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Cost Containment and the Politics of Health Care Reform

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As the diverse array of viewpoints expressed in the foregoing chapters makes clear, “health care reform”—even with the more specific goal of cost containment—means different things to different people. As a political catchphrase, health care reform garners nearly universal support, since individual observers view the issue through the lens of their own policy preferences. In virtually every federal election since the 1960s, the “health care issue” has polled near the top of the public’s concerns.

Despite this fact, precious little that most serious analysts would consider reform actually seems to get done. While our political system has shown a willingness to busy itself about the margins of programs of public-sector health care financing, efforts to reform the broader health care financing and delivery systems have proven largely ineffectual despite nearly universal support, at least in the abstract, for such efforts.

To understand why this happens, we trace what we believe are the major impediments to large-scale reform through the last two decades of national political experience and then offer our conclusions, in light of this experience, about what needs to happen to make successful reform occur.

The Legacy of the Clinton Reform Plan

Two vivid images stand out from the early years of the Clinton administration. The first is “It’s the economy, stupid,” the mantra of the 1992 Clinton presidential campaign. Slowing the growth of health care costs was central to Clinton’s strategy for restoring the nation’s economic health. Second is President Bill Clinton lifting his pen before a joint session of Congress, emphatically asserting his commitment to veto any health insurance legislation that failed to provide universal coverage. Costs and coverage were integrally intertwined in the Clinton administration’s health reform. This is a political as well as a policy relationship, driven by the reality of health care financing—that unless there is a willingness to spend more money, it is not possible to cover the uninsured without placing restrictions on the already insured. This reality stalled movement toward national health insurance after Medicare’s enactment, simultaneously motivated and doomed the Clinton health reform plan, and not only impedes efforts to expand coverage today but actually contributes to its demise. This section reviews the emergence of the cost-coverage connection in the 1960s, illustrates its role in both motivating and destroying the Clinton plan, and examines the political stalemate it creates today.¹

The Buildup to Reform

The social insurance activists who designed Medicare saw its 1965 enactment as a step—hopefully a large one—toward national health insurance, modeled on Social Security. Instead, Medicare’s (and with it Medicaid’s) enactment established an institutional and fiscal path that impedes, rather than facilitates, universal coverage.

As institutions, Medicare and Medicaid are the public side of a public-private partnership that insures 85 percent of Americans. This insured population powerfully resists changes to the existing structure, which systematically excludes the low- and modest-income uninsured. The private side of that partnership emerged in the 1940s and 1950s, as multiple forces combined to produce employer-sponsored health insurance:

—the labor movement’s shift from national politics to collective bargaining as the way to gain health insurance;

—business interests’ preferences for fringe benefits over government-run (or labor-organized) health insurance;

—insurance industry capacity for and interest in providing those benefits; and

—administrative action, backed by legislation establishing tax preferences—most important, the exclusion of employer-paid premiums from employee taxable income—that subsidized employer-sponsored health insurance.²

Establishment of employer-sponsored health insurance, in turn, created a case for adding public health insurance for the nonworking population. Beginning in the 1950s, national health insurance advocates shifted their attention away from the general population and toward the elderly—a politically attractive group “deserving” of public protection and unlikely to be reached by work-based or other private health insurance. The political compromise that established Medicare as universal social insurance for the elderly also established Medicaid as means-tested health insurance for certain population subgroups—specifically, low-income persons who received cash assistance because of age, blindness, disability, or (in the case of children living with single mothers) “dependency” status.³ The result was creation of a public health insurance system targeted to people not expected to work and built around the private, albeit tax-subsidized, insurance system for workers and their families.

Employer-sponsored health insurance expanded dramatically to cover a growing share of workers and their families through the 1970s. But then growth stopped. The numbers—and the proportion—of working-aged Americans without health insurance coverage have grown steadily from that time forward.⁴ Even when the economy is booming, employer-sponsored insurance fails to reach millions of low- and modest-wage workers in both large and small firms.

