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Pursuing cost containment in a pluralistic payer environment: from the aftermath of Clinton's failure at health care reform to the Balanced Budget Act of 1997

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Abstract: Following a decade in which Medicare operated as the leading 'change agent' within the US health care system, the private sector rose to the fore in the mid 1990s. The failure of President Clinton's attempt at comprehensive, public sector-led reform left managed care as *the* solution for cost control. And for a period it worked, largely because managed care organizations were able to both squeeze payments to selective networks of medical providers and significantly reduce inpatient hospital stays. There was a lot of 'fat' in the nation's convoluted health care system that could be (and was) eliminated through competitive negotiations between medical providers and insurers, employers, or managed care organizations. One of our primary arguments in this article is that managed care operated partly as a systematic suppression of price discrimination or differential pricing (often referred to as 'cost shifting'), as managed care organizations *qua* purchasing agents prevented hospitals and physicians from summarily raising prices to private payers to meet their financial requirements. Over time, however, managed care fell victim to inflated expectations, its own initial success, and larger fiscal forces. During this same period, Republicans and Democrats struggled to reach a consensus over the future direction of Medicare. Their disagreements contributed to the impasse over budget policy in 1995 and the infamous partial federal government shut-down. After President Clinton's reelection in 1996, partisan disagreements over Medicare dissipated. And, in 1997, Congress and the president passed the Balanced Budget Act of 1997, which emerged as a massive piece of patchwork legislation that sought to balance the federal budget, rein in Medicare spending, and increase the number of the programme's beneficiaries in private health plans.

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Around the mid 1990s there was a respite of sorts ... We weren't doing the deficit reduction stuff every year. That probably led partially to the BBA [Balanced Budget Act] in '97, which we've been trying to dig ourselves out of ever since.¹

Rick Pollack

Executive Vice President, American Hospital Association

The changes to Medicare in the BBA were clearly budget-driven in terms of the numbers, but they were also policy-driven to an extent ... Congress had budget numbers [deficit reduction targets] that they wanted to get to, so they went back and forth with CBO [Congressional Budget Office] in scoring various proposals ... Congress eventually ended up with things like the significant cuts in Home Health care, Skilled Nursing and hospital payments. Almost everyone in Congress voted for these things with their hands up. They knew exactly what they were doing and, yet, they also knew that they would have to come back and fix it all at some point.²

Donald Young

Former Executive Director, ProPAC and MedPAC

Introductory overview

Medicare is largely viewed by the general public in the US as a somewhat dowdy but dependable and, thus, valued public health insurance programme for the elderly. To US policy makers, however, Medicare is – and has long been – much more than just a senior citizen's social insurance programme, paid for by mandatory contributions from workers and their employers (through a payroll tax) and federal tax revenue. Medicare has been the primary vehicle for the federal government's general subsidization and expansion of the US health care system (Iglehart, 1999a). This role evolved soon after the programme began operation in 1966. Medicare quickly became an enormously expensive programme, which currently costs the US federal government nearly \$325 billion a year and serves approximately 42 million people (US Department of Health and Human Services, 2005). In addition to financing the medical care for millions of senior citizens and the disabled, Medicare provides significant funds for medical education, research, and increased access – the care of disadvantaged and vulnerable people (Oberlander, 2003). Yet medical providers often claim that they have to rely on increasing the prices they charge to their private patients, via differential or discriminatory pricing (Reinhardt, 2006), to make up for losses incurred treating public patients when Medicare's generosity has decreased (Dobson *et al.*, 2006). 'Medicare is the 800 pound gorilla of the US health care system', argues David Abernethy, former Staff Director of the US House of Representative's Ways and Means Health Subcommittee.

1 Rick Pollack interview with Rick Mayes, August 16, 2002.

2 Donald Young interview with Rick Mayes, October 11, 2002.

‘When it slows its rate of expenditure growth, [providers’] overall rate of revenue growth slows; and that, in the end, puts the final pressure on private payers’ (Abernethy, 2002).

This complex interplay between public and private purchasers that distinguishes the US health care system also underscores the challenge of pursuing successful cost containment goals. The private sector’s embrace of managed care in the 1990s, and the backlash it eventually spawned, can be better understood by viewing it largely as private purchasers’ response to the effects of Medicare’s prospective payment system (PPS), introduced in 1983.³ The success of the PPS – which established fixed prices for inpatient episodes of hospital care – in controlling Medicare’s rate of expenditure growth in the late 1980s and early 1990s fueled inflation in private health insurance premiums, which triggered employers’ demand for cost control (Clement, 1997/1998; Ginsburg, 2003; Lee *et al.*, 2003; Mayes, 2004).

The image of a river and flooding rains is perhaps helpful. The ‘rain’ comes down (cost drivers are continually raising the cost of medicine) and there are many tributaries – new medical technology, rising prices, more elderly patients – feeding into the river. Medicare’s PPS functioned, in part, as a diverting dam that helped to keep the ‘flood’ away from Medicare; yet the water was simply diverted back into the river. In other words, only Medicare was (temporarily) sheltered from ever-increasing medical inflation. And after the PPS went into effect, the flooding problem became even worse because more water (cost drivers) was now moving down a smaller channel. In short, a huge part of the medical establishment, Medicare, was no longer doing as much as it had before to absorb a significant portion of ever-increasing medical inflation, which left employers in the private sector to make up the difference.⁴ Moreover, the cycles for private health insurance premiums and Medicare cost growth moved out of sync (Boccuti and Moon, 2003; Gabel *et al.*, 1991; Gabel and Jensen, 1992; Rosenblatt, 2004).

Medicare’s payment reforms, however, did not trigger a fierce backlash, as did managed care. Why? Because the dramatic changes associated with Medicare’s PPS remained hidden from the programme’s beneficiaries. Medical providers and administrators were the ones who adapted their behavior in response to Medicare’s new payment incentives and, not inconsequently, demanded higher payments from private purchasers (Guterman, 2002). Managed care, on the other hand, did alter patients’ traditional and customary medical arrangements, as it tried to curtail both utilization of and prices paid for medi-

3 See Fein (1999), ‘As Medicare and Medicaid tightened their reimbursement policies in the late 1980s and early 1990s, they paid hospitals less than the hospitals believed was a fair share of total hospital expenses. Hospitals reacted by increasing charges to other payers, especially to commercial insurance carriers, in order to cover the shortfall in total receipts. In turn, private insurers raised their premiums in order to, as they would put it, “subsidize” patient care only partly paid for by government.’ (p. 95)

4 Many thanks to David Smith for this observation. For more on the history and evolution of Medicare payment policy, see Smith (1992, 2002).

cal care. By its very nature, it undermined the basic principles that made traditional indemnity health insurance so popular.⁵ Managed care created incentives for medical providers to withhold care instead of oversupplying it; it restricted patients' choices and access instead of leaving them unfettered; and it violated the decision-making autonomy of medical providers, which was anathema (Swartz, 1999).

