

The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System

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ABSTRACT. This article explains the origins, development, and passage of the single most influential postwar innovation in medical financing: Medicare's prospective payment system (PPS). Inexorably rising medical inflation and deep economic deterioration forced policymakers in the late 1970s to pursue radical reform of Medicare to keep the program from insolvency. Congress and the Reagan administration eventually turned to the one alternative reimbursement system that analysts and academics had studied more than any other and had even tested with apparent success in New Jersey: prospective payment with diagnosis-related groups (DRGs). Rather than simply reimbursing hospitals whatever costs they charged to treat Medicare patients, the new model paid hospitals a predetermined, set rate based on the patient's diagnosis. The most significant change in health policy since Medicare and Medicaid's passage in 1965 went virtually unnoticed by the general public. Nevertheless, the change was nothing short of revolutionary. For the first time, the federal government gained the upper hand in its financial relationship with the hospital industry. Medicare's new prospective payment system with DRGs triggered a shift in the balance of political and economic power between the providers of medical care (hospitals and physicians) and those who paid for it—power that providers had successfully accumulated for more than half a century. **KEYWORDS:** Medicare, prospective payment, hospitals, diagnosis-related groups (DRGs), Social Security, Nixon, Carter, Reagan.

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Medicare's traditional model of cost reimbursement was insanity. On the face of it, it encouraged people to do more; it *paid* them to do more and not in any particularly rational way. Going to prospective payment with DRGs, therefore, had all the right things going for it politically and conceptually. . . .

—Sheila Burke, Chief of Staff
Former Senator Bob Dole (R-KS)

The CEO of one of the companies in my Federation, who shall remain nameless, said to me, "The day this becomes law," he told me this as the Medicare legislation was going through in '83, he said, "I'm selling the company the day this [prospective payment] law passes." I said, "Why?" He said, "Because you could be an idiot and make a fortune on Medicare reimbursement. Any mistake you made you got reimbursed." I suppose that was true, but on the other hand if you want to do the right thing and reward efficiency, then the law was good.

—Michael Bromberg, Former Executive Director
Federation of American Hospitals

THE 1970s marked a period of enormous change within the American health care system. Rapidly increasing medical inflation forced those who paid for patients' care—employers and the government—to begin pursuing limits on medical providers' professional autonomy. They felt that they had no choice. Medicare's expenditures, in particular, were doubling at what was perceived as an unsustainable rate of every five years, and employers' health insurance premiums were increasing by upwards of 15–20% a year.¹ "In a short time, American medicine seemed to pass from stubborn shortages to irresponsible excess," Paul Starr has noted. "Rising costs brought medical care under more critical scrutiny, and the federal government, as a major buyer of health services, intervened in unprecedented ways."²

The assault by policymakers on the medical profession's authority took different forms and involved shifting tactics over the course of the decade. It began with crude wage and price controls imposed by President Richard Nixon in 1972 and included major changes enacted by Congress to Social Security and Medicare, which placed the first-ever limits on what hospitals could charge for Medicare

1. See Theodore Marmor, *Political Analysis and American Medical Care* (Cambridge: Cambridge University Press, 1983), 61–75.

2. Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 379.

patients' routine or "hotel" costs (room and board). Meanwhile, innovative researchers at Yale and the University of Michigan pioneered new systems for measuring and categorizing what hospitals actually did to patients and how much it cost them. For the first time, policymakers could compare prices across different hospitals for the same services. And when they did, they found significant and inexplicable variation, which contributed to a stunning loss of confidence in the ability of doctors and hospitals to regulate their own affairs.

By the end of the decade, unrelenting medical inflation forced President Jimmy Carter to subordinate his national health insurance proposal to an ambitious plan for containing hospital costs. The goal that had guided policymakers for years—to expand medical care and insurance coverage—became eclipsed by (and then contingent on) the urgent need to control health care costs.

THE PINNACLE OF MEDICAL PROVIDERS' POWER

When the decade began, doctors and hospitals ruled American medicine. Their efforts at accumulating economic, professional, and political power, dating back to at least the 1920s, had met with extraordinary success. Even the first political "defeat" that the American Medical Association (AMA) suffered—the passage of Medicare and Medicaid in 1965—turned out to be to physicians' and hospitals' enormous financial benefit. With hospitals and physicians in control of American medicine, those who paid the bills they charged had little to no means of questioning either the legitimacy or the necessity of the care that patients received. The not-for-profit Blue Cross (hospital) and Blue Shield (physician) systems, along with commercial insurers, essentially served as efficient payment operations. As such, they made the practice of medicine very lucrative.

The federal government had become deeply involved in expanding the country's health care system.³ It built up the supply of hospitals and doctors through increased funding of medical research and federal subsidies for hospital construction. It also greatly expanded the demand for, and access to, medical providers' services through Medicare and Medicaid. Medicare, in particular, strengthened

3. Lawrence Brown, *Politics & Health Care Organization: HMOs as Federal Policy* (Washington, D.C.: The Brookings Institution, 1983), 12–13.

doctors' and hospitals' power by paying them on a "customary, prevailing, and reasonable" basis,⁴ which was preceded by Blue Cross/Blue Shield's "usual, customary, and reasonable" system of reimbursement.⁵ Medicare essentially adopted the same third-party, fee-for-service reimbursement model developed by Blue Cross/Blue Shield, and then incorporated them as "primary intermediaries" to perform the bulk of Medicare's day-to-day work of receiving bills from doctors and hospitals and making payments to them.⁶ Consequently, professional power was cemented through a reimbursement system that neither imposed limits nor required outside approval. Instead, the system "insulated the doctor-patient relationship from lay interference, and preserved the physician's right to untrammelled use of his own and the hospital's resources to resolve the patient's medical problem," explains Jeff Goldsmith.⁷

With medical providers in control of the health care system, unrestricted cost reimbursement became the *modus operandi* for financing American medical care. Moreover, demand on the nation's medical system increased, which resulted in skyrocketing health care spending. When hospitals increased their costs, they received more revenue and could expand their operations. If they lowered their costs, they received less revenue and ran the risk of falling behind their competitors. Thus there was no incentive whatsoever to lower costs.⁸ William Hsiao, who later spearheaded the development of Medicare's fee schedule for physicians in the 1980s, began his career in 1969 by examining hospitals for the Social Security Administration (SSA). He remembers the hospital industry's opposition to even adopting standard accounting procedures:

The first question I asked was: "Why do we pay hospitals 2 percent extra on top of their costs?" The answer was that they had bad debts, that hospitals had to grow, and so on and so forth. So I then asked: "Alright, how do the hospitals calculate their costs?" And we discovered that there was no uniform accounting system or anything close to it. . . . So I was deputized

4. Starr, *The Social Transformation of American Medicine*, 385.

5. *Ibid.*

6. See Herman Somers and Anne Somers, *Medicare and the Hospitals: Issues and Prospects* (Washington, D.C.: The Brookings Institution, 1967), 32–34.

7. See Jeff Goldsmith, "Death of a Paradigm: The Challenge of Competition," *Health Aff.*, 1984, 3, 5–19.

8. See George Whetsell, "The History and Evolution of Hospital Payment Systems: How Did We Get Here?," *Nurs. Adm. Q.*, 1999, 23, 1–4.

by the SSA to meet with the AHA's leaders in Chicago and raise these issues with them. . . . This eventually led me to Blue Cross, because the government paid the hospitals based on what Blue Cross was paying on a cost-basis to the hospitals. I came to realize that the AHA really did not know that much and that the rules were set by Blue Cross. Although I and others pushed, we could not make the hospitals adopt uniform accounting systems.⁹

With little to no constraints, hospital costs soared. In retrospect, "cost reimbursement was just stupid," admits Michael Bromberg, former Executive Director of the Federation of American Hospitals (FAH), which represents the nation's for-profit, investor-owned hospitals. "I mean, it was just stupid. The Pentagon learned this lesson; you don't give people their costs, because you just give them an incentive to spend more,"¹⁰ which is what hospitals did. One result was that Medicare's financial health became a subject of intense debate among leading policymakers.