The public health insurance system also grew in the second half of the twentieth century. Very shortly after its enactment, Medicare extended coverage to disabled beneficiaries of Social Security and people with end-stage renal disease.⁵ And although its coverage was immediately narrowed, Medicaid has grown enormously and is now the nation’s largest insurance program, covering more than 50 million people. In the 1980s and early 1990s, growth came primarily through the extension of eligibility standards

beyond cash assistance standards for children and pregnant women. More modestly and more recently, growth came through the 1996 enactment of the State Children's Health Insurance Program. Medicaid covers the low-income aged and disabled persons, but the bulk of its enrollees are children and, to a much lesser extent, their mothers. For the most part Medicaid excludes low-income workers.⁶

Overall, employer-sponsored insurance and the public programs designed primarily for people outside the workforce—Medicare and Medicaid—cover about 85 percent of our population. However, by their explicit structures they exclude people who work but who are not offered health insurance through their jobs and who, primarily because they work, remain outside the categories covered by public programs.

Why is that a barrier to coverage expansions? Although it is true that any person can fall out of employer-sponsored coverage—by, for example, losing a job or getting divorced—the vast majority of Americans can count on receiving health insurance through the workplace. The primary political and policy problems are that it is almost impossible to insure the “have-nots” without in some way disrupting the status quo of the “haves.”

The fiscal path established with the nation's public-private insurance system is at the core of that disruption. This system has fueled an escalation of health care costs that not only strains the nation's economic and political capacity to guarantee universal coverage, but it also threatens to unravel the coverage Americans already have. The fault lies not with the public programs—rather, the problem is intrinsic to insurance. Protecting people against the costs of illness (the fundamental purpose of insurance) removes sensitivity to price as a constraint on care. Unless insurers, public or private, find ways to constrain what they pay, costs are destined to rise—whether through support for technology that demonstrably improves the public's health or through inefficiency and waste in the system.

Despite payment reforms that have made Medicare, if anything, more effective than the private sector in containing costs, the “crisis” of rising health care costs first declared in 1972 by President Richard Nixon persists today.⁷ Clearly, the “cost crisis” comes from service to those who have health insurance, not from those who do not. But rising costs create

an enormous barrier to coverage expansion. First, rising health care costs contribute to growth in the number of uninsured, as premiums become less affordable to employers and individual purchasers.⁸ Second, rising costs raise the political, as well as the economic, costs of political action to expand coverage. The full cost of employer-sponsored coverage of a typical family is now more than \$11,000 per year.⁹ If comparable insurance were available to individuals outside employment, it would absorb more than 20 percent of income for the bulk of the uninsured. Virtually every health insurance expansion proposal, regardless of its form, recognizes that the cost of health insurance is too high to expect the uninsured to purchase it without subsidies. Higher health care costs mean more expensive subsidies, which increase the resources that must inevitably be shifted from those who have health insurance to those who are without.

This redistribution has always been a hard sell, and it gets harder the more it costs and the more the better-off insured have to pay for their own health insurance and health care. Politically, the uninsured are held hostage to the unwillingness of the insured to control their health care costs. The Clinton experience is a good example of this situation.

The Clinton Coverage Strategy

Reluctance to disrupt Americans who have health insurance, whether through redistribution or changes in health care that universal coverage might bring, has inhibited most politicians from directly taking on displacement. The Clinton health reform proposal focused at least as much on those who had health insurance as on those who lacked it and assiduously tried to avoid private-to-public coverage shifts.

Cost containment was the motivator and the linchpin of this strategy. Clinton saw slowing the growth of health care costs as essential to achieving the critical goals of balancing the federal budget and growing the economy. Universal coverage became part of that strategy—necessary to ensure that slower spending came not from reductions in coverage, or shifts in costs from one payer to another, but instead from greater efficiency in purchasing care. The fundamental challenge in achieving this strategy was finding a way to cover everyone, including the then 37 million uninsured, while also slowing health care spending in general and avoiding increases in public spending in particular.

The Clinton health plan built universal coverage by securing and extending existing employer-sponsored insurance through an employer mandate. All employers would have been required to provide coverage for their workers at benefit levels that matched those held by the well-insured. This mandate aimed to appeal to the currently covered in two ways. First, the requirement that employers provide comprehensive coverage secured the health benefits that workers were afraid of losing in a weak economy. Second, because most of the uninsured were working, the mandate meant that employers and employees would bear the immediate responsibility for paying for the expansion without having to impose new taxes on the already-insured.¹⁰

The Clinton proposal also contained an approach for financing subsidies for lower-income families without imposing new taxes.¹¹ Public funds to finance these subsidies—and others included in the proposal, such as those to finance coverage for the minority of uninsured persons outside the workforce—would have been generated through aggressive cost containment, which would produce savings in federal health programs that could be reinvested. It was estimated that slower growth in health costs would reduce projected federal spending (which was most important for Medicaid) and also would reduce federal revenue losses or “tax expenditures” for employer-sponsored health insurance.¹² Lower-than-projected public expenditures and higher-than-expected tax revenues made room in the federal budget to finance the new subsidies that were essential to the success of the Clinton plan.