Notwithstanding improving efficiency – especially among hospitals after the PPS went into effect – Medicare spending continued to grow rapidly through the 1990s, in large part because Republican and Democratic leaders found themselves unable to forge a consensus on how to control the programme's rate of spending growth. Ironically, Medicare became a relatively generous payer again as provider costs grew more slowly than their Medicare payments. In 1995, the programme's Trustees predicted that Medicare would run out of money beginning as early as 2002 (Social Security Administration, 1995). The subsequent political push to 'save' Medicare coincided (conveniently) with a nasty partisan struggle between President Clinton and senior congressional Republicans over how best to achieve a balanced federal budget (Kahn and Kuttner, 1999). Republicans wanted substantial Medicare spending reductions to help balance the federal budget and pay for large tax cuts.

President Clinton and congressional Democrats countered with smaller proposed spending reductions and charged Republicans with threatening both the financial integrity of Medicare and the welfare of the programme's beneficiaries. The impasse that ensued culminated in President Clinton vetoing the Republicans' Medicare legislation with the same pen that Lyndon Johnson had used to sign Medicare into law in 1965. Clinton's veto triggered the infamous partial federal government shutdown in late 1995 and early 1996 (in which approximately 800,000 of the nation's 2.1 million civilian workers at the time were furloughed for three weeks until the White House and Congress could agree on a new short-term continuing funding resolution).⁶ From this episode, Clinton emerged victorious politically at the expense of

5 See Swartz (1999), 'In the fee-for-service world of health insurance that existed before managed care organisations had a large proportion of the US population as enrollees, consumer trust in physicians was based on three mechanisms. First, the consumer recognized that the physician had no financial incentive to ration medical care. To the contrary, a doctor, like a mechanic, had financial incentives to do more than might be absolutely necessary. But the second mechanism at work in fostering consumer trust in a physician was the insurance system, which diffused the doctor's charges among all policyholders. Hence, the individual consumer paid less attention to the possibility of physician overcharging or overprescribing of tests and visits. Last, the consumer lived in a world of free choice of providers. If a patient feared that a particular provider was advising too many diagnostic tests or unnecessary invasive surgery, he or she could seek out a different physician or other health care provider. Together, these three mechanisms – no incentive for underprovision of medical care, no fear of overcharging, and the option to change providers – were enough to counter the information asymmetry inherent in health care transactions and maintain consumer trust in providers and health insurance.'

6 During this period only 'essential' federal employees – uniformed military personnel and those personnel performing duties vital to national defense, public health and safety, or other crucial operations – reported to work.

congressional Republicans, who saw their public opinion ratings tumble (Marmor, 2000).

The legislative turmoil stemming from the debate over Medicare in 1995, together with an improving economy and President Clinton's landslide reelection in 1996, realigned political incentives for Republicans and Democrats. Rather than risk another government shutdown, leaders of both parties endeavored to reach a bipartisan compromise over Medicare and the federal budget (Palazzolo, 1999). The product of their pragmatic and conciliatory negotiations – the Balanced Budget Act (BBA) of 1997 – involved the subordination of Medicare payment policy to larger fiscal policy goals (Waxman, 2002), and set in motion renewed pressures on private purchasers to try to hold the line on the negotiating demands of providers that ultimately were to drive up insurance premium increases to their highest level in a decade (Gabel *et al.*, 2004).

Managed care reduces cost inflation and private payments

The impact of the implementation of the Medicare PPS in 1983 on inpatient costs and care has been extensively documented (Guterman *et al.*, 1988; Kahn *et al.*, 1990; Sloan *et al.*, 1988). The average length of stay for Medicare patients dropped by 20% almost immediately and continued to decline for several years (Rettig *et al.*, 1987). After early revenue windfalls – due in part to poorly calibrated initial payment rates – very limited increases in payment rates for the remainder of the 1980s resulted in declining profit margins for hospitals for their provision of Medicare services (Altman and Ashby, 1992; Guterman *et al.*, 1990). But because private purchasers continued to pay rates that were neither fixed nor aggressively negotiated,⁷ hospitals were able to offset their declining Medicare margins with improving private margins (see

⁷ Julian Pettengill interview with Rick Mayes, October 29, 2002: 'That's the funny part about it, the sort of ironic part about it, because it was not Medicare officials saying, "I know that the private sector isn't paying attention, so I can just hold down the rate of [Medicare payment] increases and I'll saw off this burden on someone else, you know, I'll force the hospital staffs to shift costs on private insurance." That's not what happened at all. What happened was that the hospitals were allowing their costs to increase, and ProPAC repeatedly made the judgment that costs were going up much faster than they should have and that Medicare shouldn't pay those increases. In other words, Medicare should hold those increases to those that were the legitimate results of changes in technology and real changes in case-mix and changes in input prices in hospitals and not to increase payment rates to accommodate the cost increases that hospitals were allowing to occur. Nevertheless, the hospitals didn't stop raising their costs, because the insurers in the private world simply were not paying attention. Actually, it's a little odd and it mischaracterizes the situation to say that the insurers weren't paying attention, because consider what the private insurance world looked like. It was some private insurers who were selling insurance to employers who were providing it to their employees and their families. But a lot of it was that they were doing the administrative work for employers who, under ERISA, were self-insured. So it wasn't just the private insurers selling traditional indemnity insurance, and so forth, who weren't paying attention. It was the employers who weren't paying attention too. And, indeed, why would one really expect them to? Would they understand at that level what was going on? Most of them didn't.'

Table 1. Hospitals' overall payment-to-cost ratio by payer, 1988–97

Year	Total Medicare	Total Medicaid*	Total Private Payer
1988	0.94	0.80	1.22
1989	0.91	0.76	1.22
1990	0.89	0.80	1.27
1991	0.88	0.82	1.30
1992	0.89	0.91	1.31
1993	0.90	0.93	1.30
1994	0.96	0.94	1.25
1995	0.99	0.94	1.24
1996	1.03	0.95	1.21
1997	1.04	0.96	1.18

Note: *Medicaid's payment-to-cost ratios increased dramatically after 1991 due to Congress' creation of the disproportionate-share hospital program, which provided significant subsidies to hospitals that treat a disproportionate share of poor patients (subsequently known as 'DSH' payments).

Source: MedPAC, 'Report to the Congress: Medicare Payment Policy' (June 2003).

Table 1 and Figure 3) and, overall, maintain their profitability (Guterman *et al.*, 1996).

Princeton health economist Uwe Reinhardt has referred to this phenomenon as a form of 'indirect taxation', whereby the public sector spreads 'its constrained budgets over more people by paying prices below fully allocated costs for the health it finances – a practice commonly known as 'cost shifting'' (Reinhardt, 1989: 19). In a written reply to a series of questions posed by the Senate Labor and Human Resources Committee, the American Hospital Association (AHA) stated that hospitals routinely extracted higher payments from their privately insured patients to make up for declining reimbursements from their publicly insured patients (US Congress, 1984).⁸ And according to Michael Bromberg, former president of the Federation of American Hospitals (which represents the investor-owned, for-profit hospital industry in the US), 'Hospitals absolutely cost shift, but HMOs took that away from us. Before HMOs, you could cost shift and insurance companies would just pass it on to employers' (Bromberg, 2002). This factor, along with others, contributed to the significant increase in private health insurance premiums between 1985 and 1992: by 150% in nominal terms and 45% in real terms (Feldstein and Wickizer, 1995).

