

Introduction

While growth rates in private health spending per capita have bounced up and down, federal Medicare expenditures per enrollee have shown a consistent downward trend. Why? Because history shows that government regulation works. Through regulatory efforts—prospective payment of hospitals, volume performance standards for physicians, and the (unpopular but effective) Balanced Budget Act (BBA) of 1997—Medicare has slowed its rate of expenditure growth . . . The not-so-sad history of Medicare cost containment shows that solutions do exist and they do work.

—*Thomas Bodenheimer, M.D., University of California, San Francisco*

I hate this whole G— d— system [Medicare]. I'd blow it up if I could, but I'm stuck with it. If it were up to me, I'd buy everybody private insurance and forget about it. Obviously that's what the Republican view is: We ought to do what we do for federal employees—go out and buy every senior citizen a community-rated, structured, and regulated private insurance plan. Let them all go buy an Aetna product, or a Blue Cross product; that's the Republican philosophy. Why should Tom Scully and his staff fix prices for every doctor and hospital in America? Which is what we do.

—*Tom Scully, Administrator (2001–4), Centers for Medicare and Medicaid Services, President and CEO (1995–2001), Federation of American Hospitals*

Most Americans think of Medicare as a health insurance program for providing medical care to elderly persons. To policy makers, however, Medicare is—and has long been—much more than just an entitlement for senior citizens. For more than three decades, it has operated as the leading vehicle for the federal government's subsidiza-

tion and massive expansion of the U.S. health care system. This role evolved and grew in the years following Medicare's implementation. Over time, it has become an enormously expensive program, which currently costs the government more than \$330 billion a year and serves approximately forty-two million people (up from \$1.3 billion and nineteen million people in its first full year of operation, 1967).¹ In addition to financing medical care for millions of senior citizens and people with disabilities, Medicare provides significant funds for medical education, research, and the care of disadvantaged and vulnerable people. It is also the single largest purchaser of hospital and physician services, which makes it "the eight-hundred-pound gorilla" of the U.S. health care system.² So when the federal government makes a dramatic change to Medicare's payment methods, it profoundly affects (directly and indirectly) the cost-benefit calculations and policy decisions of medical providers, insurers, employers, and health care administrators across the country.

The biggest and most intense battle within the U.S. health care system during the past two decades has been over two interrelated questions: first, who will control the manner in which medical care is paid for, and second, how much will it cost? The primary argument of this book is that—contrary to conventional wisdom and whole libraries of books and articles that point to managed care as the biggest "change agent" in American medicine in the last twenty years—the private sector neither initiated this battle nor provided the critical innovation that transformed health care in the United States. Instead, it was Medicare's transition to a prospective payment system (PPS) that triggered and repeatedly intensified the economic restructuring of the U.S. health care system. With prospective payment, "Medicare sets prospectively the payment amount (rates) providers will receive for most covered products and services and providers agree to accept them as payment in full," according to the Medicare Payment Advisory Commission (MedPAC). "Thus, in most instances, providers' payments are based on predetermined rates and are unaffected by their costs or posted charges."³

Medicare payment reforms have empowered the federal government, making it similar to health care systems in other Western countries.⁴ They have given the U.S. government control over the price of most medical care and ended the era—dating back to the 1920s—in which doctors and hospitals' authority over medical prices and decision making went virtually unquestioned.⁵ The key to Medicare's role as the leading catalyst for change in the U.S. health care system is the program's immense size and influence.⁶ As the single largest individual buyer of health care and the "first mover" in the annual payment game between those who provide medical care and those who pay for it, Medicare invariably drives the behavior of medical providers and private payers.