MEDICARE'S COST PROBLEMS

Medicare spending increased dramatically following the program's implementation. Policymakers knew that Medicare lacked adequate cost controls. Wilbur Cohen admitted as much when the program passed: "The sponsors of Medicare, including myself, had to concede in 1965 that there would be no real controls over hospitals and physicians. I was required to promise before the final vote in the Executive Session of the House Ways and Means Committee that the Federal agency would exercise no control."¹¹

The manner in which Congress inaugurated the program partly explains why Medicare's expenditures exploded so quickly.¹² Basically, it immediately "blanketed in" nineteen million beneficiaries on 1 July 1966, without any of them ever having paid into the program. Medicare's structure precluded it from experiencing a "grace" period in which its trust funds could build up some measure of reserves from annual surpluses.¹³ Instead, Medicare began operation as a genuine

9. William Hsiao, oral history interview with the author, 22 October 2002.

10. Michael Bromberg, oral history interview with the author, 23 July 2002.

11. As quoted in Linda Demkovich, "Devising New Medicare Payment Plan May Prove Easier than Selling It," *Natl. J.*, 1982, 14, 1981-85, 1981.

12. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore, Md.: Johns Hopkins University Press, 1998), 284-93.

13. Marian Gornick, Joan Warren, Paul Eggerset, et al., "Thirty Years of Medicare: Impact on the Covered Population," *Health Care Financ. Rev.*, 1996, 18, 179-237, 184.

“pay as you go” system, in which payroll tax revenues from workers went (and continue to go) directly to providing Part A hospital benefits for retirees.¹⁴ Retirees’ monthly contributions helped finance Part B, but over time they covered less and less of the program’s costs.¹⁵

Medicare’s cost control problems were also the result of what Theodore Marmor and Starr have both referred to as the program’s “politics of accommodation.”¹⁶ In attempting to gain the cooperation of doctors and hospitals, the Social Security Administration’s approach to running Medicare demonstrated three accommodating characteristics: (1) a commitment to remaining primarily a distributor of popular entitlement benefits; (2) a desire to avoid controversy and have operations run smoothly; and (3) an effort to secure exclusive administration of Medicare.¹⁷ The SSA’s strategy was eminently successful in getting Medicare up and running, notes Judith Feder. “But in the process, maintaining the compromises through which the goal was achieved became an end in itself.”¹⁸ One result of the SSA’s desire to have the medical community embrace Medicare was that doctors’ “customary, prevailing and reasonable” fees—the criteria on which the program based its reimbursement—rose precipitously. Young doctors began billing at unprecedented levels, and the SSA paid them. When older doctors saw the behavior of their younger associates, they too raised their fees.¹⁹

While doctors’ demands became a major cause of Medicare’s profligacy, increased physician costs paled in comparison to those of hospitals. “Medicare gave hospitals a license to spend,” according to Rosemary Stevens. “The more expenditures they incurred, the more income they received. Medicare tax funds flowed into hospitals in a golden stream, more than doubling between 1970 and 1975, and

14. See Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003), 74–106.

15. The monthly premiums of participating senior citizens contributed only 50% of Part B’s total costs. Moreover, the elderly’s share of Part B’s costs had dropped to 25% by 1983, because the increase in their premium rate was limited to the percent increase in OASI benefits, which rose much more slowly than increases in medical costs.

16. Theodore Marmor, *The Politics of Medicare*, 2nd ed. (New York: Aldine de Gruyter, 2000), 96–99; Starr, *The Social Transformation of American Medicine*, 374–76.

17. Marmor, *The Politics of Medicare*, 374–77.

18. Judith Feder, “The Social Security Administration and Medicare: A Strategy of Implementation,” in *Toward a National Health Policy: Public Policy and the Control of Health-Care Costs*, ed. Kenneth Friedman and Stuart Rakoff (Lexington, Mass.: Lexington Books, 1977), 19. See also Judith Feder, *Medicare: The Politics of Federal Hospital Insurance* (Lexington, Mass.: Lexington Books, 1977), 149.

19. Starr, *The Social Transformation of American Medicine*, 385.

doubling again by 1980.”²⁰ Medicare’s formula for hospital reimbursement invited abuse because it operated on a “cost + 2% basis” for all services. Since the 2% was a percentage of costs (and added by Congress to reflect, among other things, the added nursing costs for Medicare patients),²¹ it amounted to an open-ended proposition by offering hospitals a small bonus for each and every cost increase. So while the Consumer Price Index increased 89% between 1966 and 1976, hospital costs grew a staggering 345%.²²

In effect, medical providers took advantage of the unique economic dynamics surrounding medical care: although the occurrence of illness usually exists beyond one’s control, the demand for care constitutes essentially a discretionary decision. Insurance against the financial costs of health services, such as Medicare, allows the consumption of those services to vastly increase.²³ Moreover, as economist Kenneth Arrow famously demonstrated, patients are uniquely and utterly dependent on physicians to make informed decisions on their behalf due to the patients’ lack of medical knowledge.²⁴ Therefore, if physicians decided that some form of medical care was needed, it was promptly provided and paid for without question by third-party insurers.²⁵

Because Medicare lacked sufficient financial restraint, cost estimates soon fell glaringly short of initial predictions.²⁶ When Congress

20. Stevens, *In Sickness and in Wealth*, 284.

21. Email exchange with Clif Gaus, former Associate Administrator of Policy, Planning & Research, HCFA, 11 February 2003.

22. Executive Office of the President’s Council on Wage and Price Stability Staff Report, “The Rapid Rise of Hospital Costs” (Washington, D.C.: Government Printing Office, 1977), 9–11.

23. For more information on these dynamics, see Martin Feldstein, *Hospital Costs and Health Insurance* (Cambridge, Mass.: Harvard University Press, 1981), 176, 306. See also Congressional Budget Office, “Expenditures for Health Care: Federal Programs and Their Effects” (Washington, D.C.: Government Printing Office, 1977), 5; and Feder, *Medicare: The Politics of Federal Hospital Insurance*, 143: “The Medicare law promised to pay for medical care for the elderly without interfering in its delivery. But this promise ignored a basic economic fact: How care is paid for significantly influences the quantity and quality of care delivered. Thus a payment program necessarily interferes in the practice of medicine. If an agreement to pay for care has no strings attached, it removes any fiscal constraints on physicians’ and hospitals’ development and delivery of medical services.”

24. See Peter Hammer, Deborah Haas-Wilson, Mark Peterson, William Sage, eds., *Uncertain Times: Kenneth Arrow and the Changing Economics of Health Care* (Durham, N.C.: Duke University Press, 2003).

25. *Ibid.*

26. See Staff Report, “Medicare and Medicaid: Problems, Issues, and Alternatives,” *Senate Committee on Finance*, 91st Congress, 1st Session (Feb. 1970), 4.

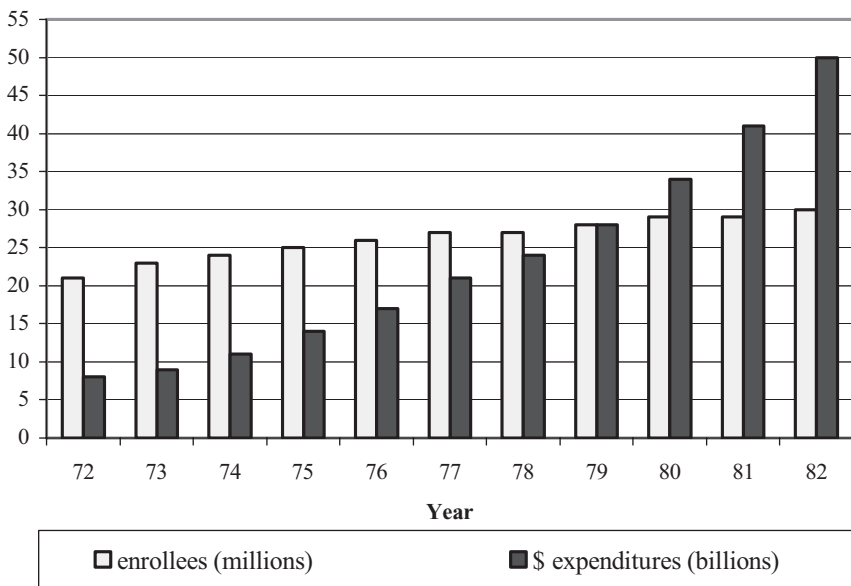


Fig. 1. Medicare Enrollees and Expenditures, 1972–1982.

