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THE POLITICS OF PROSPECTIVE PAYMENT:
A LEGISLATIVE CASE STUDY

A Dissertation Presented

By

PATRICIA BODELSON

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 1988

Political Science

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A LEGISLATIVE CASE STUDY

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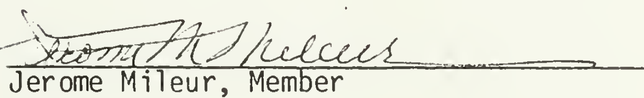
PATRICIA BODELSON

Approved as to style and content by:

George Sulzner, Chairperson of Committee



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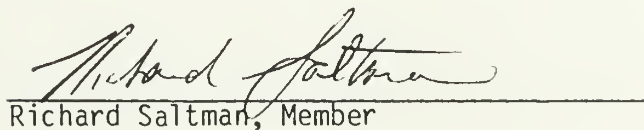

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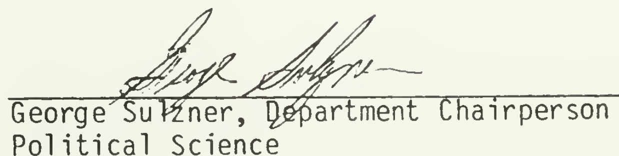

George Sulzner, Department Chairperson
Political Science

To my daughters,

who kept me focused on life

enabling me to keep my goals in perspective.

ACKNOWLEDGMENTS

At the onset of this discourse, I would like to expressmy appreciation and gratitude to those who contributed to this effort in many ways.

The data could never have been gathered without the cooperation of individuals who took time from their busy schedules to meet with me and discuss their perceptions of the events which led to the enactment of prospective payment. A special thanks goes to Julian Pettingill, formerly of the Office of Research and Demonstrations at Health and Human Services, who met with me on several occasions over lunch to discuss my work and provide his insight. And a debt of gratitude is owed to J. C. Comolli, Policy Coordinator to the Executive Secretariat, Health and Human Services, who permitted me to review departmental documents that enabled me to delineate the events which led up to the adoption of prospective payment. And of course, I am grateful to the Chairman of my Dissertation Committee, George Sulzner of the University of Massachusetts, whose guidance made the completion of the dissertation a reality.

A special thanks is extended to the person who gave me the confidence to make this dream come true, my dear friend and mentor, Alice Friedman of the University of Massachusetts, who provided moral support, ideas, resources, and typing services. The topic may never

have emerged, if not for Mark Legnini of the University of Massachusetts, who encouraged me with ideas and laughter. He is appreciated despite the fact that he moved on prior to completion of the task.

The support of my daughters, Mary, Caroline, and Erin, even in her absence, was essential for the completion of such an onerous task. Caroline and Mary's willingness to share their time and energy with my work epitomizes our love.

All of these people and so many more that it is impossible to name them individually have aided me in my quest to reiterate the events that lead to the passage of prospective payment.

And is always the case, the responsibility for inevitable errors or failings in the work are the sole responsibility of the author.

ABSTRACT

THE POLITICS OF PROSPECTIVE PAYMENT:

A LEGISLATIVE CASE STUDY

May 1988

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Directed by: Professor George Sulzner

Following Committee hearings, in February 1983, Congress adopted a system of prospective payment for the Medicare program that was signed into law on April 20, 1983. This is a case study that attempts to explain why an innovative reimbursement mechanism that drastically altered Medicare fiscal management was so swiftly enacted. Analysis of the events using John Kingdon's work as a conceptual framework provides a rationale for the policy outcome. The federal government appeared to be facing a fiscal crisis with diminishing revenues and rising expenditures of which a major component was Medicare hospitalizations. At the same time, the Social Security System was on the verge of bankruptcy because the Hospital Insurance Trust Fund had defaulted on a 12 million dollar loan.

Richard Schweiker, Secretary of Health and Human Services proposed a prospective payment system based on diagnosis related groupings. The model selected by Schweiker had proven its effectiveness when implemented on a statewide basis and a research team in the Office of Research and Demonstration in Health and Human Services had developed a strategy for national implementation.

Upon request of the Congress, Schweiker submitted a report that outlined the prospective payment system to the Senate Finance and House Ways and Means Committees. Prior to its submittal, Schweiker functioning as a policy entrepreneur, informed and canvassed the Congress, special interests, and the general public. Then following Committee hearings during which no adamant opposition was voiced, the respective committees voted to attach the proposal to the Social Security Amendments thereby insuring its adoption. Special interests endorsed the proposal for various reasons. The hospital industry supported it because it rewarded efficient operation of hospitals by allowing them to retain the difference between the price set by the government and the actual cost of care. Senior citizens believed that without the proposal, the entire Social Security System might be dismantled.

All of the effects of the policy are undetermined to date but it appears that prospective payment may be containing in-patient Medicare hospital expenditures while increasing outlays for other treatment modalities. Until the actual impacts are known, final conclusions

regarding the merits of prospective payment are premature. Although the system may have flaws, major changes are unlikely to occur in the near future because, as noted in this case, dramatic changes in health policy are the culmination of events which gradually evolve over decades.

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CHAPTER I

INTRODUCTION

The following is a case study of Title VI of Public Law 98-21 (P.L. 98-21). This piece of legislation altered the reimbursement of the federal Medicare program and changed American health care policy. Prior to the bill's enactment, hospitals were reimbursed retrospectively for the reasonable costs which they incurred in providing care to Medicare recipients. Title VI of P.L. 98-21 prospectively set reimbursement rates based on the discharge diagnosis of the patient receiving treatment. The specific reimbursement received by the hospital is established according to a classification system called Diagnosis Related Groups (DRGs).

In response to the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) in August 1982, Richard Schweiker, Secretary and Health and Human Services (HHS) submitted a prospective payment strategy to the Senate Finance and House Ways and Means Committees in December of that year. Congressional hearings on the proposal were held in February 1983 and following a vote in both chambers in March, the prospective payment system was signed into law April 20, 1983. A national prospective payment system to reimburse hospitals for care provided to Medicare recipients was implemented in October 1983.

P.L. 98-21 was selected for study because of the relative ease with which this innovative policy was enacted. The question to be addressed is why it passed so quickly when a myriad of other health policy proposals, with far less impact on health care, remain forever in what Theodore Marmor refers to as a constant state of indecision.[1]

PURPOSE OF THE STUDY

This dissertation is an attempt to explain the process which lead to the enactment of prospective payment. The importance of the dissertation is related to three aspects of health care policy in the United States. The first is that health care delivery is a rapidly growing industry with a significant level of government involvement. The second is that the health care industry functions in a unique manner which is a product of its market design. The third is that there had been little research done which provides decision makers with an explanation of what influences health policy outcomes.

The health care industry has grown over the past 50 years. The provision of health care was seen as a substantially private matter until the end of World War II. Since then, health care has become more of a public responsibility. Especially since the passage of Medicare/Medicaid in 1965, there has been substantial increase in government expenditures for health care. Currently, the federal government is the largest single purchaser of health care in the United States.[2] Federal health care expenditures have more than tripled since 1965 and in 1982 accounted for 10.5% of the Gross National Product.[3] Other indicators of growing government involvement

in health care include the fact that in 1976 the public sector provided 42% of health outlays compared to 26% in 1965 and 13% in 1930.[4] By 1982, federal expenditures for Medicare reimbursement were $33.4 billion with an anticipated increase to $50.4 billion by 1985.[5] In 1985 Medicare expenditures were limited to $40 billion because of the enactment of a prospective payment system.[6]

Increased government involvement is one reason the politics of health care policy need to be studied. Another reason is that the health delivery system does not operate in a free market; there is both controlled access to the industry and there is dominance of third-party reimbursement. The use of third-party reimbursement has been identified as a major underlying cause of rising health care costs.[7] It is believed that hospitals respond to increased insurance coverage by changing the style of care provided.[8] This indicates that increased reimbursement for care insures that providers will provide a more complex style of care. What begins to emerge is a form of Parkinson's Law of medical care: "Standards of practice will eventually rise to absorb the dollars available."[9] These characteristics question the propriety of applying other public policy models (e.g., those drawn from public transportation) in the realm of health care.

Although the need for research has been established, there is an enormous gap in this area. Most political scientists studying the politics of health state the need for a means of elucidating the outcome of proposed health policies. The few explanations offered to

date, are specific to the policy studied and are unable to explain the rapid adoption and implementation of prospective payment.

Marmor states the desirability of political analysis of health policy and the need for instruments to predict and hopefully control the outcomes of proposed health policy.[10] He points out that political science efforts have been more descriptive than explanatory or predictive, but suggests that the greatest contributions political science can make is in the creation of "analytic models and explanatory paradigms" that can be applied in a variety of health settings.[11] Because of the increase of government involvement in health care delivery and the rising budgetary costs for health, policy makers need a means of analyzing a proposed policy to determine in advance its potential legislative outcome.

METHOD AND DESIGN

The methodology to be used is a case study approach involving an indepth investigation into the process that led to the passage of P.L. 98-21, prospective reimbursement for hospitals. The case study methodology has the advantage of providing highly detailed data for one example and can help one understand the process by which an outcome was reached. The information obtained from a case study is also valuable in exploratory research where the goal is to develop generalizations which can be subsequently examined in other studies. The case study, if well chosen, provides an example of representative processes, structures, and actions.

The major disadvantages of a case study are the biases introduced by the qualitative nature of the data collected and the limitation of a single instance which may or may not be representative. Consequently, a case study approach may be of limited utility in testing hypotheses, but it is the preferred approach to generating hypotheses where there is little confirmed knowledge.[12]

Data collection in the project included: (1) review of government documents relating to P.L. 98-21, (2) review of congressional hearing reports, and (3) review of regulations developed for implementation. In addition, thirty interviews with those intimately involved in passage and implementation were conducted. Key participants included: (1) Richard Schweiker, former Secretary of Health and Human Services, (2) Carolyne Davis, Director of the Health Care Finance Administration; (3) Julian Pettingel and James VerTrees, Office of Research and Development, Health Care Finance Administration (HCFA); (4) John D. Thompson, Professor, Yale University; and (5) staff members at the HCFA who participated in the formulation of the proposal and represented the Administration during the process of policy adoption. Further, interviews with four selected lobbyists were held and a review of the position papers of various special interest groups directly affected by the policy was completed. Included were the American Hospital Association, the American Medical Association, the Federation of American Hospitals, Medical Records Association, Blue Cross and Blue Shield Association, National Task Force of Gray Panthers, National Council of Senior Citizens, Medical Society of New

Jersey, American Association of Retired Persons, and the Association of American Medical Colleges.

Ten members of Congress, who worked to insure passage of P.L. 98-21, were also interviewed. Particular attention was given to the sponsors of the bill and their health policy staff members. The latter included: Sheila Burke from the Senate Finance Committee, Subcommittee on Health; Keith Kahn from Senator David Durenberger's Office; Paul Rettig, Professional Staff of the House Committee on Ways and Means; and John Salmon, Chief Council of House Committee on Ways and Means. Selection of persons interviewed was based on records of their testimony at hearings, correspondence submitted to committee members and referrals from interviewees.

The organizing design for the study draws upon John Kingdon's theory of public policy generation. Kingdon states that when the three factors of problems, policies, and politics join together, there is a "coupling" which opens the "window of opportunity" allowing change to occur through the enactment of new policy.[13]

According to Kingdon, problems are identified by systematic indicators and focusing events. An example is the systematic evaluation of federal expenditures for Medicare that indicated a rapid growth in outlays for the program. Once a problem is identified, it will not necessarily be addressed in the political arena unless a triggering event or crisis occurs which focuses attention of decision makers on the problem. Identification of a problem does not insure the adoption of the policy in response to a crisis, but it removes barriers that may have previously stifled enactment.

The second element in Kingdon's model emphasizes phases of policy formulation and the characteristics of the policy which emerges. Policies are successfully formulated, Kingdon asserts, when the policy is the product of a policy community activated by a policy entrepreneur.[14]

The national policy community, Kingdon observes, consists of policy specialists drawn from executive agencies and congressional staff units, academicians, and analysts for interest groups. These aggregates are united by a shared interest in a field of policy and tend to be familiar with one another's work. The policy community functions outside the formal political environment, yet, within the community, policies are formulated with an awareness of the political milieu.[15]

An obstacle to efficient operation of a policy community is a lack of communication among its members, which often leads to "fragmentation" and may produce "disjointed policy" that is lacking a common orientation causing unintended impacts and agenda instability. To avoid fragmentation, Kingdon prescribes open communication within the policy community.[16]

Policy communities, Kingdon relates, become involved in policy formulation most often in response to a policy entrepreneur or individual who advocates a specific policy. Policy entrepreneurs willingly invest their resources in the pursuit of a future return in the policy arena. The incentives which motivate policy entrepreneurs are promotion of personal interests, promotion of a philosophy or value, or interaction with a like-minded group.[17]

The role of the policy entrepreneur is to work with the policy community to formulate a policy and collaborate with experts resulting in a mutual enhancement of the credibility of the policy in the eyes of legislators when the policy is considered for adoption. The final task of the policy entrepreneur is "softening up" the general public, specialized interest groups, and the key governmental actors. Softening up is essentially an educational process which through informed exposure of the content of policy can add to its acceptance upon enactment.[18]

The work of the policy entrepreneur would be futile, according to Kingdon, unless the proposal the entrepreneur advocates meets three criteria. The first is that it possesses technical feasibility which (1) is developed after delving into the details and technicalities of the proposal to eliminate inconsistencies, (2) attends to feasibility of implementation, and (3) specifies the actual mechanism by which the solution can be put to practical use.[19] The second criteria is that it contain value acceptability so that the content will remain more or less intact and survive the policy process. Although Kingdon does not specifically define value acceptance he suggests that it is present when a proposal reflect mainstream thinking and is equitable and efficient in its design. The final criteria is that it be structured with an anticipation of future contraints. The proposal must be able to survive the inevitable budgetary constraints, which will be imposed during adoption, and that unintended impacts are controlled through the policies design.[20] If policy adheres to these guidelines, Kingdon

projects the emergence of a consensus that can be expanded through the use of coalition-building techniques such as bandwagoning and tipping.

The last component of Kingdon's model focuses on policy adoption which he designates as the political stream. Actions in the political stream are influenced by the national mood, organized interests, and government officials.

Kingdon postulates each ingredient of his model as relatively independent tributaries which eventually flow together to form a political mandate. The convergence creates a policy window, which offers the optimal chance of policy enactment. As Kingdon relates, "...at some critical juncture the three streams are joined, and the greatest policy changes grow out of that coupling of problem, policy proposals, and politics."[21]

Congressional hearings on prospective payment for Medicare began in February 1983 in the United States Senate and the United States House of Representatives. By October of 1983, an entirely new mechanism for Medicare reimbursement had been adopted and was ready for implementation. This apparent speed in enactment is misleading. The avenue to success was paved by years of activity on the problem identification and policy formulation fronts and wading in the political stream. The nine months of intensive involvement in 1983 reflects the opening of the window of opportunity for a prospective payment system for hospitalization which was creatively and successfully entered. Using Kingdon's approach, the following three chapters probe the phases of the policy process. Chapter II examines the question of problem identification relative to prospective payment

of hospitalization costs. Chapter III looks at the development of the contents of a prospective payment system. Chapter IV follows the detailed maneuvers which led to legislative enactment of a prospective payment system. Chapter V attempts to relate what implications this case study might have for health policy analysis in particular and public policy in general.

A necessary first step toward the goal of creating a comprehensive health care program for the citizens of the United States is the accumulation of better information about how the policy process can be leveraged to advantage. This dissertation represents a modest start in that direction. Through increased understanding, a health care delivery system may emerge which is not vulnerable to external economic and political whims and provide the key essentials basic to acquired and sustaining a healthy and productive populace.

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CHAPTER II

THE PROBLEM

Development of Health Policy in the United States

The focus of health policy in the United States has shifted throughout the 20th Century. Each new policy direction has been a response to the social, economic, and political influences of the day. According to Paul Starr, this evolutionary pattern can be neatly divided into three periods. He labels the periods of health policy chronologically as progressive, expansionary, and containment.[2] During the progressive stage (1900-1920), proposed policies focused on income maintenance for ill or disabled employees. This shifted as the country moved into the expansionary stage (1920-mid 1970) which focused on providing access to health care regardless of financial status or geographic location. The current stage focuses on control of rapidly escalating health care costs.[2] Review of the development of health policy, the proposed policy solutions, and the support generated for endorsement of potential solutions in the political stream in each stage and particularly in the expansionary and containment stages, helps explain the problem facing legislators when DRGs were offered as a mechanism capable of controlling rising health care costs.