To gain sufficient room in the federal budget, growth in health care costs had to be held to levels of general inflation—a level never previously achieved. The Clinton administration advocated “managed competition” for this purpose. Specifically, the proposal sought to guarantee everyone 80 percent of the average cost of a choice of health plans, all of which offered a guaranteed scope of benefits and uniform cost sharing. These competing plans would be made available to consumers through newly structured and highly regulated insurance markets, labeled “alliances.” Consumers—either directly or in very large firms through their place of employment—would shop for, and financially benefit from, selecting a lower-cost plan. The theory was that insurers would compete for consumers by keeping their costs down. Prohibited from competing on

benefit levels or by avoiding high-risk enrollees, plans would be forced to compete by securing efficient delivery of quality care.

Under the congressional budget rules then in place, the Congressional Budget Office (CBO) was responsible for determining whether the Clinton proposal provided sufficient financing to cover its costs. CBO did not share the high expectations of the Clinton administration and other proposal proponents for cost containment through managed competition. Avoiding the need for new revenues and satisfying CBO required including what the proposal designers saw as a “backup” mechanism: caps on the rate of growth in insurance premiums, enforced through reductions (as necessary) in provider payments.

Mandatory contributions from employers and individuals, accompanied by aggressive cost containment to produce federal budget savings, enabled the Clinton administration to claim that it guaranteed health insurance to all Americans at no new federal cost and that over the next 10 years it would actually lead to lower health care costs for the nation than would have occurred in its absence.¹³

The administration believed this strategy would not only create a healthier nation; it would overcome the long-standing political obstacles to reform posed by resistance to redistribution from and disruption of the already-insured. But the Clinton strategy was no more successful than previous national health insurance efforts at avoiding controversy about disruption and redistribution. Interest groups for whom cost containment meant revenue loss joined forces with ideological opponents of the Clinton reform to support a massive lobbying campaign against its enactment. That campaign successfully reframed the health reform debate, shifting attention from the benefits to the risks of reform, making it safer for politicians to support the status quo.

Rather than being welcomed as simplifying and securing private coverage, the Clinton proposal’s new insurance markets were attacked as big government interference with employer-sponsored insurance. Rather than being applauded for reducing the growth of health care costs, the Clinton proposal’s cost containment was criticized as rationing care. Rather than making everyone a winner, as its designers intended, the plan was characterized as making losers of all who already had insurance, in terms of access to quality care, in no small part because their health benefits would

be subject to aggregate, alliance-wide standards and the cost of their coverage subject to aggregate controls. At the end of the Clinton health reform debate, polls indicated that only about one in five Americans believed reform would make them better-off—in general and with respect to quality of care. A far larger proportion—more than one in three—believed they would be worse-off from enactment of the proposed health reform.¹⁴

It was undoubtedly these concerns that led the public to resonate with advertisements run by the Health Insurance Association of America featuring an all-American couple named Harry and Louise, who memorably lamented, “There’s got to be a better way.”¹⁵ But, holding the specifics of the Clinton plan aside, the truth is there simply is no way to design a universal coverage policy that can cover the uninsured without affecting the already-insured; and no way to achieve political success if the already-insured perceive that they would be worse-off as a result. Even if “new” revenues are identified in an attempt to finance new coverage without diminution of current coverage, all of the presently-insured would still be materially affected by whatever cost containment strategy was established to hold the total costs within the expanded resource envelope thus created. The experience of the Clinton era reinforces the conclusion that it is structurally impossible to expand coverage in a way that all actors in the health care system would consider “free.” That being the case, relief for the 15 percent of the population without coverage will only arrive if the bargain fashioned to achieve that coverage looks reasonable to the 85 percent of the population who are satisfied with, but concerned about the security and continuation of, their existing health care coverage

Political Realities Today

Coming forward from the experiences of the Clinton era, it is apparent that wherever U.S. health care policy is headed it will make its way forward in an increasingly polarized environment.