Source: Data from Centers for Medicare & Medicaid Services, Tables 3.5 and 3.6; also found in Rick Mayes, *Universal Coverage* (Ann Arbor, Mich.: University of Michigan Press, 2005), 113.

passed Medicare in 1965, the House Ways and Means Committee projected annual expenditures of \$238 million. Assuming that 95% of the elderly might enroll in Part B (this prediction proved accurate), the committee estimated that, at most, total Medicare expenditures would be \$1.3 billion in 1967, the first full year of operation.²⁷ The figure instead came in at \$4.6 billion. The committee also predicted hospital spending to be \$3.1 billion for 1970 and \$4.2 billion for 1975, with money left over in the hospital trust fund. Actual expenditures were \$7.1 billion and \$15.6 billion, respectively.²⁸ Medicare

27. "Summary of Major Provisions of P.L. 89-97, the Social Security Amendments of 1965," *House Committee on Ways and Means*, House of Representatives, 89th Congress, 1st Session (Sept. 1965), part F, "Statistical Data," 20–21. See also "Administration of Medicare Cost-Saving Experiments," *Hearings before the Subcommittee on Oversight, Committee on Ways and Means*, House of Representatives, 94th Congress, 2nd Session (14–17 May 1976); "History of the Rising Costs of the Medicare and Medicaid Programs and Attempts to Control These Costs, 1966–1975," Department of Health, Education, and Welfare (Washington, D.C.: Government Printing Office, 1976).

28. *Ibid.*

spending was doubling every five years. Consequently, as Jonathan Oberlander explains, Medicare “quickly acquired a reputation, as chairman of the Senate Finance Committee Russell Long put it, as a ‘runaway program.’”²⁹

THE 1972 SOCIAL SECURITY AMENDMENTS

As more and more policymakers became concerned about Medicare's finances, they began looking for ways to control the program's costs. The process began with an admission by some leading government officials, who had championed the program and pushed for its passage, that Medicare's design was inherently inflationary. Toward the end of his service as Social Security Administrator in 1972, Robert Ball stated that Medicare had “simply accepted the going system of the delivery of care” by modeling its reimbursement patterns on Blue Cross plans for hospitals and private insurance policies for doctors. Seven years after Medicare's passage, he argued, attitudes had significantly changed. The public was beginning to favor reforms in the basic system of health care financing and looked to Medicare “to help provide the leverage to bring about change.” According to Ball, “the program no longer received criticism for interfering too much in the health care system but rather for interfering too little.”³⁰

Policymakers' initial efforts to control Medicare's cost growth culminated in Section 223 of the 1972 Social Security Amendments. Stuart Altman, President Nixon's key health care policy advisor, explains the legislation's background and intent:

Now that's a fascinating piece of legislation, because it's a combination of half cost controls and half expanded spending. It included new Medicare coverage for “end stage renal” patients, the disabled, nursing homes, and so on. But it also included Section 223, which said that even though Medicare is obligated to pay for whatever a hospital's costs are in treating Medicare beneficiaries, there are certain costs that can be deemed “unreasonable.” There was a lot of controversy over what was “unreasonable.” But ultimately what they implemented were limits that differentiated two

29. Jonathan Oberlander, “Medicare: The End of Consensus,” paper presented at the Annual Meeting of the American Political Science Association, Boston, Mass. (3–6 Sept. 1998), 4.

30. Edward Berkowitz, *Robert Ball* (Madison, Wisc.: University of Wisconsin Press, 2004), 205.

kinds of hospital costs: (a) routine and (b) ancillary. The argument was that if a cost was ancillary and if it was related to how sick the patient was or if it was new technology, then Medicare should and would pay for it. But if the cost was routine, then there should be limits to it.³¹

In short, Section 223 attempted to define what allowable costs were and then constrain the variability in these costs across hospitals.³² Or, as James Mongan, a senior health policy advisor to President Carter, put it: “We understood that people might be sicker and have different ancillary costs, but by God the routine or ‘hotel’ costs ought to bear some similarity to all other hospitals.”³³ The limits began operation in 1975, soon after Nixon’s Economist Stabilization Program ended (under which hospitals’ annual wage and price increases had been limited to 5.5%).³⁴ Over time, the new restrictions on allowable hospital costs had a modest effect in limiting hospital cost inflation.

As with virtually all regulatory efforts, though, hospital administrators quickly learned how to maximize reimbursement. “Now if you look over the course of the 1970s, the hospitals kept modifying the definitions and extending the line beyond which costs were considered ‘unreasonable.’ Essentially, the hospitals kept redefining what was ‘routine’ and what was ‘ancillary,’” explains Altman. “For example, they would take nurses and change them into ‘respiratory nurses,’ which made them a fully reimbursed ancillary cost. In other words, what were previously considered routine costs became ancillary by category and fully reimbursed.”³⁵

In addition to setting the first limits on what Medicare would pay hospitals, the 1972 Social Security Amendments also authorized the government to begin experiments with alternative forms of hospital reimbursement (Section 222). Fortunately for the SSA, it did not have to construct its own experiments in new forms of hospital payment from scratch. After the 1972 Social Security Amendments passed with Section 222 included, several states approached the SSA with requests to conduct payment experiments. Maryland was the

31. Stuart Altman, oral history interview with the author, 22 July 2002.

32. Margaret Sulvetta, “Achieving Cost Control in the Hospital Outpatient Department,” *Health Care Financ. Rev. Annu. Suppl.*, 1991, 13, 95–106, 95.

33. James Mongan, oral history interview with the author, 4 October 2002.

34. See Marsha Gold, Karyen Chu, Suzanne Felt, Mary Harrington, and Timothy Lake, “Effects of Selected Cost-Containment Efforts: 1971–1983,” *Health Care Financ. Rev.*, 1993, 14, 183–89.

35. Altman, oral history interview with the author.

first state to seek a waiver from the SSA in order to set its own Medicare payment rates. As part of an “all-payer” system, Medicare, Medicaid, and private insurers would all pay the same rates for the same hospital services. One purpose of the “all-payer” model was to make sure no patients became viewed as “second class” due to their status as lower payers.

In the long run, Robert Hackey has observed, Section 222 had a tremendous impact on health care regulation and reimbursement politics. It encouraged the proliferation of state rate-setting experiments that redefined the relationship between payers, providers, and government regulatory agencies. In addition to strengthening the power of state health care bureaucracies, the “Section 222” demonstration projects provided federal officials with unique opportunities for extensive policy learning at the state level that would otherwise have been impossible.³⁶

CONCEPTUAL INNOVATION AT THE UNIVERSITY OF MICHIGAN
AND YALE UNIVERSITY

The same year that the SSA gave the approval for state Medicare waivers saw the first scholarly article on the topic of what became known as “prospective payment.” In September 1974, *Inquiry* published University of Michigan Professor William Dowling’s article “Prospective Payment of Hospitals.”³⁷ It was the first conceptual description of the significant transformation and shifting of financial risk that Medicare would initiate a decade later.³⁸ The concept of prospective payment was predicated on the controversial and untested theory that the cost of medical care was relatively predictable and responsive to changing economic incentives. Yet how would the prospective rates be determined, especially if each patient’s medical cost varied significantly across and even within hospitals, due to factors such as a patient’s age, gender, or the severity of his or her condition? In other words, how predictable could the costs of medical care truly be? Nobody knew for sure.

36. See Robert Hackey, “Groping for Autonomy: The Federal Government and American Hospitals: 1950–1990,” *J. Econ. Issues*, 1999, 33, 625–46.