⁸ US Congress (1984) at 187.

US Senate Finance Committee: How do hospitals finance uncompensated care?

American Hospital Association: The vast bulk of under- and uncompensated care is financed through charges paid by private insurers and individual patients ... A substantial part of the 'cost shift' is the private sector's contribution to the cost of treating those individuals not covered – or inadequately covered – by public programs.

In response, the bulk of private employers channeled their workers into managed care arrangements that, by the mid 1990s, covered roughly 75% of employees or approximately 100 million Americans – up from just 15 million in the mid 1980s (Bodenheimer and Grumbach, 1995). The limitations that managed care organizations placed on covered services – coupled with their use of selective contracting with medical providers willing to provide deep discounts – sent shock waves through the country's health care system. For the first time, negotiating leverage had shifted in favor of the purchasers of medical care rather than its providers. Employers' demands concerning cost growth for health insurance premiums became severe: 'no or low growth' became the marching orders for insurers (Thorpe, 1999).

The term 'managed care' only came into wide usage in the early 1990s, and encompassed a wide variety of organizational designs and reimbursement methods (Hacker and Marmor, 1999). As distinct from traditional indemnity health insurance, though, managed care essentially restricted patients' access to and choice of medical provider and established (through negotiation) pre-determined rates of payments to 'network' providers (McLaughlin, 1999). Unlike the world of indemnity insurance, patients in a managed care plan ordinarily had to select a primary care physician and obtain a referral if they wanted to see a provider outside of the plan (Gabel *et al.*, 2000). A managed care plan could take the form of a Health Maintenance Organization (HMO) or a Point of Service plan (POS) that, unlike the traditional restrictive HMO, allows members – with prior approval – to go outside of the plan's provider network to receive care from other medical providers without making members pay most of the cost.

Essentially, then, managed care organizations became effective 'managed cost' plans. A portion of the lower prices they received from negotiating with a limited number of participating providers (on behalf of a larger number of patients) was passed on as savings to employers or to employees in the form of expanded benefit packages or lower out-of-pocket costs (Halvorson, 1999).

Eager to attract market share and increase their revenues, managed care organizations promised to meet employers' demands. Two major consequences emerged from this new arrangement: (1) managed care organizations became employers' vehicle for cost control – in effect their purchasing agents – and, in the process, (2) employers shifted a large portion of financial risk to managed care organizations that could no longer simply pass along large, annual premium increases to employers (Thorpe, 1999). At the same time, the accumulation of more enrollment in managed care organizations provided them with greater negotiating leverage with providers.

Businesses were encouraged to steer their employees into more restrictive health plans by mandate and through restructuring their financial incentives. In other words, they either offered only managed care options or made their employees pay more for non-managed care, higher-cost policies (Bodenheimer and Sullivan, 1998). By 1996, slightly more than half of

all US businesses offered only one health insurance option to their workers, usually a managed care plan (KPMG, 1996). The effects were dramatic (see Figure 1). In 1996, premium growth was almost non-existent (Gold, 1999).

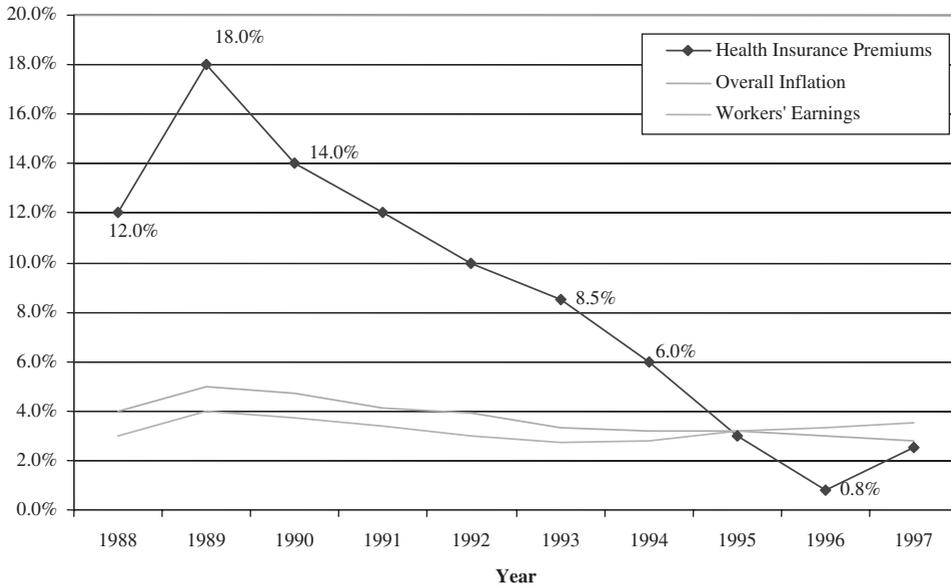
With the rise of managed care, hospitals' ability to cost shift (or price discriminate) to payers willing to pay higher prices rapidly dwindled (Gardner, 1995; Morrisey, 1996). In fact, one could characterize managed care as a kind of systematic suppression of differential pricing or price discrimination, as the managed care organizations *qua* purchasing agents prevented hospitals and physicians from summarily raising prices to meet their financial requirements. Instead of the average increase of 11% per year that hospitals had previously received from their private payers between 1986 and 1992, their payment-per-case actually *decreased* in real terms by an average of 0.7% per year between 1993 and 1997 (Gold, 1999). As a result, private payers' payment-to-cost ratio, an indicator of the extent of cost shifting, fell from a high of 131% in 1992 to 118% by 1997 (Table 1). With excess bed capacity widespread within their industry, many hospitals entered into multi-year contracts with private payers in the early 1990s in order to maintain their patient volume.⁹ Securing these contracts, however, required that hospitals agree to lower payments. 'A lot of hospital executives cut deals that they later came to regret', notes the American Hospital Association's Executive Vice President Rick Pollack (Pollack, 2002). Areas of the country that experienced greater managed care penetration saw significantly lower rates

⁹ With low marginal costs and public patients as half of their revenue base, hospitals' expenses have often chased their revenues. In other words, when Medicare payments increase, hospitals frequently expand their purchase of new technologies and other capital investments and, thereby, increase their overall operating expenses in the long run. For instance, according to former President of the Federation of American Hospitals and former Centers for Medicare and Medicaid Services (CMS) Administrator Tom Scully, Medicare's generous rate of reimbursement – especially of capital expenses prior to 2001 – often encouraged hospitals to expand their resources (sometimes unnecessarily):

Rick Mayes: Others I've interviewed have said that hospitals will cry, cry, cry [about their financial status and Medicare reimbursement], but that you have take it with a grain of salt sometimes.

