Summer 2005

Medicare and America's Healthcare System in Transition: From the Death of Managed Care to the Medicare Modernization Act of 2003 and Beyond

Rick Mayes
University of Richmond, bmayes@richmond.edu

Journal of Health Law

Summer Volume 38, No. 3

Articles

Medicare and America's Healthcare System in Transition: From the Death of Managed Care to the Medicare Modernization Act of 2003 and Beyond

Rick Mayes

AMERICAN HEALTH LAWYERS ASSOCIATION

SAINT LOUIS UNIVERSITY SCHOOL OF LAW
CENTER FOR HEALTH LAW STUDIES

Medicare and America's Healthcare System in Transition: From the Death of Managed Care to the Medicare Modernization Act of 2003 and Beyond

*Rick Mayes**

ABSTRACT: This Article traces the transition—in Medicare, specifically, and in the American healthcare system, generally—from the aftermath of the Balanced Budget Act of 1997 to the passage of the Medicare Modernization Act of 2003. During this time, restrictive managed care died under an onslaught of resurgent cost pressures, legislative and legal attacks, and a vehement physician and consumer backlash. The subsequent reversion to more generous (and more expensive) health plans coincided with a recession in 2001 to trigger a return to rapidly escalating healthcare spending and yet another in the Nation's series of healthcare crises. Current trends suggest that future policymakers will have no choice but to confront the consequences of rapidly rising rates of healthcare spending.

America's healthcare system experienced something of a structural and economic reckoning in the late 1990s. Healthcare reform by way of "managed competition" in the free market offered only a temporary solution to the Nation's

* Assistant Professor of Public Policy, Department of Political Science, University of Richmond; Faculty Research Fellow, Petris Center on Healthcare Markets & Consumer Welfare, University of California, Berkeley. Dr. Mayes' writings have appeared in *Heath Affairs, The Journal of Health Care Law & Policy,* and *Applied Health Economics & Health Policy*. He is the author of *Universal Coverage: The Elusive Quest for National Health Insurance* (University of Michigan Press 2005) and *Policymaking for Medicare: Prospective Payment and the Economic Transformation of American Health Care* (Johns Hopkins University Press, forthcoming). He may be reached via email at: bmayes@richmond.edu.

ongoing struggle with medical inflation.[1] Eventually, renewed cost pressures, the 1997 Balanced Budget Act's (BBA) significant Medicare cuts, and years of minimal (or nonexistent) payment increases from private payors left: (1) the hospital industry with its lowest overall margins in a decade; (2) most physicians with increased workloads, less autonomy, and often reduced incomes; and (3) a slew of bankruptcies and near-bankruptcies among a wide variety of healthcare management and delivery organizations.[2] Yet medical providers were not alone. Even as managed care organizations (MCOs) experienced their own severe "profitability crisis," the consumer and physician backlash against them led to an aggressive legislative and legal assault on the industry. The general public came to view commercial managed care as responsible for turning doctors "into entrepreneurs who maximize profits by minimizing care."[3] Hence, Republican and Democratic politicians at the state level competed with each other to see who could attack health maintenance organizations (HMOs) the most.[4] The result is that the managed care revolution—which was principally about the private sector "efficiently" rationalizing, and rationing, healthcare—stalled and essentially ceased.

Medical providers hastened the demise of traditional, restrictive managed care by consolidating into larger networks and practice groups, which vastly improved their bargaining leverage. By the early 2000s, most hospitals and physicians were receiving sizeable payment increases and regaining much of the professional autonomy they had lost in the 1990s. Private health plans followed suit and pursued their own consolidation strategy. Many MCOs and traditional health insurance companies either merged or exited the market altogether. The surviving plans, facing less competition, quickly restored their profitability by dropping money-losing patient populations and increasing premiums. They also

---

1 *See* Stephen Heffler et al., *Health Spending Growth Up in 1999; Faster Growth Expected in the Future, Americans Could Once Again Face More Complex Health Care Spending Choices* , Health Aff., Mar.–Apr. 2001, at 193, 193–94.

2 *See* Henry J. Kaiser Family Found., Pub. No. 7031, Trends and Indicators in the Changing Health Care Marketplace § 6, figs. 6.4, 6.5, 6.8 & 6.9 (2005), *at* www.kff.org/insurance/7031/print-sec6.cfm (last visited July 7, 2005); Thomas Bodenheimer, *The American Health Care System: Physicians and the Changing Medical Marketplace*, 340 New Eng. J. Med. 584, 585 (1999); Michael Romano, *'It's Like Enron': FPA, Other Physician Practice Management Companies Hear the Death Knell*, Mod. Healthcare, Feb. 18, 2002, at 12, 12.

3 Deborah Stone, *Bedside Manna: Medicine Turned Upside Down*, Am. Prospect, Mar. 1, 1997, at 42, 48 *available at* www.prospect.org/web/page.ww?section=root&name=ViewPrint&articleId=4843 (last visited June 7, 2005).

4 *Your Money or Your Life*, Economist, Mar. 7–13, 1998, at 23, 23.

dropped most of their low-cost HMOs in favor of less restrictive, more generous, and more expensive HMOs and preferred provider organizations (PPOs).

The resurgence in medical inflation that resulted from these changes, together with a recession in 2001, and a period of sluggish economic growth thereafter, triggered the rise of another healthcare crisis in America.[5] As the cost of private health insurance soared, growing numbers of employers either shifted more of the costs to their workers or ceased to provide coverage altogether. Enrollment in public health insurance programs—such as Medicaid and the State Children's Health Insurance Program (SCHIP)—increased substantially. The programs subsequently became huge financial burdens for state governments already struggling under reduced tax revenue. Even worse, millions of individuals fell through the cracks. Between 2001 and 2003, four million individuals became uninsured.[6] One in every three non-elderly Americans (81.8 million people) experienced a lapse in health insurance coverage for all or part of 2002 and 2003.[7] Health-related problems became a leading cause of the increasing numbers of personal bankruptcy in America.[8]

In the midst of these deteriorating healthcare trends and growing federal budget deficits, President George Bush and a Republican-controlled Congress narrowly passed the biggest expansion of Medicare since the program's creation in 1965. The 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) added a $724 billion prescription drug benefit to the program.[9] It also expanded the role of private health plans in Medicare by renaming the failed Medicare+Choice program as "Medicare Advantage" and substantially increasing payments to participating

5 Rick Mayes, Universal Coverage: The Elusive Quest for National Health Insurance 147–55 (2d ed. 2005).

6 *See* John Holahan & Marie Wang, *Changes in Health Insurance Coverage During the Economic Downturn: 2000-2002*, Health Aff.- Web Exclusive, Jan. 28, 2004, at W4-31, -40, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.31v1 (last visited June 7, 2005).

7 Families USA, Pub. No. 04-104, One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003, at 19 (2004), *available at* www.familiesusa.org/site/DocServer/82million_uninsured_report.pdf?docID=3641 (last visited June 7, 2005).

8 *See* David U. Himmelstein et al., *Market Watch: Illness and Injury As Contributors to Bankruptcy*, Health Aff. Web Exclusive, Feb. 2, 2005, at W5-63, -70, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1 (last visited July 12, 2005).

9 Robert Pear, *Estimate Revives Fight on Medicare Costs*, N.Y. Times, Feb. 10, 2005, at A20.

plans.[10] The MMA, however, departed from the dominant pattern of Medicare policymaking that had existed for two decades. With Medicare fully "prospectivized" and the medical community having only recently recovered from the BBA's Medicare cuts, the MMA made no pretense of either saving money or prolonging Medicare's solvency. Instead, when President Bush and a slim majority of mostly Republicans and some Democrats in Congress filled a widely acknowledged gap in the program's coverage with a controversial catastrophic prescription drug benefit, they also moved Medicare in the direction of increased privatization.[11]

I. Medical Providers' "Perfect Storm"

The late 1990s marked one of the most difficult financial periods for many of the nation's medical providers in living memory. After years of reluctantly giving discounts to health plans and making a myriad of often painful cost cutting reforms, growing numbers of medical providers found themselves at a crossroads. Their revenues were flat or even declining, but their costs were increasing.[12] Some hospitals and physicians began to try to push back against managed care at this time.[13] Nevertheless, the managed care industry was still a force—despite the growing backlash against it—in part because of its continued, albeit slowed, rate of enrollment growth.[14] If anything, MCOs were more desperate than ever in the late 1990s to pay medical providers less, or only marginally more than they had before, because the majority of them were losing money.[15]

Hospitals, in particular, faced an unprecedented confluence of financial pressures. In 1998, both private and public payments to hospitals decreased at the same time (a first), while healthcare costs jumped after more than four years of very low and even negative

---

10 *See* Henry J. Kaiser Family Found., Pub. No. 2052-08, Medicare Fact Sheet: Medicare Advantage (2005), *at* www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=52979 (last visited July 7, 2005).

11 *See* Bruce C. Vladeck, *The Struggle for the Soul of Medicare*, 32 J.L. Med. & Ethics 410, 413 (2004).

12 *Cf.* David Blumenthal, *Controlling Health Expenditures*, 344 New Eng. J. Med. 766, 766 (2001); Bodenheimer, *supra* note 2, at 584.

13 Sara Selis, *Just Say No!*, Healthcare Bus., Jan.–Feb. 2000, at 66

14 *See* Paul J. Feldstein, Health Policy Issues: An Economic Perspective 222–23 (3d ed. 2003).