The Progressive Stage

The problem which reformers of the progressive stage addressed was that of income stabilization during illness. Prior to the 20th Century, workers were insured through sickness funds sponsored by mutual societies, unions, and employers to provide cash benefits in case of illness to compensate for lost wages. Such programs had dwindled by the turn of the century; and after the passage of insurance against industrial accidents (workmen's compensation), interest in health insurance (sickness pay) developed.[3]

Reformers who addressed the problem were from outside the government. The group which took the initiative to insure wage compensation during illness was the American Association for Labor Legislation (AALL).[4] The AALL presented its case for sickness insurance based on two objectives. First, they wanted to relieve poverty caused by illness by distributing individual wage losses and medical costs through insurance. Second, they wanted to reduce the social cost of illness through medical care and by creating monetary incentives for disease prevention.[5]

As the Progressive Era ended in the 1920's, no policy had been generated that would respond to the crisis of wage loss due to illness. The solution developed by the AALL was unable to rally enough support to ever establish the plan as national health policy. Consequently, the period did not directly affect later health policy eras. What is noteworthy about the Progressive era is that, although unsuccessful, citizens groups and professional associations emerged who thought the government should become involved in the issue.

Expansionary Stage

Policies developed and instituted in the Expansionary stage were ultimately responsible for the fiscal crisis facing the 98th Congress. Review of the events of this period is necessary to comprehend the subsequent need for controlling federal health care expenditures.

There was very little activity on health care issues in the 1920's and early 1930's. The country was heading toward unprecedented prosperity after World War I. The presidencies of Harding and Coolidge symbolized "back to normalcy," and major health and welfare policies were given little consideration by either the public or private sector. Yet, the issue of health insurance did not totally dissipate.[6]

The concept of health insurance was revived during the New Deal and following World War II. The two major issues were: "increasing medical costs and unmet 'needs'." The problem was that "the cost of services were rising to the point that not only wage earners, but also people of 'moderate means', were finding them hard to meet. And as a result of this economic barrier, society was failing to meet individual's health care needs."[7]

The increase in health care costs originated during the Progressive Period, but its impact was not actually felt until the 1920's. The cost of both physician's services and hospitalization increased, but especially the latter. The increase in physician's fees came from two sources: improvement in the quality of services due to scientific advances; and increased monopoly power due to licensing restriction which, by the 1920's, gave physicians higher

returns on their investment in education than were, perhaps, justifiable.[8] The rise in hospital costs was the result of the transformation of hospital care. Prior to 1870, hospitals were caretakers of the chronically ill that operated basically as charities.[9] As hospitals became centers for surgery and acute medical care, their construction and operating costs soared. As hospital care became more common and derived more income from services, their charges grew.[10]

An informal conference was held in Washington, D.C. in April 1926 to discuss the social and economic aspects of health care. At the conference, a committee of five members who were either physicians, public health professionals, or economists was formed to conduct studies regarding the social and economic aspects of health care.[11]

This formal committee presented its findings in conjunction with the annual meeting of the AMA in Washington, D.C. in May 1927. Participants in the conference, who had connections with individuals in private foundations, believed that the findings presented warranted further study. The result was the creation of the Committee on the Cost of Medical Care (CCMC) consisting of 42 people. According to Odin Anderson, the committee "membership read like a Who's Who in Health Services Public Policy."[12]

The CCMC planned five areas for intensive study: (1) the incidence of disease and disability in the population, (2) existing health care facilities, (3) family expenditures for health care, (4) incomes of service providers, and (5) plans for health services for

specific population groups. Six private foundations contributed approximately $1 million for this research, and nearly everyone of note in health care and social sciences participated in the ensuing research.[13]

The studies done by the CCMC found that, "the need for medical care as defined by professional standards was higher than the rate of utilization even among the highest income group."[14] The CCMC estimated the social costs of medical care at four percent of national income. Most advocates did not find that figure excessive; in fact, they believed people needed more medical care than they were receiving. This perception of a problem spawned policy analyses based on the premise that there was an inadequate supply of health care resulting in an inability to meet the "health needs of a nation."[15] The presumptions were that more health care was necessary and the government should be compelled to devote more resources to insure expansion of the health care delivery system.[16] In the introduction to the CCMC final report, Chairman Ray L. Wilbur wrote, "More money must be spent for medical care; and this is practicable if the expenditures can be budgeted and can be made through fixed periodic payments."[17]

The stance taken, requiring more expenditures to meet the health needs of the nation, marks the shift of health policy from a means of distributing wage losses and medical costs through insurance into expansionary financing to facilitate access. The chief concern became increasing access to and consumption of health care rather than income protection.[18]

Nearly all public and private programs of the era were characterized by the desirability of expanding medical services and a general willingness to accommodate the interests of hospitals and doctors. After World War II, the federal government began to subsidize hospital construction and medical research with the principle objective of expanding medical resources. National health insurance proposals reflected this objective.

During the expansionary period, many proposals were offered to solve the problem of restricted access to medical care. On the whole, proposals were directed toward solving the problem of inaccessibility of care due to rising costs. Recommendations for national health programs were proposed by Presidents Roosevelt and Truman; but neither could rally enough support to insure the enactment of any national health policy.

Some of the early attempts at improving access to health care were made in 1939 with the introduction of Senate Bill 1920 by Senator Wagner of New York, the Caper Bill in 1941 (Senate Bill 489), the Eliot Bill in 1942 (House of Representatives Bill 7354), and the Wagner-Dingell Bill in 1945 (Senate Bill 1606). These bills were substantially the same; the intent of each was to remove the financial burden of illness from the people. There was no direct change in the existing health delivery system in any of these plans. The major issue which led to their demise was ideological--that is, endorsement of the programs was not forthcoming because most individuals and organizations considered it inappropriate for the government to use

payroll deduction and/or taxation to finance health services for everyone.[19]

There was not enough support to enact any national health care plan until the landslide elections in 1964. When the 89th Congress convened in 1965, a national health care plan was a priority for both the Congress and the Administration. The plan did not provide health care to all Americans, but instead covered only the indigent and the elderly. The coverage for the financially needy was called Medicaid; and for the elderly, it was called Medicare. Medicare grew faster and consumed more federal dollars than Medicaid. Since Medicare was the primary focus of attention during the transition into the cost containment stage of health policy in the United States, it is the topic of discussion here.

Once signed into law on July 30, 1965, Medicare became the primary payer of health care for the elderly. The program was designed in conjunction with the Social Security System and became known as Title XVIII of the Social Security Act. Medicare was divided into two major components. The first was the basic health insurance plan for hospitalization which is generally referred to as Plan A. The other component of Medicare, referred to as Plan B, dealt with reimbursement to physicians for care provided to the elderly. The prospective payment system (PPS) of Title VI of the 1983 Social Security Amendments (SSA) only addressed reimbursement for Plan A, consequently only the description of it and its financing are relevant to this exposition.

Medicare

Eligibility

Those eligible for benefits under this plan were persons 65 years of age or older, except active or retired federal employees who were eligible for the federal health benefits program, and unlawful aliens or aliens who had not lived in the United States for at least five consecutive years. An outline of the main components of Plan A follows.

Benefits

- In-patient hospital costs for up to 90 days per illness with deductibles of $40 for the first 60 days and $10 per day for the subsequent 30 days. All routine hospitalization charges were included under the plan except for care provided by psychiatrists, radiologists, anesthesiologists, and pathologists. The only in-house physician services which were covered were those offered by residents or interns in approved teaching programs. A lifetime limit of 190 days and the limit of 60 days per illness were set for psychiatric care.

- Post-hospital care, such as provided by a skilled nursing facility, was provided to patients following a hospitalization of three days or more with the patient incurring $5 per day of the costs after the first 20 days of care.

- Out-patient diagnostic services were covered, with a $20 deductible, for all services provided by the same hospital during a 20

day period. After 20 days, Plan A covered 20 percent of the remaining costs.

- Up to 100 home health visits made by health care providers other than a doctor following a hospitalization of three days or more were covered. Payments would be made based on "reasonable cost" of the services.

Financing

Funds for the program were obtained through payroll taxes of .35 percent in 1966; .50 percent in 1967-72; .55 percent in 1973-75; .60 percent in 1976-79; .70 percent in 1980-86; and .80 percent in 1987 and thereafter. The taxable annual earnings base for the health insurance payroll tax was set at $6,000 effective January 1, 1966. There was no ceiling set on income tax deductions for medical expenses.

It was determined that general revenue would pay the coverage cost of those who had not participated in the Railroad Retirement fund or Social Security. All moneys collected were to be placed in a separate Hospital Insurance Trust Fund in the Treasury.

Administration

The Secretary of Health Education and Welfare was designated as the major administrator of the plan. An Advisory Council was also created to advise the Secretary on the administration of the plan.[20]

Projected Costs of the Medicare Program

The estimated cost of Medicare in 1965 was, according to the House Ways and Means Committee Report, "in long-range balance with contribution income."[21] Payroll tax increases were set according to the guidelines of Table 1, presented below. It was assumed that this increase would cover the major portion of the costs incurred by the Medicare program, but not necessarily all of them.

Medicare was quoted as an enormous breakthrough in overcoming the barriers to health care. Stephen M. Young (Democrat-Ohio) clearly stated, for example, "The measure represents the greatest advance in social legislation ever presented to the Senate."[23] The overall tenor of the decision to have health care insurance provided for the elderly was noted in President Johnson's address at the signing of the bill in Independence, Missouri, with former President Harry Truman, on July 30, 1965.

> No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a life time so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their hopes, eaten away simply because they are carrying out their deep moral obligation to their parents, and to their uncles and their aunts.
>
> And no longer will this nation refuse the hand of justice to those who have given a life time of service and wisdom and labor to the progress of this progressive country.[24]

For all its innovation, Medicare did not drastically change the health care delivery system. The program maintained the established pattern of delivery of care and remuneration for services to hospitals and physicians. Because Medicare based reimbursement on the rate set

Table 1

Annual Revenue Collected[22]

Years	Employer-Employee Rate (Each)				Self-Employed Rate			
	Former Law	Under Bill	Former Maximum	New Maximum	Former Law	Under Bill	Former Maximum	New Maximum
1965	3.6%	3.5%	$174.00	$174.00	5.4%	5.4%	$259.20	$259.20
1966	4.1%	4.2%	$198.00	$277.20	6.2%	6.15%	$297.60	$405.90
1967	4.1%	4.4%	$198.00	$290.40	6.2%	6.15%	$297.60	$422.40
1968	4.6%	4.4%	$198.00	$290.40	6.0%	5.40%	$331.20	$422.40
1969-70	4.6%	4.9%	$222.00	$323.40	6.9%	7.10%	$331.20	$468.60
1971-72	4.6%	4.9%	$222.00	$356.40	6.9%	7.10%	$331.20	$468.60
1973-75	4.6%	5.4%	$222.00	$356.40	6.9%	7.55%	$331.20	$498.30
1976-79	4.6%	5.45%	$222.00	$359.70	6.9%	7.60%	$331.20	$501.60
1980-86	4.5%	5.55%	$222.00	$372.90	6.9%	7.70%	$331.20	$508.20
1987	4.6%	5.65%	$222.00	$372.90	6.9%	7.80%	$331.20	$514.80

by the institution or physician, the government had relatively little control over the outlays for the program.[25]

Medicare is the culmination of the expansionary health policy era. Through the rest of the 60's and during the early 70's, many other expansionary health policies were proposed. Although the passage of other expansionary health policies was rare, the proposals were driven by the same philosophy that health care was a right of all individuals.[26] A recurring theme in proposed health policy was the attempt to develop a national health insurance program that would provide health care not just to the indigent and elderly, but also to all citizens of the country. A major proponent of such a plan, Senator Edward Kennedy (Democrat-Massachusetts), worked tirelessly to establish such a program. Several other variations of his theme were proposed, but to no avail.[27] Proposals for the expansion of government subsidized health care failed because the emphasis on the problem of access began to diminish as federal expenditures for health began to rise. The background of the movement to deal with cost containment of hospitalization under Plan A of Medicare will be the subject of analysis for the remainder of this chapter.

Cost Containment Stage

By the mid 70's, the United States entered into a new phase of concern about health policy. Proposed policies began to reflect the need to control the ever-rising costs of health care. The necessity for the shift in focus is indicated by the fiscal trends that the Medicare program began to display. A program that had been initially

designed to provide a stable fiscal base for the provision of health care to the elderly began to grow beyond expectation.

Another factor which influenced the movement from the expansionary to cost containment stage was a shift in power within the health care delivery system. According to Alford, hospital administrators began to emerge as institutional leaders in the health care delivery system. Along with the increasing power within health care institutions, administrators also became more influential in the formulation of health policies. The emergence of this new interest group affected a shift in the focus of health policy from one which addressed the amount of care provided to one which addressed the economic efficiency of health care.[28]

This change in attitude also stemmed from the fact that those who were involved in the creation of Medicare did not anticipate the rate at which health care expenditures would increase or the demographic changes in the country. In 1966, 19.1 million aged persons were enrolled in Medicare. By 1982, this number had risen to 29.5 million. The proportion of the total population receiving Medicare benefits rose from 9.6 percent in 1966 to 12.4 percent in 1982. By 1982, nearly 97 percent of those over 65 years of age received some type of Medicare coverage compared to 82 percent in 1966. During 1982 alone, 1.8 million aged were newly enrolled in Medicare; of those who terminated their coverage (1.6 million), nearly all did so due to death.[29]

By 1982, the number of Medicare enrollees had risen more than 55 percent since its first year in operation. The number of eligible

persons who actually received reimbursements under the Medicare program more than doubled from the first year of Medicare until 1982. At the same time, the number of Medicare recipients who were hospitalized increased from 18.5 percent in 1966 to 24.3 percent in 1982. The average reimbursement per recipient per year also increased from $592 in 1967 to $2,439. The results of the increase in the number of enrollees, increased hospitalizations, and increased per recipient reimbursement was a large increase in expenditures for the Medicare program. The cost of the program increased nearly ten fold from $4,239 billion in 1966 to over $41,524 billion in 1982.[30]

The majority of this money was allocated to hospitalization costs. The federal government paid $39.4 billion for hospitalization for the elderly in 1982. According to the Health Care Finance Administration (HCFA) projections, this figure was projected to rise to $150 billion by 1990. Hospitalization coverage accounted for over 69 percent of monetary outlays for Medicare reimbursement.[31] Consequently, Medicare hospitalization insurance became the primary target for cost containment reform, and was a major concern of Congress when DRGs were proposed.[32]

As the outlays for the elderly steadily rose, the number of individuals in the workforce contributing to the Social Security Trust Fund (SSTF) began to decline. In 1950, 16 workers contributed to the SSTF for every benefit recipient. During the 60's this ratio shifted so that, for every recipient, only five workers contributed to the Fund. In the 80's, three workers are responsible for the support of one recipient, and projections indicate that the ratio will be two

workers per recipient by the year 2000. The amount of contribution necessary from each worker to support a recipient would become astronomical under these conditions.[33]

Escalating health care costs did not go unnoticed by the Federal government and Congress attempted many different strategies to control rising health care costs. But each solution offered to ameliorate the problem was either ineffective in achieving the goal of cost containment or unable to rally the support necessary to insure its enactment.