37. See William Dowling, “Prospective Reimbursement of Hospitals,” *Inquiry*, 1974, 11, 163–80.

38. *Ibid.*

In order to establish a system for paying hospitals' predetermined rates, patients would first have to be separated into unique "product" categories based on different diagnoses or procedures (e.g., pneumonia, hip replacement, congestive heart failure, etc.). Performing the necessary research for establishing product categories and payment rates would require the cooperation of hospitals, which was hard to come by. Moreover, hospital record-keeping in the 1970s was generally sloppy at best and occasionally nonexistent at worst. Even if researchers had readily available and comparable hospital data, how would they run their analyses? At the time there were no statistical software systems for analyzing complex medical records. Personal computers did not yet exist. And performing massive statistical analyses was a labor-intensive, arduous activity involving enormous and enormously expensive mainframe computers that only a select number of major institutions could afford.

Serendipitously, the solutions to these formidable obstacles came by way of researchers trying to solve other problems and answer different questions. In the early 1970s, a research team at Yale University headed by John Thompson—a former nurse who once worked the night shift on Bellevue Hospital's prison ward and a professor of public health and hospital administration—was trying to find out why the cost of maternity, newborn, and non-maternity medical care among Connecticut's thirty-five hospitals varied by as much as 100% (double).³⁹ This striking variation in costs had no obvious explanations because "Connecticut is not like other states," Thompson observed. "There is essentially one labor market [with] people going from town to town. Moreover, all hospitals in Connecticut were accredited, and there were no for-profit hospitals."⁴⁰ In short, all hospitals in Connecticut were not-for-profit and had roughly the same labor costs. So, as Thompson asked, "What was going on in the most expensive hospitals and in the cheapest hospitals?"⁴¹

At the time, Yale was uniquely positioned to generate the kind of conceptual innovation necessary for developing prospective payment. It had some of the brightest researchers within small departments, which provided for far more interdisciplinary collaboration

39. John Thompson, oral history interview with Lewis E. Weeks, Jr. (July 1989, Ann Arbor, Mich.), 46, manuscript in possession of author.

40. *Ibid.*, 46–47.

41. *Ibid.*, 47.

than is usually the case at most major research universities. According to Richard Averill, who became the lead project manager for Thompson's research team:

It all began when Thompson said that studying the significant variation in hospital costs "sounds like an industrial control problem. But I don't necessarily know all that much about industrial control, so I'll find out whoever the guru is at the School of Administrative Sciences in this area." So he went over and spoke with Bob Fetter—a Professor at the School of Organization and Management—and he said, "Well, tell me what your products are." And John said something like, "We treat patients." And Bob would say something like, "and Ford makes cars, but there's a big difference between," in those days, "a Pinto and a Lincoln."

And so this started the genesis of essentially saying, "In order to do any analysis of real statistical quality with controls, you need a product definition in a hospital." But then you kind of start working backwards and say, "Okay, in order to come up with a product definition, we first need some data."⁴²

In order to categorize all the different products that hospitals produced and how much it cost them for each one, Thompson and Fetter needed a significant amount of hospital data. Fortunately, by law, the thirty-five hospitals in Connecticut had been reporting audited costs to the state legislature since 1948 according to a uniform chart of accounts. From 1960 on, the Connecticut Hospital Association (CHA) had collected the standardized financial information from all thirty-five hospitals, broken down among maternity, newborn, and non-maternity patients.⁴³ In addition, recalls Thompson, "We had the Connecticut Hospital Association and Connecticut Blue Cross who were very close to our program and who gave us a lot of data."⁴⁴ Given the unprecedented amount of claims data from multiple Connecticut hospitals, Thompson and Fetter could perform the first major analysis of substantial variation in costs between hospitals.

With the assistance of their colleagues, Fetter and Averill created an interactive computer program designed to facilitate the rapid analysis of complex medical information.⁴⁵ "You could sit doctors

42. Richard Averill, oral history interview with the author, 19 March 2003.

43. William White, ed., *Compelled by Data: John D. Thompson* (New Haven, Conn.: Yale University Press, 2003), 72, 85.

44. Thompson, oral history interview with Weeks, 45.

45. Ronald Mills, Robert Fetter, Donald Riedel, and Richard Averill, "AUTOGRP: An Interactive Computer System for the Analysis of Health Care Data," *Med. Care*, 1976, 14, 603-15.

down and say, 'Now here's a diagnosis. What factors do you think are going to affect the use of resources treating this diagnosis? Is it age? Is it certain complications? Is it the patient's sex? What is it?'" explains Thompson. "We could sit there and test it on this interactive program, which was called AUTOGRP."⁴⁶

Thompson and Fetter's goal was to group all patients into a limited number of distinct and medically meaningful diagnostic categories (Diagnosis Related Groups, or DRGs), and then measure each individual patient's consumption of hospital resources. Ironically, the primary purpose of prospective payment with DRGs was not cost control, which is what it became later at the state (New Jersey) and federal level. Rather, they envisioned their work serving as a basis for quality assessment to improve care for patients and for the better use of limited and expensive medical resources. Thompson and Fetter were surprised at the total lack of interest within the hospital community over their findings:

There we were with what we thought was a major management breakthrough. In other words, hospital administrators could now begin to see how much it was costing them to produce these "products" [Diagnosis Related Groups, DRGs] and whether the medical staff was treating these patients differently, keeping some patients in too long, ordering too many X-rays or too much lab work. . . . This was the first time anybody in hospital management could do this. . . . We went all over the United States to preach the gospel of hospital product lines, and it was absolutely amazing how little attention anybody paid to this idea.⁴⁷

Thompson and Fetter had demonstrated for the first time that hospitals could separate their patients into distinct categories based on the diagnosis and then measure how much each category cost the hospital financially. Hospital administrators were slow to realize the extent to which Thompson and Fetter's innovation could transform American medicine, but a handful of progressive health officials were ready for a revolution.

NEW JERSEY AS A "POLICY LABORATORY" FOR EXPERIMENTATION

Following their "discovery" of prospective payment, as Thompson later described it, he and Fetter grew increasingly eager to test their

46. Thompson, oral history interview with Weeks, 48.

47. *Ibid.*, 49.

new system of hospital reimbursement somewhere. "Then one of those serendipitous things happened," according to Thompson. "The health officer of New Haven was a young physician by the name of Joanne Finley, and she was called down to New Jersey by a candidate for governor by the name of Brendan Byrne who said that hospitals had become a big issue in his campaign. . . . She knew all about DRGs, because, as health officer in New Haven, she was on the Yale faculty and had come to the various research symposiums on the new system. She said yes and Byrne was elected."⁴⁸

Joanne Finley and her department set about transforming the traditional relationships between hospitals and payers. They moved to a new rate review system known as the Standard Hospital Accounting & Rate Evaluation (SHARE) system.⁴⁹ SHARE was designed to have all hospitals report their expenditures in a standardized way to allow for meaningful comparisons between hospitals. The essential feature of the SHARE system was "peer grouping" hospitals within different categories (for example, small, large, urban, suburban). The unit of payment to hospitals under the new system was a "per diem" (or a "per day" rate), and the basis of payment was the hospital's costs.⁵⁰ If any hospital's proposed budget for the following year exceeded by 10% the median increase of its peers, it had to negotiate with New Jersey's Department of Health for an exception in order to receive per diem rate increases from both Blue Cross and Medicaid.⁵¹ In other words, it had to persuade the state's Department of Health that, because of its "uniqueness," it deserved to receive higher payments than its peer institutions for the same hospital procedures and services. Only 12.3% of all hospital requests for such an exception were successful.⁵² Moreover, the state established a target percentage increase in per diem payment rates for each year. In the system's first year, 1975, the target rate was 2%, which was laughable on its face given the overall rate of economic inflation at that time. The state quickly had to compromise upward to a 9% annual increase.⁵³

48. Ibid.

49. See Robert Fetter, Youngsoo Shin, Jean Freeman, Richard Averill, and John Thompson, "Case Mix Definition by Diagnosis-Related Groups," *Med. Care*, 1980, 18, vii-53.

50. Ibid., 33.

51. Office of Technology Assessment, *Diagnosis Related Groups and the Medicare Program: Working Paper* (Washington, D.C.: Government Printing Office, 1983), 6-7.