Medicare's revolutionary transition from traditional cost reimbursement (generally paying hospitals and physicians their costs) to a prospective payment model began in 1983. In that year, Congress changed the program's method of paying hospitals to a system of predetermined payment amounts for individual diagnosis-related groups (DRGs). Following the success of DRGs at restraining the rate of growth in Medicare's hospital expenditures, Congress in 1989 enacted a similar program—a resource-based relative-value scale (RBRVS) with a standardized fee schedule—for Medicare's reimbursement of physicians. It went into effect in 1992, with a volume performance standard (VPS) provision that was designed to operate as an expenditure target (or total limit on how much Medicare would spend on physician services).⁷ With the Balanced Budget Act (BBA) of 1997, Congress reformed the reimbursement processes of the remaining cost-based components of Medicare, including outpatient ambulatory services and postacute care (such as skilled nursing facilities and home health agencies). By 2003, twenty years after Medicare started the payment revolution within the U.S. health care system, the program had become fully "prospectivized" in its reimbursement of all medical providers.

Each time Congress and the Health Care Financing Administration (HCFA, later renamed the Centers for Medicare and Medicaid Services, or CMS) changed one part of Medicare from cost reimbursement to prospective rate setting, the overall growth of the program's expenditures slowed. Yet these spending reductions often came at the expense of providers compensating by increasing their revenues from private payers. "When Medicare slows its rate of expenditure growth," explains David Abernethy, former senior Medicare specialist and staff director of the House Ways and Means Health Subcommittee, "hospitals' overall rate of revenue growth slows and that, in the end, puts the final pressure on private payers."⁸ This use of cost shifting (or, if one prefers, "cross subsidization" or "differential pricing") by medical providers in which, as Paul Ginsburg, president of the Center for Studying Health System Change, explains, "changes in administered prices of one payer lead to compensating changes in prices charged to other payers for care," propelled the growth of private sector efforts (namely, managed care) to achieve similar cost control. Chapter 4 explores this issue in greater detail.

Ultimately, the change in Medicare's reimbursement policy temporarily altered the balance of power between the federal government and medical providers. By increasing the scope and extent of Medicare's regulation through prospective payment, Congress for the first time gained the upper hand in its financial relationship with hospitals and then with physicians in terms of setting medical *prices*. Yet, apart from Medicare's VPS (later replaced by a sustainable growth rate, or SGR) for Part B—which has fallen apart since 2000—the federal government has done relatively little

to effectively extend Medicare's success in controlling prices to controlling the *volume* of services provided.⁹ So although Medicare's PPS has been more responsible than anything else for rationalizing health care prices in America, the program has done much less to control utilization. Thus, Medicare's rate of expenditure growth remains an issue of enormous political concern.¹⁰

Policy Feedback and Causal Chains

Social scientists often take a “snapshot” view of political life, explains political scientist Paul Pierson. “How does the distribution of public opinion affect policy outcomes? How do individual social characteristics influence propensities to vote? . . . Disputes among competing theories center on which factors (“variables”) in the current environment generate important political outcomes.”¹¹ But the significance of such factors, he points out, is “frequently distorted when they are taken from their temporal context.”¹² So there is a strong case to be made for shifting from snapshots to “moving pictures,” especially for studying events or phenomena that unfold over longer periods of time (often years).¹³ Pierson quotes sociologist James Mahoney, who argues that this is particularly true for studying sequences in which “an event may trigger a chain of causally-linked events that, once itself in motion, occurs independently of the institutions that initially trigger it. This sequence of events, while ultimately linked to a critical juncture period, may culminate in an outcome that is far removed from the original juncture.”¹⁴ The trick is to trace the chain of events and test how strong the links are.¹⁵

This study of Medicare's role as the leading change agent of the U.S. health care system contributes to a growing body of research that focuses on how public policies can be as much of an influence (an independent variable) on political and private actors—through the political and economic feedback they generate—as they are an outcome of them (a dependent variable).¹⁶ The goal is to try to separate the specific order of cause and effect, because sequence analysis is critical for causal analysis.¹⁷ A parallel goal with this type of inquiry is to try to account for how individuals and institutions respond to changes in public policy, recognizing that government reforms often reconfigure incentives other than those originally intended. For example, Jacob Hacker has shown that the parallel growth of public welfare programs (Social Security) and private welfare (health insurance) is a classic example of how “private social benefits have ‘policy feedback’ effects that are not all that different from the policy feedback effects that are created by public social programs.”¹⁸ In both instances, “major public policies constitute important rules, influencing the allocation of economic

and political resources, modifying the costs and benefits associated with alternative political strategies, and consequently altering ensuing political development.”¹⁹

Organization

This book is designed to explain how and why Medicare’s transition to prospective payment radically transformed the economic orientation of American health care. We argue that the development and major changes in the organization of health care in the United States over the last thirty years have been significantly influenced by major changes to Medicare payment policy. The first several chapters survey the origins, development, and short-term consequences of Medicare’s prospective payment system for hospitals.