Tom Scully: Oh, they're doing great! I'll tell you, go find me a hospital that hasn't built a giant new bed-tower in the last few years. They've actually slowed down, because the government has phased out Medicare capital (reimbursement) ... We used to pay for capital in Medicare; it was a DRG add-on for capital expenditures. Well, if you're getting 40 per cent of your revenues from Medicare and you want to build a new building and Medicare will pay for 40 per cent of it, right? Then, why not? So what you were getting all through the 1980s was a massive building spree up into the early 1990s and even through the '90s, because it was a 10-year phase out. If you wanted to build a new hospital wing in 1990 – even if you didn't have any patients for it – if you budgeted \$100 million, Medicare would write you a check for \$40 million! So what do you get? You got a hell of a lot of big new hospital wings, need them or not. This is one of the reasons we've had such massive over-capacity ... You'd have to be an idiot *not* to put up a new building every couple of years, because Medicare paid for such a big part of it. That is slowing down now and you're starting to see the demand catch up on capacity in a lot of markets.

Figure 1. Average annual percentage increase in private health insurance premiums, 1988–97
 Source: Adapted and modified from Mercer/Foster Higgins; Health Insurance Association of America/KPMG Peat Marwick Survey, (1998), C3; Annual Change in CPI from the US Dept. of Labor, Bureau of Labor Statistics.



of hospital cost growth, especially those areas with a high level of hospital competition (Bamezai *et al.*, 1999; Gaskin and Hadley, 1997).

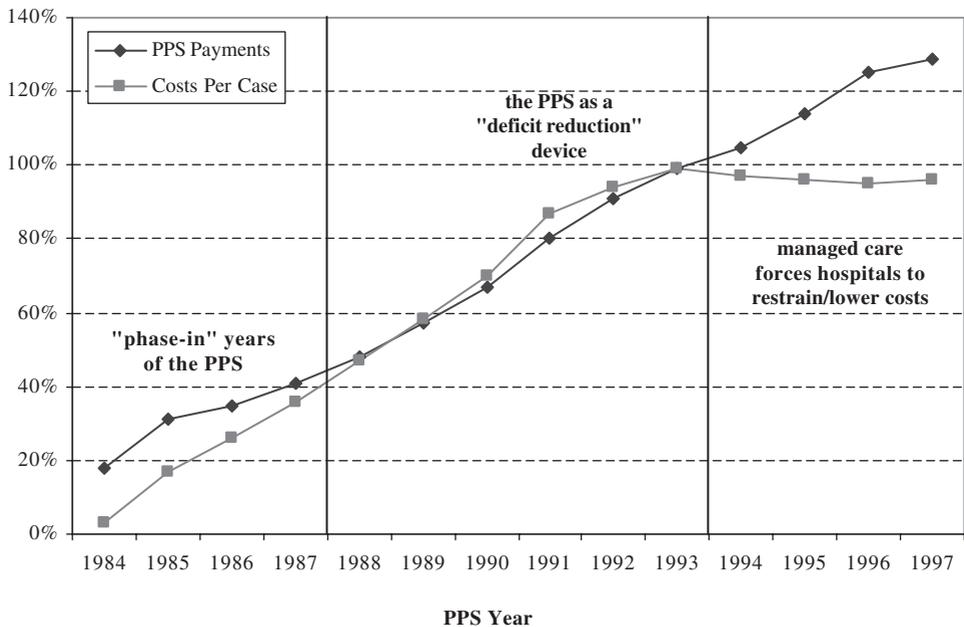
Hospitals restrain inpatient cost growth and shift more care to alternative locations

Constrained by Medicare PPS payments and squeezed by aggressive managed care price negotiation, financial necessity forced most hospitals to achieve substantial cost control. The industry as a whole held its overall cost growth down to an average of just 1.6% per year between 1994 and 1997, which resulted in Medicare's payment updates rising faster than the costs of treating the programme's beneficiaries (Figure 2).¹⁰ This phenomenon occurred during the

¹⁰ See Guterman (2000), 10–11: 'Another way of looking at this situation is to compare explicitly the pattern of cross-subsidies across sources of revenue over time. In 1992, hospitals received payments from private payers that exceeded their costs by \$29 billion. This more than offset the \$26 billion by which payments for Medicare and other patient care fell short of costs. Combined with \$8.8 billion in net revenues from other sources (including philanthropy, revenues from assets, etc.), hospitals realized \$11.8 billion in total net revenues, for a total margin of 4.6 per cent. In 1997, despite considerably slower cost growth, the surplus from private payers had fallen to \$20.3 billion—still substantial, to be sure, but a drop of \$8.7 billion from five years before. Medicare, however, had gone from a \$10.8 billion shortfall to a \$4.2 billion surplus. Therefore, although the private payer surplus still was much greater, the \$15 billion improvement in Medicare net revenue was crucial in offsetting the falling private payer surplus.'

Figure 2. Cumulative increase in medicare PPS payments and hospitals' costs per case, 1984–1997

Source: Adapted and modified from Stuart Guterman, 'Putting Medicare in Context,' Urban Institute, 2000, Figure 4.



mid 1990s, when Medicare was left untouched by budget cuts because Congress and the Clinton administration could not agree on how to curb the programme's rate of growth (Iglehart, 1999a).

Hospitals' success in reducing their cost growth stemmed primarily from two major strategies that they pursued: (1) restructuring their workforce, and (2) shifting a greater proportion of medical care away from inpatient settings. First, beginning around 1993–1994, hospitals set about reducing the size and cost of their salaried workforce (Bellandi, 1998). In particular, some replaced many of their registered nurses (RNs) and licensed practical nurses with less-educated, cheaper aides and clerks (Buerhaus and Staiger, 1999). Annual employment growth for RNs had averaged almost 4% between 1983 and 1994, nearly double the rate of employment growth among all occupations over the same period. But after 1994, employment growth for RNs slowed to less than 2%, and virtually all of it occurred in non-hospital settings (home health services, freestanding clinics, and nursing homes). Moreover, the deceleration in the rate of employment growth for RNs coincided with a noticeable decline in their earnings. RNs had previously experienced solid wage growth during the 1980s, but it leveled off between 1990 and 1994, and then fell 1.5% annually over the next three years (Buerhaus and Staiger, 1999).