52. Ibid., 7.

53. Ibid., 6-7.

SHARE was an initial but modest attempt to both rationalize hospital payments and challenge the hospital industry's power in New Jersey.⁵⁴ The program only regulated Blue Cross and Medicaid payment rates (roughly 40% of total hospital payments), which led hospitals to shift more of their costs to their unregulated payers, mostly commercial insurers. Within five years, payments from commercial insurers were 30% higher than payments from Blue Cross for the same services.⁵⁵ Many urban hospitals, which served a disproportionate share of Medicaid and uninsured patients, were experiencing serious budget deficits under the new SHARE system. Due to their location, they did not have enough commercially insured patients to whom they could shift their costs. Eighteen of the state's hospitals were pushed to the verge of financial collapse.⁵⁶

Dissatisfied with a system that regulated hospitals on a per diem rate and only for Medicaid and Blue Cross payers, Finley and her colleagues in the Department of Health entered into negotiations with the New Jersey Hospital Association and Blue Cross for the purposes of moving to a new system.⁵⁷ They wanted a statewide prospective payment system. In order to regulate prices for *all* payers in the state—which constituted far more governmental control over the hospital industry than had ever existed—Finley and her colleagues found an ingenious way to neutralize the hospital industry's otherwise unified and formidable political opposition.⁵⁸ They proposed that the state's new regulatory system for all payers should set hospital payment rates in such a way as to cover hospitals' uncompensated charity care (or bad debt). Because both would benefit financially, the state's inner-city hospitals—often headed by charismatic and articulate nuns—became aligned with the state's commercial insurers in favor of the state's new proposal.⁵⁹ Finley was reported to

54. Fetter, Shin, Freeman, Averill, and Thompson, "Case Mix Definition by Diagnosis-Related Groups," 33–34: "The SHARE methodology was not equipped to address the problems of 1) defining and measuring hospital case mix, productivity and effectiveness; 2) providing incentives for better management; 3) avoiding business gamesmanship; 4) fostering communications between the hospital financial systems and physicians."

55. James Morone and Andrew Dunham, "The Waning of Professional Dominance: DRGs and the Hospitals," *Health Aff.*, 1984, 3, 73–87, 77.

56. *Ibid.*

57. Office of Technology Assessment, *Diagnosis Related Groups and the Medicare Program: Working Paper*, 34.

58. Morone and Dunham, "The Waning of Professional Dominance," 80.

59. *Ibid.*

have told Jack Owen, president of the New Jersey Hospital Association, "If you don't come along on this plan, I'll split your damned association."⁶⁰

This clever mixture of cross-cutting politics enabled Finley and her allies to push their reform legislation (S.446) into an advantageous political position. Urban hospitals desired financial assistance for providing care to their disproportionately poor patients; commercial insurers wanted relief from increased cost shifting imposed on them by all hospitals; state legislators desired an increased measure of cost control to address Medicaid's cost escalation; and the federal government wanted states to experiment with different forms of hospital reimbursement in order to develop a national model of reform for Medicare. As a result, S.446 passed easily in 1978.⁶¹ The legislation outlined a timetable for a new, prospective system of reimbursement to begin in early 1980.

PRESIDENT CARTER AND HOSPITAL COST-CONTAINMENT BATTLES

The late 1970s were marked by a growing national preoccupation with inflation, particularly in the area of health care. In 1977, Medicare and Medicaid expenditures were double what they had been only three years earlier.⁶² From 1974 to 1977, hospital costs increased at an annual rate of approximately 15%, more than double the economy's overall rate of inflation.⁶³ Public opinion polls showed that health care costs were among Americans' top three domestic policy concerns.⁶⁴ Consequently, hospital cost containment emerged as the leading health policy initiative by President Carter and his administration, particularly Joseph Califano (Secretary of Health, Education & Welfare). With medical inflation growing at unsustainable rates, Carter's campaign pledge of achieving national health insurance became linked to the goal of first trying to control hospital costs.

Carter's initial proposal in April 1977 marked the first major attempt by the federal government to aggressively regulate the

60. Thompson, oral history interview with Weeks, 51.

61. Office of Technology Assessment, *Diagnosis Related Groups and the Medicare Program: Working Paper*, 34-35.

62. Starr, *The Social Transformation of American Medicine*, 406.

63. Gold, Chu, Felt, Harrington, and Lake, "Effects of Selected Cost-Containment Efforts: 1971-1993," 189.

64. *Ibid.*

hospital industry. The president actively campaigned for his proposal, arguing that its passage would “slow a devastating inflation trend, which doubles health costs every five years.”⁶⁵ Carter’s plan entailed setting a 9% cap on the annual growth in hospital prices; it also imposed strict limits on the construction of new health care facilities.⁶⁶ The plan would have placed limits on *all* hospital payment rates, public and private. An extreme step, and perhaps outside the government’s regulatory power, Carter’s proposal was justified on the basis that “rapid increases in hospital spending” threatened “presidential objectives to balance the federal budget.”⁶⁷ Califano claimed that hospitals had abused the cost reimbursement model for too long. Rather than being “institutions of last resort,” he argued, hospitals had become “settings of first choice for treating too many minor ailments, especially when the insurance coverage was good.”⁶⁸

President Carter’s proposal galvanized the hospital industry. “Califano helped us achieve the unanimity when he talked about hospitals making obscene profits,” according to Alex McMahon, president of the American Hospital Association (AHA) at the time. “Nothing drives you together better than a very visible enemy, and Califano became one by his own choice.”⁶⁹ The industry responded by vigorously opposing Carter’s proposal and offering a Voluntary Effort (VE) in its place.⁷⁰

Carter’s 1977 proposal failed in large part because congressional Democrats, notably Representatives Dan Rostenkowski (Chair of the House Ways & Means Health Subcommittee) and Richard Gephardt, favored going with the hospitals’ voluntary approach first. “I’ve got commitments from the hospital Associations that if I let them come up with a voluntary program, they will embrace cost containment,” Rostenkowski recalls telling President Carter in one

65. Congressional Quarterly, *CQ Almanac, 1977* (Washington, D.C.: Congressional Quarterly, 1977), 499–500.

66. Hackey, “Groping for Autonomy,” 640–41.

67. Gold, Chu, Felt, Harrington, and Lake, “Effects of Selected Cost-Containment Efforts: 1971–1993,” 189.

68. Quoted in Stevens, *In Sickness and in Wealth*, 309.

69. John Iglehart, “Hospitals, Public Policy, and the Future: An Interview with John Alexander McMahon,” *Health Aff.*, 1984, 3, 20–34, 25.

70. Gold, Chu, Felt, Harrington, and Lake, “Effects of Selected Cost-Containment Efforts: 1971–1993,” 190.

highly charged conversation. "And I told the hospital representatives, as I stuck my index finger in their nose, Mr. President, 'You screw me and I'll be around for a long time and you better watch out.'" ⁷¹ As it turns out, the hospitals' VE did have a salutary effect in 1978, bringing the rate of hospital cost inflation down to 12.8%, but it proved to be short-lived. ⁷²

In an effort to improve Medicare's operation, President Carter removed the program from the Social Security Administration's control in March 1977. As Feder explains, the "purpose was to unify administration of the federal government's two major health financing programs, Medicare and Medicaid, which had been run independently, and often without coordination, since their inception. Congress created a new agency, the Health Care Financing Administration (HCFA), to administer the programs." ⁷³ The idea to remove Medicare from the SSA came from those who were deeply committed to social insurance. Yet many within the SSA were devastated: "The saddest day for Medicare is the day that Califano took the program away from Social Security and gave it to the Health Care Financing Administration. . . . Medicare was never the same after that." ⁷⁴

In 1979, hospital spending increased 14.5% as Carter reintroduced a modified version of his original cost containment plan. ⁷⁵ The only significant difference between the president's first and second proposal is that the latter bill had a "sunset clause" of five years. ⁷⁶ This time Carter's proposal advanced further than his 1977 proposal had. It was voted out of committee and onto the House floor. Carter's new plan would impose controls on hospitals *only* if their cost increases exceeded a limit of approximately 13%. ⁷⁷ Again, though, the hospital associations—together with the help of the American

71. Dan Rostenkowski, oral history interview with the author, 25 June 2002.

72. Gold, Chu, Felt, Harrington, and Lake, "Effects of Selected Cost-Containment Efforts: 1971-1993," 191.

73. Feder, *Medicare: The Politics of Federal Hospital Insurance*, vii.

74. "Recollections (Discussions) by Social Security Administration Officials' Knowledge and/or Involvement in Certain Stages of Early Implementation of the Medicare Program" (Calendar Year 1966), SSA Regional Office, Atlanta, Georgia, 25 September 1992, 20, provided to the author by Arthur Hess.