Since at least the Bush-Gore election finale in 2000, U.S. politics has become acutely polarized, both from the perspective of traditional inter-party warfare and a more recent factionalism that pits opposing ideological orthodoxies against each other on virtually every front.¹⁶ Issues

arising in health care are, not surprisingly, as susceptible to factionalization as any other issue of public discourse. Yet health care interacts with American political discourse in some distinctive ways.

First, several of the hot button social issues that mobilize activism across the ideological divide lie inextricably within the health care realm. The legality of abortion services has dominated debate over reproductive health issues since the early 1970s. More recently, the controversy over the ethics and federal funding of stem cell research has opened yet another factional front within health research policy.

Second, the growing fiscal importance of public and private spending on health care services (well documented in preceding chapters) has come to dominate political agendas at the state and federal levels. As more and more of what government does involves setting health care policy, it is natural that both partisan and ideological battles spill over into this arena.

Third, the increasingly perceived disappearance of the center in politics has particularly strong effects in health care policy.¹⁷ Given the size and complexity of the health care system, a substantial amount of year-to-year legislative and regulatory action is needed simply to keep the existing programmatic framework running smoothly. For most of the last forty years, since the enactment of Medicare and Medicaid, there has been a sufficient core of lawmakers in both parties who—regardless of where they stood on the major thematic battles of their times—were willing to work together to keep the trains running smoothly.

Increasingly, however, partisans of various factions seek to use every available vehicle to advance hot button priorities from their ends of the polar divide. This tendency has become increasingly evident since enactment of legislation to implement the new Medicare prescription drug benefit.

The Politics of the Medicare Modernization Act

When Medicare was first enacted in 1965, no thought was given to providing coverage for prescription drugs because, frankly, there was not much to cover. The limited number of prescription drugs available at that time—notably antibiotics and vaccines—were commonly injected in physician offices rather than sold through pharmacies. Hence, the prevailing

mode of Medicare coverage for prescription drugs dealt only with drugs administered “incident to” physician services.

By the mid-1980s, however, the widening availability of clinically effective oral medications changed public perceptions of the adequacy of the Medicare drug benefit. The growth of explicit outpatient prescription drug coverage through managed care organizations, in particular, created pressure to provide all Medicare beneficiaries with a comparable benefit.

The first effort to do so is widely acknowledged as one of the great political reversals in the history of health policy.¹⁸ The Medicare Catastrophic Coverage Act (MCAA) of 1988 conferred new Medicare benefits, in the form of increased protection against excessive out-of-pocket costs for acute medical-surgical services, as well as first-time-ever coverage for outpatient prescription drug subscriptions filled in pharmacies.¹⁹ In the “pay as you go” spirit of the late Reagan era, the incremental cost of these benefits was to be financed by new income-related premiums administered by mandatory deductions from the beneficiaries’ Social Security benefits. Since many elderly beneficiaries already had some form of coverage for cost sharing and drug coverage that at least partially duplicated the new MCCA benefits, these “Social Security taxes” triggered a revolt against the program that caused nervous lawmakers to repeal the entire statute before implementation.

While analysts drew different conclusions from this sequence of events, one notable subplot was the role of the pharmaceutical industry in shaping the final product.²⁰ Concerned about the prospect of drug price controls, the Pharmaceutical Research and Manufacturers of America (PhRMA) actively campaigned against the bill until all references to price-related policy adjustments were stripped from the final legislation. Hence policymakers reached the conclusion that when it came to outpatient prescription drug benefits, beneficiaries would refuse to pay for coverage and manufacturers were inalterably opposed to any version that provided an explicit cost containment mechanism—which most fiscal analysts perceived to be a *sine qua non* of an effective program.

This lingering perception dominated health policymaking in Washington for the next decade. Despite rapidly rising drug use by the elderly—and rapidly rising drug costs—drug coverage under the regular Medicare benefit was broadly understood to be politically unworkable.²¹

This perception changed in 1999 with the Medicare reform program generated, but not formally adopted, by a National Bipartisan Commission on the Future of Medicare.²² The central controversy revolved around the report's proposal of a historic quid pro quo: a prescription drug benefit would be added to Medicare, but the basic Medicare benefit would be converted from a defined benefit to a defined contribution model, under which Medicare would offer each beneficiary a fixed level of premium support that the beneficiary could use to select among benefit options requiring greater or lesser amounts of supplemental premium payments.²³ This recommendation, which was understood by all parties to represent a marked departure from the social insurance character of the Medicare program as originally enacted, became the fault line for the ensuing debate.²⁴

For conservatives, the drug benefit recommended by the Breaux-Thomas model was understood as the reluctant price to be paid for conversion of Medicare to what was perceived to be a more stable fiscal model.²⁵ Social insurance activists, by contrast, saw an opportunity to press for modernization of the Medicare program via a drug benefit—while at the same time strongly opposing any effort to modify the defined benefit structure of the program. Since both sides of the divide saw merit in pushing toward a drug benefit, the debate shifted from the pro quo of the benefits controversy to the quid of a free-standing prescription drug program.