A short-term attempt to contain health costs was Nixon's Economic Stabilization Program (ESP). It began with Phase I, a 90 day freeze on wages and prices in the entire economy. Phase I was followed by Phase II which was aimed at specific controls for each major sector of the economy. HEW applied for an exclusion from ESP based on the uniqueness of the health care industry, but the Administration denied the request. According to Abernathy and Pearson, ESP caused problems for hospitals because hospital reimbursement methods were in fact unique among government contracting practices for goods and services. It was unclear whether the health care cost controls applied to charges or to cost-based third party payers. HEW regulations clarified this problem by defining the cost-based payments as prices. The ESP limited the increase in aggregate annual revenue for prices to six percent, with aggregate wage and salary increases limited to 5.5 percent, aggregate nonwage and nonsalary current expenditure increases limited to 2.5 percent, and aggregate increases for new technology and new services limited to 1.7

percent. The program was effective in containing costs below the inflation level of the general economy, but as soon as the temporary program ended, health care costs began to rise.[34]

Other attempts to control costs were focused on controlling the supply of health care. Control of supply to limit the increase in health care costs has based on a demand-pull theory rather than supply-demand theory used to explain the relationship of goals to consumption in most industries in a capitalist economy. The argument is that when third party coverage is extensive the consumer accepts more care regardless of need. A kind of Parkinson's Law of medical care exists, which states, "standards of practice will eventually rise to absorb the dollars available."[35]

The National Health Planning and Resource Development Act of 1974 is an example of the effort to control supply. Under the Planning Act, 205 regional Health System Agencies (HSAs) were required to recommend to a State Health Planning and Development Agency (SHPDA) whether or not proposed health capital expenditures were appropriate to the need of the community. Certificates of Need (CONs) were issued if approval was obtained, enabling the hospital to receive federal monies for capital expenditures. The initiation of CONs provided a national means of coordinating health services funding by the federal government. By 1979, every state but Missouri had some method of review of health capital expenditure.[36]

The true test of success for this legislation was how effective it was in controlling the increase in the supply of facilities and services. The evidence indicates that CONs have been less than

successful. By 1976, this program reduced the rate of growth on capital expenditures by nine percent. This record must be judged in light of the fact that without such a program, the decrease was projected to be 4.8 percent.[37] When these results were updated in 1974, 25 states had certificate of need programs; the data indicated that of those 25, only five experienced any decrease in the growth of capital expenditures.[38]

It became clear that the lack of success of the program was due, at least in part, to the fact there were no general guidelines or criteria upon which programs could base their decisions as to whether or not to issue a CON to a health care facility. Therefore, in September 1977, HEW released a Notice of Proposed Rulemaking which contained ten standards, "respecting the appropriate supply...of health resources."[39] The guidelines required that there be no more than four beds per thousand population in any health service area and an occupancy rate of at least 80 percent. The Notice also stated guidelines regarding supply and occupancy criteria for obstetrical beds, neonatal intensive care units, pediatric beds, coronary care units, C.A.T. scanners, radiation therapy units, and end-stage renal disease units.

A public outcry began immediately in response to the guidelines. Most opposition was based on the mistaken assumption that the guidelines gave HEW the right to close hospitals and services. This assumption was shared by legislators. The effect of the outcry against the guidelines was that HEW revised them so that the HSAs and State Health Planning and Development Agencies could deviate from them

if they found that using the guidelines disrupted access to care.[40] With the guidelines weakened, the impact of the Planning Act was small to non-existent.

The Social Security Amendments of 1971 mandated the creation of Professional Standards Review Organizations (PSROs) as another cost containment mechanism. PSROs were formed and charged with the responsibility to review the appropriateness of institutional utilization of Medicare and Medicaid recipients. PSROs suffered from the same lack by guidelines and criteria faced by HSAs. Without guidelines or clearly delineated sanctions, enforcement of the program was virtually impossible. One of the most exhaustive evaluations of the effectiveness of PSROs was done by HEW's Office of Planning, Evaluation and Legislation (OPEL) in 1977. This study provided very little conclusive evidence that PSROs were effective in decreasing utilization and in fact, found that the operational costs of the program were actually increasing federal health expenditures.[41]

In April 1977, President Carter attempted to control soaring health costs by proposing the Hospital Cost Containment Act. The Carter proposal placed a ceiling on reimbursement rates to hospitals, which was to be lowered over several consecutive years. After long and turbulent debates and negotiations in Congress, it failed to be passed.[42] Because of the need for some mechanism to control costs in light of the failure of the Carter Administration's proposal, Representative Daniel Rostenkowski (Democrat-Illinois) challenged health care providers to voluntarily control their costs. Major health groups such as American Medical Association (AMA), American

Hospital Association (AHA), and Federation of American Hospitals (FAH) quickly responded and by December of 1977 had formed a steering committee to meet his challenge.

During the first few months of operation, the voluntary program appeared to be successful. By May 1978, the rate of increase in hospital expenditures had dropped to 12.6 percent.[43] Unfortunately, later in the year it became clear that the early evidence had been too optimistic and that the voluntary program did not have enough clout to control health costs.

This was the last attempt during the Carter Administration at health care cost containment legislation. Other issues became the focus of his attention and the last year was dominated by his concern over the Americans held hostages in Iran. In November 1980, President Carter was defeated by Ronald Reagan who became the 40th President of the United States. The Reagan campaign promised voters lower taxes and decreased government spending.

In an effort to adhere to his campaign pledge, President Reagan proposed an enormous tax reduction program in 1981. The subsequent law was referred to as the Economic Recovery Act (ERTA) of 1981, and provided a $3.7 billion tax cut in fiscal year 1982.[44] A tax reduction of this magnitude had a large impact on collected revenues. The estimated amount of lost revenues under the plan was $267,627 million by 1986.[45]

The rationale for the bill reflected a desire to enhance the real growth of the economy which had slowed in 1978 and 1979 and stopped in 1980. The unemployment rate rose significantly in 1980,

and the belief was that tax breaks to business and industry would increase the demand for labor. Problems from the decreased revenue would disappear if projections of the economic growth effect of the tax reductions were correct and devastating if the anticipated results did not materialize.[46] Obviously, funding for Medicare could be a very serious problem if the worst case scenerio became reality. Thus at the same time that taxes were being reduced, Congressional concern regarding the rising costs of Plan A of Medicare was voiced within the Omnibus Reconciliation Act of 1981.

Part of the law required that the Secretary of Health and Human Services (HHS) formerly Health Education and Welfare develop a prospective payment system for Plan A of Medicare. Throughout the first quarter of 1982, the staff at HCFA intensified their discussion of different models of prospective pricing without deciding on a specific one to base the model called for in the Omnibus Reconciliation Act of 1981. The urgency to select a specific PPS was diminished in February 1982, when Carolyne Davis, Director of the HCFA, wrote to Ann T. Hunsaker, Assistant General Council, HHS, informing her that the staff at HCFA was working on a PPS that would be ready for implementation by the summer or early fall of 1982, "as requested by Richard Schweiker in accordance with the Omnibus Reconciliation Act." In response to the memo from Davis, Hunsaker wrote that the law required that a PPS be developed, but did not imply implementation. Such a move, according to Hunsaker, would raise an "inevitable and immediate" legal battle.[47] Congress, in other words, might want to have something to say about the form a PPS might take.

Unfortunately, many of the optimistic projections relating to economic growth were incorrect. It became apparent early in 1982 that the country was headed toward a fiscal crisis. Moreover, disturbingly, the cost of medical care continued to rise in 1982 despite a declining inflation rate. Hospital costs constituted the major part of health care expenditures and were rising faster than any other form of health service.[49] The increase was particularly unnerving to legislators because the federal government paid for more medical services under its programs than any other single insurer.

Before congressional action was taken to allow implementation of the prospective payment system requested in the Omnibus Reconciliation Act of 1981, Congress repeated its request for the development of a prospective payment in another piece of legislation: the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). In July of 1982, the Committee on Ways and Means of the House was unable to draw up a bill for proposed tax reform and instead developed a print which recommended legislative action. The print was designed to represent H.R. 6878, upon which the Committee on Ways and Means did not vote. Instead of voting, on July 15, the Committee decided to go directly to conference on the Senate amendments to H.R. 4961 (H.R. 4961, as amended and approved by the Senate, contained the spending and tax provisions developed by the Senate Finance Committee pursuant to the fiscal year 1983 First Concurrent Budget Resolution). The print, which explained the potential bill, was prepared to provide further information on committee decisions which would serve as a reference point for conferees and members of the public. In it, the Committee

required the Secretary to develop a prospective payment plan for hospitals to be implemented in October, 1983 unless it was disapproved by both the House and Senate by July 1, 1983. The print intended to insure implementation of a prospective payment system (PPS) which was not accomplished in the Omnibus Reconciliation Act of 1981.[50]

The Senate bill, which corresponded to the House Committee Print, required that the Secretary develop a PPS proposal in consultation with the House Committee on Ways and Means and the Senate Finance Committee, stipulating that implementation of the proposal would require a vote of acceptance in the House and Senate. The deadline for submission to Congress of the PPS proposal was December 31, 1982. The intent and language of the Senate amendment emerged in the conference report.[51]

The legislative outcome of the House Committee Print and the Senate Bill was the Tax Equity and Fiscal Responsibility Bill of 1982 (TEFRA) Public Law 97-248, which was enacted in August. TEFRA was a response to the budget deficit. It contained a $98.3 billion increase in revenue through tax increases and $17.5 billion in spending cuts. Most of the spending cuts made by the bill ($13.3 billion) were targeted at Medicare. Savings were estimated at $2.9 billion in 1983, $4.4 billion in 1984 and $6 billion in 1985.[52] The source of savings was expected to emerge from the control of the cost of hospitalization. The bill placed a ceiling on the amount the federal government would reimburse hospitals for care provided to Medicare recipients. Also included in the law were provisions that created new guidelines regarding individual coverage, membership of Medicare

recipients in Health Maintenance Organizations (HMOs), and alternative health plans and modes of instructional care.

Hospital Reimbursement Provisions in TEFRA

In terms of understanding the passage of prospective payment legislation in 1983, the hospital reimbursement provisions of TEFRA are important because they established a context for the later deliberations and actions. Some of the key provisions were:

- An expansion of existing cost limits restricting payments to a hospital for routine operating costs. It set the limit at 120 percent of such costs in 1983, 115 percent in 1984 and 110 percent in 1985.

- A hospital whose costs rose less than the ceiling could keep the difference. One whose costs rose more were to receive one-fourth of the excess costs incurred, but only for the first two years after the bill's enactment. After that, no reimbursement would be provided for excess costs. The Secretary of HHS received authorization to adjust hospital target costs based on a case-mix index.

- An authorization for the Secretary of HHS to calculate Medicare reimbursement based on state rather than federal standards in states with their own cost containment program.

- A requirement that the Secretary of HHS submit to Congress within five months of enactment, a procedure for "prospective" payments to hospitals and nursing homes. Payments were then to be set each year based on the institutions' anticipated costs of caring for medicare clients. This new reimbursement plan would not be enacted unless authorized by Congress.

- A provision to suspend payments for the last six weeks of fiscal year 1983 and 1984 until the beginning of the following fiscal year.[53]

TEFRA set the stage for the DRG legislative proposal in 1983. It placed the responsibility for the development of a plan for prospective payment in the hands of the Secretary of HHS, Richard Schweiker. It also established a timetable for presentation of his proposal to Congress. The report Schweiker sent to Congress in December 1982, in accordance with the provisions of TEFRA, became the framework for P.L. 98-21, Title VI of the Social Security Amendments, which, for the first time, established a prospective payment system for Plan A coverage of Medicare.

Hospitals began to view rising health care costs as a problem following the passage of TEFRA. The fiscal constraints on hospitals caused by the reimbursement ceiling established in TEFRA hurt hospitals. Consequently, the AHA and FAH were predisposed to accept any reasonable alternative (prospective payment) when it was presented to them in December of 1982. According to legislative staff, hospitals' fear of the tightening reimbursement guidelines was one of the primary reasons DRGs were readily accepted.[54]

Legislators began the 98th Congress in January of 1983 with the bleak economy and a growing deficit as the pressing issue. One of the biggest public expenditures was fixed to a politically volatile program, Social Security. The funding crisis of the Social Security Program related to rising health care costs did not come out of the blue. It was the culmination of the evolution of health policy and

the result of some unanticipated fiscal impacts that arose from previous legislation. The Medicare program that came out of the expansionary period of health policy enactments was designed to increase the accessibility of health care to the elderly and through its enactment, the Federal government became the primary purchaser of health care. But it was the growth of this program and others similar to it that led to the concern over rising health care expenditures. There was growing realization that action must be taken to control health costs. Legislators were challenged to find a means of meeting their objective which would be palatable to their constituents; but, much of the groundwork had been laid as they turned their attention to this problem in the early months of 1983. This is the subject of the next chapter.

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CHAPTER III

THE POLICY

Recognition by Congress and the Administration in 1982 of the problem of escalating health care costs as set forth in the previous chapter was a necessary first step in the policy process. The explanation of the adoption of Diagnosis Related Groups (DRGs) as the mechanism for controlling escalating health costs takes us deeper into the bureaucracy. The decision to present a Prospective Payment System (PPS) based on the DRG model was made within the Department of Health and Human Services (HHS). When the Omnibus Reconciliation Act of 1981, calling for a PPS proposal from the Secretary of HHS, passed in August 1981, the actual configuration of such a system was undecided. A task force was formed in early 1982 by Carolyne Davis, Director of the Health Care Finance Administration (HCFA), Division of HHS and chaired by Thomas Burke, Chief of Staff at HHS, "to review alternative prospective payment systems and to provide the Administrator with an analytical report on these options."[1]

Task force membership consisted of Norman Passas of Ernst and Whinney, Martin Drebin, V.P. Finance, Evanston Hospital Corporation, Frank Sloan, Vanderbilt Institute of Public Policy Studies, Health Policy Center and James Bentley of the American Association of Medical

Colleges (AAMC).[2] There were eight PPS mechanisms for controlling health expenditures presented to the Prospective Payment Task Force (PPTF). The task force evaluated each option in terms of its impact on beneficiaries, providers, the Federal budget, third-party payers, total system costs, implementation protocol, and overall pros and cons.

The eight options presented to the Task Force for analysis were:

Option I: Prospective Payment by Groupings

- Variation A: Payment per admission with a Patient Mix Adjustment (DRG Model)
- Variation B: Payment per admission for Similar Hospitals

Option II: Indemnity

- Variation A: Set the indemnity at a per diem basis
- Variation B: Set the indemnity on a per admission basis with a patient mix adjustment
- Variation C: Set the indemnity on a unit of service basis
- Variation D: Set the Indemnity based on patient groupings with co-payment.

Option III: Competitive Bidding

Option IV: Payment on Individual Case Rate

Option V: Rate of Increase Control (on hospital costs/ admission)

Option VI: Individual Hospital Budget Review

Option VII: Individual Hospital Negotiated Rates

Option VIII: Capitation

The PPTF gave the DRG model a relatively positive evaluation. In its final report submitted to Thomas Burke on March 1, 1982, the

PPTF identified only two potential problems with a prospective payment system based on a case-mix index. The first was a potentially decreased aggregate reimbursement for hospitals that care for less complex patient mixes. The other was that of possible manipulation of diagnoses to maximize reimbursement.[3]

Other options did not fair as well under the scrutiny of the task force. The average number of negative impacts identified in the seven alternative options was four with no other option receiving less than three.[4]

Along with the PPTF's appraisal of each option, the staff at HHS solicited an outside opinions to obtain more information regarding the three options (Option I A. payment with adjustment for Patient Case Mix; III. competitive bidding; and VIII. capitation) which were most favorably judged by the task force. Richard J. Melman, Vice President and Actuary, in the office of Health Policy Coordination of the Prudential Insurance Company was consulted because of his involvement in the development and implementation of the DRG model of prospective payment in New Jersey. The only documented consultation in HCFA files is the one solicited from Mellman by Burke.

Mellman responded in a letter to Thomas Burke, dated February 11, 1982, providing a brief evaluation of the options and indicating which option he thought would be the most feasible solution to control health care costs. Mellman addressed the strengths and weaknesses that he found in each option, but, cautioned that each of the three might be construed as a preferred provider plan. A major pitfall in this, according to Mellman, was that "anti-discrimination and free

choice of provider laws commonly stifle innovation in this area." According to Mellman, the foible in the capitation (Option VIII) was that it would encourage hospitals to shift those costs that the government did not reimburse to other patients who are privately insured. Competition (Option III) according to Mellman, would create "dominance of hospitals that are not burdened with social responsibilities to the degree that are teaching hospitals or inner-city hospitals that minister to the medically indigent."[5]

Mellman's evaluation of the options favored the DRG-based model, which he selected because this system had not had major negative impacts on the New Jersey health care system. According to him,

> a. Preliminary indications are that the program is saving the public millions of dollars without impairing quality of care and that hospital expenditures in New Jersey are now increasing significantly less steeply than the national average.
>
> b. The program provides for equitable charges to all patients, regardless of who provides their coverage. This means there can be more meaningful competition between Blue Cross, insurance companies, Health Maintenance Organizations, and employer and union health benefit plans, competition which will accrue to the advantage of all New Jersey citizens.
>
> c. The program has restored the solvency of New Jersey's inner-city hospitals, most of which were financially distressed because of the shortcomings of the previous methods of hospital payment. As long as the New Jersey Hospital Rate Setting program is operative, center-city hospitals in Newark, Camden, Paterson, and Atlantic City need not fear that they will suffer the fate that is befalling hospitals in New York and in many of our country's other major cities.[6]

In July 1982, despite Mellman's detailed analysis and vigorous advocacy and the task force report, the legislative staff at the Health Care Finance Administration (HCFA) remained undecided as to what model prospective payment would adhere.