15 InterStudy, The InterStudy Competitive Edge 8.2, Pt. II, HMO Industry Report, at xiii (1998); *see* Chris Serb, *Another Vicious Cycle?*, Hosp. & Health Networks, Oct. 20, 1998, at 24, 25.

cost growth.[16] These two phenomena—decreasing revenue and increasing costs—continued and intensified the following year. As a result, the hospital industry's average overall margin fell in half, from 6% in 1997 to just 3% in 1999, its lowest level in more than a decade.[17] That same year almost 40% of the nation's hospitals reported a financial operating loss, which represented an 80% increase from 1996 (see *Table 1*).[18] The industry's average overall margin, however, masked a considerable amount of geographic variation. The mid-Atlantic and New England regions, which include hospitals from New Jersey to Maine, saw their hospitals' average overall margin drop to an alarmingly low 2% in 1998, while the eight-state Mountain region posted an 8.5% operating margin.[19] The extent of managed care's penetration explains much of the difference. MCOs controlled a larger share of the markets in the mid-Atlantic and New England regions than in the Midwest and Mountain regions.[20]

The BBA succeeded in dramatically slowing Medicare's rate of expenditure growth, especially in the post-acute areas of home healthcare and skilled nursing.[21] Prior to the BBA's implementation, Medicare spending on both home healthcare services and skilled nursing facilities was growing annually at the unsustainable rates of more than 30%.[22] From 1998 to 1999, after the BBA went into effect, Medicare payments to skilled nursing facilities (SNF) fell by 17%, as "[t]he average SNF rehabilitation charge per hospital stay

---

16 Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy 69 fig. 5-9 (2001) [hereinafter MedPAC 2001]. *Cf.* Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy 80 fig. 3A-8 (2004) [hereinafter MedPAC 2004] (showing costs increased per discharge for Medicare inpatient services).

17 Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy 62 tbl. 2B-4 (2002); MedPAC 2001, *supra* note 16, at 70 fig. 5-10.

18 MedPAC 2001, *supra* note 16, at 71 fig. 5-11.

19 Deanna Bellandi & Ann Saphir, *Location, Location, Location, Hospital Profit Margins Vary Widely by Region, AHA's Most Recent Performance Data Show*, Mod. Healthcare, Dec. 20, 1999, at 8, 9; *see Hospital Operating Margins Decline in 2002*, Healthcare Fin. Mgmt., Feb. 2004, at 98 (showing variation of operating margins by region, 1997-2002).

20 *See* David Dranove et al., *Determinants of Managed Care Penetration*, 17 J. Health Econ. 729, 730, 743 (1998) (arguing that managed care penetration is higher (1) in areas with a better educated population, (2) where workers are employed in very large and very small firms, and (3) in relatively concentrated markets with a growing number of hospitals).

21 Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy 6 tbl. 1-1 (2003) [hereinafter MedPAC 2003].

22 *Id.* at 6.

dropped by 44.6 percent."[23] In addition, Medicare spending on home healthcare decreased by 45%.[24] "A whole lot of home health agencies got eliminated real quick," notes Tom Scully. "So that caused a lot of pain."[25] In 1999, home healthcare visits were less than half the level in 1997,[26] as a third of all home health agencies went out of business in 1998-1999.[27]

Table 1: Changes in Medicare Spending and Hospitals' Financial Conditions, 1996-2000[28]

	1996	1997	1998	1999	2000
Real Medicare Spending (in billions of 2000 dollars)	$214.2	$224.0	$221.0	$217.3	$221.8
Percent Increase/Decrease in Real Medicare Spending (deflated)	6.7%	4.6%	-1.3%	-1.7%	2.1%
Hospitals' Average Total Medicare Margin	9.9	10.4	6.0	5.6	5.1
Hospitals' Average Overall Margin	6.1	6.0	4.3	3.0	3.4
Percent of Hospitals with Negative Overall Margins	22	26	34	37	35

Even the annual growth in Medicare spending on inpatient hospital care—which represents the bulk of the program's Part A expenditures—virtually ground to a halt, increasing only 0.1% between 1998 and 2000.[29] The nationwide effects of this radi-

[23] Chapin White, *Rehabilitation Therapy in Skilled Nursing Facilities: Effects of Medicare's New Prospective Payment System*, Health Aff., May–June 2003, at 214, 219; Joseph P. Newhouse, Medicare 26 (June 27, 2001) (prepared for Conference on American Economic Policy in the 1990's, John F. Kennedy School of Government, Harvard University), at www.ksg.harvard.edu/cbg/Conferences/economic_policy/Medicare_Newhouse.pdf (last visited June 8, 2005) (edited version published as Joseph P. Newhouse, Medicare, in American Economic Policy in the 1990s 899 (Jeffrey A. Frankel & Peter R. Orszag, eds., 2002)).

[24] Newhouse, *supra* note 23, at 26.

[25] Telephone Interview with Tom Scully, Administrator, Centers for Medicare & Medicaid Services (CMS) (Oct. 24, 2002). Scully was CMS Administrator from May 2001–Dec. 2003.

[26] Richard S. Foster, *Trends in Medicare Expenditures and Financial Status, 1966-2000*, Health Care Financing Rev., Fall 2000, at 35, 50 (appended comment: *Did the Balanced Budget Act of 1997 Do Too Much?*), *available at* www.cms.hhs.gov/review/00fall/00Fallpg35.pdf (last visited July 7, 2005).

[27] Jeanne Schulte Scott, *BBA Bad News Gets Worse, Thanks to Flawed Calculations*, Healthcare Fin. Mgmt., Sept. 1999, at 24, 24.

[28] Newhouse, *supra* note 23, at 62 tbl. 10; MedPAC 2001, *supra* note 16, at 60–71; MedPAC 2003, *supra* note 21, at 6-39.

[29] MedPAC 2003, *supra* note 21, at 6.

cal spending slowdown were striking.[30] Real, inflation-adjusted Medicare spending did not return to its 1997 levels until 2001 (see *Table 1*).[31] Moreover, the BBA's impact varied depending on the type of hospital. All hospitals received lower payments, but the reduction in Medicare spending came disproportionately at the expense of teaching hospitals and hospitals that treat large numbers of poor patients, which are often the same hospitals.[32] Consequently, many policymakers who led the charge in passing the BBA were the first to change their minds afterwards and push for "fixing" the BBA.[33]

The BBA was not solely responsible, however, for Medicare's significant spending reductions between 1998 and 2000. The federal government's aggressive efforts to deter Medicare fraud and abuse, vividly illustrated by its high-profile investigation of Columbia/HCA, led many hospitals to submit more conservative claims to avoid the risk of large retroactive payment settlements to Medicare. For the first time since the prospective payment system (PPS) began in 1984, Medicare's Case Mix Index for inpatient admissions, which measures the severity of a hospital's mix of medical cases, fell 0.5% in 1998 and again in 1999.[34] The Health Care Financing Administration (HCFA) found that this decline was "primarily attributable to changes in the coding of certain hospital admissions, particularly shifts in coding from 'respiratory infection' to 'simple pneumonia,' and from cases 'with complications' to those 'without complications.' Not coincidentally, these coding categories were the focus of a[n] . . . investigation by the U.S. Department of Justice."[35] Medicare fraud and abuse did not cease to exist,[36] but its frequency and scope did decrease, which contributed to the slowdown in Medicare spending.[37] Policymakers had estimated

30 *Id.* at 10 fig. 1-6.
31 MEDPAC 2004, *supra* note 16, at 70, 71 fig. 3A-2.
32 *See* John K. Iglehart, *Support for Academic Medical Centers: Revisiting the 1997 Balanced Budget Act*, 341 NEW ENG. J. MED. 299, 300 (1999); Stuart Guterman, Putting Medicare in Context: How Does the Balanced Budget Act Affect Hospitals? 13–14 (July 1, 2000), *available at* www.urban.org/url.cfm?ID=410247 (last visited June 8, 2005).
33 Jonathan Gardner, *Lawmakers Changed Tune About '97 BBA*, MOD. HEALTHCARE, Feb. 7, 2000, at 2, 2.
34 Newhouse, *supra* note 23, at 27.
35 Foster, *supra* note 26, at 50 ("These behavioral changes had a very substantial impact on Medicare expenditures . . . (roughly $3 billion in 1999)").
36 *E.g.*, Kurt Eichenwald, *How One Hospital Benefited from Questionable Surgery*, N.Y. TIMES, Aug. 12, 2003, at A1.
37 *Improper Medicare Home Care Payments Drop*, HEALTHCARE FIN. MGMT., Dec. 1999, at 21, 21 ("The percentage of Medicare payments for improper or highly questionable home care services fell from 40 percent to 19 percent between 1995 and 1998 . . . according to a report issued by the Office of Inspector General.")

that the BBA would reduce Medicare expenditures by $115 billion, but that figure rose to $217 billion by summer 1999.[38]

Squeezed financially by both their public and private payors (as well as their own increasingly conservative billing practices), hospitals lobbied Congress intensively for two successive "BBA relief" bills. They argued that "[t]otal Medicare margins were approaching zero; total margins including Medicare and private payers were in the 2-3 percent range regarded as unsafe by the [AHA]; bond ratings were plunging; and [industry] averages masked an alarming proportion of hospitals with negative margins."[39] Their efforts paid off. The hospital industry managed to get two relief, or "give-back," bills—one in 1999, the Balanced Budget Refinement Act, and another in 2000, the Budget Improvement and Protection Act—which increased payment rates for almost all hospitals, SNFs, and home health agencies.[40] Tom Scully, President of the Federation of American Hospitals at the time, maintains that while the "relief" bills were financially necessary, the purpose of Medicare payment policy should not be to make *every* hospital profitable:

> The hospitals deserved to get some money back. They went from having a picnic in '96 and '97 to having the worst years they'd had in thirty years in '98 and '99 . . . . Yet 33 percent [of hospitals losing money] is the historical average going back to 1965. . . That's a fact. So when 25 percent of the hospitals are losing money, like they were in '96 and '97, you know they're being paid too much. But when almost 40 percent are losing money, like they were in '98 and '99, you know you've got a problem . . . .
>
> The majority of hospitals are wonderful, but there are always those ratty little hospitals that aren't very good that are probably losing money and are close to closing. That's not necessarily bad. Not *every*

[38] Newhouse, *supra* note 23, at 27 n.66.