75. Gold, Chu, Felt, Harrington, and Lake, "Effects of Selected Cost-Containment Efforts: 1971-1993," 192.

76. *Ibid.*, 190.

77. *Ibid.*, 191.

Medical Association—were able to defeat Carter’s plan.⁷⁸ Virtually all Republicans opposed Carter’s plan as excessively complex and an overly intrusive violation of the private sector by the government at a time when deregulation was rapidly gaining popularity. Democrats were split. Urban Democrats generally favored the president’s plan, but Sun Belt and southern Democrats from areas with growing populations were less enthusiastic. Many of them thought that Carter’s plan would restrain the growth of hospital revenues in an inequitable manner that would lock southern hospitals into an inferior quality level relative to their northern counterparts (the “fat will get fatter,” critics charged).⁷⁹ On 15 November 1979, the president’s proposal went down in defeat in the House by a vote of 234 to 166.⁸⁰

The onus now was squarely on the hospital industry to deliver results. Caps and price controls were rejected in favor of renewed pledges from hospital representatives that they would “clean up their act.” Their voluntary effort failed. Hospital cost inflation jumped 13% in 1980 and 18% in 1981.⁸¹ The hospital industry’s political credibility plummeted as the failure of its second Voluntary Effort embarrassed even its closest political allies.⁸² The voluntary effort “was tremendously successful in its first year,” argues the AHA’s McMahan, “partially successful the second year, and then really fell apart in about its third year when nobody paid attention” anymore.⁸³ Looking back on this period as one of “treading water,” McMahan noted that the hospital industry “began to hear a message from the federal and state governments and, increasingly, from business, a thoroughly powerful message that said, ‘Okay, if you don’t like government price controls, figure out something to do.’ The pressures were there, and so ‘treading water’ pretty soon turned into a movement toward finding a new system of incentives.”⁸⁴ The

78. Paul Feldstein, *The Politics of Health Legislation: An Economic Perspective* (Chicago: Health Administration Press, 2001), 153.

79. Iglehart, “Hospitals, Public Policy, and the Future: An Interview with John Alexander McMahan,” 26; Don Moran, oral history interview with the author, 28 October 2002.

80. Starr, *The Social Transformation of American Medicine*, 414.

81. Gold, Chu, Felt, Harrington, and Lake, “Effects of Selected Cost-Containment Efforts: 1971–1993,” 192.

82. See Linda Demkovich, “Who Can Do a Better Job of Controlling Hospital Costs?,” *Natl. J.*, 1979, 11, 219–23.

83. Iglehart, “Hospitals, Public Policy, and the Future,” 25.

84. *Ibid.*, 26.

stage was now set for a radical transition in hospital reimbursement. Yet it did not come from the private sector. Ironically, it came from a Republican president who professed a love for the free market and inveighed against government intrusions in the private sector.

NEW POLITICAL LANDSCAPE AMID MOUNTING FISCAL PRESSURES

The 1980s began with a continuation and worsening of medical inflation from the previous decade. Hospital spending grew more than 10% per year, as the nation's total health care expenditures reached \$230 billion in 1980, a threefold increase from \$69 billion in 1970.⁸⁵ Ronald Reagan, the Republican Party's presidential nominee, won a landslide victory over the Democrat incumbent, Jimmy Carter, by, among other things, arguing for the expansion of the free market and reduced government regulation. Yet the free market was not solving the problem of medical inflation. In Reagan's first full year in office, hospital spending increased 17.3%.⁸⁶ The following year the country slipped into the worst recession in half a century, with the unemployment rate reaching almost 11%.

The Republicans' takeover of the White House and Senate coincided with a deep recession, as well as a growing conviction among policymakers of both political parties that Medicare's rate of expenditure growth was unsustainable. The hospital industry had been given two opportunities to voluntarily contain its cost growth and had markedly failed at both. It appeared that the forces that drove hospital inflation were beyond hospital administrators' control. Thus, by 1981, even leading representatives of the hospital industry were convinced of the political inevitability of major reform to Medicare's payment system.⁸⁷

Paradoxically, the Republican takeover actually created a more favorable political environment for a Medicare reform plan—one involving *increased* government regulation—than had previously existed. With Republicans in control, the onus fell squarely on them to find a way to avoid Medicare's approaching insolvency. Given the administration's short-term goals for reducing domestic spending,

85. Starr, *The Social Transformation of American Medicine* 380

86. See Congressional Budget Office, *Hospital Cost Containment Model: A Technical Analysis* (Washington, D.C.: Government Printing Office, 1981).

87. Iglehart, "Hospitals, Public Policy, and the Future: An Interview with John Alexander McMahon," 25–26.

however, a free market approach to reforming Medicare was not possible.⁸⁸ As a result, fiscal necessity overwhelmed political ideology.⁸⁹ Republicans would have to increase the government's authority over medical providers, because the federal government needed budgetary savings immediately and the hospital industry had shown it was unable to reform itself. "We basically concluded that we had to fix the hospitals because there are fewer of them, they're less political, there's a lot of money there, and we thought we could beat them up a lot easier than three to four hundred thousand doctors," recalls Allen Dobson, head of HCFA's Office of Research.⁹⁰

Reagan's choice for Secretary of Health & Human Services, former Republican Senator from Pennsylvania Richard Schweiker, proved particularly auspicious for Medicare reform. In contrast to Carter's HHS Secretary, Joseph Califano, Schweiker was a more conciliatory policymaker. He also had years of experience handling health care policy in Congress as a senior member of the Senate Finance Committee. The failure of the hospital industry's two voluntary efforts had persuaded him that the government would have to initiate payment reform.⁹¹ In fact, restraining the escalation in health care costs became his highest legislative priority as Secretary of HHS.⁹² As a regular summer visitor to the New Jersey shore, Schweiker formed close personal relationships with health care representatives and policymakers who were initiating the state's experiment using prospective payment for hospitals.⁹³ He had read the two existing books on DRGs and, over time, grew convinced that prospective payment was the way to go.⁹⁴ Transitioning Medicare to a prospective payment system emerged as his primary goal, "sort of his crowning achievement as secretary of HHS," according to Julian Pettengill, a leading HCFA analyst at the time.⁹⁵

88. Oberlander, *The Political Life of Medicare*, 123.

89. *Ibid.*

90. Allen Dobson, oral history interview with the author, 11 October 2002.

91. Oberlander, *The Political Life of Medicare*, 123.

92. Linda Demkovich, "Relying on the Market—the Reagan Approach to Containing Medical Costs," *Natl. J.*, 1982, 14, 194–97, 194.