Schweiker was committed to a case-mix model of prospective payment. According to Schweiker, his desire to have prospective payment enacted during his appointment as Secretary of Health and Human Services stemmed, in part, from the fact that as Senator he had been unable to contain health care costs. One specific cost containment legislative faux pas identified by Schweiker was his support for voluntary cost containment in 1979, which was unsuccessful in curbing escalating health care costs. Schweiker's interest in prospective payment went back to his consultation with John Thompson of Yale University during the Senate hearings on cost-containment from 1977 to 1979.* Schweiker was also strongly influenced by Jack Owens who supported the DRG system first as President of the New Jersey Hospital Association and later as the Executive Vice President of the American Hospital Association (AHA). According to Schweiker, Owens had told him that the prospective payment system in New Jersey was able to decrease health care expenditures and increase hospital profits while maintaining quality care. Owens believed that hospital associations would support prospective payment because of these attributes and Schweiker respected Owen's opinion, having worked with him, as well, during his years on the Health and Human Resources Committee of the Senate.[7]

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*Richard Schweiker (Republican-Pennsylvania) represented the 13th District of Pennsylvania from 1960-1967 and was Senator from Pennsylvania from 1969-1980. In the Senate Schweiker was a member of the Appropriations Committee, Rules and Administration Committee and the Ranking Member of the HEW Subcommittee of the Labor Committee and Ranking Member of the Health and Human Resources Committee. In that capacity he was able to significantly influence the direction of the United States' health policy.

Schweiker sought support for a case-mix prospective payment model within HCFA. This was difficult because this approach was not supported by most of the HCFA staff who had come on board with the Reagan Administration. The newcomers viewed the staff in the Office of Research and Demonstrations (ORD) who had been developing a method of setting national health care prices based in part on DRGs since the middle of the 1960s, with disdain.[8] The incoming staff perceived DRGs as the product of a democratic administration that was excessively regulatory. Actual antagonism developed between the groups. "DRGs became a dirty word" among HCFA legislative and policy staff, according to one researcher.

Some staff recall that Schweiker consistently supported the DRG case-mix model despite its unpopularity in HCFA. An example of this attitude was evidenced when Michael Maher, Director of the Office of Reimbursement Policy, was describing the wage index adjustment under the DRG model for two different geographic regions. Most of the staff complained that Maher's presentation was vague and incomprehensible. Schweiker interrupted their criticism to support Maher and praise the clarity of the presentation.[9] According to Thomas Burke, Chief of Staff at HHS, the final decision to go with the DRG model of PPS was "a Schweiker call all the way."[10]

By July 1982, Richard Schweiker had gathered enough data to support his position. Correspondence from Juan del Real, General Council at HHS, and Thomas Donnelly, Assistant to the Secretary for Legislation at HHS indicated that the best of the eight alternative options presented to the PPTF was the one based on DRGs.[11,12]

In a memo from Richard Schweiker to Carolyne Davis dated August 4, 1982, Schweiker confirmed that the PPS was going to be based on the DRG model.[13] Schweiker's selection of the DRG model was based, in part, on the fact that there were serious flaws in several of the other options, which Mellman had indicated. But perhaps more importantly, Schweiker realized that the DRG model was technically feasible because it was a well-developed and refined system which had been an effective mechanism for health cost control for an entire state for a two year period. Furthermore, ORD within HCFA had already devised a strategy for implementation of a national prospective payment system. A detailed review of the development of the model, its subsequent link to resource consumption, evaluation of its ability to contain health costs and examination of the results of ORD's efforts will illustrate the attractiveness of this option to Schweiker and how he was able to persuade key legislative actors to his point of view. The DRG option was simply the most viable approach to the goal of cost containment.

The Development of the DRG Model

The development of DRGs began in 1969 at Yale University. Initially, the model was designed as a means of evaluating both the quality of care and the utilization of services in the hospital setting.[14] Its primary objective was to provide a definition of case types of patients, each of which should receive similar outputs or services from hospitals. The following attributes of the model were deemed necessary by researchers to permit implementation in a wide

range of settings as well as make the system meaningful to medical and non-medical users:

1. It must be interpretable medically with subclasses of patients from homogeneous diagnostic categories. That is, when the patient classes are described to physicians, they should be able to relate to the patients and be able to identify a particular patient management process by them.

2. Individual classes should be defined on variables that are commonly available on hospital abstracts and are relevant to output utilization, pertaining to either the condition of the patient or the treatment process.

3. There must be a manageable number of classes, preferably in the hundreds instead of thousand, that are mutually exclusive and exhaustive. That is, they must cover the entire range of possible disease conditions in the acute care setting, without overlap.

4. The classes should contain patients with similar expected measures of output utilization.

5. Class definitions must be comparable across different coding schemes.[15]

Following these guidelines, researchers constructed a basic framework of case types consisting of 500 different diagnostic groups. They then began to test potential ways of organizing the groups. The first approach they tried was surveying physicians by asking them to define case types using variables which the physicians believed to be important for determining the type and amount of resources utilized. This method was abandoned because physicians tended to define patients based on specific data that was unavailable on patient abstracts. The resulting specificity increased the potential number of diagnostic classes into the thousands. Consequently, the decision was made to base class definition on data from acute care hospitals with consultation from physicians. This data was examined to

determine the general characteristics and relative frequency of discharges. Statistical algorithms were used on the data to suggest ways of forming patient classes that were "homogeneous with respect to some aggregate output utilization measure."[16] Length of stay was the initial measure of output.

The DRGs were then formed by partitioning the data base into mutually exclusive and exhaustive primary diagnoses referred to as Major Diagnostic Categories (MDCs). Each MDC was subdivided based on variables determined by the statistical algorithms. Each category was then subjected to further physician review. The variables included in class definitions varied in different categories. For example, age was found to be important in explaining utilization in hernia patients, but not in gastric ulcer patients. From each MDC a number of final classifications were formed.[17] Initial division of classes was made into 83 MDCs, which were mutually exclusive and exhaustive.

The next phase of development was the identification of the subdivisions for the MDCs. The set of records analyzed to determine the MDCs was used as input in the second stage of category development. In this stage, algorithms were applied to indicate groups of observations on the basis of independent variables that had been determined prior to statistical analysis. The set of independent variables was limited to those which related to the patient's condition, his treatment process (which was readily accessible on the patient abstract), along with his age, sex, and in some cases the clinical service. Groups were then generated based on the most appropriate variable, i.e., the variable that: (1) exhibited a

significant decrease in variance relative to other variables, (2) created a manageable number of groups based on a relatively small number of values of the independent variable, and (3) created groups whose means were significantly different.[18]

The groups were further subdivided, according to the same criteria used for generation of the initial MDCs. The partitioning into groups continued until the group became too small to warrant further classification or until none of the variables reduced unexplained variation by at least one percent.

This process yielded 388 final groups or DRGs. Each of the groups was defined according to the patient characteristics of primary diagnosis, primary surgical procedure, secondary surgical procedure, age, and (in one instance) clinical setting.

An example of the partitioning process involved in the formation of DRGs is seen in Figure 1. The MDC, Urinary Calculus, includes patients with calculus of the kidney or ureter and calculus of other parts of the urinary system. First, the MDC is subdivided into three groups based on the variable of surgical procedure. Then the non-surgical category is further subdivided into two groups based on the presence or absence of a secondary diagnosis. In all, the MDC of urinary calculi results in the formation of four DRGs.

The next step was a comparison of hospitals' performance on the basis of patient care -- related measurements such as length of stay, costs and mortality to observe whether or not differences among hospitals could be attributed to their case-mix index. This was an effort to determine if hospitals with high costs were treating

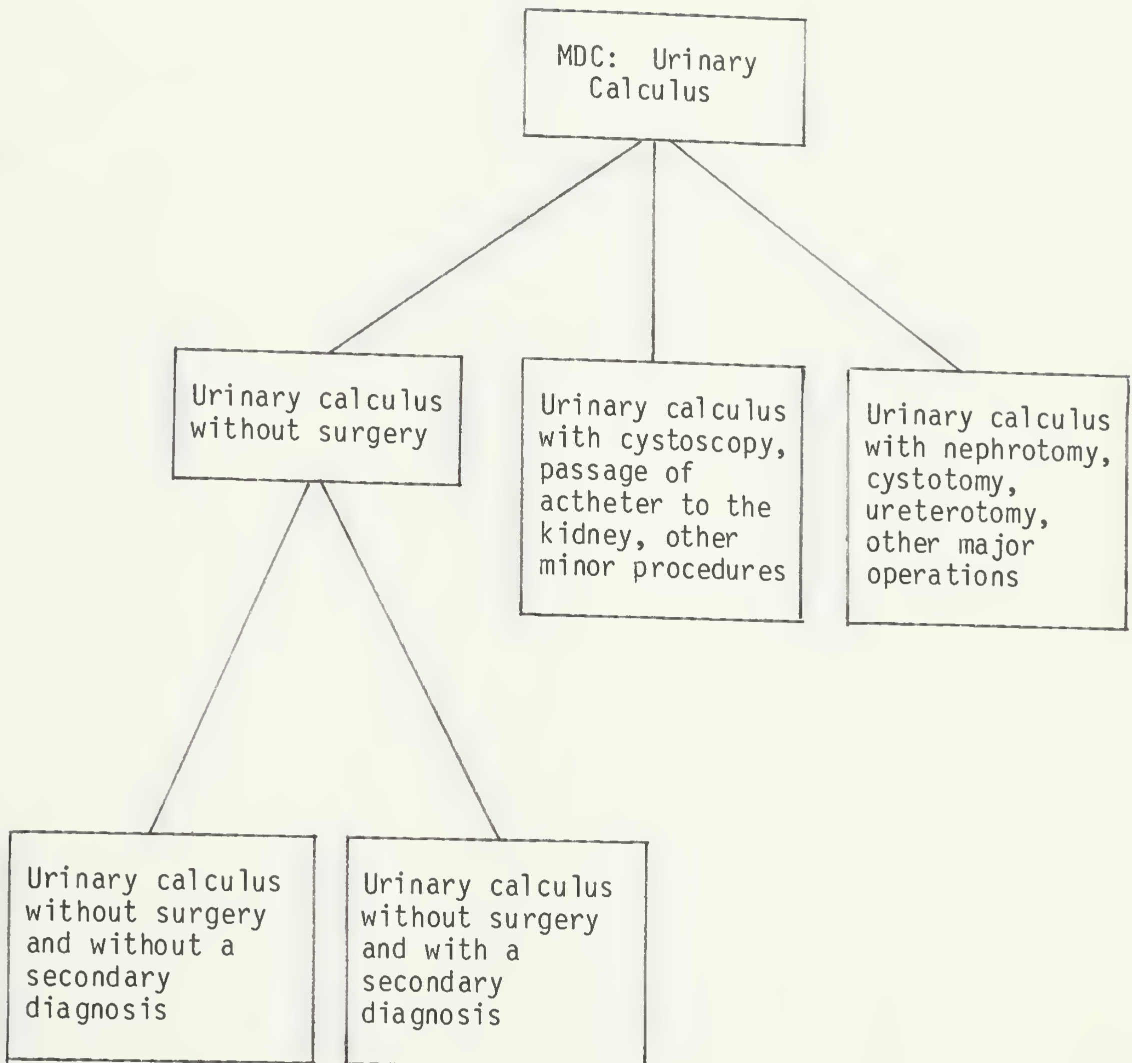

Figure 1. Tree diagram illustrating partitioning of urinary calculus patients.[20]

severely ill patients with long lengths of stay or if they were consuming more resources for patients for other reasons.[21]

DRGs, by themselves, were not particularly useful instruments. Their value was not realized until they were applied clinically to predict resource consumption based on patient classification. Work done in the late 1970s was directed toward the development of DRGs on a hospital-wide basis. All patients in an institution were classified according to DRGs providing a case-mix index of the hospital. Based on them, hospitals could measure and define more precisely output products in a complex health delivery system.

The major objective was to group patients into categories that have similar resource consumption patterns. The projected result of classification was to enable planners to potentially control the "production process."[22]

A software package entitled AUTOGRP was developed to refine statistical analysis. The development of the AUTOGRP software package increased the confidence of those working on the DRG based system that it could predict and potentially control in-patient health costs. Using AUTOGRP data could be analyzed on an individual basis (as in the preliminary development of DRGs), on an institutional basis for case-mix adjustments, and potentially on a regional or national level.[24]

With funds from the Public Health Service, Thompson, Fetter, and Moss (the Yale research team) studied eighteen hospitals' "diagnostic-related product groups" for hospital in-patient non-maternity clients. Using AUTOGRP they tested the case-mix differences according to DRGs and demonstrated a significant relationship between the diagnostic

groups of patients and service costs. Resource consumption was then predicted for each hospital based on case-mix and fees from other hospitals in the area. The goal of the study was to determine if the predictions were accurate enough that prices and reimbursement rates for hospitals could be set based on a diagnosis specific indicator. They concluded "...Serious consideration should be given to the use of these diagnostic-specific case costs as a basis for reimbursement for hospital services."[25]

By 1978 the research team, began to publish evidence of the usefulness of the DRG case-mix system as a pricing and potential reimbursement mechanism for in-patient health care in the acute setting. They also began to market this model to health administrators. They emphasized the fact that accounting based on the DRG model could enhance management's control over health care, by allowing hospital administrators to more firmly grasp the production process.

Further refinement and testing of the DRG concept occurred during the next several years. The major application took place, however, in New Jersey. The effectiveness of the New Jersey experiment provided Schweiker with further justification for his selection of a case-mix model of prospective payment.

The New Jersey Experiment

During the sixties a consensus had emerged in New Jersey for increased state regulation of health care. Governor Brendan Byrne in 1974 furthered that objective by appointing Dr. Joanne Finley,

Commissioner of the Department of Health. Prior to her appointment, Dr. Finley served as city health officer in New Haven, Connecticut, and as an adjunct faculty member at the Yale University School of Medicine, Department of Public Health.[26]

As commissioner, Finley's primary goal was improvement of the New Jersey health care delivery system through exploration of alternative mechanisms of finance. Not surprisingly, prospectively setting health care costs according to diagnosis was the instrument of reform favored by Finley. She solicited aid from Thompson and Fetter at Yale to develop a prospective payment system that could be implemented throughout the state.[27] The basic objectives of the system were to:

- establish a hospital case-mix profile;
- establish reasonable costs related to that case-mix;
- reimburse promptly;
- approve the payment promptly and equitably among payers according to the kinds of patients for which they are responsible; and
- reward hospitals which perform well under such standards.[28]

The system was developed based on diagnosis and cost data collected from New Jersey hospitals for the period 1976-1979. Thompson and Fetter separated costs into three overall categories. They were: (1) direct patient care costs, (2) mixed direct and indirect costs, and (3) indirect patient care costs. Then, projecting these costs over a 12 month period, a model was developed.[29]

There were four major ingredients of the New Jersey program. The first was the concept of hospital incentives. This meant the hospitals which provided services at less than the cost allocated by DRGs could keep the difference. The second aspect was labor and teaching equalization. This reflected that eleven labor markets had been identified to account for different wage compensation patterns in New Jersey. A set of requirements were designed also to differentiate between teaching and non-teaching hospitals to adjust for compensation differences based on resource consumption in each.

Outliers were also introduced as a concept into the system. (Outlier was a term used to denote a patient who did not fit into a standard DRG.) Outliers were identified by reviewing the patient's record regarding length of stay. Data indicated that two percent of all patients in New Jersey fell into this category.

