodology and the information it generates are available to the public.

The HCAHPS survey contains 18 patient perspectives on care and patient rating items that encompass eight key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, and quietness of the hospital environment. Twenty-seven questions in length, the survey also includes four screener questions and five demographic items, which are used for adjusting the mix of patients across hospitals and for analytical purposes.

The Federal Government is determined to transform health care's structure into one that is performance based, thereby redistributing responsibility, but providers will not bear this burden alone. Under PPACA authority, CMS has established a \$500 million fund to aid health care providers in improving patient care, preventing "never events," and reducing readmissions. Named the Partnership for Patients, this program is symbolic of the permanence PPACA hopes to establish. Even as partisan politics in America attempt to bring the issue of PPACA's constitutionality before the United States Supreme Court, health care reform continues to extend its reach with each passing day.

### **Medicare's Lasting Effects**

While the competing motivations between doctors and hospitals caused by the implementation of Parts A and B may eventually come together through ACOs and other similar provisions contained within PPACA, other Medicare driven transformations in the nation's health care system are almost certainly permanent. For example, the trend of multihospital systems replacing freestanding, community hospitals, historically picked up speed after 1965, although driven in part by economic factors and advances in medicine. The five hospital consolidations noted in 1961 ballooned to upwards of 50 per year in the 1970s. By the 1980s, an estimated thirty percent of the hospital beds in the United States existed within hospital systems.<sup>89</sup>

In 2008, the American Hospital Association estimated that almost half of the nearly 6,000 U.S. hospitals belonged to a hospital system, defined as either "multihospital" or "diversified". A multihospital system connects two or more hospitals through a central organization via ownership, leasing, or otherwise. Individual hospitals can become part of a "diversified system" by bringing into membership three or more facilities.<sup>90</sup>

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<sup>89</sup> See, e.g., Johnson, Donald E. L., *Multihospital System Survey*, 11 *Modern Healthcare* 80 (Apr. 1981); Starkweather, David B., *Hospital Mergers in the Making* (Health Administration Press, 1981).

<sup>90</sup> American Hospital Association, *Hospital Statistics* (1981).

Even many of the non-profit, faith-based hospitals directly descended from the original almshouses and charity hospitals of the 18<sup>th</sup> and 19<sup>th</sup> centuries have come to seek refuge in consolidation. By 1872, there were approximately 75 Catholic hospitals in the United States, including the Sisters of Charity, the Benedictine Sisters, the Daughters of Charity, the Sisters of Mercy, and the Ursulines, among others. Today, most of these institutions have been incorporated into regional “systems” that are governed by leadership teams comprised of health care experts as well as members from the original congregations.<sup>91</sup> While fluctuations in the role of religion in modern society and the restructuring of the health care system through the decades are responsible in large part for this transformation, changes in the economics of medicine have certainly played a role as well.

In direct opposition to the Hill Burton Act of 1946, which had earlier shed light on ways in which government funding could influence hospital performance by demanding that nearby hospitals pool resources, the hospital reimbursement structure introduced by Medicare, and DRGs in particular, forced the community-driven cooperation between hospitals to end. Under Medicare’s payment structure, separate institutions cannot share any sort of patient-related expenses without significantly impacting reimbursement. For better or worse, under Medicare hospitals could no longer look to peer institutions in the community for help, and financially speaking each institution became somewhat of a self-standing island in the sea of the American health care system.

Without question, the Medicare introduced in 1965 is not the Medicare of today. But regardless of any fundamental transformations since its inception, Medicare continues to offer one vital aspect that has not changed at all. To millions of Americans, Medicare means health insurance. In these trying economic times, as people are forced to push back retirement (assuming they are not part of the growing unemployment statistic) and enjoy an overall longer life expectancy that is a direct result of the advances in modern medicine, Medicare’s stalwart commitment stands as a beacon of hope to its beneficiaries.<sup>92</sup>

If PPACA’s changes to the core of the Medicare system did not attract the nation’s attention, the methods with which they have been and will be implemented certainly did. Before PPACA, adjustments in Medicare reimbursement originated from the Medicare Payment Advisory Commission (MedPAC). MedPAC recommendations needed congressional action for enactment.<sup>93</sup> Beginning in 2015, PPACA will charge the Independent Payment Advisory Board (“IPAB”) with the task of making changes to the Medicare program, limited only by congressional override. PPACA mandates IPAB action when Medicare spending exceeds certain thresholds, determined by the CMS’ Chief Actuary. Although public criticism has compared IPAB to a “death panel” under PPACA, IPAB shall *not* make decisions that “include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost sharing (including deductibles, coinsurance, and co-payments), or otherwise restrict benefits or modify eligibility criteria.”<sup>94</sup>

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<sup>91</sup> See, e.g., Risse, *Mending Bodies, Saving Souls*, 522-24; Starr, *The Social Transformation of American Medicine*, 172-77.

<sup>92</sup> Again, Belgium provides an excellent example of a European nation facing similar issues in the delivery of health care to an expanding and increasingly elderly population. While spending only half as much as the United States in relation to its national budget, Belgium’s health care system combines public and private elements to create universal and comprehensive coverage, including hospital and physician services as well as prescription drug coverage, all within the notion of individual choice of physicians and acceptable waiting times for non-emergency treatment. See, e.g., *European Observatory on Health Care Systems*, Belgium (2000).

<sup>93</sup> *Balanced Budget Act of 1997* (P.L. 105-33).

<sup>94</sup> PPACA, §§ 3403 and 10320.