93. Robert Rubin, oral history interview with Edward Berkowitz, 16 August 1995.

94. *Ibid.*

95. Julian Pettengill, oral history interview with the author, 29 October 2002.

Political and economic events in the early 1980s were making Medicare reform seem increasingly necessary. The Republicans' takeover of the Senate in 1981 coincided with the highest recorded rates of hospital cost inflation. Bob Dole became chair of the powerful Senate Finance Committee, which, along with the House Ways & Means Committee, controlled Medicare policy. Recognized at the time as the most important figure on Capitol Hill for health financing legislation, Dole saw the failure of the hospital industry's voluntary efforts as evidence of the need for radical reform to safeguard Medicare's financial solvency.⁹⁶

Dole's chief of staff, Sheila Burke, became the key staff member on the Senate side in leading the effort for Medicare payment reform. A former nurse, she viewed the traditional model of cost reimbursement as “. . . insanity. On the face of it, it encouraged people to do more; it paid them to do more and not in any particularly rational way,” she explains. “Going to DRGs, therefore, had all the right things going for it politically and conceptually. . . . In effect, you could say to the average member of Congress—who tended to not want to get into the minutiae of Medicare policy because it was one of the more boring aspects of their lives—‘Why should it [a specific hospital service or procedure] cost anything different between L.A. and San Francisco or San Francisco and Chicago, or Chicago and Detroit?’”⁹⁷

Dan Rostenkowski, who became chair of the powerful House Ways & Means Committee in 1981, similarly concluded that the private sector was incapable of reforming itself. Paul Rettig, who worked for Rostenkowski, observed that most members of the Ways & Means Committee shared Rostenkowski's opinion that cost reimbursement was something they had to get rid of as soon as possible.⁹⁸ The key to a prospective payment model, Rettig added, was that select members of Congress thought it could fundamentally

96. John Iglehart, “Health Policy Report: Medicare's Uncertain Future,” *N. Engl. J. Med.*, 1982, 306, 1308–12, 1308. “Our current fiscal crisis, which is, I assure you, a real, not a fictitious crisis, is *forcing* us to examine very carefully what health services we pay for, and how we pay for them. The problem becomes even more evident when we look down the road to a nation with a growing population of elderly citizens and a Medicare trust fund which is sure to go broke within a short period of time if we don't take appropriate action. In fact, the entirety of the Social Security system is in real trouble.”

97. Sheila Burke, oral history interview with the author, 2 October 2002.

98. Paul Rettig, oral history interview with Edward Berkowitz, 14 August 1995.

change the decision-making habits of doctors and hospitals.⁹⁹ Previous efforts had failed to do this, but it was necessary if Medicare's rate of expenditure growth was ever to be brought under control. Conveniently, federal policymakers could turn to some of their colleagues at the state level, especially in New Jersey, to learn from their experiments with different forms of prospective payment.

NEW JERSEY'S EXPERIMENT WITH DRGs

New Jersey's experimental hospital reimbursement plan, which had passed legislatively in 1978 and began operation in 1980, seemed particularly promising.¹⁰⁰ The state's new prospective payment system sought to significantly transform the financial incentives for hospital administrators. With traditional cost reimbursement, the more a hospital did for a patient, the more money it received in payments. Under New Jersey's DRGs, however, policymakers established a standard price in advance for each and every case that a patient could present. If a hospital could treat the patient for less than the standard DRG payment, it could keep the difference as profit. If the hospital spent more than the standard DRG payment, it had to absorb the difference as a loss.

A major problem with evaluating the new program's performance, however, was the considerable lag in hospital data that researchers could analyze. Bruce Vladeck, who later became Administrator of HCFA (1993–1997), was Assistant Commissioner for Health Planning & Resources Development under Joanne Finley from 1979 to 1982. As the Principal Investigator of New Jersey's DRG experiment, Vladeck had the responsibility to assess the DRGs' performance. He explains how technology limitations hindered the process of evaluating the state's experiments:

Vladeck: The most amazing thing about this experience was that all of the time we were doing this until when I left the Department in early 1982 and even after we had set the 1982 [hospital payment] rates, the New Jersey Department of Health did not own a computer!

Mayes: You did it by calculators?

Vladeck: No, it was done on computers. The Yale people did some of the work on their computers and then we had to time-share with 1 of the 3 or

99. *Ibid.*

100. Morone and Dunham, "The Waning of Professional Dominance," 80.

4 state mainframe computers in those days, which was controlled by New Jersey's Department of Transportation. But it was always very frustrating. We also bought time through the time-sharing system at Rutgers University. But we could only afford, given our budget constraints, to run our stuff at night. It was all mainframe stuff and all the data entry was still pretty much done manually, so it took us quite a while. And the data submissions from the hospitals themselves were manual, so we had to get them all keypunched in before we could do anything with them.¹⁰¹

Ultimately, the New Jersey experiment, as much as anything, provided a feasible alternative to traditional cost reimbursement. "Over time we clearly demonstrated that at the barest minimum, you could get such a system off the ground and the hospitals kept functioning and, lo and behold, they seemed to be responding to the incentives in the system," recalls Averill. "Hospitals got paid, grandma was not thrown out onto the street prematurely by hospitals, and so it was generally viewed as a positive change despite all the predictions to the contrary."¹⁰² Federal policymakers were especially encouraged that an alternative reimbursement system existed, because Medicare's financial health was deteriorating rapidly.

SOCIAL SECURITY & MEDICARE'S TRUST FUND CRISES

By 1982, federal policymakers' concerns about the financial stability of Medicare were escalating and becoming part of even larger worries about growing federal budget imbalances. Mushrooming budget deficits (stemming from Reagan's major tax cuts passed the previous year), together with the highest unemployment rate and the worst recession since the Great Depression, created a sense of fiscal and economic crisis. The immediate concern of leading members of Congress was the fact that declining payroll taxes threatened to exhaust Social Security and Medicare's trust funds. When the Social Security Boards of Trustees released their annual reports on 1 April 1982, they noted "that unless action was taken soon, the Social Security system would be unable to pay cash benefits on time to retirees and survivors, beginning in July 1983."¹⁰³ Medicare's trust

101. Bruce Vladeck, oral history interview with the author, 14 August 2002.

102. Richard Averill, oral history interview with the author, 19 March 2003.

103. See Social Security Board of Trustees, *Summary of the 1982 Annual Reports of the Social Security Board of Trustees: Old-Age, Survivors, and Disability Program* (Washington, D.C.: Office of the Actuary Social Security Administration, 1 April 1982).

funds were in better shape, they reported, but the program still “faces very serious financial problems—indeed, bankruptcy—in the late 1980s or early 1990s unless taxes are increased considerably or expenditures are greatly reduced.”¹⁰⁴

The short-term solution to Social Security’s crisis that policymakers adopted only exacerbated Medicare’s financial problems. They borrowed from Medicare’s Hospital Insurance (HI) trust fund to shore up Social Security’s Old Age and Survivors Insurance (OASI) trust fund.¹⁰⁵ Carlyne Davis, HCFA’s Administrator, recalls that inter-fund borrowing became a leading catalyst for forcing a major reform of Medicare:

I remember when Secretary Schweiker called and he said, “I really need to borrow \$14 billion.” That sounded very odd, and I remember saying to him, “Mr. Secretary, I would really like to *not* give it to you, because our [Medicare] trust fund is going to be bankrupt in 1995.” And he said, “I can appreciate that, but you don’t understand that I have to send Treasury checks out next month to Social Security beneficiaries and we don’t have the money. So I have to borrow it from you even though I am sympathetic to the fact that you’ve got a problem with that. But we’ll fix it.” That was my first acknowledgement that they were going to fix Medicare. . . .¹⁰⁶

Inter-fund borrowing and the recession’s effect on payroll tax revenue combined to move up the projected insolvency date of Medicare’s HI trust fund to 1988.¹⁰⁷ It also did not help that hospital costs in 1982 increased at three times the general rate of inflation.¹⁰⁸

Congress responded to the mounting fiscal crises by passing the Tax Equity and Fiscal Responsibility Act (TEFRA) in August 1982.¹⁰⁹ Signed into law on 3 September 1982 by President Reagan, TEFRA predominantly dealt with closing tax loopholes and other revenue provisions entirely unrelated to Medicare.¹¹⁰ But it also

104. Iglehart, “Health Policy Report,” 1309.

105. Summary of the 1982 Annual Reports of the Social Security Boards of Trustees.

106. Carlyne Davis, oral history interview with Edward Berkowitz, 8 November 1995.

107. Medicare Board of Trustees, Federal Hospital Insurance Trust Fund, *1983 Annual Report, Federal Hospital Insurance Trust Fund*, House of Representatives, 98th Cong., 1st Sess., Doc. No. 98-75 (Washington, D.C.: Government Printing Office, 1983), 19–20.