Chapter 1 focuses on how rampant medical inflation in the 1970s forced policy makers to search for ways to control Medicare’s rapidly escalating costs. With doctors and hospital executives in control of the U.S. health care system for decades, virtually unrestricted cost reimbursement had become the dominant model for financing public and private medical care. Independent not-for-profit hospitals and physicians practicing alone or in small groups dominated the medical landscape, notes Bradford Gray, principal research associate at the Urban Institute. “Third-party payers (both private and public) played their financing role passively, reluctant to interfere with medical decision making and the doctor-patient relationship. They paid for medical care by reimbursing for costs incurred or charges billed by health care providers and did little to control which services were provided or how much they cost.”²⁰ The medical inflation that grew directly out of these delivery structures and payment systems became unsustainable.

Out of financial necessity, therefore, Congress and a handful of state governments commissioned experiments in alternative reimbursement systems. The most promising conceptual innovation—prospective payment with predetermined reimbursement rates—was the product of pioneering research at the University of Michigan and, particularly, Yale University. Using data from Connecticut’s hospitals, Yale professors John Thompson and Robert Fetter demonstrated that medical care could be standardized and measured. As a result, policy makers and administrators were able, for the first time, to compare prices across different hospitals for the same services. They found an enormous amount of unjustifiable variation, which called into question medical providers’ authority to regulate their own affairs. By the late 1970s, solving the problem of hospital cost inflation had become one of the leading domestic policy priorities. But no real progress was achieved in either the public or private sec-

tor. The failure of President Jimmy Carter's proposals for hospital price controls and of the hospital industry's voluntary efforts at reducing inflation opened a window of opportunity for a drastic change of Medicare's system for reimbursing hospitals.

Chapter 2 examines how Medicare's new system for hospital payment did not come from the private sector or at the urging of a Democratic president. Instead, it came from government-sponsored (and government-tested) health services research. And it was advocated by a new Republican administration that professed a disdain for government regulation. Congressional leaders and members of President Ronald Reagan's administration settled on a variant of New Jersey's alternative hospital reimbursement model—prospective payment using diagnosis-related groups (DRGs)—that came from Thompson and Fetter's research at Yale. Instead of simply paying hospitals their costs, the new model established predetermined (or “prospective”) hospital payment rates for hundreds of distinct diagnostic groups. Thus, if a hospital could treat a Medicare patient for less than the standard DRG payment, it was rewarded by being allowed to keep the savings as a profit. If it cost more, it took a loss that policy makers assumed would encourage the hospital's executives to make improvements in efficiency and productivity.

The new and vastly increased amount of government regulation that Medicare's PPS represented was paradoxical in that it purported to mimic the dynamic forces of the free market. By realigning financial incentives, policy makers designed the new system to bring Medicare's rate of cost growth under control. A financial crisis affecting Social Security in 1982–83 provided the Reagan administration and leading members of Congress with the necessary legislative opportunity to pass Medicare's PPS as part of a larger and even more urgent package of welfare state reforms.