[39] Robert Cunningham, *Hospital Finance: Signs of 'Pushback' Amid Resurgent Cost Pressures*, Health Aff., Mar.–Apr. 2001, at 233, 233.

[40] *See* Cathy Cowan et al., *National Health Expenditures, 2002*, Health Care Financing Rev., Summer 2004, at 143, 149, 150 fig. 7, *available at* www.cms.hhs.gov/review/04Summer/04Summerpg143.pdf (last visited July 7, 2005).

> hospital should *always* be making money. If it's a well-run hospital, if it's well managed, it should be making a reasonable return.[41]

The two give-back bills were still "modest on the scale of the entire program," notes Joseph Newhouse, former vice chair of the Medicare Payment Advisory Commission (MedPAC).[42] They only "raised Medicare spending above what it otherwise would have been by about 3 percent."[43]

Physicians faced many of the same financial pressures in the late 1990s as other medical providers. In contrast to virtually all other professional, specialty, and technical occupations—whose wages and salaries increased—physicians' average net income dropped five percent in real (inflation-adjusted) terms during the latter half of the 1990s.[44] This trend represented a dramatic shift from 1991 to 1995, when other professional occupations lagged behind the growth in physicians' income.[45]

In response, tens of thousands of physicians across the country turned to Physician Practice Management Companies (PPMCs). PPMCs arose as corporate entities intent on running physicians' practices more efficiently and helping physicians develop a countervailing power against the managed care industry.[46] As for-profit, investor-owned companies, they purchased physicians' practices and then linked them together in large networks to gain economies

[41] Interview with Tom Scully, *supra* note 25.

> I think you also have to look at it from "what's the right margin for a provider to make?" not "how much money do we need to save this year in the budget?" Because frequently what happens when you use budget deals is that the Budget Committee would say, "We need this much money from Medicare," and then the committees would go back and backfill on how to get to that number, rather than, "What's the right margin and how do you get there?" They should be looking at the hospitals and saying, "What's the right margin to make a hospital run right?" "What's the right margin for a physician practice?" "What's the right margin for a home health agency?" Instead, the Budget Committee would say, "We need $200 billion dollars; go back and figure out how to do it." They were coming up with [Medicare payment] policies to meet budget targets that weren't realistic. That's what happened in '97 with the BBA.

Id.

[42] Newhouse, *supra* note 23, at 27.

[43] *Id.* at 28.

[44] Marie Reed & Paul B. Ginsburg, Ctr. for Studying Health System Change, Data Bull. No. 24, Behind the Times: Physician Income, 1995-99 (2003).

[45] *Id.*

[46] Stephen Kraft, *Physician Practice Management Companies: A Failed Concept*, Physician Executive, Mar.–Apr. 2002, at 54, 54.

of scale and scope.[47] By selling their practices, physicians received extra capital to invest in their operations and stock in their PPMCs. At the same time, however, they gave up the right to work for themselves and became, in effect, employees of the PPMCs.[48] The three largest companies—Phycor, MedPartners, and FPA Medical Management—went public in the mid-1990s and saw their stock prices and revenue soar.[49]

As was the case with MCOs, PPMCs performed well initially. They infused many physicians' practices with badly needed investment capital and, for a brief period of time, were one of Wall Street's "darlings."[50] Yet they were also similar to MCOs in that the earnings gains proved to be short-lived. Furthermore, those earnings came almost exclusively through acquiring physician practices, not through sustained productivity improvements and increased profitability.[51] Their promises to streamline services, improve billing, and reduce physicians' operating costs did not materialize. In 1998, Wall Street's valuation of the fifteen largest PPMCs fell by more than sixty percent, and the entire industry lost upwards of half its stock market value.[52] That same year, FPA Medical Management and Phycor declared bankruptcy, and MedPartners sold its doctors groups in order to become exclusively a pharmacy benefits company.[53]

In sum, many medical providers found themselves struggling financially in the late 1990s. With lower payments from both public and private payors, the American Hospital Association (AHA) reported that sixty percent of the nation's hospitals lost money on

[47] *See* Lawton R. Burns, *Physician Practice Management Companies*, HEALTH CARE MGMT. REV., Fall 1997, at 32, 43.

[48] *See* James C. Robinson, *Consolidation of Medical Groups into Physician Practice Management Organizations*, 279 J.A.M.A. 144, 144–45 (1998). Many solo and group physician practices joined physician practice management (PPM) organizations in order to compete effectively in the healthcare marketplace. PPMCs are for-profit, investor-owned companies that contract with several hospitals rather than just one. Between 1994 and 1996, the number of physicians affiliated with MedPartners, FPA Medical Management and UniMed increased from 3,787 to 25,763. *Id.* at 147. At the same time, patient enrollment in managed care increased from 285,503 patients to over three million and MCO revenues increased from $190 million to $2.1 billion. *Id.*

[49] *See* Uwe E. Reinhardt, *The Rise and Fall of the Physician Practice Management Industry*, HEALTH AFF., Jan.–Feb. 2000, at 42, 51.

[50] *See* JAMES C. ROBINSON, THE CORPORATE PRACTICE OF MEDICINE: COMPETITION AND INNOVATION IN HEALTH CARE 151, 155 (1999).

[51] Michael S. Thomas, *The Future of Physician Practice Management Companies*, HEALTHCARE FIN. MGMT., Aug. 1997, at 71, 71.

[52] Reinhardt, *supra* note 49, at 42.

[53] Romano, *supra* note 2, at 12.

their Medicare patients in 1999.[54] Executives at teaching hospitals spoke of having to make "difficult choices" about their services and programs.[55] The failure of the PPMC industry caused massive financial problems for thousands of physicians,[56] and thousands of home health agencies went out of business. As the late John Eisenberg, former administrator of the Agency for Healthcare Research and Quality, lamented, "It's a survival of the fittest, and when the fittest are trying to survive, their generosity and charity care are diminished."[57] Medical providers were not alone, however; as they underwent tumultuous change, the managed care industry also found itself at a crisis point.[58]

II. Managed Care's "Perfect Storm"

MCOs came under intensifying pressures in the late 1990s on multiple fronts: political, economic, purchaser (employers), and consumer (patients).[59] First, just as older regulations were beginning to take effect, state legislators passed new ones requiring that health plans provide additional benefits and an expanding array of consumer protection measures.[60] The timing could hardly have been worse. A resurgence in cost growth and continued internecine price competition within the industry forced MCOs to abandon their leading strategy of increasing market share and enrollment.[61] Instead, they were forced to shift their focus to restoring profitability.[62] Meanwhile, a tight labor market and a roaring economy led employers to demand less restrictive health plans as part of their efforts to better attract and retain valuable workers.[63] Finally, the growing ranks of angry consumers and physicians made MCOs more unpopular than ever, which resulted in many individual and

[54] Mary Chris Jaklevic, *Bigger Business, Smaller Profits*, Mod. Healthcare, Nov. 26, 2001, at 12, 12.

[55] Robert Dickler & Gina Shaw, *The Balanced Budget Act of 1997: Its Impact on U.S. Teaching Hospitals*, 132 Annals Internal Med. 820, 820 (2000).

[56] *See* Kraft, *supra* note 46, at 54.

[57] Dickler & Shaw, *supra* note 55, at 820.

[58] *See* Geoffrey E. Harris et al., *Managed Care at a Crossroads*, Health Aff., Jan.–Feb. 2000, at 157, 157.

[59] Debra A. Draper et al., *The Changing Face of Managed Care*, Health Aff., Jan.–Feb. 2002, at 11, 11.

[60] *See* Cara S. Lesser & Paul B. Ginsburg, *Update on the Nation's Health Care System: 1997-1999*, Health Aff., Nov.–Dec. 2000, at 206, 208.

[61] *See* Draper et al., *supra* note 59, at 13.

[62] *Id.* at 17.

[63] Cara S. Lesser et al., *The End of an Era: What Became of the "Managed Care Revolution" in 2001?*, Health Serv. Res. 337, 344 (2003).

class action lawsuits against the industry.[64] Examining in depth these pressures—and how they interacted with each other—helps explain why the managed care revolution stalled and then retreated so quickly.[65]

Politically, adding new and extensive HMO regulations emerged as an activity that state legislators pursued with broad bipartisan enthusiasm in the mid- to late 1990s.[66] In fact, as noted by Richard Sorian and Judith Feder, many of the states leading the nation in implementing new managed care laws (New York, New Jersey, and Connecticut) had Republican governors and Democratic legislatures.[67] Elected officials were responding to the general public's hatred of managed care. In a September 1998 poll by the Kaiser Family Foundation and the Harvard School of Public Health, sixty-four percent of Americans blamed managed care for decreasing the time they spent with their doctors.[68] As the media made managed care the leading "pariah" industry[69]—and before that honor passed to pharmaceutical companies a few years later—state legislators passed hundreds of new laws requiring that health plans: (1) offer richer benefits packages; (2) explicitly outline the physician-patient relationship with full disclosure of all treatment options and physicians' financial incentives; and (3) provide for independent patient appeals.[70] Close to one thousand managed care regulations were passed between 1995 and 1999, with California, Georgia, Missouri, and Texas allowing patients to sue for damages caused by denials or delays in coverage of necessary medical care.[71]

Economically, MCOs found it harder and harder in the late 1990s to achieve profitability.[72] For years, their primary business strategy

64 *See e.g.*, M. Gregg Bloche & David M. Studdert, *A Quiet Revolution: Law As an Agent of Health System Change*, Health Aff., Mar.-Apr. 2004, at 29, 29; Aaron S. Kesselheim & Troyen A. Brennan, *Overbilling vs. Downcoding—The Battle Between Physicians and Insurers*, 352 New Eng. J. Med. 855, 855-56 (2005).

65 *See e.g.*, Milt Freudenheim, *Medical Insurers Revise Cost-Control Efforts*, N.Y. Times, Dec. 3, 1999, at A1.

66 *See* Daniel M. Fox, *Strengthening State Government Through Managed Care Oversight*, 24 J. Health Pol., Pol'y & L. 1185, 1187 (1999).