Finally, penalties were also built into the system. The major penalty was the rule that hospitals which spent over the sum allocated based on the case-mix DRGs would be forced to incur the cost. Upon receipt of its proposed reimbursement, hospitals could accept it or engage in a series of appeals to adjust it to a more suitable level. Once an appeal process was completed, the rate was fixed for the institution for the upcoming fiscal year.[30]

Application of the DRG model of prospective payment system in New Jersey was effective in controlling health care costs. The annual percent increase of in-patient costs per capita was 11.7 percent for New Jersey in 1977 and 12.8 percent nationally that year. In 1981,

the comparative figures were for New Jersey 11.5 percent and nationally 17.7 percent.[31]

The National Implementation Plan

Another factor which motivated Schweiker to submit a case-mix model of prospective payment to Congress was that a strategy for national implementation of the system had been established prior to the passage of TEFRA. As early as the mid-sixties, staff within the Social Security Administration Bureau of Health Insurance were working on a national prospective payment system. When HCFA was established within HHS in 1977 to oversee Medicare and Medicaid in lieu of the Bureau of Health Insurance, several of the staff involved in the project became employees of ORD within the new agency.[32]

The methodology used to develop the national prospective payment plan was analogous to that employed by Thompson and Fetter in New Jersey. The sources of data used by the team to compute a national reimbursement rate were a 20 percent random sample of Medicare patient bills (referred to as the MEDPAR file), and a wage index collected by the Bureau of Labor Statistics (BLS) of the Department of Labor.[33] The MEDPAR data file contained charges, diagnosis, procedures, age, etc. The data enabled DRG weights to be set describing in relative terms the expected cost of different Medicare cases compared to an average Medicare case. An example of the mechanism is that of a craniotomy. The relative DRG price for a craniotomy case (DRG 1) is 3.5, meaning that craniotomy cases are expected to be 3.5 times more expensive than the average Medicare case which would have a value of 1.0.[34]

Medicare cost reports, the wage index from BLS, and a Medicare case mix index were combined to create a national representative cost per discharge. This treated each hospital as though it served an "average" mix of patients, paid the national "average" wage and had no teaching program. The initial price set per discharge was low enough that the total hospital annual reimbursement did not exceed the ceiling already set by the passage of TEFRA in 1982. Expansion on the craniotomy example indicates the impact of this process. If the national representative cost per discharge is set at $3,000, then the price for DRG 1 (cranitotomy) became $3,000 x 3.5 = $10,500. This was the mechanism used to set the prices for each of the 467 DRGs.[35]

Researchers adjusted the national schedule according to variations in the wage index established by the BLS for approximately 300 different geographic areas. Consequently, based on the location, a separate price was established and could be further subdivided within a state into Standard Metropolitan Statistical Areas (SMSAs) and non-standard Metropolitan Statistic Areas (non-SMSAs). This meant that in any given SMSA, payment became the same for the same type of case, independent of the hospital in which service was provided.[36]

Several basic premises emerged as the team at HCFA analyzed the data for potential implementation. These served as a framework for the development of the proposal which eventually became known as the Schweiker Report.

1. Prospectivity itself seems to be effective in holding down rates of increase of hospital costs.

2. All prospective payment systems require consideration of a hospital's case-mix for the system to be equitable.

3. When a prospective payment system does not recognize case-mix adequately an active appeals process has been required to adjust for unfair reimbursement policies.
4. Most budget control systems develop a "management by exceptions" process so that every hospital does not go through a complete budget review each year.
5. Small, rural hospitals require exceptions frequently unless the case mix is explicitly recognized in the payment process.
6. In order to establish payment rates, most systems begin with a base year cost report that recognizes Medicare reimbursement principles.
7. Successful prospective payment systems require a firm legal basis, strict enforcement and a lack of escape mechanisms.
8. Individual hospital budget review systems are complex to administer and are generally not applicable to single payer systems.
9. All systems have inherent undesirable incentives which necessitate some counter measures to be built into the system.[37]

Take into account these premises, the staff at HCFA designed a system which could predict the total annual costs for each hospital in the United States through analysis of the hospital's case-mix index based on the DRG model. The staff further decided that a technically and politically feasible legislative proposal for prospective payment should include the following exclusions from the prospective payment formula:

(1) The evaluation of the capital worth of a facility: This exclusion included interest, rent and depreciation. The rationale was based on variability of interest rates, age of hospitals, and equipment which made measurement of these values difficult.

(2) The direct and indirect costs associated with medical education in teaching hospitals: These costs had always been paid by

Medicare, it was recommended not to terminate this practice. Continuance would also assure that the base rate related to patient outcome would not be affected. There are always indirect increased costs which occur when a patient is treated in a teaching hospital (more tests, procedures, examinations, etc.). In an attempt to avoid penalizing teaching hospitals for their intensive care regimes the higher costs were excluded or passed through the prospective payment system. The recognition of the cost was handled by providing a lump sum payment to teaching hospitals.

(3) Out-patient care: These practices were excluded mainly due to lack of an instrument that could reliably set the price for the services.

(4) Plan B services: Consisting of the ancillary services provided by hospitals, they were excluded mainly on the grounds of precedence in that Medicare had traditionally allowed separate suppliers. A major potential problem was noted here in that hospitals could begin to contract out all of these services to increase reimbursement. The need for monitoring was indicated.

(5) Special classes of hospitals: Including psychiatric, pediatric and long-term care facilities, they were placed outside the coverage based on the fact that DRGs were designed to be used in short-term general hospitals and therefore had questionable validity for specialty institutions.

(6) Atypical Cases: Defined as outliers or cases which were extremely short or long in length of stay, they were relatively rare but the cost consequences were determined to be so variable that they

had to be excluded. These cases were to be identified by the institution prior to admission. Full reimbursement for outliers was to consist of only one-half of one percent of all cases receiving care in a given year.

State Exemptions

Several states currently received exemptions from the Medicare regulations because they were engaged in experimental cost containment programs. The states designated to maintain Medicare reimbursement regulation waivers were: Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington, and Wisconsin.

For reasons primarily related to political issues, Health Maintenance Organizations and facilities that had a "sole community provider" status were specifically brought into the prospective payment system. Moreover, it was thought that the legislation should provide for recalibration of DRG prices by the Secretary of Health and Human services on an annual basis. The recalibration was designed to reflect changes in health prices and in the relative price structure of the country, and provide an opportunity to regularly review the fairness and effectiveness of the PPS system. It is noteworthy that once the rate was set, because the prospective payment system was budget neutral, the annual funds designated for Medicare hospitalization reimbursement remained constant. For example, to increase revenues for outlier compensation, funds could be decreased in the wage rate adjustment to adjust for the growing expenditures elsewhere in the budget without altering the system's net budget.[39]

Summary

As noted, in August 1982, the stage was set for the Secretary of HHS to meet the mandate of TEFRA and submit a report to Congress on a prospective payment system to contain costs associated with hospitalizations under Medicare. The system focused only on hospitalization charges for two reasons: they constituted the most significant Medicare outlays and the DRG model had only been tested in the acute care setting. The narrow focus of the system minimized potential opposition from the AMA and alternative health care facilities. Most importantly, the DRG model of cost containment was chosen because it had been tested at the state level and found effective. Still, while prospects looked promising from the perspective of "downtown bureaucrats," it was clear to Schweiker that "on the hill" widespread ignorance about the issue existed. A major effort in "legislative persuasion" remained to be accomplished if PPS was to be enacted. This is the topic of the next chapter.

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CHAPTER IV

THE POLITICAL STREAM

Rising health care costs were identified as a problem and a policy had been developed to contain these expenditures, but the issue needed to enter the political stream before it could be embodied in legislation. The proposed prospective payment system (PPS) entered the political stream after several unsuccessful attempts, as a result of the passage of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). A component of TEFRA required Schweiker to submit a proposal for prospective payment to the Senate Finance and House Ways and Means Committee for review and discussion. A review of the events surrounding placement and subsequent adoption of the proposal indicate that the course the policy took in the political stream insured the enactment of prospective payment.

Getting on the Agenda

The following paragraph in TEFRA placed a prospective payment system on the legislative calendar:

> The Secretary shall develop, in consultation with the Senate Committee on Finance and the Committee on Ways and Means of the House of Representatives, proposals for legislation which would provide that hospitals, skilled nursing facilities, and, to the extent feasible, other providers, would be reimbursed under Title XVIII of this Act on a prospective basis. The Secretary shall report such proposals to such committees not later than December 31, 1982.[1]

In response to this paragraph, Schweiker began to carefully choreograph the events which insured the enactment of prospective payment. Even before the Schweiker Report was submitted to the legislatively designated Congresional committees, Schweiker and the staff at HHS began canvassing the Hill, sponsoring luncheon and breakfast information sessions consulting special interest groups, and establishing a system of communication to answer constituent's questions regarding the plan. According to several HCFA staff, who were involved in the preliminary efforts to obtain support for prospective payment, key actors began to endorse the proposal plan prior to reading the actual administrative report. Carolyne Davis reported that "Schweiker made it (adoption of prospective payment) possible" by paving the way for the proposal.[2]

As the staff in the Office of Research and Demonstrations (ORD) made minor alterations on their previously devised plan for national implementation of prospective payment, legislative staff at HCFA began polling Congressmen's reaction to the concept in September 1982. The staff met with members of the six committees within the House and Senate primarily involved in health policy legislation. The committees in the House were: Ways and Means, Energy and Commerce, and Appropriations; and Senate Committees on Finance, Labor and Human Resources, and Appropriations. Some of the results of the HCFA staff efforts were outlined in a memo from Thomas Donnelly, Assistant for Legislation, Health and Human Services, to Richard Schweiker.

According to Donnelly, the general reaction of Congressional staff was neutral with nearly all of the staff requesting more

information and analysis of data on the proposed Prospective Payment System (PPS) as soon as possible. The reaction of the Senate Finance Committee was supportive. Finance Committee staffers voiced specific requests and concerns, the most common of which was the request for a phase-in period for implementation of a PPS. Another concern of the Finance Committee staff was that although adoption of a PPS for Medicare patients would control recipients health costs it may simultaneously raise the hospital costs to non-Medicare recipients and thus merely shift the burden rather than solving the problem of rising health care costs. Because of the problem with cost shifting, a few staff recommended an all-payer system which would regulate cost of hospitalizations for everyone. The Finance Committee staff had reservations also about the broad discretion given to the Secretary to update rate schedules. Moreover, some staff were worried about the effect PPS may have on public and financially distressed hospitals. Requests were made by the staff for the inclusion of a rate appeal process and a provision that would call for a periodic reevaluation of the system. Finally, Donnelly indicated that the staff was concerned about equity return and the coverage of bad debts under the Administration's proposal.

Senate Labor and Human Resources Committee staff, Donnelly noted, knew very little about the PPS proposals. The staff's major concerns, when informed, were the potential for cost-shifting to non-Medicare recipients created by the proposal and the negative impact a PPS may have on the quality of health care.

The worries, Donnelly observed, of the staff of the House Committee on Ways and Means focused on the impact of a PPS. The staff saw a need for a more specific payment rate and requested more data on the system. There were also concerns regarding the potential for cost-shifting created by the proposal. The House Ways and Means staff was additionally uneasy about the future of State rate setting programs, which presently had waivers that exempted them from current Medicare reimbursement regulations. And finally, the staff voiced some anxiety in that the system might cause "gaming" or tampering with diagnoses to increase the reimbursement amounts. Donnelly reported that the reaction of House Energy and Commerce Committee was similar.

Overall the key concerns identified by Donnelly at the end of the week were: (1) the Hill wanted more data on the research at Yale University on the development of the DRGs; (2) they wanted to know the impact the system would likely have on hospitals; (3) they wanted to know how budget updating would be accomplished; (4) they wanted to know how cost-shifting would be prevented; and (5) they wanted information on how public hospitals would be affected by the system.[3]

Although there were no substantive changes made in the ORD national prospective payment system, some minor alterations were incorporated to enhance the political feasibility of the proposal in response to the data gathered by Donnelly. For example, a detailed description of DRGs and their development became an addendum to the report. Monitoring mechanisms that were devised to control potential problems identified by Congressmen such as gaming, cost-shifting and increased admissions were highlighted in the document. Another

adjustment was made to address congressional disquietude, about the continuation of state initiated experimental cost containment projects.

Following informal polls taken by Donnelly and briefing sessions offered by Schweiker, other HCFA staff, under Schweiker's direction, also measured Congressional reactions to PPS. Patrice Finstein, Associate Administrator for Policy at HCFA, Larry O'Day, Director, Bureau of Program Policy at HCFA, and Thomas Antone, Deputy Executive Secretary of HHS similarily sized up Congressional response to PPS. The "Key Congressmen" with whom Finstein, O'Day, and Antone spoke were members of either the Senate Finance Committee, House Ways and Means Committee, or House Energy and Commerce Committee, the three committees which could have jurisdiction over legislation which might emerge from the report. In a memo dated November 18, 1982, Patrice Finstein summarized the attitudes of key Congressmen toward PPS.

Senator David Durenberger (Republican-Minnesota) Chairman of the Subcommittee on Health of the Finance Committee thought the Administration's PPS was an improvement on the current system and should be promptly enacted. He envisioned it as a stop-gap measure until an even better system could be designed that would address utilization as well as service. He also noted that there was a need for financial incentives for patients to choose less expensive health care.

Senator Robert Dole (Republican-Kansas) Chairman of the Finance Committee endorsed the Administration's PPS and concurred that once the dollar amount could be identified for a given service, the federal government should prospectively pay that amount. Dole also firmly

believed, according to Finstein, that hospitals should be rewarded for economic efficiency.

Representative Ron Wyden (Democrat-Oregon) member of the Subcommittee on Health and the Environment of the Energy and Commerce Committee was one of the strongest proponents for PPS. Wyden called PPS an approach to give providers incentives to reduce costs because he believed retrospective reimbursement was the primary factor draining the Medicare Trust Fund.

Representative Henry Waxman (Democrat-California) Chairman of the Subcommittee on Health and the Environment of the Energy and Commerce Committee stated that he had advocated a PPS for a long time. Finstein reported that Waxman's major concern was the risk of cost shifting without additional reforms or regulations.

Representative Bill Gradison (Republican-Ohio) member of the Committee on Ways and Means stated PPS was a fundamental change which may be able to help keep down health care costs in the long run.

Representative Edward Madigan (Republican-Illinois) member of the Subcommittee on Health and the Environment of the Energy and Commerce Committee stated that although he favored PPS he was unable to support any specific program at that time.

Representative Charles Rangel (Democrat-New York) member of the Subcommittee on Health of the Committee on Ways and Means preferred a statewide PPS, according to Finstein. Rangel preferred that a plan be implemented whereby, HHS would approve an individual state's plan. He foresaw that the program could be operational within two years.

Representative James Jones (Democrat-Oklahoma) member of the Committee on Ways and Means and James Martin (Republican-North Carolina) member of the Subcommittee on Health of the Committee on Ways and Means did not foresee the development of a PPS that could be implemented nationwide. Therefore, both Jones and Martin supported individual state PPSs that could be approved by the Secretary of HHS.[4]

While HCFA staff polled the Hill and ORD modified the report to enhance it political feasibility. Schweiker turned to the general public and special interests to engender their support. At a press conference on October 6, 1982 Schweiker formally unveiled the Administration's proposal for prospective payment. He reviewed the development of DRGs, the plan for national implementation, and fielded questions regarding the proposal. Later in the month, Schweiker met with representatives of major special interest groups including the American Hospital Association (AHA), the Federation of American Hospitals (FAH), the American Medical Association (AMA), Blue Cross/Blue Shield (BC/BS) and the Health Insurance Association of America (HIAA), to brief them on the details of the plan and request a response to the plan from each organization. At the same time, HCFA set up a hot line to respond to questions any of the groups' members may raise. Both major special interests and Congress voiced support for the concept of prospective payment, but admonished the Administration to move slowly and carefully deliberate over the proposal prior to taking steps toward its legislative adoption.[5]

Despite the informal polling and dissemination of information by HCFA staff on the Hill, enactment of prospective payment did not, at

least to some "professional hill observers," appear to be imminent. In the latter half of November 1982, a National Journal article by Linda Demovitch reported that the Administration's prospective payment proposal would not be readily adopted. According to Demovitch, the proposed PPS could be an effective means of cost containment, but it would be several years before prospective payment would become a national health policy.[6]

By early December it began to appear that Demovitch's prediction was incorrect. In response to growing support for the Administration's proposal, Representative Edward Madigan (Republican-Illinois) became concerned that legislative adoption of prospective payment may be in the offing. HCFA staff reported that other members of the Senate Finance and House Ways and Means Committees verbalized concerns similar to Madigan's as momentum grew for enactment of prospective payment, but only Madigan wrote of his unease. Because the correspondence reflects general sentiments and is the only primary source of information prior to submission of the Schweiker Report, its contents and Schweiker's response are noteworthy.