Chapter 3 explains how Medicare's new payment model changed hospital administration during its four-year phase-in period. During this time, the hospital industry's financial view of Medicare patients changed significantly. Instead of providing as much care as could be medically justified, hospitals shifted their focus to increasing efficiency and shortening Medicare patients' length-of-stay. The PPS operated as a huge shock to the nation's hospital industry, because it completely reengineered the billing structure accounting for approximately 40 percent of every hospital's total revenue. The rate of growth in Medicare's hospital expenditures slowed considerably. No change in the private sector could ever have effected so much change in the U.S. health care system in so short a time. The Medicare payment reforms “were the most drastic and far-reaching changes in federal health policy since the passage of Medicare itself,” notes political scientist David Smith. They were “remarkable for the comprehensiveness and sophistication of their design—indeed, the sheer technical achievement was astonishing.”²¹

Medicare's PPS made hospital executives think for the first time about how to become more productive. Previously, hospital executives had no incentive to use their personnel more efficiently, to control their costs on a per-case basis, or to try to figure out what it actually cost to do a specific medical procedure or service. They rarely kept accurate patient records or paid attention to diagnostic coding. Medicare's PPS, therefore, represented a very different way of doing business and an assault on the status quo. Under Medicare's new method of reimbursement, hospitals could make unprecedented profits, but they could also be left with unprecedented financial losses. Hospital executives responded by adopting a more corporate orientation and reaped windfall profits in the early years of Medicare's new payment system.

Hospitals did so well financially that the industry failed to grasp how Medicare's PPS had temporarily shifted the balance of political and financial power from the hospitals to the government. They eventually realized the significant implications involved when Congress began to use Medicare's PPS in the mid-1980s as a major deficit reduction device. Mounting budget deficits led policy makers to change the focus of prospective payment. They manipulated Medicare payment rates in order to generate substantial budgetary savings and financially subsidize specific segments of the hospital industry (teaching, rural, and inner-city hospitals). As a result, instead of becoming more simple and technocratic, Medicare payment policy became more complicated and political.

Chapter 4 outlines how Congress and successive administrations expanded their use of Medicare's PPS in the late 1980s and early 1990s to reduce budget deficits and increase spending in other areas of the federal budget (particularly Medicaid). In addition to mounting fiscal pressures, congressional leaders were responding to the hospital industry's enormous profits in the early years of Medicare's PPS. "By 1987," notes the chairman of the Prospective Payment Assessment Commission (ProPAC), Stuart Altman, "we realized what was going on and so then it became a 'whittling down' or 'taking back' phase."²² Congress repeatedly adjusted Medicare's payment rates at levels below annual increases in medical inflation, which would not have been enormously consequential had the hospital industry as a whole restrained its cost growth. But it didn't. In the late 1980s and early 1990s, hospitals' costs continued to increase at their pre-PPS rates.

As Congress tightened Medicare's reimbursement policies, hospitals responded by increasing their charges to privately insured payers (the majority of Americans who receive health insurance from their employers). "Why it took private payers until the early 1990s before they began to marshal even a modicum of countervailing market power" is perplexing, notes health economist Uwe Reinhardt.²³ But eventually employers found their paradigmatic response: managed care. The term managed care is

problematic, because it conflates and confuses two separate forms of organizational behavior: selective contracting to drive down prices, which became the source of most managed care savings, and actual management of treatment, which became the subject of most of the managed care hype and hysteria.²⁴ For the purposes of this book, however, we mean by managed care a payment model that is distinct from traditional indemnity health insurance by virtue of the fact that it attempts to influence the way health care is provided and often even restricts patients' access to and choice of medical provider. Prepaid group practice, a form of managed care, did precede Medicare's PPS. But organized medicine's traditional opposition to any form of reimbursement other than the fee-for-service model associated with indemnity insurance kept managed care marginalized for decades.

What ultimately played the biggest role in making market incentives sufficient to induce a paradigm shift in the private sector away from indemnity insurance and toward managed care was the success of Medicare's PPS in controlling health care costs in the public sector. What is ironic about the rapid shift in the U.S. health care system from a predominantly not-for-profit ethos to a more corporate orientation is that it was largely the incidental byproduct of federal policy initiatives designed to control Medicare's costs.²⁵ In other words, before business behavior triggered the managed care revolution, it largely responded to and was an unintended consequence of government policy making: in this instance, Medicare payment reforms.