When first introduced, Medicare predominantly sought to cover those individuals entering retirement until their death, a period estimated at four to six years.<sup>95</sup> Today, however, that same span is expected to be in excess of twenty years. As the Baby Boomer generation continues to age and life expectancy continues to increase, now more than ever Medicare proves vital to the nation's access to medical treatment. According to a CMS estimate, by 2020, 12 million older Americans will need long-term care. A study by the DHHS predicts that individuals who reach 65 will have a 40% chance of entering a nursing home, and approximately 10% of those will remain there for five years or longer.<sup>96</sup>

Most agree that Medicare does a solid job at addressing the acute care needs of its beneficiaries. Part A of Medicare provides coverage for 90 consecutive days of inpatient hospital care, including treatment at a SNF, defined by what is known as "benefit periods." A benefit period begins upon hospital or SNF admission, and ends when the beneficiary has not received any qualified care, either hospital or SNF, for 60 days in a row. A patient can have multiple hospital stays within the same benefit period, though there is a limit on the number of days during that period Medicare will cover. There is no limit on the number of benefit periods in a beneficiary's lifetime.<sup>97</sup>

If a beneficiary is no longer covered for acute care services under Medicare during a benefit period, there are a limited number of options available. Absent paying for this care directly or through a third party long-term health care policy, the last resort for many is Medicaid. The state programs that may cover certain long-term health services and/or nursing home care for individuals without financial resources do exist, but they vary greatly by region. In most states, however, Medicaid will pay for some long-term care services, though eligibility is usually based on income and personal resources.<sup>98</sup>

From Medicare's laudable yet contentious beginnings, through a series of bipartisan, almost Herculean efforts, Congress has for the past 47 years managed to offer nearly everyone in the United States 65 years of age and older a foundation on which to place their trust in times of sickness. Even so, today's Americans are living in historic times as pertain to the future of health care, a notion that reinforces itself in the media on a daily basis. Republicans and Democrats continue to spar over the best way for our system to deliver quality care in an efficient way to the estimated 310 million people under its aegis, leaving its fate in what often appears to be a state of near-perpetual limbo. As this debate endures and uncertainty grows about the survival of health care (and Medicare in particular), we must reflect on the program's longstanding track record in an effort not only to understand its past, but to reinforce the indisputable fact that the necessity of its existence in the future has much to do with the way in which we view the program today.

Historically, the American people have repeatedly issued mandates to Congress that Medicare must survive, providing as it does a much-needed safety net to offset the ever-increasing cost of medical care in this country. Sometimes spoken and sometimes more subtle, these mandates serve as landmarks spanning six decades that chart not only the history of Medicare, but the evolution of our country's health care structure as a whole. Each major revision stands as a reaction to the political and economic climate of the times in which it occurred, shedding light on our health care system's struggle to adapt and survive as it has grown and matured. True, many seniors who enjoyed Medicare's initial benefits in 1965 did not get the chance to witness the introduction of DRGs into the

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<sup>95</sup> Japan introduced health care for its entire elderly population in 1983. See generally Colby, Mark, *The Japan Healthcare Debate* (Global Oriental, 2004).

<sup>96</sup> See generally Agency for Healthcare Research and Quality, *Research on Long-term Care*.

<sup>97</sup> 42 U.S.C. § 1395d.

<sup>98</sup> *Id.*

system. Likewise, seniors in the early days of DRGs may not have reaped the benefits of EMTALA, nor did some of those first Medicare beneficiaries who enjoyed unfettered access to the emergency department at their local hospital live to see the era of Health Care Reform. Still, one thing has remained consistent through the years: Regardless of the growing pains and structural changes felt by nearly every generation of Medicare beneficiaries, losing this vital public benefit has been and continues to be the only true fear with which to contend.

APPENDIX:

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| ACO:    | Accountable Care Organization                                      |
| AMA:    | American Medical Association                                       |
| ARRA:   | American Recovery and Reinvestment Act of 2009                     |
| CMS:    | Centers for Medicare and Medicaid Services                         |
| CPOE:   | Computerized Provider Order Entry                                  |
| DHHS:   | Department of Health and Human Services                            |
| DRA:    | Deficit Reduction Act  |
| DRG:    | Diagnosis-Related Group  |
| EHR:    | Electronic Health Record   |
| EMTALA: | Emergency Medical Treatment and Active Labor Act                   |
| ERISA:  | Employee Retirement Income Security Act of 1974                    |
| HCAHPS: | Hospital Consumer Assessment of Healthcare Providers and Systems   |
| HCFA:   | Health Care Financing Administration                               |
| HIPAA:  | Health Insurance Portability and Accountability Act                |
| HITECH: | Health Information Technology for Economic and Clinical Health Act |
| HMO:    | Health Maintenance Organization                                    |
| INAMI:  | Institut National d'Assurance Maladie Invalidite                   |
| IPAB:   | Independent Payment Advisory Board                                 |
| MA-PD:  | Medicare Prescription Drug Plan                                    |
| MCCA:   | Medicare Catastrophic Coverage Act                                 |
| MedPAC: | Medicare Payment Advisory Commission                               |
| MIC:    | Medicaid Integrity Contractor                                      |
| MMA:    | Medicare Prescription Drug, Improvement, and Modernization Act     |
| NHS:    | National Health Service  |
| OCR:    | Office of Civil Rights   |
| PDP:    | Prescription Drug Plan   |
| PHI:    | Protected Health Information                                       |
| PPACA:  | Patient Protection and Affordable Care Act (Health Care Reform)    |
| PPS:    | Prospective Payment Systems  |

PSRO: Professional Standards Review Organization  
RAC: Recovery Audit Contractor  
SNF: Skilled Nursing Facility  
SSI: Federal Supplemental Security Income

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