This tilt in direction was—at least passively—enabled by the pharmaceutical industry, which endorsed the notion of a Medicare drug benefit *in the context of market-based reforms of the Medicare program*.²⁶ At the time, this characterization was perceived as an endorsement by PhRMA of the premium support model embodied in the Breaux-Thomas recommendations. As will be seen, however, PhRMA's position ultimately proved more flexible than the pure quid pro quo position embraced by conservatives.

In the ensuing four years, the health policy debate in Washington was anchored around the advance of legislation implementing a drug benefit. Quite quickly, the debate over a free-standing benefit transformed into a stylized argument over high-level design principles. Republicans, who were nominally at the wheel because of their control of both the White

House and the House of Representatives, promoted designs based on choices among options in a pluralistic private market.²⁷ Democrats differed on how pluralistic the model might be but coalesced around the notion that a centralized federal plan should be available as an option and that it should have the authority to negotiate drug prices with manufacturers. PhRMA, while not actively supporting any particular approach, did not object to discussions of a free-standing option as long as its codicil regarding private-market administration of that benefit was honored.

When the debate began, it arose in the context of unprecedented budget harmony at the federal level; in 1999 budget surpluses totaling \$5.6 trillion were forecast for the ten-year budget horizon. As debate wore on, however, the projected surplus proved ephemeral, and conservatives became increasingly concerned about the rising cost estimates for the program. Hence when the House passed its version of the plan in 2003, House leaders added language providing for a phase-in of a Breaux-Thomas-style model of premium support beginning toward the end of the decade. While the *quid pro quo* view of the drug benefit had largely disappeared from the general policy landscape, it was alive and well in the House of Representatives.

That view in the Senate, however, was “deader than a doornail.” A Senate bill could not have been fashioned without active support from Democratic leaders, who were not buying the notion that the debate was about anything other than a free-standing drug benefit for Medicare.²⁸

It is not surprising, when these competing visions clashed in conference, that the dissonance was substantial. Ultimately, eleven Democratic senators were convinced to sign on when any semblance of the House *quid pro quo* was thrown over the side.²⁹ While this neatly solved the problem in the Senate, it created a firestorm in the conservative wing of the House, who saw their trump card—acquiescence in a drug benefit—about to be cashed for no net gain.

The resulting saga of the House passage of the conference report will long be studied as a natural experiment in tactical legislative engineering. Since the Senate had already passed the product, and was unlikely to pass another, House leaders found themselves in a “one suit squeeze,” in which they had to put together 218 votes for passage without the ability to add inducements to the bill to cushion the agony for conservatives of voting for

what they suspected to be a fiscal disaster waiting to happen. After keeping the final vote open for hours, House leaders ultimately found enough Democrats to join the remaining Republicans and pass the conference agreement. The fallout from the experience just described, occurring as it did in an environment that was already politically and ideologically polarized, sets the stage for substantial challenges going forward.

First, with respect to the drug benefit itself, the normal political posture that might be expected upon passage of a major new entitlement was inverted. In the emerging political order, Democrats apparently see political advantage in heaping scorn upon an entitlement program that Republicans amazedly find themselves championing as their major domestic policy accomplishment. It seems likely that Democratic efforts to amend the programmatic status quo that Republicans now find themselves reflexively defending will materially affect both legislative and regulatory tactics in health policy for many years to come.

Second, it means that as leaders in both parties look forward to the impending fiscal crisis in both public and private health care finance, it is not easy to visualize how to grow a political center large enough to take concerted action to restore fiscal sanity before the financial divide between promises and resources proves unbridgeable. Neither political party has a motive, in the current environment, to offer an olive branch on these issues to the other side. Thus the situation awaits individual leaders, in both parties, who can figure out how to frame the debate in a way that permits them to draw enough of their colleagues across present battle lines to form a working coalition to make fundamental changes in the fiscal terms of trade in health care.