One of the issues raised by Madigan was the degree of statistical accuracy in the Administration's proposal. Madigan was also concerned about the potential created by the proposal for hospital skimming by increasing the volume of low intensity cases or by the refusal of private hospitals to care for public patients. Another problem addressed by Madigan was the absence of a device in the Administration's proposal to control the incentive rates, which according to Madigan, may lead to an unfair reward system. Madigan

was also worried about the complexity of the cost reporting system, which would be necessary for every hospital to possess for successful implementation of the Administration's proposal. Madigan, like many other Congressmen, was distressed about the system's potential for cost-shifting and increased admission rates. Another potential problem addressed by Madigan was the possibility of DRG creep or fudging a diagnosis in order to classify a patient in a higher DRG category. Along with these concerns, Madigan feared that enactment of the Administration's PPS would obliterate efforts to develop a better PPS. In conclusion, Madigan endorsed the concept of PPS, but urged Schweiker to study the proposal further and delay its enactment for at least a year.[7]

Schweiker immediately responded to Madigan delineating the mechanisms within the proposal that addressed the issues he raised. In relation to the statistical accuracy, Schweiker reminded Madigan that the DRG model was over ten years old and had been carefully researched prior to its successful implementation as a statewide reimbursement mechanism in New Jersey. In reference to Madigan's concern regarding the proposal's potential for skimming, Schweiker replied that the Administration's proposal included a monitoring mechanism that would identify the number of admissions and the diagnoses of each hospital's Medicare patients. Monitoring could also discover hospitals that were skimming or admitting only profitable DRGs and eliminate DRG creep or classification of patients in a higher DRG than appropriate to increase hospital reimbursement. To Madigan's distress regarding the lack of incentive controls Schweiker responded

that physicians will have some control over this issue in that physicians will not drastically cut costs or care to avoid malpractice litigation. Schweiker also pointed out to Madigan that the Administration's proposal included a five percent incentive cap to prevent excessive hospital profits. In response to the issue of the complexity of the system, Schweiker indicated that the system would be less complex than the retrospective system and reminded Madigan that all the necessary information for reimbursement is on the patients' discharge summaries. Regarding cost-shifting, Schweiker stated the situation would be monitored and that this was more of a problem for other third party payers. In reference to future research, Schweiker reminded Madigan that there were still several states with Medicare waivers experimenting with alternative prospective payment systems. In conclusion, Schweiker thanked Madigan for expressing his concerns and encouraged him to support the Administration's proposal.[8] Because of Madigan's letter, the mechanisms designed to control negative impacts were even more clearly described in the Schweiker Report before it was submitted later that month.[9]

The effort to canvass Congress, conduct informal polls prior to submission of the proposal to the designated committees, and disseminate information to interest groups was crucial in building consensus for the resultant legislation. Schweiker's history as a Senator enhanced his effectiveness in this role and the effort itself undoubtedly reflected his Congressional experience. The results of Schweiker's effort to soften up members of the Senate Finance and House Ways and Means Committee and interest groups prior to submission

of the Administration's proposal was evidenced by the supportive testimony at subsequent prospective payment hearings in the Spring. Congressional staff reported that consensus building and softening up also made the eventual attachment of the bill to other legislation more palatable.

The report reached the designated Congressional members by the legislated deadline, December 31, 1982. It described the development and demonstration of DRGs, explained the resource utilization measurement associated with each DRG, and addressed the major concerns that had emerged from Congress during the previous months of canvassing.

Committee Hearings

Committee hearings regarding the Hospital Prospective Payment proposal in the Schweiker Report were scheduled for February of 1983. The Hearings were to elicit reactions to the PPS plan based on the DRG model designated in the Schweiker Report. The interest groups invited to testify included the AHA, the FAH, the AMA, and the Association of American Medical Colleges (AAMC). Their endorsement would be necessary for subsequent adoption of the proposal in the form of legislation by Congress.

When Congressional hearings on the Medicare prospective payment system began, nearly all key actors were facing circumstances that rendered them amenable to change in the present Medicare reimbursement system. Because the conditions which engendered support from key actors were unique to each group, they will be reviewed in conjunction with testimony provided at Congressional hearings. The

Administration's proposal also gained the endorsement of key actors because of its specific design features, which were perceived as an improvement over retrospective cost reimbursement. The relationship between the significance of the problem and the appeal of the policy, although different for each actor, generated the support necessary for the enactment of a prospective payment system for Medicare. For example, the endorsement from the hospital industry emerged because of the inclusion of incentives which allowed hospitals to retain all the funds that were allocated for a specific diagnosis if the treatment was provided at a lower cost.

The key actors in the enactment of prospective payment legislation in the spring of 1983, included: Schweiker and the staff of HCFA; the Senate Finance Committee and the House Ways and Means Committee and their respective Subcommittee on Health; the hospital industry represented by the FAH, the AHA, and the Catholic Hospital Association (CHA); the medical profession represented by the AMA and the AAMC; the insurance industry represented by the Health Insurance Association of America (HIAA) and Blue Cross/Blue Shield (BC/BS); Medicare recipients who were represented by the Gray Panthers, the American Association of Retired Persons (AARP), and the National Council of Senior Citizens (NCSC); and the American Medical Records Association (AMRA).

The Subcommittee on Health of the Senate Finance Committee held hearings on February 1-3, 1983, and again on February 17, 1983. The Subcommittee on Health of the House Ways and Means Committee conducted hearings on February 14 and 15, 1983. The general mood of the

testimony was supportive with nearly every group endorsing the proposal and recommending minor alternations in the Administration's plan.

Richard Schweiker provided the first testimony. He began his presentation by indicating the need for a mechanism that would contain rising health care costs. He followed this with a detailed explanation of DRGs. In conclusion, Schweiker encouraged the members of the committee to support his proposed PPS.[10]

The Administration's impetus for the enactment of prospective payment primarily stemmed from rapidly rising Medicare expenditures and budgetary constraints due to decreased revenues and a stagnating economy. In 1982, reimbursement for Medicare increased $33.4 billion with a projected increase of $50.4 billion by 1985, if cost containment legislation was not enacted.[11] The Social Security Trust Fund appeared to be on the verge of bankruptcy and reduction of benefits was not perceived to be a politically feasible solution. The Medicare Hospital Insurance Trust Fund had borrowed $12 billion from the Social Security Trust Fund which it could not repay, exacerbating the economic woes of the entire program. Federal revenues were declining as the Medicare expenditures increased. In an attempt to bolster the economy in 1981, the Economic Recovery Tax Act was passed decreasing federal revenues by $104 million with a projected revenue decrease of $267,627 million by 1986.[12] Along with rising Medicare costs and declining revenue, the country showed signs of economic stagnation. In December 1982, the federal deficit had risen to a

record high of 1,201,898 million dollars, unemployment was at 10.7 percent, and the inflation rate was approximately four percent.[13]

Along with economic issues which influenced Schweiker's position, his support for prospective payment was also motivated by a personal ambition to insure its enactment. The personal reasons included his desire to make amends for what he referred to as his embarrassment because he supported voluntary cost containment as a Senator in 1979. He also believed that prospective payment could alleviate the problem of escalating national health expenditures without jeopardizing the quality of care.[14]

The concern of the Senate Finance and House Ways and Means Committee members regarding the plight of the Medicare program and the Social Security Trust Fund is evidenced by statements made by their members at Committee hearings addressing prospective payment for hospitalizations of Medicare recipients. At the Senate Finance Committee's Subcommittee on Health hearings on prospective payment, David Durenberger (Republican-Minnesota) stated he was worried about the future of Medicare and the "mess" in the health care delivery system due to cost-based reimbursement. Durenberger went on to state that retrospective reimbursement had encouraged hospitals to be inefficient and spend more money because whatever was spent would be reimbursed. This retrospective cost-based reimbursement system led to rapidly rising health care costs, excessive outlays for capital, and inefficiency in the health care delivery system.

Durenburger stated further that prospective payment could save Medicare and increase efficiency in the health care delivery system

without directly affecting the quality of care making the proposal "good for senior citizens" and "good for the country."[15] Although Durenberger's initial motivation to support a means of cost-containment was the problem of escalating health care cost, he would have been unwilling to quickly adopt prospective payment, if there had been a significant outcry against the proposal, according to one of his staff.[16]

Senator Max Baucas, another member of the Finance Committee (Democrat-Montana) stated that there was a problem with Medicare's cost-based reimbursement which led to uncontrollable health care cost inflation. He praised prospective payment as a realistic solution, which could contain health care costs and therefore stabilize the Medicare program while maintaining the present distribution of benefits. Baucas believed that it was necessary for Congress to address the problem of rising Medicare expenditures, but his support of the Administration's policy was related to the fact that the DRG-based model of prospective reimbursement was technically feasible and acceptable to other key actors according to Senate Finance Committee staff.[17]

Robert Dole (Republican-Kansas) chair of the Senate Finance Committee noted that preserving the financially unstable Medicare program was a major problem for the 98th Congress. Dole encouraged Senate Finance Committee members to endorse prospective payment as a means of controlling rising health care costs without limiting available hospitalization benefits.[18]

Senator Russell Long (Democrat-Louisiana) believed that Congress was faced with the problem of rising Medicare expenditures which could lead to the insolvency of the entire Social Security System. According to Long, retrospective reimbursement rewarded expensive inefficient health care because those hospitals that spent more money received more Medicare dollars regardless of the quality care provided by the institution. Long stated that he endorsed prospective payment as a means of controlling rising health care costs and that it would also reward hospitals that could efficiently provide care. According to HCFA staff, Long supported the Administration's proposal primarily because it appeared to be a technically feasible instrument for containing Medicare costs and stabilizing the fiscal status of Social Security.[19] As heavyweight Senators on the Finance Committee, the position of Durenberger, Baucus, Dole and Long were quite influential in the generation of support for the proposal from other committee members.[20]

At the House Ways and Means Committee hearing, held later in February, 1983 the mood of the members was similar to that in the Senate Finance Committee. At hearings on Social Security Reform, the context in which PPS was introduced to Ways and Means, Daniel Rostenkowski (Democrat-Illinois) pleaded with committee members to "put Social Security back on firm footing."[21] In the same vein, Willis Gradison (Republican-Ohio) stated his concern regarding the $12 billion debt which had been incurred by the Social Security Hospital Trust Fund for the Medicare program.[22] Gradison encouraged committee

members to seek an equitable and feasible solution to the fiscal problems of Medicare.

Henson Moore (Republican-Louisiana) supported the prospective payment proposal stating without it, Congress would be forced to face more unappealing choices in the future such as a decrease in Medicare benefits or an increase in taxes to maintain the current level of benefits.[23] Andrew Jacobs (Democrat-Indiana) echoed the concerns of Moore, as he reminded the committee members of the fiscal constraints they were facing and pleaded with the committee to find a solution to uncontrollable rising health care expenditures.[24]

The Senate Finance and House Ways and Means Committee members were motivated to act because of rising Medicare expenditures, which were threatening the financial stability of the entire Social Security System. The 1982 Congressional elections emphasized the problem, and further, Schweiker's lobbying campaign in the fall of 1982 also had a positive effect. Once motivated to act, the Committees willingness to support rapid action stemmed from a previous failed attempt to enact cost containment legislation during the Carter Administration. It was defeated because it was "nibbled to death" during a long tedious process of adoption.[25]

The hospital industry association took the lead in backing the Schweiker formula. The FAH and AHA represented the industry at the hearings. Michael Bromberg President of the FAH, summarized the FAH's position in the following statement:

> We (FAH) felt last year and still feel that the most important provision in TEFRA was the mandating of the Secretary to develop a prospective proposal by the end of the year. And now that that proposal has been submitted to

> you, we view it as a most promising one and urge you to adopt it with recommended changes.[26]

FAH's recommended changes focused on specific aspects of the Administration's proposal such as a request for a provision for states to develop their own systems, but overall the association was supportive.

Alexander McMahon, President of the AHA, assured the Committee that prospective payment had the organizations backing:

> ...then the move toward prospective payment, Mr. Chairman is the key issue, and exceeds all others. It's time to move and we will do all we can to help you strike a reasonable compromise between the competing interest that will change incentives, but that will bring us all out to where you all want us to be, which is a lower rate of increase in hospital costs in the years ahead.[27]

The hospital industry's positive response was related to the problems that it was facing and the design of the proposed prospective payment system. The industry's problems stemmed from the fact that the demise of the Medicare program would destroy the largest purchaser of health care. The passage of TEFRA heightened the hospital industry awareness of the severity of the problem.

Under TEFRA, a ceiling was placed on hospitalization reimbursement rates for Medicare, which were to be lowered for each year until 1986, at which point the rate would be fixed. Within a year after TEFRA was passed, hospitals began to realize the negative impact of its budgetary limitations leading both the FAH and AHA to encourage committee members to adopt an alternative to TEFRA despite any flaws in the Administration's proposal. Bromberg clearly stated this position when he observed:

> The price-per-diagnosis system, while not necessarily the one we would have recommended, is one we can support, because we believe it is clearly preferable to the existing system.[28]

McMahon also addressed the constraints TEFRA had placed on hospitals, "Our support is the result of more than two years of careful study of the effects on hospitals of steadily worsening payment shortfalls under traditional retrospective cost-based reimbursement."[29]

The hospital industry may have been unwilling to support the prospective payment policy simply to alleviate the burden imposed by TEFRA, if the policy had not been carefully formulated. Schweiker included the industry in the policy development process from the earliest stages of consideration. Michael Bromberg worked with Carolyne Davis to insure acceptance by the FAH and Schweiker's relationship with Jack Owens enhanced communication between the Administration and the AHA so that the support of both associations could be elicited prior to the submission of the Schweiker Report to the appropriate congressional committees.

Moreover, the policy, included a mechanism that would reward efficient hospital administration. If a hospital provided care to a patient at a lower cost than was designated by the DRG, the hospital could retain the difference. This aspect of prospective payment undoubtedly enhanced its appeal to the hospital industry.

Another association of the hospital industry, the CHA, did not provide testimony at prospective payment hearings. Despite its absence, Paul Retting, Chief of Staff of the Subcommittee on Health of

House Ways and Means, reported that the CHA was influential in establishing a phase-in period for prospective payment. According to Retting, the members of the CHA were not facing the same fiscal constraints that plagued the AHA because members of CHA received funds from church affiliated agencies such as the Catholic Stewardship. Retting also reported that the appeal of incentives which engendered the FAH's support was not as strong a motivator for the CHA, because its members were church affiliated and non-profit.[30] The diminished significance of financial problems for the CHA curtailed its support for the proposal. Although the CHA was less enthusiastic than the AHA and FAH, Schweiker and the staff at HCFA worked closely with the CHA's representative, John Thompson of Yale University, and Schweiker was able to elicit the association's support by including a four year phase-in period for the prospective payment system. With the three major hospital industry associations supporting prospective payment, the momentum began to build for enactment.

Despite growing acceptance, the AAMC was one association that did not jump on the bandwagon and actively support the Administration's prospective payment proposal. John Cooper representing the AAMC stated:

> While the AAMC recommends that the payment limits enacted in the Tax Equity and Fiscal Responsibility Act of 1982 be replaced with a prospective payment system for hospitals, the defects and weaknesses in the HHS proposal are serious, raise substantial questions of equity and assume hospitals have essentially homogeneous products.[31]

When reviewing the position taken by the AAMC, it is important to keep in mind several factors. First, hospitalization reimbursement

limitations legislated in TEFRA did not apply to physician reimbursement rates, which were still set according to reasonable costs and the funds allocated for medical education under TEFRA were not significantly limited. Another factor which influenced the position of the hospital industry; the potential bankruptcy of the Social Security System and Hospital Insurance Trust Fund, had far less impact on the medical profession because only 20 percent of funds expended by the Medicare program were allocated to physician reimbursement.[32] Therefore, the AAMC had a diminished perception of the problem of rising care costs. Lack of understanding or input into the formulation of the proposal was not a reason to oppose because the AAMC had been represented by James Bentley on the Prospective Payment Task Force formed by Carolyne Davis in 1981. Despite that fact, the association was not as enamored with the proposal as the hospital industry. Efforts to bring them around began shortly after their testimony. The amount of funds allocated to hospitals for medical education under TEFRA remained the same in the Administration's prospective payment proposal. During the first weeks of Congressional hearings, executive and Congressional staff negotiated with the AAMC and doubled the amount of funds allocated in TEFRA for medical education in the prospective payment proposal. Although the AAMC subsequently did not support the Administration's proposal, they did not openly oppose it either, which given their prestige within the industry and the profession, justified the effort put into the previously mentioned negotiations.

The AMA, represented by Jerald Schenken like the AMAC, took a position of studied neutrality. The lack of support or opposition from the AMA stems from the fact that physicians were not directly affected by TEFRA or the proposed prospective payment system. Had they been, it seems likely the political terrain would have been much rockier.