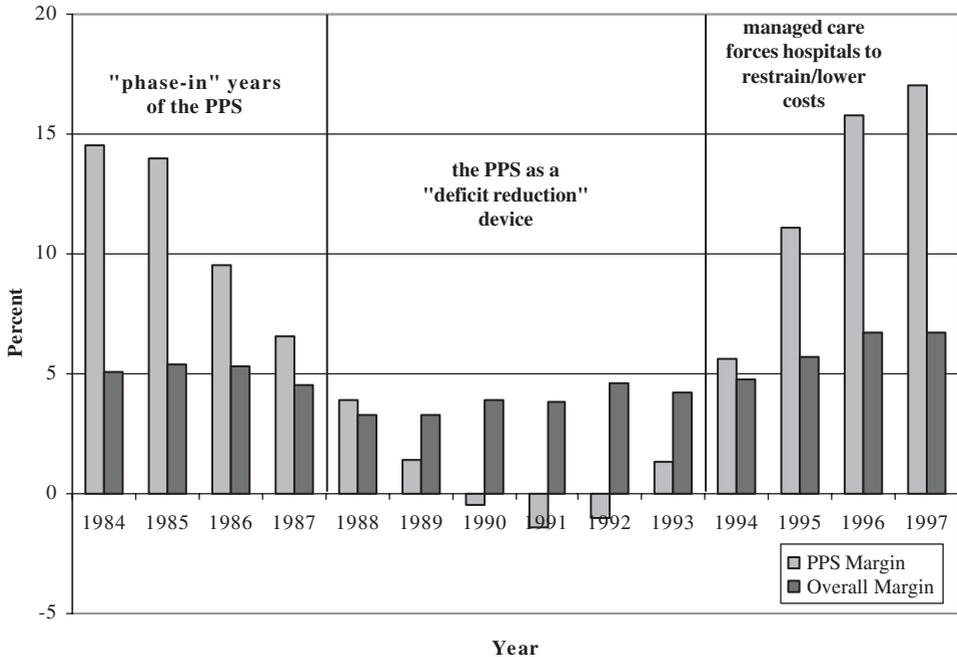
The hospital industry's other leading cost containment strategy was to shift the locus of patient care (Johnson, 1994). New developments in clinical techniques and technology – and the financial incentives to avoid hospitalization altogether or move patients through their stays more expeditiously – promoted expansion of alternatives to inpatient care. Hospitals expanded their ownership of post-acute services and shifted an increasing proportion of care away from inpatient acute settings toward cheaper settings (home health care, skilled nursing facilities, and rehabilitation hospitals) where less-regulated, cost-based reimbursement systems were still in operation (Newhouse, 2001). Facilitating this strategy were innovations in clinical technologies, including the development of many new, non-invasive surgical techniques that could be performed on an outpatient basis and, thus, precluded the need for hospital admission (Herzlinger, 1994; Wickham, 1994). Between 1990 and 1996, the number of outpatient visits increased by 46%, as the ratio of outpatient visits to inpatient days rose from 1.3:1 to 2.3:1 (Guterman, 2000).

The pressure and incentives to move patients through the hospital quickly – produced by the PPS – created a new set of cost concerns for Medicare by fueling the massive growth in spending on skilled nursing facilities (SNFs) and home health care, where payments continued to be retrospective, cost-based reimbursements (until the BBA of 1997 finally put a stop to that). Changes in payment policy interpretations, stretching back to the late 1980s, also contributed to this spending growth (Cotterill *et al.*, 2002). The number of SNFs grew 6.8% annually and the number of home health agencies grew 9.3% annually (Newhouse, 2001). Between 1988 and 1995, home health care experienced an enormous employment increase (168%), which made it the single fastest growing segment of the US health care system. The number of home health agencies skyrocketed from 5,663 in 1990 to 9,838 by 1996 (Mauser, 1996). 'It seemed every person in the state of Louisiana in 1996 opened a home health agency', joked former Administrator of the Centers for Medicare and Medicaid Services (CMS), Tom Scully. 'You just had tons of hospitals and individuals coming in and chasing the carrot' (Scully, 2002).

In the mid 1990s, Medicare spending on both skilled nursing services and home health care was increasing at the unsustainable rate of approximately 25% each per year (Vladeck and Miller, 1994). Half of the total projected increase in Medicare spending between 1996 and 2002 was accounted for by hospital outpatient, skilled nursing, and home health services combined, where prospective payment systems had yet to be introduced (Guterman, 2000). This shift away from inpatient settings led to a 30% reduction in Medicare patients' average length-of-stay between the early and late 1990s, as compared to a less than 10% reduction in non-Medicare patients' average length-of-stay during this same period (MedPAC, 1998).

Ultimately, the hospital industry reaped significant financial rewards from the changes it made in where care was being delivered, as well as in the incentives to move this care outside of the inpatient setting. By 1996, hospitals were

Figure 3. Hospitals' inpatient (PPS) medicare margin and overall margin, 1984–97
Source: Adapted and modified from MedPAC and American Hospital Association's Annual Survey of Hospitals, 2000.



enjoying their highest Medicare and in overall margins since the first two years of the PPS' operation in the mid 1980s (see Figure 3) (Weissenstein, 1995). Between 1994 and 1997, while the industry's rate of cost growth increased only 1.6% per year, Medicare's average annual increase in spending per beneficiary was a comparatively generous 4.7% (Wilensky and Newhouse, 1999). As a result, by 1997, 'Health care providers were all way overpaid by Medicare', argues Scully (Scully, 2002). Medicare fees were higher than average managed care fees in more than a quarter of procedure codes (Meyer, 1997). It was not surprising, therefore, to find articles in hospital trade industry journals entitled 'Changing tunes: no more 'whining for dollars' by Healthcare Lobbyists in Washington' (Weissenstein, 1996). By 1997, the hospital industry's profits were such that they didn't need to whine. The financial health of the private sector managed care industry, however, was another matter, as its cost trends were clearly out of sync with Medicare's experience.

The beginning of the managed care backlash

The origins of managed care's problems and growing unpopularity in the mid 1990s were principally financial. In the early years, managed care

organizations found it relatively easy to lower patients' hospital use and obtain significant discounts from medical providers worried about their loss of patient volume if they were not included on managed care plans' networks of 'participating providers' (Feldstein, 2003). The discounts were necessary for managed care plans to make a profit and also to pass on some savings (or slower increases) in premiums to employers to demonstrate their value as purchasing agents. But the ability of managed care organizations to continue lowering hospital use and to obtain discounts from medical providers proved harder as time went along. There were fewer 'one-time' cost savings to be had (Kertesz, 1996). Nearly 90% of all HMOs were profitable in 1994, but slightly less than half were by 1997, and the average profit margin by then was only 1.2% (Gold, 1999). When the price of health care services invariably went up – while employers' contributions remained flat – many managed care organizations turned to unpopular strategies in order to remain profitable and keep their contracts with employers. They limited or eliminated coverage for many medical services and increased employee cost sharing in the form of higher deductibles and co-payments (Titlow and Emanuel, 1999). In effect, the lowered premiums, enriched benefit packages, and reduced cost-sharing characteristic of early managed care products could no longer be 'financed' by provider discounts.

Consequently, the mid 1990s marked a sea change in the public's perception of managed care (Iglehart, 1997a). Frustrations became commonplace among the general public (Blendon *et al.*, 1998). 'Drive-through deliveries', in which new mothers were limited to 24-hour maternity stays in the hospital, became a leading symbol of managed care's myopic focus on the financial bottom-line. Nitpicking utilization reviews and outpatient mastectomies added additional fuel to the public relations fire. Managed care achieved what everyone considered was necessary cost control, but in the process it demonstrated that cost control was inherently unpopular with both medical providers and the general public. Moreover, contracting and care restrictions in managed care – discharging patients 'quicker and sicker' and forcing them to poorer quality facilities long distances from their homes – led to reports of serious quality problems (Hellinger, 1998; Mitchell and Schlesinger, 2005).