Looking Forward

When these leaders come forward, what must their agenda be?

Based on our reading of the experience described above, we believe that progress on all fronts will be stymied until a framework can be created—as suggested in the preceding chapters—in which the health care system can get serious about cost containment.

We use this phrase with some trepidation, since admonitions to “get serious about cost containment” have been a staple in the health policy

debate since at least the early 1970s. In such discourse, cost containment is invoked as if it were some monolithic strategy that would be uniformly efficacious in restraining the growth of health care costs, if only Congress were virtuous enough to invoke it. Yet cost containment is no more a strategy than is good government. As chapter 2 in this volume emphasizes, getting serious about cost containment means that the American political system must disavow the notion that such a magic bullet exists.

Costs in the American health care system are determined by hundreds of thousands—if not millions—of decisions made by individual Americans every day. Costs go up when a pharmaceutical manufacturer signs a contract to conduct a clinical trial of a promising but uncertain chemical compound. Costs go up when a hospital administrator decides to order a new 64-slice CT machine to replace an older piece of equipment that still performs to its original specifications. Costs go up and down when people in the system are hired, fired, or transferred to new assignments. And costs throughout the system ride heavily on the myriad decisions made each day to seek or not to seek care of various types.

To be serious about cost containment, it will be necessary to admit that containing costs will require affecting the decisions that individual Americans make every day in all the settings in which they make them. If this country wants a system that is more economical, lots of people will have to economize; perhaps everyone will. While we have demonstrated our capacity, as a society, to support devoting a growing level of real resources to the system each year, “everything someone can think of for anybody who asks” is neither desirable nor sustainable. Getting serious about cost containment will require policymakers to develop the evidence and the policy process that will allow the system to rationally and acceptably say no.

Getting to No

As we contemplate the prospect of whether the American political system can consciously accommodate economizing in health care, it is important to observe that, in the normal course of political business as usual, as the numbers of uninsured and underinsured continue to rise in the absence of policies designed to make broad-based insurance affordable, more and more Americans will face stark incentives to economize on health care

each year. We will not have to advocate explicit rationing to keep the costs of treating the uninsured in check. Americans will do the rationing themselves, occasionally in ways that we might consider suboptimal from the perspective of costs to society as a whole. Increasingly, those who seek employment at establishments that do not offer insurance, together with those employed at establishments that embrace catastrophic-only insurance designs, will be in the free market for health care products and services. In that market, they will trade off health care services they would have previously consumed in a regime of insurance for other necessities and pleasures of life. They will, in truth, be serious about cost containment in ways that fully insured Americans hope that they will never have to adopt.

Unless those who design the nation's public and private health insurance systems get serious about cost containment, the drift toward this de facto "uninsured free market" cost containment model is likely to accelerate. Getting serious means developing strategies that go beyond a focus on the price of services to a focus on the value of services.

The private insurance sector has a mixed history in terms of seriousness about cost containment. After the sharp insurance premium run-up in the late 1980s, the private sector embraced managed care, which in theory attempted to steer patients to preferred providers and to actively control access to expensive technologies via discretionary, patient-by-patient decisionmaking. Although this strategy temporarily contained costs, concern that insurers cared more about managing costs than managing care—thereby putting patients at risk—produced a substantial political backlash against these models. Throughout the present decade, employers have responded by relaxing efforts to control premium costs, and instead they are decreasing what they would otherwise have provided to employees as compensation, such as wage growth or other benefits. The growth in employment at establishments that do not offer insurance, however, is a sign that this strategy too has its limits.³⁰

In public insurance systems, serious cost containment has not been the dominant mode of operation. Public programs, notably Medicare, have shown a marked tendency to lower payment rates to providers, rather than attempting to steer decisionmaking by physicians and their patients toward more economical outcomes. The effectiveness of this strategy is

limited by its perverse result of inducing providers to offset the income loss by increasing unit volumes of services ordered.

Serious Cost Containment in Insurance Systems

There are three types of control handles that could be used in public and private insurance systems to implement more serious efforts to promote cost-conscious decisionmaking.

First, insurance programs can manage cost exposure by managing coverage policy. Rather than routinely covering each new medical technology, insurers could tie coverage of new services to evidence of effectiveness. In addition to permitting insurers to avoid paying for treatments considered to be ineffective, the discretionary capacity to set coverage policy could also be used to extract pricing concessions from manufacturers when the evidence for comparative efficacy is more ambiguous. As discussed in chapter 2, success in implementing such a policy, public or private, will require significant efforts to build a solid base of evidence about the comparative efficacy of treatment alternatives.