Yet to be heard from, and likely to carry great weight, was the insurance industry. Much to the relief of the Administration, Blue Cross/Blue Shield and the Health Insurance Association of America supported the proposal, but both requested an all-payer system rather than one merely for Medicare recipients.[33] According to Paul Rettig, the insurance industry did not enthusiastically support prospective payment because it would be to its advantage if Medicare benefits were decreased or even terminated and senior citizens needed more coverage from private sources; but the industry did not openly oppose the Administration's proposal because by the time the industry provided testimony, bandwaggoning was so prevalent that the industry did not want to be left out.[34]

A group most directly affected by the prospective payment system was, of course, Medicare recipients. They were represented at the hearings by the Gray Panthers, the AARP, and the NCSC. The Gray Panthers, position was presented by Frances Klafter, who praised the concept of prospective payment as a cure for the health care system's ills. On the other hand, Klafter did indicate concern regarding the potential for the development of a two-tiered health care delivery system in which Medicare recipients received one standard of care and

all other patients received higher quality care unless the national prospective payment rates were applied to all payers. Because of this fear, Klafter encouraged legislators to move slowly and consider alternative prospective payment systems.[35]

AARP, represented by Jack Christy, pointed out that hospital cost containment was one of the organization's highest priorities because rising hospital costs were responsible for the present fiscal instability of Medicare's Hospital Insurance Trust Fund. AARP was supportive of the Administration's proposal, but cautioned committee members not to rush the policy "along on a fast track."[36]

Jacob Clayman, President of the NCSC, indicated the association supported the Administration's proposal as an attempt to save Medicare from financial insolvency. In his statement, Clayman hinted that the organization would not oppose the attachment of the prospective payment proposal to the Social Security Reform Package because of the serious need for hospital cost containment which Clayman believed was necessary to salvage the Medicare program.[37] Although none of the consumer organizations appear to be particularly enamored with the Administration's proposal, the impact of which they questioned, their acceptance was primarily motivated by the realization of the problem of Social Security financing which they believed could lead to the demise of the entire Medicare program.

Finally, the association representing medical records personnel, who would be responsible for the records which indicated the diagnosis of the patients upon discharge, testified. Although the AMRA was not perceived as a significant lobbying force, the testimony from the

association was an important indication of the potential difficulties which might occur if the proposal were implemented. Sally Simons, Director of Medical Records at Overlook Hospital in Summit, New Jersey emphasized that the DRG model of prospective payment had been successfully implemented in New Jersey. According to Simons, the system was so well developed that it did not increase the workload of medical records personnel. At the conclusion of her testimony, Simons encouraged committee members to adopt the proposal and offered the assistance of the AMRA in refining the system, particularly since by the time Simons was heard on February 15, 1983 in the House Ways and Means Committee and on February 17, 1983 in the Senate Finance, both committees were "considering a fast track," for legislation.[38]

Schweiker was unable to attend the prospective payment hearings before the Subcommittee on Health of the House Ways and Means Committee on February 13, 1983 because he had resigned from his post nearly two weeks earlier to become President of the Health Insurance Association of America. In lieu of the opportunity to testify there, he did present the Administration's prospective payment proposal at the House Ways and Mean's hearings on Social Security Reform on February 3, 1983 his last day in office. At that time Schweiker hoped that the Committee would consider attaching prospective payment to the Social Security Amendments of 1983 (SSA), which were in the offing. The SSA that year, unlike customary practices of consideration, were unique in that without their swift enactment the entire program faced bankruptcy and the primary source of the crisis was Medicare

expenditures. The response to Schweikers testimony was neutral with only a few questions posed regarding the details of the policy.[39]

An additional committee, the Special Committee on Aging, looked at the proposed PPS at a hearing on February 4, 1983. The hearing, however, focused on testimony regarding deaths due to negligence in a Texas nursing home. Because the deceased were Medicare recipients, the committee addressed the issue of the quality of care under this program. As a "potential" alteration in the Medicare system, PPS was discussed in terms of any affects it may have on the quality of health care to senior citizens. PPS was a secondary topic at the hearings and was only briefly reviewed.[40]

Voting Results in Senate Finance
and House Ways and Means Committee

Following their hearings, the respective Subcommittees marked-up the Administration's proposal. At that point, each Subcommittee forwarded their revised prospective payment plant to the full Senate Finance and House Ways and Means Committees. The contents of the Bills reflected each branches' perception of political feasibility of prospective payment. Because Representatives have a more significant degree of constituent dependency than their counterparts in the Senate, House Bill 1900 contained more liberal guidelines than Senate Bill 1. For example, both the Senate and the House Bills increased the Administratively designated percentage of reimbursement for outliers, but unlike the Senate, the House version did not place any cap on the total allocations a hospital could claim as outlier costs.

The differentiation between urban versus rural hospitals (absent in the Administration proposal) reflects the dominance of urban representation by subcommittee members, most of whom were from large metropolitan areas. In accordance with its openhanded ideology, the House based its guidelines on nine versus the Senate's four census track divisions, optimizing each hospitals reimbursement potential. The House version called for a four year phase-in period while the Senate advocated a three year settling-in time. Both the House and Senate requested that the Administration incorporate a severity-of-illness index in its proposal to insure efficient and equitable implementation of prospective payment. A more detailed description of the proposals and the subsequent compromises will be examined in review of the Conference Committee Report. Both Committees concluded that prospective payment would be an addendum to the SSA of 1983.[41]

According to Ways and Means Committee staff, the plan to attach PPS to the Social Security Amendments of 1983 was discussed in the early part of February, 1983. At a meeting attended by staff from the House Committee on Ways and Means and its Subcommittee on Health, and staff from HCFA, John Salmon, Chief Council for the Ways and Means Committee, who had taken on the role of policy entrepreneur following Schweiker's resignation, announced that PPS would be attached to SSA if the legislation could be drafted within the next three weeks. According to informed sources, it appeared the time was ripe for quick and effective action. A window of opportunity existed and Salmon intended to take advantage by attaching the prospective payment proposal to the 1983 Social Security Amendments.[42]

According to Salmon, his impetus for placing prospective payment on the "fast track" emerged for several reasons, one of which was that he had witnessed the defeat of Carter's cost-containment efforts in 1977-1979 and wanted to avoid a similar outcome for prospective payment. Another rationale cited by Salmon for attachment of prospective payment to the Social Security Amendments was that due to the early lobbying efforts of Schweiker and his staff and the growing distress regarding the financial insolvency of Social Security, there was a ground swell of support for the strategy. These factors coupled with endorsement of the tactic by Representative Daniel Rostenkowski (Democrat-Illinois), Chairman of Ways and Means, motivated Salmon to pursue swift adoption of prospective payment.[43] The Administration and members of the House Committee on Ways and Means and the Subcommittee on Health worked together to draft the bill (H.R. 1900). The Ways and Means Committee was the only House Committee involved in its development. There was some controversy surrounding this decision when Representative Henry Waxman (Democrat-California) requested that the Subcommittee on Health of the Energy and Interstate Commerce Committee, of which he was chair, review the proposal before it went to the floor of the House. Because the bill only affected hospitals' in-patient services for Medicare recipients, the Committee on Ways and Means was able to maintain sole control over the bill prior to its placement as an attachment to the SSA in the Committee meeting on March 4, 1983.[44] It was evident that Medicare was not part of the Energy and Commerce Committee's jurisdiction and therefore, the Speaker of the House would have surely upheld a recommendation of the

Ways and Means Committee to by-pass the Energy and Commerce Committee. Another reason Waxman did not contest the issue further as related by one of his staff, was the fact that there was general acceptance of the prospective payment proposal in the House and from special interest groups. Consequently, Waxman did not perceive a need for him to advocate a position contrary to the proposal being taken by the Ways and Means Committee.[45]

The individual who "hammered out" the Senate's analogous legislative package was Sheila Burke, Assistant to the Senate Majority Leader. In conjunction with Salmon, she worked with the Senate Subcommittee on Health of the Finance Committee as it developed its version of prospective payment (Senate Bill 1), which was attached to the Social Security Amendments by the Senate Finance Committee on March 3, 1983. The fact that Schweiker had left the Senate less than two years prior to the hearings on prospective payment enhanced his credibility with his former colleagues when he testified before them as Secretary of HHS. Consequently, Senate staff were less intimately involved in the adoption of prospective payment than their counterparts in House.[46]

Once both Committees agreed to attach prospective payment to the amendments, it became known as Title VI and was thereafter heard only in closed hearings.[47] According to Rettig, once the decision to attach the prospective payment proposal to the Social Security Amendments had been made, the proposal developed a "full head of steam" and its passage took on an image of "inevitability."[48]

Following its attachment to the Social Security Amendments, prospective payment became a part of the legislative agenda to be addressed by Congress-as-a-whole. Staff on both House and Senate Committees observed that as Title VI of the Amendments, the PPS was perceived by congressmen as a "little something tacked on to Social Security" that was noncontroversial and appeared to be an effective mechanism for the containment of rising federal health care expenditures.[49] Under these circumstances, success appeared to be guaranteed.

The Social Security Amendments, following three days of closed hearings were received in the House on March 14, 1983 and placed on the House calendar. On March 23, 1983 the Bill (H.R. 1900) was passed by a 243 to 102 margin. H.R. 1900 was received in the Senate on March 14, 1983 and placed on the Senate calendar. On March 23, 1983 it was passed by a roll call vote of 88 yeas and 9 nays.[50]

Conference Report

Because the House and Senate bills differed in significant aspects, a conference committee was formed. In a conference on March 23, 1983, which was described by a HCFA staff as a "free-for-all," the differences were resolved.[51,52] The major issues that created obstacles between the House and Senate, as earlier stated were outliers, the urban/rural split, regionalism and the lack of a severity of illness index in the system. The results of the sessions were reflected in the conference amendments.[53]

In reference to outliers, the Administration, Senate, and House took unique positions regarding (1) the definition of an outlier; (2) the proportion of total DRG reimbursement that would be expended for outliers; and (3) the means of determining the reimbursement rate for outliers. According to the Administration's proposal, outliers were defined as "atypical cases" that could not exceed more than one half percent of reported cases, and would be reimbursed at a rate determined by the Secretary of HHS. The Senate bill defined outliers a clients whose length of stay exceeded an undetermined number over the mean length of stay or standard deviation from that mean, whichever was less. The proportion of total cases that could be reimbursed under the Senate's bill was set at not less than five percent, but not over six percent. The rate of reimbursement in the Senate's bill was to be determined by the Secretary of HHS based on approximated marginal costs. The House bill defined outliers as cases which exceeded the DRG designated length of stay by over thirty days and limited the proportion of possible outliers to not less than four percent of all cases. The Secretary of HHS was to determine the rate of outlier reimbursement.

The conference amendment followed the Senate's bill in all three areas, definition, total proportion of reimbursement allocated to outliers, and reimbursement rate-setting. The Senate's amendment was selected, as reported by informed staff, because it had the highest degree of technical feasibility of the three proposals.

There was also controversy regarding the urban/rural reimbursement adjustments. The Administration's proposal did not contain a

provision differentiating urban from rural hospitals. The Senate's bill addressed the differences between urban and rural hospitals by applying separate rates of payments to urban and rural areas based on the four census regions. The House bill, on the other hand, applied separate payment rates to urban and rural areas based on the nine census divisions. The conference agreement followed the House bill, because it more clearly delineated the reimbursement trends of each section of the country.

A similar controversy emerged regarding the issue of regional reimbursement adjustments during PPS's phase-in period. The Administration's proposal did not contain a provision addressing the issue. The Senate bill required regional reimbursement adjustments based on the four census regions which would no longer apply after the third year of implementation. The House bill required regional reimbursement adjustments based on the nine census divisions which would no longer apply after the fourth year of implementation. As a compromise the conference agreed to base the regional reimbursement modifications on the nine census divisions, but the adjustment would no longer apply after the third year of implementation of the system.

The final major obstacle facing conferees was the determination of a mechanism that would address the perceived lack of a severity-of-illness index in the Administration's proposal. The Administration's proposal did not contain a specific severity-of-illness index, because it believed that that measurement was inherent in the design of DRGs. The Senate and House bills contained similar provisions that indirectly addressed the issue. The conference agreed to maintain

experimental state cost containment programs, which may eventually develop a useful severity-of-illness index and to establish a panel of experts that would conduct studies and issue reports on the effects the prospective payment system based on DRGs had on hospitals, Medicare recipients, and health care expenditures.

Other less controversial details regarding the Administration of prospective payment were also addressed by the conference committee.

Similar impetus to contain rising Medicare expenditures without jeopardizing the quality of care motivated Congress and the Administration to develop a legislative package that was acceptable to both. Consequently, the Conference Report was not drastically different from the Administration's proposal. Specific regulations such as the definition and reimbursement rates for outliers and delineation of geographic regions did not affect the basic premise of prospectively determining a resource allocation for any given diagnosis. Also, because the system was budget neutral, revenues for increased allocations in one area were raised by decreasing expenditures for another. For example, the funds for increased outlier compensation could be obtained by decreasing each DRG price designation by a minute amount.

On March 24, 1983 both the House and Senate approved the Conference Report. The bill was signed into law (Public Law 98-21) by President Reagan on April 20, 1983, altering the original reimbursement mechanism for Medicare.[54]

Implementation

The process of implementing Public Law 98-21 (P.L. 98-21), Title VI was relatively easy. The law was concisely written with regulatory limitations clearly delineated so that there were very few technical details requiring the attention of HCFA staff prior to implementation of the law in October 1983. Julian Pettingill and other staff in ORD of HCFA had completed the necessary work for implementation before preparing the Schweiker Report. According to one staff member, this greatly facilitated implementation.[55]

Summary

The adoption of prospective payment seems remarkably swift yet, in reality, represented months and years of preliminary efforts. The problem of rising federal health expenditures had reached monumental proportions, and the plan had been developed and tested for more than a decade prior to its incorporation into legislation. By the time the Schweiker Report was submitted to the appropriate committees, the Administration had actively engaged in communicating and persuading the key actors involved in the adoption process. Schweiker's unambiguous advocacy and his creative leadership produced a ground swell of endorsement which assured smooth passage. The consequence of the preliminary efforts was the development of a momentum of support giving the policy an image of inevitability. Thus, the unique circumstances which served as a precursor for the placement of a well designed policy on the legislative agenda and the subsequent effectively executed lobbying strategy go a long way to providing an

adequate explanation for legislative adoption of prospective payment. The concluding chapter explores the lessons to be learned from this case history of policy enactment for a broader understanding of how policy issues are addressed at the national level of government.

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CHAPTER V

CONCLUSION

On October 1, 1983 the Federal government implemented a new system of reimbursement for hospitalizations under Medicare. The new system changed the cost based retrospective payment mechanism to one which prospectively set the reimbursement amount according to the patients diagnostic classification. The alteration in reimbursement policy was implemented less than ten months after the first public hearings were held in the Congress in February 1983.

The analytic framework which is most helpful in explaining the swift passage of prospective payment is that offered by John Kingdon. As detailed in the Introduction, Kingdon postulates that the convergence of problem recognition, policy feasibility, and political acceptability produces legislative enactment.[1]

According to Kingdon, as noted, problems are identified by systematic indicators or focusing events and come to the fore by means of a triggering mechanism or crisis. The systematic indicators in this case that signaled a need to control national health expenditures were the annually increasing Medicare outlays coupled with annually declining federal revenues. The event which focused national awareness on the issue was the 1982 congressional elections in which the economic instability of the nation and the Social Security system were highlighted by the candidates. Even with an enhanced national

awareness of the impending problem during the '82 elections, the issue may not have been placed on the legislative agenda without the existence of a crisis and subsequent triggering mechanism.

The crisis which forced the Congress to address rising health care expenditures was the potential demise of the entire Social Security System. The System was near bankruptcy in 1982 and the problem exacerbated when the Hospital Insurance Trust Fund defaulted on a $12 million loan it had received from Social Security Trust Fund.

In 1982, faced with a need to act, Congress legislated TEFRA, which became the triggering mechanism for enactment of prospective payment. TEFRA required the Administration to develop a proposal to address the issue of rising expenditures for Medicare hospitalizations. Simultaneously, it placed a financial burden on the hospital industry which led them to accept an alternative reimbursement mechanism in 1983.

Although the problem was becoming obvious to key legislators, involved interests, and the attentive public, a policy that could solve the crisis had not emerged. The proposal had to be palatable to those responsible for its enactment and implementation. A review of the Schweiker Report against the backdrop of Kingdon's deliniation of the ingredients of successful policy further illuminates why prospective payment was rapidly enacted because its development appears to adhere to Kingdon's guidelines. The foundation of the system rested on the operational adequacy of DRGs, which had been incubated in academic think tanks prior to their selection by the Administration as the basis of the Schweiker Report.

Fragmentation within the policy community, which Kingdon cites as detrimental to the formulation of a cohesive policy, was minimal because direct channels of communication among its members were assured by the formation of the Prospective Payment Task Force. Following the deliberations of the Task Force and further consultation within the Administration, Richard Schweiker became the policy entrepreneur who worked to insure acceptance of the proposed policy. He was extremely effective in the position of policy entrepreneur at softening up key actors because he had served as a Senator (1969-1980) during which time he was heavily involved with the development of health policies. Schweiker's effectiveness as an entrepreneur was enhanced further by his firm belief that prospective payment could control rising health costs without jeopardizing the quality of care.