Chapter 5 analyzes how the success of Medicare's DRGs for hospitals led policy makers to rationalize the program's reimbursement of physicians. They adopted a resource-based relative-value scale (RBRVS) with a standardized fee schedule. One goal was to reduce payments to surgeons and specialists and increase them to internists and general practitioners. The main goal of the RBRVS and fee schedule, however, was to slow the rate of cost growth of Medicare Part B. After the new payment system went into effect in 1992, the growth in volume and intensity of Medicare's spending on physician services slowed dramatically. Thus, the federal government succeeded in temporarily shifting another balance of power arrangement: in this instance, from physicians to Medicare.

The last two chapters examine the economic transformation of health care in the private sector, the promise of "market competition" and its ultimate failure. Chapter 6 focuses on the ascendancy of managed care in the mid-1990s and the backlash it eventually spawned. During these years, employers experienced minimal to no growth in their health insurance costs, largely because managed care clamped down on medical spending and decreased hospitals' ability to charge privately insured patients more. The United States spent almost \$120 billion less on health care in 1996 than the Congressional Budget Office (CBO) had predicted in its 1993 forecast.²⁶ With

declining private payments from managed care, the hospital industry finally achieved significant cost control.

Meanwhile, Republican and Democratic leaders struggled to reach a political consensus on the future direction of Medicare policy. The resulting impasse that developed between President Clinton and congressional Republicans—led by House Speaker Newt Gingrich—became the focal point of bitter budget conflicts in 1995 and a partial federal government shutdown. Following this political debacle and President Bill Clinton’s landslide reelection in 1996, leading representatives from both parties returned to using Medicare as a huge “cash cow,” passing the Balanced Budget Act (BBA) of 1997. The BBA constituted the ultimate subordination of Medicare to larger fiscal policy goals; it achieved approximately 73 percent of its total budgetary savings (\$224 billion) from reductions in Medicare spending.²⁷ The BBA also attempted to more widely disseminate the supposed virtues of managed care (particularly for coverage of supplemental benefits such as prescription drug coverage) by encouraging millions of Medicare beneficiaries to enroll in private health plans as part of a new Medicare + Choice program.

Chapter 7 documents the economic reckoning the U.S. health care system experienced in the late 1990s and its consequences in the early 2000s. The BBA’s major Medicare cuts and the final death throes of restrictive managed care left medical providers with declining payments from both public and private payers in 1998–99. Hospitals and the home health industry were particularly hard hit. When increasing cost pressures returned in the late 1990s, growing numbers of medical providers and managed care organizations found profitability difficult to achieve and bankruptcy a growing threat. In response, hospitals led the way among medical providers in increasing revenues where they could, which was from private payers. Their goal was to negotiate more favorable contracts with private payers and employers. Managed care organizations followed suit and—in reaction to the vehement backlash against them—dropped most of the business practices that had (at least temporarily) restrained health care inflation in the U.S. Many of them also dropped their participation in Medicare + Choice, after years of overreaching for “easy” Medicare profits, which left millions of the program’s beneficiaries scurrying to reestablish their coverage under the program’s traditional fee-for-service arrangements.

This increased consolidation and the declining effectiveness of market forces triggered a return to rampant medical inflation in the early 2000s. Health plans and hospitals successfully negotiated significant payment increases after years of minimal or no revenue growth. These increases restored most of them to solid financial health. But skyrocketing health insurance costs and a sluggish economy left an additional five million Americans without health insurance coverage by 2004, bringing the nation’s

total number of uninsured to forty-five million (or 15.6 percent of the population).²⁸ Medical-related bankruptcies increased substantially, as did the costs of, and enrollment in, Medicaid. In the midst of these and other deteriorating health care trends, President George Bush and Congress passed the largest expansion of Medicare since the program's enactment in 1965. The 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) differed from the pattern established between the 1983 Social Security reforms and the 1997 BBA. It added a hugely expensive (roughly \$700 billion) drug benefit, yet with major coverage gaps for millions of people who spend moderate to high amounts on prescription drugs.²⁹ It injected the first elements of means-testing into Medicare, by which wealthier beneficiaries will pay more than poor beneficiaries for both their Part B (physician and outpatient) services and Part D (drug) benefits. And it pushed the program toward increased privatization with a financial overcommitment to private health plans that enroll Medicare beneficiaries. Nevertheless, it did not provide for true market competition, nor did it increase Medicare's ability to control costs. This fact helps to explain why so many Democrats and Republicans have intensely criticized the MMA.