Second, insurance programs can vary the out-of-pocket costs that beneficiaries face when considering choices among available diagnostic and treatment options. Drug benefit programs, for example, often use tiered co-payments, under which beneficiaries face substantially higher co-payments if they elect to use nonpreferred products. The preferred product in these circumstances is designated today on the basis of purely economic considerations, for example, the willingness of the manufacturer to offer deep discounts in exchange for favorable formulary placement. However, such incentives could also be used to influence patient and provider decisionmaking so that decisions are based on clinical criteria, including comparative efficacy. Such efforts are currently very limited, as the evidence base to support such clinical distinctions is sparse. Moreover, it is difficult to make such decisions on a wholesale basis, because a therapy that proves superior for the vast majority of patients may still prove inferior to available alternatives for a limited subset of patients.

Third, insurance programs can condition coverage for a particular service for a particular patient on prospective review of the appropriateness of the service before the service is rendered. Although this approach has long been used to deter unnecessary elective hospitalizations, traditional

insurance programs and managed care plans have extended such prior authorization programs to costly services, such as advanced technology imaging procedures. However, there may be limits to expanding this approach. Such gatekeeper programs were an important driver of the backlash against tightly controlled managed care systems in the late 1990s. In addition, subsequent evaluations by the health benefits management industry have demonstrated that prior authorization may be truly cost effective only for very high cost items such as extended inpatient stays.

Looking forward, our assessment is that the only hope for the adoption of administrative measures or pricing signals to promote serious cost containment lies in investment in developing research and policy processes that the public—as well as providers and patients—can regard as evidence based, not politically based.

Facilitation and Forbearance

Apart from their role as stewards of public-sector insurance systems, what role should public policymakers play in easing the transition to serious cost containment?

As suggested above, the primary barrier to evidence-based decision-making is the lack of rigorous evidence about the comparative effectiveness of most of what is done in medicine. While this has long been true regarding clinical issues, separate and apart from considerations of cost, it is equally true of evidence that would be helpful in assessing trade-offs between comparative efficacy and cost. To enable serious cost containment, it is essential to make substantial progress on building the evidence base.

We believe that the public sector has a critical role to play in facilitating the development of this evidence base. As noted in chapter 2, the government can be an important actor by funding required research and coordinating this research to ensure that private-sector efforts are directed toward the most pressing cost management problems. We are aware that many affected constituencies will perceive an active conflict between the government's role as a sponsor of insurance plans and its role as research facilitator. As long as there are federally funded insurance systems, we do not believe that this can be helped. If serious cost containment is to succeed, government as facilitator must fund this research and government

as payer must use it. To be successful in this dual role, government must become far more transparent than it is today regarding the use of clinical evidence in making coverage and payment policy decisions. The key to serious cost containment, we believe, lies in the creation of a process that encourages the generation of balanced, scientifically rigorous research to inform decisionmaking about coverage and reimbursement policies. If that process, in turn, facilitates transformation of the public and private health financing system into a mechanism to internalize the incentives that will promote cost-conscious care for all Americans, then the public's long-term interest in health care reform will have been finally satisfied.

Notes

1. This section draws heavily on previously published material. See Judith Feder, "Crowd-out and the Politics of Health Reform," *Journal of Law, Medicine & Ethics* 32, no. 3 (2004): 461–64.

2. Timothy S. Jost, *Disentitlement? The Threats Facing Our Public Health-Care Programs and a Rights-Based Response* (Oxford University Press, 2003); Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton University Press, 2003); Jacob Hacker, *The Divided Welfare State* (Cambridge University Press, 2002).

3. Medicaid also supplements Medicare for its low-income elderly and the later-added disabled beneficiaries and provides long-term care to those who satisfy eligibility and financial requirements.

4. For data on the uninsured, see Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America, 2002 Data Update* (Washington: Henry J. Kaiser Family Foundation, 2003).

5. Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Free Press, 1974).