Consumer and physician agitation eventually led to legislative action. By the end of 1996, 35 states had passed laws restricting HMOs and Congress had enacted the Health Insurance Portability and Accountability Act, which made the federal government significantly more involved in regulating and setting stricter standards on private health insurance (Bodenheimer, 1996). The backlash was 'classic American populism', argues health policy scholar James Morone, whereby 'a frightened middle class denounces greed in the face of a new economic order' (Morone, 1999). When increasing numbers of physicians joined in, the strength of the backlash shook the managed care industry. In

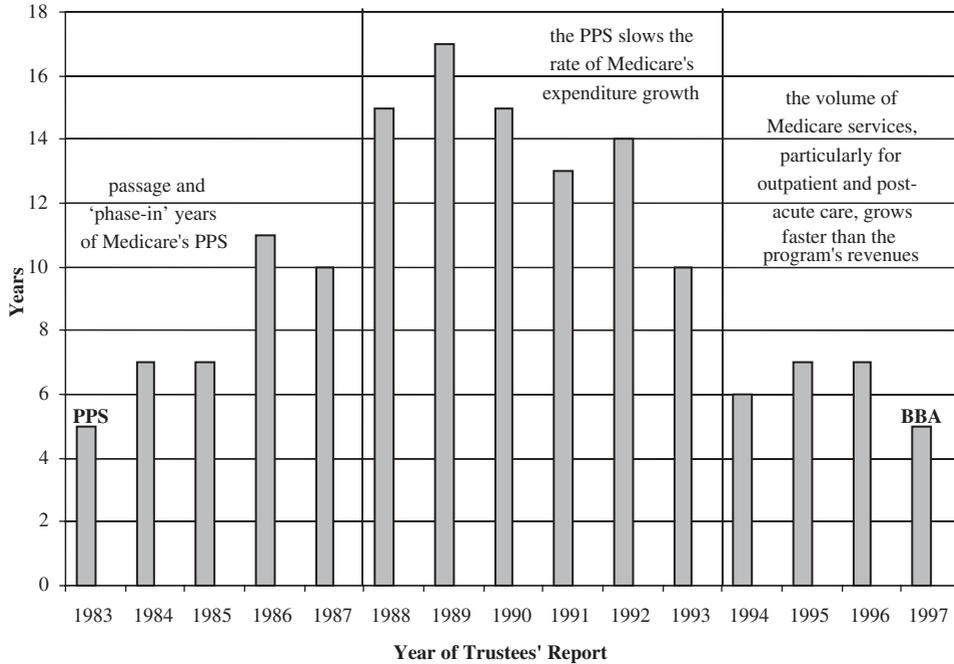
December 1996, the American Association of Health Plans, which represented managed care organizations, issued new voluntary guidelines, 'including steps to curb the use of gag clauses in contracts with physicians'. The guidelines also encouraged health plans 'to provide their members with information on how their doctors are paid, including any financial incentives' (Iglehart, 1997b).

By 1997, managed care organizations were struggling to overhaul their public image, defeat government efforts to increase regulation, and remain profitable (Kertesz, 1997). President Clinton appointed a 34-member, bipartisan advisory committee to draft a 'Consumer Bill of Rights and Responsibilities'. The committee's report in November of the same year did not lead to legislative passage, but it did contribute to the managed care industry's continued decline in public opinion (Rice, 1999). The loss of public support also brought into sharper focus the transformation in ownership that had been occurring for some time in the managed care industry, as it became increasingly controlled by regional and national commercial carriers and less influenced by traditional HMOs that had their origins in prepaid group practice or consumer cooperatives that had remained predominantly not-for-profit (Gold, 1999). In September, three prominent not-for-profit HMOs (Kaiser Permanente, the Health Insurance Plan of Greater New York, and Group Health Cooperative of Puget Sound) turned against the for-profit members within their industry and endorsed greater federal regulation of managed care (Kuttner, 1998). Finally, the downward trend in health insurance cost increases eventually ceased (see Figure 1). In 1997, insurers and managed care organizations raised their premiums more than they had the previous year in response to growing profitability pressures and government requirements for expanded benefits (Gold, 1999).

As the country's honeymoon with managed care came to an acrimonious end, Medicare and its financing reemerged on the political agenda. After winning reelection in late 1996, President Clinton was ready and eager to leave a major legacy: the first balanced budget in thirty years. What the president and Republican leaders in Congress already knew, based on previous legislative experience, was that the only means by which they could achieve this goal was to return to using Medicare as a huge 'cash cow'. Given the size of Medicare expenditures, any significant budgetary savings would – as many times before – have to come from substantial reductions in future Medicare spending. Unfortunately, the programme did not appear to have surplus funds to share. Medicare's Trustees came out with their annual report in 1995 showing that the programme's hospital trust fund would run out of money by as early as 2002 (Social Security Administration, 1995). Major changes in Medicare payment policy – the PPS in 1983 and the BBA in 1997 – often seemed to be triggered by actuarial threats of Medicare nearing insolvency (see Figure 4).

Figure 4. Number of years until medicare Part A's trust fund insolvency (intermediate projection), 1983–97

Source: Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *Annual Report* (Washington, D.C.: Government Printing Office, 1983–1997).



The BBA: using patchwork legislation to achieve multiple health and fiscal policy agendas

Republicans in Congress seized upon the Medicare Trustees’ 1995 report as an opportunity to try to dramatically change Medicare, while, at the same time, balancing the federal budget and providing tax cuts. Fresh from defeating Clinton’s ambitious attempt at comprehensive health care reform and an enormous electoral victory in fall 1994, in which Republicans gained control of both the House of Representatives and the Senate for the first time since 1954, Republican congressional leaders proposed \$270 billion in Medicare spending reductions over seven years as part of a ‘Save Medicare’ campaign. President Clinton countered with \$128 billion in projected Medicare spending reductions. An impasse developed with Republican charges of demagoguery against the Democrats and Democratic charges of Republican heartlessness (Marmor, 2000).

Clinton’s veto of the Republicans’ Medicare and other budget legislation triggered a nearly complete shutdown of the federal government in late 1995. He emerged the political winner from his battle with House Speaker Newt Gingrich and his colleagues after public opinion turned against the Republican Party

(Smith, 2002). Polls showed that the public viewed Clinton and the Democratic Party as the defenders of a beloved government programme (Rushefsky and Patel, 1998). When Clinton won reelection handily in late 1996, any desire for continued partisan conflict disappeared. In its place emerged a broad bipartisan desire to achieve a balanced federal budget and to ‘save’ Medicare (Oberlander, 2003). This ostensible salvation of Medicare could be accomplished either by major reductions in payment levels or by refinement in payment methods (or both, as events were to prove).

In August 1997, Clinton and Congress enacted some of the most extensive Medicare reforms in the programme’s history through the passage of the Balanced Budget Act (BBA) (Iglehart, 1999b). The BBA called for \$115 billion in budgetary savings from reductions in future Medicare spending between 1998 and 2002.¹¹ The figure was just slightly less than half of the BBA’s total projected savings, despite the fact that Medicare only constituted 12% of federal spending (Iglehart, 1999b).