67 Richard Sorian & Judith Feder, *Why We Need a Patients' Bill of Rights*, 24 J. Health Pol., Pol'y & L. 1137, 1141 (1999).

68 *Id.* at 1138.

69 *See id.* at 1139.

70 *See* R. Adams Dudley & Harold S. Luft, *Health Policy in 2001: Managed Care in Transition*, 344 New Eng. J. Med. 1087, 1090–91 tbl. 4 (2001).

71 Sorian & Feder, *supra* note 67, at 1140; Milt Freudenheim, *Under Legal Attack, H.M.O's Face a Supreme Court Test,* N.Y. Times, Jan. 4. 2000, at A1 [hereinafter Freudenheim, *Supreme Court Test*].

72 *See* Judy Greenwald, *HMO Industry Continues Battle for Profitability*, Bus. Ins., Aug. 17, 1998, at 1.

had been to both increase the number of people enrolled in their plans in order to wield greater bargaining power in their negotiations with medical providers and achieve economies of scale.[73] In other words, MCOs wanted to get as "big" as possible, and then use their size to become more efficient and negotiate better contracts.[74] Yet market expansion proved to be a costly endeavor.[75] When new health plans entered local and national markets in the early and mid-1990s, they routinely offered their products at prices significantly below those of their competitors.[76] This "below margin" pricing strategy required that medical inflation remain minimal, which it did for a few years, but the period of low cost growth ended in 1997.[77] The following year, healthcare inflation rose at twice the rate of consumer price inflation.[78] As a result, the strategy of gaining market share by keeping premiums artificially low proved unsustainable.[79] In 1997, almost two-thirds of MCOs lost money,[80] including major losses by some of the biggest plans: United HealthCare ($565 million), Oxford Health Plan ($291.3 million), and Kaiser Permanente ($270 million).[81] By the late 1990s, growing numbers of managed care plans were teetering on the verge of bankruptcy.[82]

On the demand side, employers were once again driving change. This time, though, they were pushing in the opposite direction of the restrictive forms of managed care that they had clamored for and received in the early- to mid-1990s. Price competition among health plans was largely a response to employers' willingness to switch plans for even slightly lower premiums.[83] By the time this

73 *See* Joy M. Grossman, *Health Plan Competition in Local Markets*, Health Serv. Res. 17, 26 (2000).
74 *See id*. at 26–27.
75 *See* Fay Hansen, *Healthcare: Trouble Ahead; Costs are Rising, Quality of Service is Problematic, and More People than Ever are Going Without Health Insurance. Healthcare Issues are Heating Up Once Again*, Compensation & Benefits Rev., Mar.–Apr. 1999, at 20, 21.
76 *See* Paul B. Ginsburg, *Perspective on Change in the Health Care System During 1998*, *in* 1998 Annual Rep. (Ctr. for Studying Health System Change, 1999), *available at* www.hschange.org/CONTENT/151/98arperspective.html (last visited on June 7, 2005).
77 *Id*.
78 *Health-Care Costs: On the Critical List*, Economist, Feb. 13, 1999, at 65 [hereinafter *Health-Care Costs*].
79 Grossman, *supra* note 73, at 32.
80 *Health-Care Costs*, *supra* note 78, at 65.
81 *Year in Review 1998*, Mod. Healthcare, Dec. 21, 1998, at 26, 26.
82 David M. Cutler, Your Money or Your Life: Strong Medicine for America's Healthcare System 94 (2005).
83 *See* Mary Darby, Managed Care Woes: Industry Trends and Conflicts 1 (Ctr. for Studying Health System Change, Issue Brief No. 13, May 1998), *available at* www.hschange.org/CONTENT/68/68.pdf (last visited July 8, 2005).

strategy proved unsustainable in the late 1990s, the country's economic recovery had turned into a boom and dramatically altered employers' attitudes about health insurance. When unemployment reached thirty-year lows in 1999 and 2000, businesses became desperate to attract and keep good workers.[84] Offering their employees health plans with broader networks of medical providers and fewer restrictions to healthcare services was more expensive,[85] but with strong corporate earnings, employers were once again able and willing to absorb large premium increases.[86]

Finally, backed by state legislators and employers, the main force behind managed care's retreat was the growing consumer backlash. James Robinson notes, "Once the consumer and physician backlash against managed care began, it quickly swirled into an unstoppable political tornado."[87] *Newsweek*'s November 8, 1999 edition included an angry patient on its cover with the words "HMO Hell: The Backlash."[88] The medical directors of many MCOs—whose job involved determining what services would be covered and which medical providers patients could see—became targets of malpractice suits for "intentional infliction of emotional distress, breach of contract, fraud, [and] unfair claims practices."[89] For years, health insurance companies and MCOs had considered themselves immune from medical liability lawsuits because of the Employee Retirement Income Security Act (ERISA).[90] Moreover, as long as fee-for-service insurance dominated the industry, employees never had medical care denied.

After employers had shifted most of their workers into managed care, however, increasing numbers of consumers who experienced

84 *See* Jon B. Christianson & Sally Trude, *Managing Costs, Managing Benefits: Employer Decisions in Local Health Care Markets*, 38 Health Serv. Res. 357, 362–63 (2003).
85 *See* Jon B. Christianson, *The Role of Employers in Community Health Care Systems,* 17 Health Aff., July–Aug. 1998, at 158, 161.
86 Lesser, et al., *supra* note 63, at 344.
87 James C. Robinson, *The End of Managed Care*, 285 J.A.M.A. 2622, 2622–23 (2001).
88 *HMO Hell: The Backlash*, Newsweek, Nov. 8, 1999, at cover.
89 Thomas Bodenheimer & Lawrence Casalino, *Executives with White Coats—The Work and World View of Managed-Care Medical Directors*, 341 New Eng. J. Med. 1945, 1947 (1999); David O. Weber, *Managed Care Medical Directors Under Fire*, 26 Physician Executive, Sept.-Oct. 2000, at 12, 12–15.
90 *See* James A Wooten, The Employee Retirement Security Act of 1974, A Political History 283 (2004).

a restriction or a delay in access to medical care began to initiate liability cases. They accused their health plans of "practicing medicine" negligently by making medical decisions that should have been left solely to physicians.[91] The backlash arguably reached its zenith in October 1999, when a team of lawyers (led by David Boies) filed a class-action suit against Humana, "demanding that the company pay billions of dollars to health plan subscribers for failing to honor its promises to pay for medically necessary care."[92] The suit was ultimately thrown out three years later, but by that time the managed care industry had moved away from most of the business and administrative practices that had initially triggered the lawsuit.[93]

One final development emerged in the late 1990s, provider consolidation, which forced health plans to expedite the changes they were already beginning to make.[94] Large numbers of medical providers formed networks, physician-hospital organizations (PHOs), independent practice associations (IPAs), and system affiliations.[95] Their goal was to increase their bargaining position with MCOs, many of which were already eager to mend their damaged and frayed relationships with physicians and hospitals.

III. Medical Providers and MCOs Respond

Pushed to the financial edge by a convergence of economic forces, hospitals led the way among medical providers in seeking to shift

[91] *See* W. Devin Resides, *Holding Hmos Liable In The New Millennium: New Theories With An Old Twist*, 27 Okla. City U.L. Rev. 419, 426 (2002); Freudenheim, *Supreme Court Test*, *supra* note 71; *see also* William J. Kilberg, *The Impending Collision Between HMOs and ERISA: Can Either Emerge Unscathed?*, 25 Employee Rel. L.J., Spring 2000, at 1, 4.

[92] M. Gregg Bloche & David M. Studdert, *A Quiet Revolution: Law As an Agent of Health System Change,* 23 Health Aff., Mar.-Apr. 2004, at 29-30.

> The class action alleged that widely used cost control methods, including refusal to cover medically prescribed treatments and financial rewards to doctors for frugal practice, violated the federal laws that govern employees' fringe benefits. Within hours of the complaint's filing, managed care industry share prices dropped by as much as 10 percent. . . . The lawyers who brought the class actions against Humana and other plans spoke openly of their hope that market pressures would push the industry to settle. This hope went unrealized. But during the two years after the suit against Humana was filed, much of the managed care industry moved away from the practices targeted by the suit.

Id.

[93] *Id.*

[94] *See* Draper et al., *supra* note 59, at 11–12.

[95] *See* David Dranove et al., *Is Managed Care Leading to Consolidation in Health-care Markets?*, 37 Health Serv. Res. 573, 577 (2002).

the balance of power from the purchasers of medical care to those who provided it.[96] Building on a busy period of mergers in the mid-1990s,[97] many hospitals in the late 1990s formed concentrated systems by affiliating themselves with other local hospitals.[98] The amount of consolidation that subsequently occurred was substantial.[99] The proportion of the nation's hospitals in some form of local multi-hospital system increased from approximately thirty percent in 1995 to sixty percent by 2001.[100] The extent of this consolidation varied across the country; hospitals in areas where managed care controlled a larger share of the market were more likely to be part of a local system than those in areas of lower managed care penetration.[101] Yet, by 1998-1999, hospitals in the majority of the nation's largest markets were concentrated in just two to four hospital systems,[102] and they were not shy about their use of cost shifting. Hospital executives frequently justified their large payment rate increases as necessary for "offsetting the impact of reduced state and federal reimbursements."[103] Their efforts paid off. The hospital industry's financial health improved dramatically beginning in 2000.[104]

Concerned about the economic consequences of the hospital industry's aggressive consolidation, the Federal Trade Commission (FTC) stepped up its scrutiny of hospital mergers.[105] It charged various consolidated hospital systems of exploiting their market clout "to extract exorbitant price increases from health insurers and fix prices on behalf of their physicians."[106] The FTC, however,