6. Expansions over the years have nevertheless moved somewhat closer to workers, by covering children of lower-income workers; pregnant women in working two-parent households; and persons with disabilities who could return to the workplace with support. States have the option to cover parents (fathers as well as mothers), but in most states, parents earning the minimum wage have too much income to qualify for Medicaid. And except in a few states that operate their Medicaid programs as special federally sanctioned demonstrations that waive traditional Medicaid eligibility restrictions, federal law, today as in 1965, does not extend Medicaid eligibility to low-income adults who are not parents of dependent children.

7. Cristina Boccuti and Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," *Health Affairs* 22, no. 2 (2003): 230–37.

8. Todd Gilmer and Richard Kronick, "It's The Premiums Stupid: Projections of the Uninsured through 2013," *Health Affairs* web exclusive, April 5, 2005: W5-143–W5-151. Todd Gilmer and Richard Kronick, "Calm before the Storm: Expected Increase in the Number of Uninsured Americans," *Health Affairs* 20, no. 6 (2001): 207–10.

9. Kaiser and HRET, *Employer Health Benefits, 2006* (Washington: Henry J. Kaiser Family Foundation, Health Research and Educational Trust, September 26, 2006).

10. The Congressional Budget Office ultimately judged this employer mandate to constitute a "tax," though whether the public perceived it as such is an open question.

11. But see note 6, *supra*.

12. Medicare savings were dedicated to the proposal's prescription drug and long-term care benefits.

13. Although the Congressional Budget Office did not find these and other projected savings entirely sufficient to finance the program, its estimates came close (and indeed were achievable with modest adjustments to some of the proposed benefits and subsidies).

14. Robert T. Blendon, Mollyanne Brodie, and John Benson, "What Happened to Americans' Support for the Clinton Health Plan," *Health Affairs* 14, no. 2 (1995): 7–23.

15. The Health Insurance Association of America subsequently merged with the American Association of Health Plans to form America's Health Insurance Plans.

16. Andrew Kohut and others, *The 2004 Political Landscape: Evenly Divided and Increasingly Polarized* (Washington: Pew Research Center for the People and the Press, November 5, 2003) (people-press.org/reports/display.php3?ReportID=196).

17. John Breaux, "Ceasefire on Health Care: A Centrist's Approach to Reform," commentary (New York: Commonwealth Fund, March 2006) (www.cmf.org/publications/publications_show.htm?doc_id=362364).

18. A concise, balanced narrative can be found in Jill Quadagno, "Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare State, 1945–1996," *Journal of Health and Social Behavior* 45 (extra issue, December 2004): 25–44.

19. Congressional Budget Office, *Background Material on the Catastrophic Drug Insurance Program* (July 1989).

20. Jill Quadagno, "Why the United States Has No National Health Insurance."

21. Throughout the 1990s, however, a significant number of beneficiaries received a prescription drug benefit—frequently at no incremental premium—by electing to enroll in a Medicare managed care option.

22. Under the commission's charter, a supermajority of voting members was required to formally report recommendations. Although a majority of members voted to adopt the commission recommendation, heavy lobbying by interests concerned about the commission's proposed policy caused the commission to fail to reach the required supermajority—by one vote.

23. National Bipartisan Commission on the Future of Medicare, *Building a Better Medicare for Today and Tomorrow* (Washington, March 16, 1999).

24. "Remaking Medicare," *NewsHour with Jim Lehrer*, Public Broadcasting System, March 17, 1999.

25. The commission policy was commonly labeled with the names of the bipartisan cochairs of the commission—Senator John Breaux (D-La.) and House Ways and Means Committee chairman Bill Thomas (R-Calif.).

26. The most complete account of the policy history traced in this section is contained in Thomas R. Oliver, Philip R. Lee, Helene L. Lipton, "A Political History of Medicare and Prescription Drug Coverage," *Milbank Quarterly* 82, no. 2 (2004): 283–354.

27. While Republicans controlled Congress during the early stage of the debate from 1999 to 2002, the Democrats achieved working control of the Senate in 2003–04 when Senator Jim Jeffords of Vermont announced his conversion to Independent status and his willingness to vote with the Democrats to organize the Senate.

28. Although hundreds of other provisions came together from both the Senate and House sides to ride the train of this moving legislation, they were unrelated to the central debate over the structure of the drug benefit.

29. The final provisions on cost containment—Title VIII of P. L. 108-391—substituted procedural notice of fiscal stresses in the system for any attempt to actually change the benefit entitlement.

30. Donald W. Moran, "Whence and Whither Health Insurance? A Revisionist History," *Health Affairs* 24, no. 6 (2005): 1415–425.