The BBA involved Medicare payment policy’s subordination to policy makers’ larger fiscal goals. According to powerful Democratic Representative Henry Waxman, ‘the Clinton administration and congressional Republicans used Medicare *strictly* as a piggy-bank’ (Waxman, 2002).¹² Nancy-Ann DeParle, a senior Clinton health policy advisor, elaborates:

We looked at five or six different factors [with regard to changing Medicare]... The first one was *not* what was happening with health care spending or, particularly, what was happening with Medicare spending. The thing that drove us to the [bargaining] table was the overall level of the federal budget deficit. That was the number one thing we thought about in looking at health care policy. I’m not sure I agree that that’s what we should have been thinking about, but that was what precipitated the discussion. (Academy-Health, 2002)

As long as leading Medicare analysts and members of Congress were persuaded that hospitals’ overall margins were positive – and they were the best they had been in a decade (see Figure 3) – they generally felt comfortable manipulating Medicare’s payment policy to suit larger budgetary purposes, regardless of what corresponding impact this might have on private purchasers of services.

11 Smith (2002): 192: ‘Over half of the total [\$115 billion], nearly \$60 billion, would come from hospitals, cuts in the physician fee schedule, and leaving the Part B premium contribution at 25 per cent. Net savings from managed care plans were scored by the CBO at \$18 billion, with almost 90 per cent of that expected to result from lower growth rates in FFS Medicare, from which the capitation rates would be calculated.’

12 Waxman interview with Rick Mayes: ‘I voted against the Balanced Budget Act and there weren’t too many of us who did that. It sounded so popular to balance the budget, but the budget was going to be balanced even if we didn’t pass any legislation. The only reason that deep cuts were made in the Medicare program was to pay for a tax cut, and that was to satisfy the Republicans who wanted the tax cut and the Clinton administration that wanted to say that they passed legislation, so they were going to triangulate the issue and get this balanced budget issue off the table.’

The changes to Medicare were primarily budget-driven, but they were also policy-driven refinements to a lesser extent (Young, 2002).¹³ ‘There was considerable evidence that spending in some sectors of the programme had been increasing at annual rates – 20 to 30% – that many of us thought were unsustainable for Medicare’, added DeParle. ‘So that was another big focus of our effort – to look at what we should be doing with Medicare as part of this Balanced Budget Act’ (AcademyHealth, 2002). In addition to reducing future payment increases for important provider types – including hospitals, home health agencies, and skilled nursing facilities – the Balanced Budget Act of 1997 substantially altered the framework of the Medicare programme by mandating new payment systems for post-acute care providers that would nearly complete Medicare’s shift from cost- and charge-based reimbursement to prospective payment systems. And these new systems were to take effect quickly, because future savings estimates were contingent on their prompt enactment.

The experience with Medicare’s payment reforms for hospitals and its fee schedule for physicians had made the concept of prospective payment seem easy. ‘Prospective payment had become a magical phrase for “cost control”’, recalls Stuart Guterman, a senior official at the time in the Health Care Financing Administration. ‘All you had to do was develop a prospective payment system and assume that you were going to be able to save a ton of money on Medicare payments. The problem was that we knew a lot more about hospital and physician services, when we put them into prospective payment systems, than we knew about most of Medicare’s other services’ (Guterman, 2002). The new systems on nursing homes and home health agencies were far less developed and more likely to create disruption in those industries, as these providers struggled to deal with reversal of incentives in converting from a retrospective payment system.

The Balanced Budget Act’s ‘Medicare+Choice’ Programme

Ironically, another prominent feature of the 1997 Medicare reforms was policy makers’ creation of ‘Medicare+Choice’. Republicans’ broad vision was to dramatically increase the number of Medicare beneficiaries in participating (private) managed care plans (Biles *et al.*, 2002). The concept of shifting financial risk away from the government by moving Medicare beneficiaries into private

¹³ Donald Young interview with Rick Mayes, October 11, 2002: ‘And that’s where ProPAC played a very important role in looking at the options: “Well, if we did this, what would happen to the margins? If we titrate the teaching adjustments at this level and do the DSH changes, what would happen to different groups of hospitals?” We even got into things like the New York delegation wanting to know what would happen to New Jersey hospitals and those kinds of things. So ProPAC played a big role. The Hill [Congress] had budget numbers that they wanted to get and they were back and forth with CBO in scoring the various proposals. In looking at their options, they had us do a lot of the simulations of what the impact would be for this and that change. There was not only PPS for hospitals; it was also SNF [Skilled Nursing Facilities] and Home Health and Rehab and all of these other parts.’

managed care plans originated in the early 1970s, but the enrollment in such plans had been trivial. Moving Medicare beneficiaries into private managed care plans gained additional momentum with the 1982 Tax Equity and Financial Responsibility Act,¹⁴ which mandated that HMOs would be paid 95% of the adjusted average per capita payments made for Medicare beneficiaries in each county, with plans being allowed to keep the difference between the cost of care and the amount of payment (Berenson and Dowd, 2002). HMOs were allowed the normal level of profit, or retained earnings, they customarily received in their private sector products. Under this payment methodology, the Medicare HMO programme expanded greatly, especially in the early to mid 1990s.

By 1997, there were 5 million Medicare beneficiaries enrolled in various managed care plans, 14% of the programme's total population (Biles *et al.*, 2002). Republicans had ambitions to significantly increase that number and make progress on four separate goals: (1) expand beneficiaries' health care choices, especially in geographic areas not yet served by HMOs, (2) provide additional benefits, such as prescription drug coverage, (3) restrain the growth of federal Medicare spending by encouraging competition among private health plans, and (4) reduce the need for direct government regulation of provider payment policies (Scully, 2002).

The Balanced Budget Act provided a redesigned payment formula that was intended to address earlier payment methodology problems that had resulted in significant geographic disparities, with most enrollment being clustered in counties where payment rates to HMOs were very high and plans could purchase care for their members at lower costs (Hurley *et al.*, 2003). The main thrust of the BBA formula was to increase payments to private HMOs in areas of the country with low payment rates based on fee-for-service spending,

14 Former US Senator David Durenberger interview with Rick Mayes, July 26, 2002: 'Because of Senator John Heinz's Amendment to create the TEFRA 'Risk-Contracts' for Medicare and HMOs, we had a huge explosion of Medicare reform across the northern part of the United States in 1985, '86, '87, and so forth. In other words, this was the privatization of Medicare. It worked beautifully except for the fact that we in Washington kept all of the savings gained from the changed behavior of the doctors and the hospitals. And without rewards for good behavior, the HMOs ran out of money and they said, "The hell with it." And it just went back to where managed care, then, tried to beat up on the hospitals and doctors. But they [the managed care organizations] lost, so we're now back to the future. But that was really critical. It was Minnesota; Portland, Oregon; Rochester, New York; Utah; Hawaii, places all the way across the country where they grabbed these HMO-like contracts, made them work in their communities to spill over onto fee-for-service and then drive down costs. But instead of allowing the health plans to keep the savings and put them into something else, we took it all back. But it all began with Medicare's HMO demonstration projects, which got approved, I think, in the late '70s and I know for sure in the early '80s, because places like the Marshfield Clinic, InterMountain, people up here in Group Health in Minnesota, got risk-contracts to deliver Medicare via HMOs. At the same time, four places in the country were experimenting with Social HMOs, which are combinations of Medicare and Medicaid for the elderly or disabled. And so [Senator] John's Amendment in '82, in effect, required HCFA to move those from demonstrations to just opening them up across the country or at least the HMOs for Medicare. It put them at risk for 95% of the AAPCC [adjusted average per capita cost] and that's why they're called Medicare Risk Contracts.'