---

96 *See* Gloria J. Bazzoli, *The Corporatization of American Hospitals*, 29 J. Health Pol. Pol'y & L. 885, 888–89 (2004).
97 *Id.* at 889.
98 Linda T. Kohn, *Organizing and Managing Care in a Changing Health System*, 35 Health Serv. Res. 37, 42 (2000).
99 *See* Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 Health Aff., Mar.–Apr., 2004, at 175, 175–76.
100 *See* Bazzoli, *supra* note 96, at 889; *see also* Alison Evans Cuellar & Paul J. Gertler, *Trends in Hospital Consolidation: The Formation of Local Systems*, 22 Health Aff., Nov.–Dec. 2003, at 77, 81.
101 *See* Lesser & Ginsburg, *supra* note 60, at 215.
102 *Id.* at 214.
103 *See* John F. Hoadley, Health Care Market Stabilizes, but Rising Costs and State Budget Woes Loom in Boston 2 (Ctr. for Studying Health System Change, Cmty. Rep. No. 12, 2003), *available at* www.hschange.com/CONTENT/611/611.pdf (last visited June 9, 2005).
104 *See* Patrick Reilly, *Riding High; Study Finds Hospital Margins at Five-Year Peak*, 33 Mod. Healthcare, Mar. 3, 2003, at 16; MedPac 2001, *supra* note 16, at 60.
105 Reed Abelson, *U.S. to Step Up Antitrust Effort on Health Care*, N.Y. Times, Aug. 9, 2002, at A1.
106 *See* Mark Taylor, *All's Fair in Competition? FTC Relies on Insurer Complaints Over Price Increases to Buttress First Challenge of Hospital Merger After the Fact,* 34 Mod. Healthcare, Feb. 16, 2004, at 6.

repeatedly lost the cases it brought to court,[107] primarily because the leading antitrust test that the courts used to determine if a hospital market was overly concentrated (the "Elzinga-Hogarty" test) was originally designed to govern market consolidation in the coal and beer industries.[108] As such, it was not ideally suited to measure how concentrated the provision of hospital services had become in a given geographic market. The original focus of the Elzinga-Hogarty test was on "how far a product moved from the location of supply to the location of demand."[109] With hospital services, the equation is reversed: the location of demand (the patient) moves to the location of supply (the hospital).[110] Thus, hospital mergers and consolidation went largely unchecked.[111]

In addition to pursuing consolidation, a sense of financial desperation emboldened many hospital executives to take their negotiations with private health plans to a level of brinkmanship.[112] The late 1990s had been the hospital industry's worst in decades. While Congress increased Medicare's payment rates in the two "give-back" bills, the adjustments were not large enough to do much more than stabilize Medicare's otherwise declining payment level.[113] Moreover, hospitals' labor costs were growing

[107] *See* Thomas Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 Health Aff., Mar.–Apr. 2002, at 185, 186; *see also* Peter J. Hammer & William M. Sage, *Critical Issues in Hospital Antitrust Law*, 22 Health Aff., Nov.–Dec. 2003, at 88, 90.

[108] Interview with Kenneth G. Elzinga, Professor of Economics, University of Virginia, Richmond, Va. (March 6, 2005).

[109] *Id.*

[110] *Id.*

[111] Thomas H. Brock, *FTC Will Reevaluate Hospital Consolidations*, 56 Healthcare Fin. Mgmt. 76, 76–77 (2002).

[112] *See* Bradley C. Strunk et al., Health Plan-Provider Showdowns on the Rise 1–2 (Ctr. for Studying Health System Change, Issue Brief No. 40, 2001), *available at* www.hschange.com/CONTENT/326/326.pdf (last visited June 9, 2005).

> After years of low payments and less volume than expected under commercial contracts, providers have had to deal with Medicare payment reductions and other problems, including higher labor costs because of nursing and other staff shortages. These financial pressures, coupled with greater sophistication in managed care contracting strategies and tactics, have spelled the end of a period when some providers uncritically accepted contract terms. Emboldened by the managed care backlash, providers are testing the waters to see just how far they can push their emerging bargaining power. As a result, contentious negotiations between providers and plans are becoming more common across the country.

Id.

[113] *See generally* MedPac 2004, *supra* note 16, at 206–09.

again. Consequently, increasing numbers of hospital executives returned to the bargaining table in 2000-2001 threatening to walk away if their demands for increased payments were not met.[114] Acrimonious contract negotiations between hospitals and health plans were common across the country at this time.[115] In winning most of these showdowns, hospitals became "contract breakers," rather than the "takers" they had been in the mid-1990s.[116]

The major improvement in hospitals' bargaining position coincided with extensive changes within the managed care industry. Bowing to ever increasing pressures from consumers, politicians, lawyers, and physicians, managed care plans essentially surrendered. They either dropped most of their older, restrictive HMO plans or changed them to more closely resemble the increasingly popular PPOs, which provided a much wider array of physician options.[117] Managed care plans also pulled back on the control mechanisms that limited patients' access to medical services. They relaxed or eliminated their pre-authorization requirements, which forced patients to obtain approval from a health plan nurse or benefits manager before being admitted to a hospital, having a test or procedure done, or seeing a specialist.[118] They also loosened their grip on physicians' autonomy and financial remuneration.[119] With employers demanding less restrictive health plans and demonstrating a willingness to pay more for them, managed care plans were only too willing to ditch many of the rules and practices that were causing them so much grief.

Another key change that MCOs made at this time was to follow the hospital industry's example and pursue consolidation within the larger health insurance industry. As previously mentioned, when new managed care plans flooded the market in the early- and mid-1990s, they increased price competition considerably and, in so doing, lowered insurance premiums, but there were limits to how long this competition could continue. Eventually, all health plans

[114] Mary Chris Jaklevic, *What Hospitals 'See' They Get: Private Sector Acquiesces to Providers' Price Hikes*, 30 Mod. Healthcare, Mar. 6, 2000, at 60, 61.

[115] *See* Strunk et al., *supra* note 112, at 2–3; *see also* Kelly J. Devers et al., *Hospitals; Negotiating Leverage with Health Plans: How and Why Has It Changed?*, 38 Health Serv. Res. 419, 427–29 (2003).

[116] *See* Devers et al., *supra* note 115, at 427.

[117] See Draper et al., *supra* note 59, at 13–15.

[118] *See* Milt Freudenheim, *A Changing World Is Forcing Changes On Managed Care,* N.Y. Times, July 2, 2001, at A1.

[119] See Bradley C. Strunk & James D. Reschovsky, Kinder and Gentler: Physicians and Managed Care, 1997-2001, at 2–4 (Ctr. for Studying Health System Change, Tracking Rep. No. 5 2002), *available at* www.hschange.com/CONTENT/486/486.pdf (last visited June 9, 2005).

had to restore or achieve some measure of profitability. "Continuing losses on top of the declining interest in HMOs associated with the backlash against managed care drove a large number of plans from the market, which, in combination with the large-scale mergers of national plans, led to a more concentrated industry."[120] By the early 2000s, virtually every state in the country was dominated by three large health plans.[121] With fewer competitors, the surviving plans—now much larger—raised premiums and dropped unprofitable lines of business.[122]

For many of the surviving health plans, the first unprofitable line of business to go was Medicare+Choice. The number of plans participating in the government's managed care program for Medicare beneficiaries fell from a high of 346 in 1998 to 156 by 2002.[123] The number of senior citizens in Medicare+Choice peaked at 16% of the program's beneficiaries in 1999, falling to less than 12% by 2003.[124] From 2000-2003 more than one million Medicare beneficiaries were dropped by health plans leaving the program.[125] The private health plans that remained increased premiums and beneficiary cost sharing, which left many Medicare beneficiaries with much higher out-of-pocket expenses.[126] The plans also dramatically limited or dropped benefits such as prescription drugs.[127]

It quickly became clear that Medicare+Choice had failed as a vehicle for policymakers to expand market reforms of Medicare.[128] Medicare payments to participating managed care plans were linked to spending in the traditional fee-for-service part of the program, which after the BBA grew much more slowly than Congress and the CBO anticipated.[129] Republicans and Democrats still disagreed over

[120] Joy M. Grossman & Paul B. Ginsburg, *As the Health Insurance Underwriting Cycle Turns: What Next?*, 23 Health Aff., Nov.–Dec. 2004, at 91, 97.

[121] *See* James C. Robinson, *Consolidation in Health Insurance*, 23 Health Affs., Nov.-Dec. 2004, at 11, 13-17.

[122] Draper et al., *supra* note 59, at 17–18.

[123] *See* Marsha Gold, *Can Managed Care and Competition Control Medicare Costs?*, Health Aff.- Web Exclusive, Apr. 2, 2003, at W3-176, -177, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.176v1 (last visited July 8, 2005).

[124] MedPac 2004, *supra* note 16, at 206–07.

[125] *Id.* at 206 fig. 4-1.

[126] *See* Brian Biles et al., *Medicare Advantage: Déjà vu All Over Again?*, Health Aff.- Web Exclusive, Dec. 15, 2004, at W4-586, -590, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.586v1 (last visited July 8, 2005).

[127] *Id.*

[128] *See* Joseph R. Antos, *Medicare+Choice: Where Did the Scorekeepers Go Wrong?*, Health Aff.- Web Exclusive, November 28, 2001, at W83, W83, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w1.83v1 (last visited July 8, 2005).

[129] *Id.* at W84; *See* Robert A. Berenson, *Medicare+Choice: Doubling or Disappearing?*, Health Aff., November 28, 2001, at W65, W65–66, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w1.65v1 (last visited on July 8, 2005).

why Medicare+Choice failed—either the plans were over-regulated and underpaid by the government or the Medicare population is simply unsuited actuarially for more profit-oriented managed care plans. Yet there was simply a large element of absurdity to the timing of Medicare+Choice. During the period in which federal policymakers tried to accelerate the expansion of market forces into Medicare, restrictive managed care went into retreat, medical inflation returned, and health plans abandoned their pursuit of enrollment growth.[130] In other words, just as MCOs were giving up their tools and their will to restrain costs, the federal government actively encouraged millions of Medicare beneficiaries to enroll in private health plans.