Furthermore, a prospective payment system based on DRGs possessed attributes which would enhance its acceptability in, to use Kingdon's term, "the political stream." The primary attribute in the prospective payment proposal was that it promoted efficient operation of hospitals by rewarding hospitals that could provide care at a cost lower than the DRG determined rate. They could keep the difference and allocate it as they pleased. Schweiker pushed this feature when he sought support for the proposal from the hospital associations. The technical feasibility of the prospective payment plan was assured through earlier implementation of a similar system in New Jersey, an experience which indicated that prospective pricing of health care could contain costs without significantly altering the quality of care.

The proposal was also designed to control only Medicare hospital expenditures so as to insure technical feasibility. The decision to target Medicare recipients was based on the fact that related costs could be more centrally and uniformly regulated than fragmented programs such as Medicaid. The decentralization of and state involvement in other federally subsidized health care programs would have made implementation of a comprehensive prospective payment system too disjointed and complex to assure likely success. Moreover, DRGs had been designed, tested, and applied only at/on in-patient acute care hospitals costs, therefore the technical feasibility of the proposal when applied to other settings was unknown. Finally, the Schweiker policy anticipated future concerns by providing specific mechanisms to deal with potential implementation difficulties such as cost-shifting, skimming, gaming, DRG creep, diminished quality of care, and excessive decrease in the length of hospitalization.

As prospective payment entered the political arena, Schweiker began to choreograph events surrounding legislative adoption as if following the recipe provided by Kingdon. He set the stage by emphasizing the fiscal insolvency of the Medicare program and its potential for bankrupting Social Security. The press reinforced his position and published articles which predicted the demise of the nation's largest social program for the elderly. Using this base as a springboard, Schweiker began to lobby for his prospective payment plan, which he touted as a mechanism that would put Medicare on solid financial footing without diminishing benefits.

The canvassing and educational efforts of Schweiker and his staff enhanced the general acceptability of prospective payment. Through the process, Congressmen became more familiar with the plan and staff at HHS were able to predict congressional concerns and incorporate appropriate responses into the document prior to distribution.

Schweiker was also a willing and effective negotiator as illustrated by his handling of the early opposition from the American Association of Medical Colleges and the Catholic Hospital Association. Minimizing opposition through consensus building permitted other influential organized political interests to gain momentum. The vocal support of the two major hospital associations'--the American Hospital Association (AHA) and the Federation of American Hospitals (FAH)--for the Administration's proposal led to the emergence of bandwagoning. Coupled with the endorsement of prospective payment by senior citizen associations, this gave the legislation an image of inevitability. A perception which led to its inclusion in the 1983 Social Security Amendments, which insulated the proposal from any further significant distortion.

All the pieces came together in a manner strikingly similar to Kingdon's scenario and the Medicare payment system was changed fundamentally in 1983. This is a rare occurrence. The comprehensive nature of Kingdon's framework helps to understand why substantial breakthroughs in policy take place infrequently. More limited theoretical constructs, such as David Brown's thesis that there must be a congruent fit between health policy features and the structure of political decision-making in the United States, are useful and point

in the right direction but suffer from their partiality in focus. What is evident from this study is that the health policy process is not unique. The convergence of positive factors in 1983, which led to prospective payment legislation, are generic to all basic changes in public policy and not restricted to the health area. The differentiating characteristic of health policies is that they must be formulated to reflect unique aspects of the delivery system in the United States, but their successful adoption reflects universal aspects of the political system in the United States. Thus, Marmor and Litman's perceptions of the uniqueness of the health policy environment are, at least tentatively, called into question by the case study. As in all case analyses, further research is needed before firmer judgments can be confidently made.

The case study also confirms the predictions of Alford and Starr that hospital administrators would emerge as key actors, challenging physicians, in the health policy process. What would be fascinating to explore is whether this eroded the traditional individualistic ideology that has marked health policy in the United States. Will the common perspectives of administrators, private and public, create a professional community where corporate concepts of health care will find a more fertile ground? Will state intervention become more acceptable? Future developments may hold the promise of comprehensive rather than piece-meal change. Regardless of what happens, the "politics of health policy" is a field that cries out for more systematic study.

Epilogue

It is difficult to ascertain the precise effects of prospective payment because of the relatively short time since implementation of the policy. Most of the analyses admit to the limitations in drawing any decisive conclusions at this point in time. A report in the *New England Journal of Medicine* by John Iglehart presents data which indicates that prospective payment is an effective mechanism for containing Medicare hospitalization expenditures. According to Iglehart, the effects of the new prospective payment system have been extensive. By 1985, the reductions in Medicare expenditures, about $40 billion, totaled 12 percent of all federal budget reductions, despite the fact that the program represents only seven percent of federal outlays. President Reagan's budget proposal for fiscal 1987 called for additional Medicare reductions of $5.2 billion.[2]

Despite Medicare expenditure reductions, hospitals have found that the economic incentives, as a component of prospective payment, are an effective management tool. The new prospective payment system has improved clinical data collection and storage, focused the attention of administrators and physicians on resource consumption, and enabled many hospitals to realize a profit on Medicare business.

Since the implementation of prospective payment, the average length of stay in hospitals has declined and hospitals have taken steps to reduce expenses. There has been a substantial decrease in the length of stay per admission from 9.9 days in early 1983 to 8.7 days in the third quarter of 1985. Admissions to non-federal acute care hospitals have fallen from 9.58 million admissions in the first

quarter of 1983 to 8.59 million by the third quarter of 1985.[3] The effects of the reduction in the length of stay and the decline in admissions are reflected in the occupancy rates of hospitals which fell from 74 percent in early 1983 to 63 percent by mid 1985.[4]

It is hard to determine definitely the finances of hospitals under prospective payment because of conflicting reports and the relatively short time period since the program was implemented, but early studies indicate that, despite the decline in occupancy, many hospitals appear to have prospered under prospective payment. According to a study conducted by the inspector general's office of the Department of Health and Human Services, which examined hospital cost reports, hospitals had an average net profit of 14.12 percent in 1984. The importance of this figure is realized when it is compared to the prohibition of profits under cost based reimbursement.[5]

Other health policy analyses of the impact of prospective payment are less optimistic. Harvey Sapolsky claims that the policy reflects the incongruence between the government's commitment to accessible quality health care and cost-containment which threatens the United States health care delivery system. This is because the enactment of prospective payment gave the government an economic advantage in the health care delivery system which merely shifted the existing burden of rising health costs to other federal programs, private insurance companies, and consumers. Sapolsky predicts that this shift may lead to the emergence of several unintended impacts.[6]

The placement of increased economic burdens on inner city hospitals is one of the potential negative impacts cited by Sapolsky.

This may occur because these hospitals lack sufficient numbers of privately insured patients to absorb the losses sustained when meeting the governments demands for price control. Another problem that Sapolsky foresees as a result of the enactment of prospective payment is the emergence of chains of day surgery clinics and emergicenters, which could skim high-price, low cost, discount seeking patients from hospitals. This pattern of health care delivery could strip away profitable clients and destroy the complex web of cross-subsidies" that supports teaching and services for the poor and rare or expensive illnesses.[7]

Another dissatisfaction with prospective payment voiced by Sapolsky centers on the methodology used to determine the price that the government will pay for any one treatment. Because DRGs were derived from averages--the average cost for the average patient in the average hospital, they may not adequately reflect the cost of health services provided by the facility. This issue has been raised by other health policy evaluators. Based on analysis of variations in length of stay within DRGs, Berki, Ashcraft, and Newbrander call for further research into the determination of an efficient and equitable price for any given diagnosis. Berki concludes that the imprecision in the DRG taxonomy introduces biases into the system which must be eliminated if the system is to be equitable and efficient.[8]

In light of his predictions of negative impacts, Sapolsky's evaluation of prospective payment not less positive. Improvement in the health care delivery system through the implementation of DRGs is unlikely according to his analysis, and he concludes that prospective

payment will not live up to its expectations and will eventually be considered just another unsatisfactory reform.[9]

A study which addresses the influence prospective payment has had on hospital productivity was done by Long, Chesney,Ament, Des Harnias, Fleming, Kobrenski, and Marshall The research analyzed how hospital's products and productivity have been affected by the implementation of prospective payment. The results of the research indicate that prospective payment precipitated a slight decrease in patients discharged to home; a slight increase in patients discharged to short-term hospitals; a slight increase in patients discharged to skilled nursing facilities; and a slight decrease in patients discharged dead. Based on the data, the team concluded that there has been a change in the hospital product as a result of the implementation of prospective payment. Specifically, there was a significant decrease in the number of patients discharged for whom the hospital believes the entire episode of care is complete (discharged to home). Conversely, there was an increase in the number of patients discharged for whom further home health care was required.[10]

The policy implications of the study identified by the research team speak to the need to determine if decreasing costs in acute care setting is really saving money or merely shifting the financial burden. Because of the significant increase in the number of patients being discharged prior to the completion of their episode of illiness, other components of the health care delivery system may be incurring increased expenditures rendering this a zero sum strategy. A mechanism that could potentially enhance quality care identified by

the research is the improvement in discharge planning, which would insure the provision of care to patients until completion of the episode of illness.[11]

The previous commentaries suggest that though the federal government may be able to diminish its expenditures through the implementation of a prospective reimbursement system, the overall savings in health care costs may be significantly less than is indicated by the statistics.[12]

Newcomer, Wood, and Sankar evaluated the ramifications that prospective payment has had on the organization of hospitals, community agencies, and families of senior citizens. According to them, the management of hospitals has changed significantly since the enactment of prospective payment. Greater economic efficiency has become the focus of concern for administrators and caused readjustments in nursing staffing patterns so as to increase productivity. Certain economically inefficient services have been eliminated or marketed to enhance profitability.[13]

Newcomer, Wood, and Sankar report that vertical integration of services is another impact that prospective payment has had on hospitals. Because of the increased discharges of patients who have not completed their episode of illness, hospitals are developing their own home-health agencies and skilled nursing facilities (SNF). Vertical integration benefits hospitals because it enables them to shift patients from a high cost to lower cost care setting making money on both the sending and receiving ends. If a patient is discharged to the institution's SNF, the hospitals are reimbursed the

amount designated by the appropriate DRG and the expense of the SNF falls on another source within Medicare, Medicaid, or the patient's private insurance. Vertical integration economically benefits the hospital and creates a positive public image because it is a mechanism that enhances the appearance of improved continuity of care.[14]

Discharge planning has increased in response to the passage of prospective payment. Data indicate that this is important if patients are to receive appropriate care after leaving acute-care facilities. The incorporation of discharge planning programs diminishes complications during the recovery period and protects the hospital from potential liability as the acuity of patients at discharge increases.[15]

The passage of prospective payment, according to the research team, has several implications for community agencies. Skilled nursing facilities will be relatively unaffected by the new policy because they are unwilling to absorb the patients who are discharged early and require extensive care. These facilities, which are in high demand, tend to admit private paying patients with limited nursing care requirements. This places a burden on hospitals to create their own SNF or contract for a specified number of beds to insure timely discharge of patients who have not completed their illness episode.[16]

Home-care agencies are one community facility for which Newcomer, Wood, and Sankar predict significant growth. Since the enactment of prospective payment, there has been a significant increase in the number of Medicare-certified propriety agencies. Institutionally based agencies comprised the majority of these programs. The ultimate

effect of prospective payment on home-health agencies is yet to be determined, but predictions include an increased need for skilled nursing care, higher salaries to attract skilled providers, and rapid increases in Medicare expenditures for services.[17]

Prospective payment also has implications for the families of Medicare recipients who are strained when forced to take on the role of caregiver. The impact on the family faced with early discharge of a heavy care patient is difficult to estimate, but several studies report the situation causes increased anxiety, decreased work performance, and worsened financial status. Future policies, Newcomer, Wood, and Sankar claim, should address these impacts through provision of support for families in these circumstances.[18]

They conclude that initial research indicates that prospective payment has had a generally positive impact on hospitals, community agencies, and families but caution that the ultimate effects are ambiguous. Because of the relatively short period of time since implementation of the policy authentative, statements about its impact are inappropriate.

Another response to prospective payment is reported by Lawrence Brown who asserts that a new form of activity identified as technocratic corporatism is emerging. Brown relates this development to three changes caused by the shift of reimbursement from cost based to price setting. The three changes are: (1) prospective payment was the first occasion since the enactment of Medicare that gave program administration a fundamental role in shaping a policy that changed the program; (2) the change gave Medicare administrators a new instrument

that could enhance their role in the refinement, interpretation, and application of DRGs; and (3) the change moved the United States public health insurance system toward a loosely corporate style of negotiations.[20]

The effect of these three alterations was to change the government's role in health care delivery system from one of claims processing to one of rate setting. This broadens the purview of Medicare administrators beyond insurance to medical practice. This new role requires new skills among Medicare administrators, who must be able to identify opportunities for "gaming" the system, realize the implications of demographic patterns on demand for services, interpret medical diagnoses, monitor quality, develop a severity-of-illness index, and analyze every aspect of the health care delivery system.[21]

According to Brown, these changes have shifted power to government administrators. The government's ability and responsibility to direct the health care delivery system toward the development of equitable and efficient care is thereby enhanced. Brown states further that the Department of Health and Human Services should address the implications prospective payment has for other aspects of health care policy. One implication cited by Brown is the shift in role definition between the federal and state goverments. He predicts that states will probably adopt an all-payer system to avoid cost-shifting. The form that cost-shifting will most likely take is the movement toward increased expenditures for Medicaid reimbursement in response to an increased need for SNF for patients who are discharged prior to the completion of their illness episode.[22] Regardless of the

outcome of events, Brown believes that, under prospective payment, the federal government's leverage relative to the states has increased significantly, and he encourages federal administrators to study the situation carefully and grant waivers to states to develop a health care delivery system that meets the new demands created by DRGs.[23]

Congress is concerned about the effects of prospective payment and has been monitoring them since implementation of the system in October 1983. Hearings were held before the Senate Special Committee on Aging on September 26, 1985 to discuss the impact of prospective payment on quality care. In his opening statement, Senator Charles Grassley (Republican-Iowa) stated the intent of the hearings:

> ...I am looking for people who say that the DRGs were absolutely the wrong approach and it ought to be dumped. Now so far I have not heard that too much. It is mostly a case that, yes, we had to do something in the area of cost control and the DRGs are a place to start, but. And then from that conjunction "but," there is a lot of movements in a lot of different directions of ideas of how they ought to be changed.
>
> But for instance, I want to hear if there is anybody who believes that it was a mistake and we ought to go to square one and not start over, or we ought to got to square one and start over with something else.[24]

None of the testimony at the hearings called for the termination of prospective payment, but nearly all speakers indicated the admission and discharge pattern changes occurring since the enactment of prospective payment have created a new aggregate population requiring home health care. Speakers requested increased funding for home health agencies in order to provide care to Medicare recipients and improved hospital discharge planning. Overall, prospective

payment was seen by each speaker as an effective and important means of cost containment.[25]

More recently, on April 23, 1986, hearings were held before the House Ways and Means Committee on a bill that would ensure quality health care to Medicare recipients. Throughout the hearings, speakers cited the negative impacts of prospective payment. The consensus appeared to be that there should be increased funding for home health care to patients discharged prior to the completion of an illness episode, catastrophic health insurance, and monitoring of the system for potential negative impacts.[26]

The Senate Finance Committee held similar hearings to examine the effect of Medicare's prospective payment system on the quality of care. Although nearly all of the testimony cited a significant increase in early discharges and called for a growth in home health care agencies, each admitted that conclusive data on the impact of prospective payment are lacking.[27]

The potential for a decreased quality of health care to Medicare recipients according to a report by the Northwest Oregon Health Systems has two major policy implications: an increase in screening of patients to determine their degree of dependency at discharge; and an increase in post-hospitalization care facilities.[28] Other research echoes this conclusion.

Clearly, more research is required before all of the effects prospective payment has had on the nation's health are delineated. Initial reports, although not conflicting, provide conflicting interpretations of the policy's impact on health care. The program

appears to be able to contain the federal government's expenditures for hospitalization costs of Medicare recipients. But this does not address the question of cost-shifting because the data examine only one cost component in a complex health care delivery system. It may be that prospective payment merely shifts costs to other delivery centers such as home health agencies and that net benefits remain to be calculated. Moreover, it may be that the resultant focus on efficient management of health facilities will have a negative impact on the quality of health care. At this time, more analysis is needed before advocates of a comprehensive overhaul of the system are likely to get a serious hearing. This case study reveals that basic changes in health policy are rare, episodic events growing out of unique circumstances. What is probable is that some minor tinkering with the system will occur as defects are brought to light over the next several years. Fundamental reform awaits a longer passage of time.

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