The conclusion summarizes our analysis and discusses the major issues facing Medicare in the future. With the costs associated with ever-increasing medical innovation and the "baby boom" generation approaching retirement, policy makers will eventually have to confront the growing gap between Medicare's expected expenditures and its available revenue.³⁰ With the federal budget on an "unsustainable path," according to former Federal Reserve chairman Alan Greenspan, "Congress has promised more than it can continue to deliver and must quickly make major changes in how it manages its finances, especially as it prepares to shoulder the cost of new programs like the prescription drug benefit and growing demands on Social Security and Medicare."³¹ Severe financial pressures are likely to force a new chapter of innovative Medicare policy making in the not-to-distant future.

This book is not a comprehensive history or survey of Medicare.³² Many significant topics and events related to the program are not addressed. Instead, the book's goal is to analyze the origins, evolution, and long-term consequences of Medicare's transition to prospective payment. Our primary focus is on hospitals and physicians, because their payment systems have an extensive history and because they represent the bulk of Medicare spending. Our analysis relies extensively on oral history interviews, data from medical provider organizations, annual reports from government commissions and agencies, and other primary and secondary sources.

We wrote this book to accomplish two major objectives. First, we wanted to explain how and why Medicare, not the private sector, has played the largest role in shap-

ing U.S. health care. And, second, we believe that the 2003 MMA has expedited the necessity of another major reassessment of the program's future. The MMA expanded "an entitlement that is already the fastest growing part of the federal budget," notes Eric Cohen, director of the Bioethics and American Democracy program at the Ethics and Public Policy Center. "It leaves middle-class citizens with significant drug bills to pay, and thus invites future demands to 'sweeten the benefits.' And it punts on the hardest social questions down the road—not only about the economics of Medicare, but about the intersection of modern medicine, an aging society, and the character of American society as a whole. These deeper questions are what lie at the core of the Medicare 'crisis.'"³³ Thus, we want this book to influence both current and future political debates over Medicare's programmatic and financial future.

One of our more ironic findings is that Medicare payment policy has become more political and technically complicated since the advent of prospective payment rather than less, as its designers and advocates intended.³⁴ The increased use of Medicare as a deficit-reduction device by several administrations and Congresses explains much of this critical development. The key, according to Lisa Potetz—a senior Medicare specialist on ProPAC and the House Ways and Means and Senate Finance Committees between 1984 and 1995—is that the PPS offered a means for achieving enormous budgetary savings that Congress could, and did, use for a variety of other purposes and programs.³⁵

What adds another wrinkle of complexity to Medicare payment policy is that not all medical providers are the same. Teaching and rural hospitals, for example, have fundamentally different cost structures than for-profit suburban hospitals. Physicians who perform specialized surgeries have practices that, in terms of resource utilization, training, and even the nature of their professional activities are dramatically different from physicians who practice family or general medicine.

Thus, as payment policy becomes increasingly subordinated to fiscal policy, Congress has tried to ensure that the "rough justice" of Medicare's PPS remains as financially fair as possible for America's medical providers. But the criteria for fairness have always been open to competing definitions. Consequently, much of the increased politicization of Medicare payment policy stems from the inevitable conflict over what constitutes fairness when paying medical providers. Should all hospitals be able to cover all of their costs every year? How much more should Medicare pay specialist physicians than general practitioners? How much more should Medicare pay teaching hospitals—as compared to regular community hospitals—for the same care, given teaching hospitals' unique mission and cost structures? These are inherently, if not primarily, political questions. And they are only going to become more intense as actuarial and fiscal trends continue along their worrisome trajectories.³⁶ The aging of

the population, together with the seemingly inexorable annual increases in medical inflation and health care spending, will create fiscal problems requiring immense political remedies.³⁷ In sum, the same kind of financial pressures that led to the development and adoption of prospective payment will force future policy makers to seek a broader set of innovative reforms.