Ultimately, the changing strategies of hospitals and MCOs in the late 1990s and early 2000s restored both industries to profitability. Spending on hospital services surged beginning in 2000. By 2002, hospital operating margins were the highest they had been in five years.[131] Similarly, after consolidating, raising premiums, and dropping unprofitable patient populations, the surviving health plans saw their profits soar from $4 billion in 2001 to slightly more than $10 billion in 2003.[132] Renewed profitability helped managed care plans and medical providers repair their acrimonious relationships.[133] Major disputes between health plans and medical providers, particularly hospitals, became rare after 2001.[134] Health plans largely acquiesced to medical providers' demands for higher payments and more than passed on the increased costs to employers in the form of double-digit increases in their health insurance

[130] *See* Joy M. Grossman et al., Reversal of Fortune: Medicare+Choice Collides with Market Forces (Ctr. for Studying Health System Change, Issue Brief No. 52, 2002), *available at* http://hschange.org/CONTENT/437/437.pdf (last visited July 31, 2005).

[131] Reilly, *supra* note 104, at 16.

[132] *See* Michael Prince, *Rate Hikes Spur Managed Care Profits*, 36 Bus. Ins., Aug. 26, 2002, at 2; Robinson, *supra* note 121, at 18–19; *see generally* Laura B. Benko, *Going for the Green: As Higher Premiums and Stable Medical Costs Fuel Health Plans' Profits, Providers Say Time is Right to Win Bigger Reimbursement*, 33 Mod. Healthcare, Aug. 18, 2003, at 6, 6; Gloria Gonzalez, *Lower Medical Costs Aid Profits*, 38 Bus. Ins., Mar. 15, 2004, at 3.

[133] Justin S. White et al., Getting Along or Going Along? Health Plan-Provider Contract Showdowns Subside, 1–2 (Ctr. for Studying Health System Change, Issue Brief No. 74, 2004), *available at* http://www.hschange.com/CONTENT/641/641.pdf (last visited July 31, 2005).

[134] *Id*. at 3.

premiums.[135] Market forces were no longer strong enough to deliver cost control.[136]

IV. A Resurgence of Medical Inflation and its Consequences

Reopening the "floodgates" of private healthcare spending after a decade of cost control and rationalization had extraordinary consequences. The same problems that drove healthcare reform to the top of the nation's political agenda in the early 1990s returned—only worse—and new ones appeared.[137] First, employers' health insurance premiums skyrocketed. Between 2000 and 2004, the cost of employer-provided health insurance increased by more than fifty percent, five times the rate of inflation and growth in workers' earnings.[138] Employers absorbed most of the initial increases, but eventually they shifted a bigger proportion of the cost to their workers in the form of increased co-payments, deductibles, and monthly salary deductions.[139] More and more employers across the country also ceased to provide health insurance coverage to their retired workers. By 2003, fewer than half of U.S. companies with one-thousand or more workers provided health benefits to their retirees.[140]

135 *Id*. at 4.

136 *See generally* Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 Health Aff., Mar.-Apr. 2004, at 8 (explaining that efforts to deliver efficient health plans through competition, managed care restrictions, and increased patient costs are unlikely to slow rising cost trends).

137 Mayes, *supra* note 5, at 143.

138 *See* Jon Gabel et al., *Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage*, 23 Health Aff., Sept.–Oct. 2004, at 200, 201–02.

139 *See* John K. Iglehart, *Changing Health Insurance Trends*, 347 New Eng. J. Med. 956, 957–58 (2002); *see also* Lydia Regopoulos & Sally Trude, Employers Shift Rising Health Care Costs to Workers: No Long-Term Solution in Sight 1 (Ctr. for Studying Health System Change, Issue Brief No. 83, 2004), *available at* www.hschange.com/CONTENT/677/677.pdf (last visited July 31, 2005).

140 Hewitt Assoc. & Henry J. Kaiser Family Found., Retiree Health Benefits Now and in the Future: Findings from the Kaiser/Hewitt 2003 Survey on Retiree Health Benefits, at xv (2004), *available at* www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29862 (last visited July 31, 2005).

Second, as health insurance became significantly more expensive, fewer businesses and workers could afford it.[141] Whereas 68% of U.S. businesses with less than 200 employees offered health coverage to their workers in 2000, only 63% did so in 2004.[142] As a result, the total number of jobs in the United States that provided health insurance fell by 5 million.[143] This downward trend in coverage—together with the effects of a recession in 2001 and a sluggish recovery thereafter—increased the number of uninsured individuals from 41 million in 2001 to 45 million in 2003.[144] The growth in the number of people uninsured would have been far greater were it not for a major expansion of public coverage through Medicaid and SCHIP.[145]

A third problem that stemmed from both rising medical inflation and declining private health insurance coverage was that Medicaid costs increased substantially.[146] Many individuals and families who lost their private coverage between 2000 and 2003 became eligible for Medicaid. Consequently, the program's enrollment grew by more than 8 million people during this period, and its spending increased by more than 60% from $206 billion in 2000 to approximately $330 billion in 2005.[147] State leaders became alarmed by their soaring Medicaid costs. "Medicaid is a cancer on

[141] *See* Jennifer N. Edwards et al., The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care 3, 5 (Commonwealth Fund, Issue Brief No. 559, 2002), *available at* www.cmwf.org/usr_doc/edwards_erosion.pdf (last visited July 16, 2005); *see generally* Henry J. Kaiser Family Found. & Health Res. & Educational Trust, Employer Health Benefits: 2004 Annual Survey (2004), *available at* http://www.kff.org/insurance/7148/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46288 (last visited July 8, 2005) (providing statistics regarding costs, coverage, and benefits of employer offered health plans).

[142] Gabel et al., *supra* note 138, at 206, 208.

[143] *Id*. at 206.

[144] Carmen DeNavas-Walt et al., U.S. Census Bureau, U.S. Dep't of Com., Income, Poverty and Health Insurance Coverage in the United States: 2003 14, 17 (2004), *available at* www.census.gov/prod/2004pubs/p60-226.pdf (last visited Aug. 1, 2005).

[145] *See id*. at 14; Bradley C. Strunk & James D. Reschovsky, Trends in U.S. Health Insurance Coverage, 2001-2003, at 4 (Ctr. for Studying Health System Change, Tracking Rep. No. 9, 2004), *available at* www.hschange.org/CONTENT/694/694.pdf (last visited Aug. 1, 2005).

[146] *See* Strunk & Reschovsky, *supra* note 145, at 1, 4.

[147] Tim Hill, *Hearing on Medicare and Medicaid Improper Payments*, Senate Homeland Security and Governmental Affairs Subcommittee, U.S. Senate, 109th Congress, 1st Session (Washington, D.C.: July 13, 2005), at http://www.cms.hhs.gov/media/press/testimony.asp?Counter=1504 (last visited August 8, 2005); John Holahan & Arunabh Ghosh, *Understanding the Recent Growth in Medicaid Spending, 2000-2003*, Health Aff.- Web Exclusive W5-52, -54 (Jan. 26, 2005), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.52 (last visited July 17, 2005).

our budget," noted Mississippi governor, Haley Barbour.[148] Facing their worst fiscal shortfalls in decades, many states reduced benefits, increased patients' co-payments, restricted eligibility, or removed people from their programs.[149] The tragedy of their efforts is that they came at the very time when the public's need for Medicaid was growing.

Fourth, the number of Americans with debilitating medical debt, as well as the number filing for bankruptcy due to healthcare-related expenses, increased sharply beginning in the early 2000s. "Between 2001 and 2003, the proportion of low-income, chronically ill people with private insurance who spent more than 5 percent of their income on out-of-pocket health care costs grew . . . 50 percent . . . to 2.2 million people."[150] For many Americans, mounting medical debt eventually led to personal bankruptcy. In 1999, upwards of half a million families cited either substantial medical bills, a lapse in health insurance, or insufficient coverage as reasons for their insolvency.[151] In 2001, that number increased to slightly more than 700,000 for a total of approximately 2 million bankrupt individuals (filers plus their dependents).[152] Surprisingly, 76% of those people citing medical reasons for their bankruptcy *had* health insurance coverage at the onset of illness.[153] Researchers found that medical debtors were mostly typical, middle class Americans who were injured or became ill.[154] "They differed from others filing for bankruptcy in one important respect: They were more likely to have experienced a lapse in health coverage."[155] "Many had coverage at

148 Robert Pear, *Governors Resist Bush's Appeal for Quick Deal on Medicaid*, N.Y. TIMES, Mar. 1, 2005, at A14.
149 Robert Pear, *Most States Cutting Back on Medicaid, Survey Finds*, N.Y. TIMES, Jan. 14, 2003, at A24.
150 *See* HA T. TU, RISING HEALTH COSTS, MEDICAL DEBT AND CHRONIC CONDITIONS 1 (Ctr. for Studying Health System Change, Issue Brief No. 88, 2004), *available at* www.hschange.org/CONTENT/706/706.pdf (last visited July 16, 2005).
151 ELIZABETH WARREN ET AL., MEDICAL PROBLEMS AND BANKRUPTCY FILINGS 1–2 (Harvard Law School, Public Law and Legal Theory Working Paper Series, Working Paper No. 008; Univ. of Texas Law School, Public Law and Legal Theory Working Paper Series, Working Paper No. 009, 2000), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=224581 (last visited Aug. 1, 2005).
152 David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF.- WEB EXCLUSIVE W5-63, -70 (Feb. 2, 2005), *at* http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1 (last visited Aug. 8, 2005).
153 Reed Abelson, *Study Ties Bankruptcy to Medical Bills*, N.Y. TIMES, Feb. 2, 2005, at C1.
154 Himmelstein et al., *supra* note 152, at W5-70.
155 *Id.*

the onset of their illness but lost it. In other cases, even continuous coverage left families with ruinous medical bills" due to large and uncovered out-of-pocket expenses (deductibles, co-payments, uncovered services).[156]

Finally, the surge in medical inflation led to sizeable increases in Medicare beneficiaries' monthly Part B premiums.[157] By law, the federal government pays 75% of the cost of the program's Part B benefits (for physician services and outpatient medical care), with Medicare beneficiaries' Part B premiums covering the remaining 25%.[158] Due to the rapid rate of growth in Medicare spending on physician and other outpatient services in the early 2000s, a growing proportion of Medicare beneficiaries' Social Security income became consumed by medical inflation.[159] The cost of their monthly Part B premiums, which are automatically deducted from their monthly Social Security checks, increased by more than 50% in the early 2000s.[160] Senior citizens were also facing larger out-of-pocket costs for prescription drugs at this time,[161] which contributed to the political momentum for policymakers' paradoxical reform of Medicare in late 2003. Following on the failure of Medicare+Choice to either save money or maintain enrollment growth, congressional Republicans and President Bush added an enormously expensive drug benefit to Medicare *and* reasserted their commitment to moving more of the program's beneficiaries into lightly-managed private healthcare plans.

V. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

In December 2003, President Bush, and a Republican-controlled Congress enacted the largest expansion of Medicare in the program's history: the Medicare Prescription Drug, Improvement, and Modernization Act (MMA).[162] In 2006, Medicare will provide

---

156 *Id.*

157 *See* Fed. Hosp. Ins. & Fed. Supplementary Med. Ins. Trust Funds Boards of Trustees, 2005 Annual Report 151 (2005) [hereinafter Boards of Trustees], *available at* www.cms.hhs.gov/publications/trusteesreport/tr2005.pdf (last visited Aug. 1, 2005).

158 *Id.* at 4, 101.

159 *Id.* at 22, 26.

160 Boards of Trustees, *supra* note 157, at 82 tbl. III.C6.

161 *See* Usha Sambamoorthi et al., *Total and Out-of-Pocket Expenditures for Prescription Drugs Among Older Persons*, 43 Gerontologist 345, 357–58 (2003).

162 Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat 2066.

prescription drug coverage to the program's more than 40 million beneficiaries.[163] At a time of large and growing annual budget deficits, the MMA's cost struck many observers as both fiscally irresponsible and politically paradoxical.[164] The editorial board of the *Wall Street Journal* denounced the legislation as anathema and warned Republicans who supported the bill that they were "fooling themselves. . . . Republicans can never win an entitlement bidding war."[165] On the other end of the political spectrum, many liberal Democratic leaders in Congress found themselves in the awkward position of vehemently opposing a benefit expansion that they had pursued for more than a decade.

In hindsight, the MMA seemed as much imposed as enacted. As John Iglehart observed, "Never before had Congress enacted major Medicare legislation about which the divisions between the political parties ran so deep."[166] The House of Representatives passed the bill by a razor-thin margin, 220 to 215, with the Senate following suit by a narrow 54 to 44 margin.[167] The country's leading congressional analyst described the tactics used to pass the bill in the House as "the ugliest and most outrageous breach of standards in the modern history of the House."[168] In a public poll taken the week that President Bush signed the legislation into law, almost 50% of senior citizens said they opposed the plan, with only 26% in support of it.[169]

Unlike the period following the passage of the BBA in 1997 or the Social Security reform bill in 1983, there was no sense of bipartisan gratification following the passage of the MMA.[170] "We have only just begun to fight," said Democratic Senator Edward Kennedy on the day that President Bush signed the MMA into law.[171] "If

[163] *See* Thomas R. Oliver et al., *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283, 284 (2004).

[164] For the best comprehensive account of the history and political evolution of Medicare's new prescription drug benefit, see *id*. The Congressional Budget Office originally estimated the cost of Medicare's new prescription drug benefit to be $395 billion over ten years, but *after* the legislation passed the Bush administration publicly released its own estimate of the new benefit's cost to be approximately $534 billion. *Id*.

[165] *See* Editorial, *Medicare Drug Folly*, WALL ST. J., June 16, 2003, at A14.

[166] John K. Iglehart, *The New Medicare Prescription-Drug Benefit—A Pure Power Play*, 350 NEW ENG. J. MED. 826, 826 (2004).

[167] *Id*. at 828.

[168] *See* Norman Ornstein, . . . *And Mischief*, WASH. POST, Nov. 26, 2003, at A25.

[169] *See* Oliver et al., *supra* note 163, at 284.

[170] Vladeck, *supra* note 11, at 414.

[171] Robert Pear, *Despite New Law, the Fight Over Medicare Continues*, N.Y. TIMES, Jan. 6, 2004, at A20.

Republicans think this fight is over, they are wrong."[172] He and other Democratic congressional leaders pledged to attack specific parts of the law until they were repealed.[173] Their opposition gained growing numbers of Republicans in February 2005, when the Bush administration released new estimates projecting the cost of Medicare's prescription drug benefit to be approximately $724 billion between 2006 and 2015 (a different 10-year time period than the previous $534 and $395 billion estimates, which were for 2004 to 2013).[174]

Critical to understanding the paradoxical politics of the MMA is recognizing that for many Republicans, and conservatives, Medicare is a huge, outdated, and inefficient government program.[175] Tom Scully, President Bush's First Administrator of the Centers for Medicare and Medicaid Services (CMS), said as much in fall 2002: "I hate this whole G—damn system. I'd blow it up if I could, but I'm stuck with it."[176] Ever since taking control of Congress in 1994, leading Republicans have wanted to fundamentally change Medicare from a universal government benefit to a program that provides its beneficiaries with a defined contribution—euphemistically referred to as "premium support"—toward the purchase of a private health plan.[177] Republicans argue that private health plans competing for Medicare beneficiaries will help constrain the program's costs while also providing beneficiaries with new benefits such as prescription drug coverage.[178] The centerpiece of the BBA's 1997 Medicare reforms, Medicare+Choice, was the vehicle that they hoped would greatly accelerate this market-oriented

172 Iglehart, *supra* note 166.

173 *Id.*

174 Robert Pear, *Bush Vows Veto of Any Cutback in Drug Benefit*, N.Y. Times, Feb. 12, 2005, at A1.

175 *See* Jacob S. Hacker & Mark Schlesinger, *Good Medicine,* Am. Prospect, Oct. 1, 2004, at 34, 34, *available at* www.prospect.org/web/printfriendly-view.ww?id=8545 (last visited Aug. 2, 2005).

176 Interview with Tom Scully, *supra* note 25.

> 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.

Id.

177 *See* Jonathan Oberlander, The Political Life of Medicare 185 (2003); Jacob S. Hacker, The Divided Welfare State 327–28 (2002).

178 *See* Tom Scully, *All Seniors Gain Benefits*, Mod. Healthcare, Dec. 22, 2003, at 22.

transformation. It ultimately failed, but Republicans remained undeterred.

In early 2003, as the drive to add prescription drug coverage to Medicare was gaining political momentum, the Bush administration proposed that only beneficiaries enrolled in a private plan should receive any new drug benefit.[179] The proposal met with a conspicuous lack of enthusiasm by members of both parties and was eventually abandoned.[180] Nonetheless, it revealed the administration's underlying motivation, which was to move more Medicare beneficiaries into private plans and, in the process, shift a greater proportion of the program's financial risk to private health plans and even to beneficiaries themselves.

For years there had been widespread agreement among policymakers that some type of drug benefit needed to be added to Medicare. Yet two-thirds of the program's beneficiaries already had some form of prescription drug coverage (through plans they continued to receive from their previous employers, private Medigap policies, Medicaid, or their enrollment in a Medicare+Choice plan).[181] Thus, Republican leaders in Congress did not craft a universal, seamless, and comprehensive prescription drug benefit. Instead, they made participation in Medicare's new prescription drug program voluntary (similar to Part B); they gave the responsibility for providing the drug benefit to private companies (not to the federal government); and they limited the plan's coverage. In addition to a monthly premium of $35 and an annual deductible of $250, beneficiaries are responsible for 25% of their drug costs between $250 and $2,250, 100% between $2,250 and $5,100, and 5% of their drug costs of $5,100 and over.[182] Medicare pays the rest.

Senior Republican congressional leaders essentially designed Medicare's new drug benefit as a form of catastrophic coverage. The beneficiaries it helps the most are those not poor enough to qualify for Medicaid, but who are without private insurance coverage and unable to afford their prescription drugs without undue financial hardship.[183] Beneficiaries have to pay $1,590 before reaching a

179 Robert Pear, *Bush May Link Drug Benefit in Medicare to Private Plans,* N.Y. Times, Jan. 24, 2003, at A1.
180 Robert Pear & Robin Toner, *Bush Medicare Proposal Urges Switch to Private Insurers,* N.Y. Times, Mar. 5, 2003, at A19.
181 Oberlander, *supra* note 177, at 192.
182 Eric Cohen, *The Politics and Realities of Medicare*, Pub. Int., Summer 2004, at 37, 39; Iglehart, *supra* note 166, at 829–30.
183 *See* Cohen, *supra* note 182, at 39.

break-even point, and $4,020 (or 79%) of the first $5,100 in annual drug expenses.[184] The MMA did include a provision that waives the monthly premium for poor Medicare beneficiaries whose incomes are below 135% of the federal poverty level, and it limited the role of cost sharing for poor beneficiaries to no more than five dollars per prescription.[185] Yet, under the new drug benefit, the majority of Medicare beneficiaries still have to pay for most of their non-catastrophic drug costs. What Congress ultimately created, then, is an expensive new benefit for a minority of Medicare beneficiaries that exacerbates the program's long-term cost problems.[186]

The enormity of the new drug benefit (Title I of the MMA) overshadowed two other components of the law that represented a dramatic change in Medicare's traditional design and philosophy. First, the MMA broke with more than thirty years of social insurance tradition by providing a means-testing measure that will charge wealthier beneficiaries more for their Part B benefits (physician and outpatient services).[187] Medicare had always charged all beneficiaries—regardless of their income—the same monthly premium for participation in Part B of the program. The entire Medicare population, therefore, shared equally in paying for 25% of Part B's annual costs. The MMA changed this. Beginning in 2007, individual Medicare beneficiaries with adjusted gross incomes over $80,000 (or $160,000 for married couples) will pay higher premiums for the same Part B benefit.[188] Moreover, low-income beneficiaries—again, those whose incomes are below 135% of poverty—will pay lower premiums than other Medicare beneficiaries for an even more generous prescription drug benefit.[189] "Proposals to means-test Medicare benefits are as old as the program itself,"[190] but the MMA heralded the first time that Medicare's premiums and insurance benefits will, in fact, vary depending on beneficiaries' income.