while (at the same time) limiting increases in HMO payments in relatively high-payment counties, thereby compressing the range of payments and theoretically unlinking ‘Medicare+Choice’ payments and county-level spending for the fee-for-service part of the Medicare programme (Berenson and Dowd, 2002).¹⁵

The multiple agendas of the Balanced Budget Act fostered an internal paradox within the legislation and led to many unanticipated effects. This paradox of greater regulation coming with more market involvement, however, was neither new nor surprising; it reflected standard practice in the US health sector for the last two decades. In short, the BBA represented a historic milestone by virtue of its aspirations for a significant expansion of private, managed care elements within the Medicare programme. Yet it also continued the process of moving Medicare closer to a government-controlled, single-payer model by calling for the development of prospective payment systems for Medicare’s remaining cost-based service components. As Jonathan Oberlander explains:

These new regulatory reforms, as well as reducing payments to providers under already established regulations, generated the savings in programme spending, not the procompetitive elements of the legislation. In this the BBA echoed a familiar theme from Medicare politics during the 1980s. In 1997, as in 1983, when the prospective payment system for hospitals was adopted, the rhetoric was all about markets and competition. But the reality was that the savings were all from regulation. The secret of the BBA was that the move to competition was not projected to save Medicare any money. Given budgetary pressures for Medicare savings, Republicans and Democrats once again embraced more regulation and lower payments to providers as the best way to achieve short-term budgetary goals. (Oberlander, 2003, 183)

Using Medicare reform (again) for larger budgetary purposes meant another round of *increasing*, rather than decreasing, government regulation in the form of new prospective payment systems. Nevertheless, in terms of what the Congress set out to accomplish – balance the budget largely by reducing the rate of increase in Medicare spending – the BBA’s new payment policies were a remarkable success (Levit *et al.*, 2000; Meara *et al.*, 2004; Murtaugh *et al.*, 2003).

Another paradoxical aspect of the Balanced Budget Act is that the ceiling it instituted on payment increases to HMOs in markets with high rates of payment caused many HMOs to pull out of the programme and reduce their benefits. Moreover, future increases for all HMOs were smaller than initially anticipated, because the BBA’s success in reducing payments to providers in the Medicare programme meant that the payment base for HMOs grew more

¹⁵ Berenson and Dowd (2002): 13–14, ‘This was accomplished through a formula establishing: (1) a floor payment rate, representing a minimal payment level that all plans were guaranteed, even if actual county FFS [fee-for-service] spending was lower; (2) a minimum update guarantee applied to the previous year’s rate, which, in most subsequent years, has been 2 per cent; and (3) a blended rate combining a national rate and the local rate, representing the county-level 1997 payment rate trended forward by a national update factor.’

slowly (Hurley *et al.*, 2003). Congress had for a long time based its payments to HMOs in the private sector on what it was spending on the traditional Medicare programme in the public sector. Thus, by doing so well in decreasing payments to hospitals, physicians and other health care providers (such as home health agencies and skilled nursing facilities), Congress inadvertently reduced payments to HMOs just as they were losing control over their expenses (Beren-son, 2001). In 1997, health care inflation began rising again at twice the rate of consumer price inflation, and by the late 1990s growing numbers of HMOs were teetering on the verge of bankruptcy (Cutler, 2005). Once again, the lack of synchronization between public sector and private sector cost containment came into play and – in the case of Medicare’s efforts to rely on private sector managed care – this proved to be particularly self-defeating.

Conclusion

The mid 1990s marked a temporary transition for the US health care system, in which the balance of power *appeared* to move away from the providers of medical care toward its purchasers, first public (Medicare) and then private (insurers). The paradigm shift to various forms and styles of managed care did not ‘corporatize’ American medicine in the sense that the majority of hospitals and physicians switched to ‘for-profit’ status. But the US health care system did take on a far more corporate orientation, due in large part to the increased competition and imposition of administrative controls associated with managed care (Bazzoli, 2004; Casalino, 2004).

Managed care seemed to address successfully, for a time, the two main problems with traditional indemnity health insurance: (1) the ‘moral hazard’ problem, whereby insured patients received excessive medical care because virtually all expenses were reimbursed, and (2) the ‘demand inducement’ problem, in which physicians and hospitals tended to oversupply medical services and technology for the same reason (Feldstein, 2003). The success of managed care, however, turned out to be short-lived. In their ongoing efforts to control costs and remain profitable, the behavior of many managed care organizations triggered a populist backlash. Public and provider disenchantment with corporate-style medical care was not inevitable, but it did prove to be relatively swift (Havighurst, 2004). Managed care ultimately came to be seen as a failed mechanism for controlling costs in the US health care system, as medical providers regained leverage relative to managed care plans and rapidly increasing health care cost inflation returned (Ginsburg, 2004; Robinson, 2001).

For a period during the mid 1990s, however, the hospital industry managed to achieve extraordinary cost control. Beginning in 1994, hospital cost inflation fell for four consecutive years and bottomed out in 1997 at less than 2%. Apart from 1973 (when President Nixon’s price controls were in effect), this represented the only year on record in which hospital cost inflation was lower than

general economic inflation (Feldstein, 2003). The industry's success at reducing the cost of its workforce, exploiting new technologies, and shifting an increasing proportion of care to less expensive outpatient and post-acute settings led to sizeable financial gains. By 1997, hospitals' Medicare and total margins were even bigger than they had been in the first two years of the PPS' operation (Figure 3).

Thus, when the Clinton administration and Republican leaders in Congress sought to achieve a balanced federal budget, playing with Medicare's payment policy became the prime means (again) of generating enormous savings. Similar to the many budget reconciliation acts that preceded it, the Balanced Budget Act's significant deficit reduction came largely from cuts in future Medicare payments to medical providers. Most policy makers were not overly concerned about the effects of these reductions because, by 1997, market forces appeared to have tamed medical inflation and made medical providers more efficient. Hospitals and other medical providers seemed to be in a position that they could take a modest financial 'hit'. As a result, Medicare was once again used as one of policy makers' most effective deficit reduction devices. As subsequent events were to prove again, however, private purchasers and their managed care agents would soon be expected to pay much higher prices for their services, given the symbiotic relationship they enjoy with the Medicare programme (Gabel et al., 2004).

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