[184] Oliver et al., *supra*, note 163, at 317.
[185] Mark V. Pauly, *Means-Testing in Medicare*, Health Aff.-Web Exclusive W4-546, -547 (Dec. 8, 2005), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.546 (last visited Aug. 2, 2005).
[186] Editorial, *Social Security Breakdown*, Wash. Post, Mar. 4, 2005, at A20.
[187] Pauly, *supra* note 185, at W4-547.
[188] *Id.*
[189] *Id.*
[190] Marilyn Moon, *Medicare Means-Testing: A Skeptical View*, Health Aff.- Web Exclusive W4-558, -559 (Dec. 8, 2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.558 (last visited Aug. 2, 2005).

Many leading Republicans and Democrats have long argued that wealthier beneficiaries should pay more for their benefits than poorer beneficiaries. But *how* wealthier beneficiaries pay more is critically important, argues Bruce Vladeck.[191] If their additional contributions are specifically identified and administered as premiums costs, then at some point it no longer becomes worthwhile for the healthiest among them to participate in the Part B program.[192] The danger, then, is that wealthier and healthier beneficiaries will choose not to participate, leaving poorer and less healthy beneficiaries to face higher premium costs for remaining in the only realistic medical insurance program available to them.

The MMA's other dramatic change is that it significantly expanded the ways in which Medicare was biased to favor the role of private health plans. It did so by: (1) renaming the Medicare+Choice program as "Medicare Advantage," (2) adding billions of dollars in higher payments to participating MCOs, and (3) providing for the participation of PPOs in Medicare Advantage.[193] At first glance, recommitting to the same principles embodied in the failed Medicare+Choice program seems contradictory if Republicans' goal is to control Medicare's costs. Private health plans in Medicare+Choice did not save Medicare money; rather, they proved to be more expensive.[194] In 2003, Medicare paid private health plans participating in Medicare+Choice an average of 4% more than the average cost of a Medicare beneficiary under fee-for-service.[195] In 2004, the program renamed as Medicare Advantage paid private health plans 7.4% more on average than if the beneficiaries had remained in Medicare's traditional fee-for-service arrangement.[196] And in 2005, Medicare is estimated to have spent

191 Vladeck, *supra* note 11, at 414.

192 *Id.*

> If efforts are made to limit the government's general revenue contributions—as [MMA] requires, in the name of "cost containment"—then over time it is inevitable that more and more affluent beneficiaries will drop out of the pool, leaving an insured population that is both sicker and poorer. Eventually, it is feared, Medicare—or at least Part B—could be transformed from a universal social insurance program to a system of targeted subsidies to a small subset of the elderly population.

Id.

193 *See* Jerry Geisel, *Medicare Advantage Federal Funding Boost Renews Plans' Interest*, Bus. Ins., Feb.16, 2004, at 3, 34.

194 MedPac 2003, *supra* note 21, at 195, 197.

195 Biles et al., *supra* note 126, at W4-594.

196 Robert A. Berenson, *Medicare Disadvantaged and the Search for the Elusive "Level Playing Field,"* Health Aff.- Web Exclusive W4-572, -577 (Dec. 15, 2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.572 (last visited Aug. 2, 2005).

6.6%, or an average of $546, more for each of the almost 5 million Medicare beneficiaries enrolled in participating private healthcare plans than it did for the average beneficiary in its traditional fee-for-service arrangements (a total of $2.72 billion in extra Medicare spending).[197]

The major recommitment that the MMA made to private managed care plans stems from the belief of several prominent leaders (mostly Republicans) in Congress, including House Ways and Means Committee chairman, Bill Thomas, that "private plans and competition will help to drive down the explosive growth of Medicare spending."[198] Given the numerous empirical analyses that find that PPOs participating in the Medicare Advantage program consistently fail to save money and cost *more* than the traditional fee-for-service provision,[199] one is tempted to categorize Medicare Advantage as something of a "faith-based" initiative.

Nevertheless, as the history of Medicare policy-making suggests, Congress will likely want to (and have to) reduce payments to Medicare Advantage plans in the future as part of larger efforts to reduce federal budget deficits. The difficulty with this beloved and time-honored tradition, however, is that the country's baby-boom generation begins retiring in 2010-2011. Each year thereafter, until 2030, the number of Medicare beneficiaries is projected to increase significantly (from 46 to 77 million individuals).[200] Consequently, Medicare's costs will also increase significantly, as the program's solvency beyond 2020 has become a matter of serious concern.[201]

---

197 Brian Biles et al., The Cost of Privatization: Extra Payments to Medicare Advantage Plans—2005 Update 6 (Commonwealth Fund, Issue Brief No. 750, 2004), *available at* http://tinyurl.com/bveyh (last visited Aug. 17, 2005); Robert B. Doherty, *Assessing the New Medicare Prescription Drug Law*, 141 Annals Internal Med. 391, 391 (2004).

198 *See* Edward M. Kennedy & Bill Thomas, *Dramatic Improvement or Death Spiral—Two Members of Congress Assess the Medicare Bill*, 350 New Eng. J. Med. 747,750 (2004).

199 *See* U.S. Gov't Accountability Off. (GAO), GAO-04-960, Rep. to the Ranking Minority Member, Comm. on Finance U.S. Senate, Medicare Demonstration PPOs: Financial and Other Advantages for Plans, Few Advantages for Beneficiaries 21 (2004), *available at* www.gao.gov/ncw.items/d04960.pdf (last visited June 18, 2005); Cong. Budget Off. (CBO), Congress of the U.S., CBO's Analysis of Regional Preferred Provider Organizations Under the Medicare Modernization Act 14 (2004), *available at* www.cbo.gov/ftpdocs/59xx/doc5997/10-27-PPOUnderMedicare.pdf (last visited June 18, 2005).

200 *See* Boards of Trustees, *supra* note 157, at 34; Nat'l Bipartisan Comm'n on the Future of Medicare, The Facts About Medicare, *available at* http://thomas.loc.gov/medicare/factpage4.html (last visited June 19, 2005).

201 *See* Boards of Trustees, *supra* note 157, at 2–3.

VI. Conclusion

A unique convergence of severe political and financial pressures in the late 1990s ended the nation's brief experiment with restrictive managed care; it also ended its longest sustained period of below-average growth in per capita national health spending.[202] Steep Medicare cuts in spending on hospitals and post-acute providers, imposed by the 1997 BBA, made it impossible for many medical providers to compensate for years of declining payment generosity from private payors. Prior to the BBA, the annual growth in Medicare spending had managed to outpace general medical inflation. After the BBA, both public and private healthcare payments decreased simultaneously for the first time. In desperation, large segments of the medical provider community turned to consolidation in order to survive financially and regain professional autonomy. They were aided in their efforts by an onslaught of regulatory and legal restrictions on private health plans by state governments responding to the public backlash against managed care. When private health plans surrendered the drive for cost control and also turned to consolidation, healthcare spending returned to its long-term pattern of rapid acceleration.

The resulting surge in medical inflation triggered another in the nation's series of healthcare crises.[203] Beginning in 2001, public health insurance programs experienced major enrollment growth, and the number of uninsured increased significantly.[204] More and more employers shifted a larger proportion of their growing health insurance costs to their workers and many ceased to provide coverage altogether.[205] Medical debt and the number of health-related bankruptcies in America soared.[206] "I know what you're thinking. Hillary Clinton and healthcare? Been there. Didn't do that!" wrote Democratic Senator Hillary Clinton.[207] "No, it's not 1994; it's 2004. And believe it or not, we have more problems today than we had back then."[208]

[202] Stuart H. Altman et al., *Escalating Health Care Spending: Is It Desirable or Inevitable?*, Health Aff.-Web Exclusive W3-1, -4 (Jan. 8, 2003), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.1 (last visited June 19, 2005).

[203] *See* Rick Mayes, *Universal Coverage and the American Health Care System in Crisis (Again)*, 7 J. Health Care L. & Pol'y 242, 243 (2004).

[204] *Id.*

[205] *Id.* at 243–44.

[206] *Id.* at 244.

[207] Hillary Rodham Clinton, *Now Can We Talk About Health Care?*, N.Y. Times Magazine, Apr. 18, 2004, at 26, 26.

[208] *Id.*

Finally, the future of Medicare, both financially and programmatically, was complicated by policymakers' narrow passage of the MMA in late 2003. The MMA made Medicare a more complete health insurance program for the elderly by adding prescription drug coverage. But it did so at a high price—upwards of $724 billion over the next ten years—with large subsidies for employers that continue to provide drug coverage to their retired workers, low-income subsidies for poor beneficiaries, and major pay-offs for private health plans that participate in Medicare Advantage. Thus, the "MMA [was] a significant achievement, and in many ways an improvement," notes Eric Cohen.[209] "But one can also understand why so many people—Left, Right, and center—see the bill as irresponsible or inadequate, and why no one really believes it is what Medicare needs over the long-term."[210] The same financial necessity that became the mother of Medicare's payment innovation in the early 1980s and of the private sector's innovation in the late 1980s and early 1990s (in the form of managed care) is bound to return in the near future. Fiscal exigencies will all but require it.

[209] Cohen, *supra* note 182, at 39.
[210] *Id.*