108. John Iglehart, “Medicare Begins New Prospective Payment of Hospitals,” *N. Engl. J. Med.*, 1983, 308, 1428–32.

109. Tax Equity and Fiscal Responsibility Act, 1982, P.L. 97-248.

110. Daniel Palazzolo, *Done Deal? The Politics of the 1997 Budget Agreement* (New York: Chatham House Publishers, 1999), 27.

included various measures aimed at curtailing Medicare's cost growth, particularly stringent cutbacks on Medicare payments and a strict limit on how much the program's total hospital expenditures would be allowed to grow in future years.¹¹¹ Growth in Medicare reimbursements per patient discharge was limited for a three-year period.¹¹² These measures effectively sounded the official death knell for retrospective reimbursement, the system that the hospital industry had painstakingly fought for and solidified over decades.¹¹³ As a result, TEFRA became a key stepping-stone to passing prospective payment legislation the following year.

TEFRA represented a major political and strategic shift in policy-makers' focus on containing hospital costs. Whereas the Carter administration's proposals had sought to cap hospital prices for *all* payers, public and private, the Reagan administration narrowed its attention to just the "problems" of government programs. "The focus turned very much to, 'We're running these public programs. We have to run them better, more efficiently. We have to economize our expenses,'" according to Paul Ginsburg, Deputy Assistant Director of the Congressional Budget Office (CBO) at the time.¹¹⁴ In contrast to Carter's efforts, which were derailed by intense partisanship, Congress approved the new Medicare constraints with little disagreement between politicians of widely divergent political views. Regulating prices for just Medicare was far less threatening to the hospital industry than Carter's "all-payer" proposal. Republicans in general and Senator Dole, chairman of the Senate Finance Committee, in particular, led the attack on behalf of tough new constraints on hospital spending. Representatives of the hospital industry were reduced to a strategy of damage control.¹¹⁵

TEFRA was a preliminary but strategically effective measure. The fact that it set per diem limits on Medicare reimbursement,

111. David Abernethy, oral history interview with the author, 19 June 2002; Lawrence Brown, "Technocratic Corporatism and Administrative Reform in Medicare," *J. Health Polit. Policy Law*, 1985, 10, 579–99, 593.

112. See Congressional Budget Office, *Analysis of Medicare Hospital Reimbursement Changes in the Tax Equity and Fiscal Responsibility Act of 1982* (Washington, D.C.: Government Printing Office, 1983), 3.

113. Office of Technology Assessment, *Diagnosis Related Groups (DRGs) and the Medicare Program: Working Paper*, 23.

114. Paul Ginsburg, oral history interview with Edward Berkowitz, 22 August 1995.

115. John Iglehart, "The New Era of Prospective Payment for Hospitals," *N. Engl. J. Med.*, 1983, 308, 1288–92, 1288.

which hospitals loathed, “was not coincidental,” according to several observers.¹¹⁶ Moving to a payment system that hospitals hated and feared provided Congress with political leverage and a superior bargaining position when DRGs were introduced for consideration the following year.¹¹⁷ As something of a “doomsday device,” TEFRA signaled to the hospital industry that systemic change was inevitable and imminent.¹¹⁸ The not-so-subtle implication was that the hospital industry should “come to the bargaining table” to support the transition to a prospective payment system.¹¹⁹ It worked.¹²⁰

To show that the AHA was willing to cooperate in a transition to prospective payment, McMahon and a number of state hospital association executives asked Jack Owen, President of the New Jersey Hospital Association, to become their Washington representative in the spring of 1982.¹²¹ His experience of having worked successfully with policymakers in New Jersey gave him a unique credibility in representing the nation’s largest hospital organization. The AHA was especially eager to cooperate with policymakers to change Medicare if it meant getting rid of TEFRA’s new payment policies. “People really wanted to create a better set of incentives,” according to Rick Pollack, current Executive Vice President of the AHA, who joined the organization in 1982. “TEFRA was kind of a stopgap to put the tourniquet on Medicare spending, but it wasn’t anything that people wanted to see go beyond a stopgap kind of approach. So, yes, we were very much ‘on board.’”¹²²

116. Robert Rubin, oral history interview with the author, 23 August 2002.

117. Bruce Vladeck, oral history interview with the author, 14 August 2002.

118. Charles “Chip” Kahn, oral history interview with Edward Berkowitz, 22 August 2002: “In TEFRA you had the per diem limits. And in a sense, they were so horrendous in terms of how they were going to affect hospitals that they drove the hospitals into being willing to accept DRGs. But from the standpoint of [Senator] David Durenberger and a cadre of members of Congress—and Sheila Burke I think was a part of this, too, although I don’t know how well she conceptualized it—Dave [Durenberger] and these others had a notion that they wanted to use Medicare as a change agent. And rather than the cost containment approach where you have broad-based government intervention, they wanted to use Medicare as the big purchaser to have a payment scheme or schemes that were designed to align the incentives for providers appropriately.”

119. Oberlander, *The Political Life of Medicare*, 124.

120. Iglehart, “The New Era of Prospective Payment for Hospitals,” 1292.

121. Jack Owen, oral history interview with the author, 1 October 2002.

122. Rick Pollack, oral history interview with the author, 27 December 2002.

DEVELOPING A PROSPECTIVE PAYMENT PROPOSAL WITH OR
WITHOUT DRGS

TEFRA called for the Secretary of HHS to develop, in consultation with the Senate Finance and House Ways & Means Committees, a proposal for prospective reimbursement by 31 December 1982.¹²³ Had there not been almost a decade of research and demonstrations by HCFA, it literally would have been impossible to meet the four-month deadline.¹²⁴ But policymakers were able to draw upon years of research by HCFA's Office of Research and Development and, to a lesser extent, New Jersey's experience with DRGs. "The DRG prospective payment system moved forward as rapidly as it did, because it basically was a wrinkle on all the work that had been done for the implementation of the Section 223 cost limits," argues Judith Lave, Director of HCFA's Office of Research and Development from 1977 to 1982. "Basically, how you do DRGs, how you weight them, what you should take into consideration, how you should analyze them, so many of the technical issues—not all of them of course—but much of the analytical groundwork had already been laid."¹²⁵

The two models that the task force ultimately proposed to Schweiker both included DRGs but in different ways. The model that the task force preferred entailed a flat-rate payment per hospital discharge that only used DRGs to establish total cost limits for individual hospitals. The second model used DRGs as the central price-setting device. It bore a greater resemblance to New Jersey's system that, at the time, appeared to be working better than any of the other state experiments (see Table 1).¹²⁶ According to David Smith, Schweiker was "flabbergasted at their final recommendation."¹²⁷ The flat rate approach was "clearly unacceptable" to him, because it encouraged hospitals to "skim off" the healthier patients while offering them minimal incentives to improve their technology and become more efficient. In the end, he overruled the preferences of his task

123. Section 101(c) of the Tax Equity and Fiscal Responsibility Act, 1982, P.L. 97-248.

124. U.S. Department of Health and Human Services, *Report to Congress: Hospital Prospective Payment for Medicare* (Washington, D.C.: Government Printing Office, 1982), 1.

125. Judith Lave, oral history interview with the author, 30 July 2002.

126. David Smith, *Paying for Medicare: The Politics of Reform* (New York: Aldine de Gruyter, 1992), 33.

127. *Ibid.*, 44.

TABLE I

Annual Percent Increase in Inpatient Hospital Costs: Demonstration States vs. U.S.

	1979	1980	1981
Connecticut	8.1%	11.4%	15.9%
Maryland	12.1	9.8	15.6
Massachusetts	7.6	14.1	14.1
New Jersey	11.2	10.7	11.4
New York	8.5	10.8	14.1
Rhode Island	10.9	12.4	16.3
Washington	11.2	10.9	18.9
Wisconsin	10.7	12.6	17.6
<i>United States</i>	11.3	12.7	17.3

Source: Adapted and modified from U.S. Department of Health and Human Services, *Report to Congress: Hospital Prospective Payment for Medicare* (Washington, D.C.: December 1982), Tables 3, 21.

force and instructed its members to design his department's prospective payment proposal with DRGs as the key price-setting device.¹²⁸

The Reagan administration came to view prospective payment with DRGs as "the response of a prudent purchaser concerned with creating incentives for efficiency and reducing the federal budget deficit."¹²⁹ In short, DRGs would reduce costs by putting the hospitals at financial risk. With the threat of operating losses for those hospitals unable to deliver care at or below DRG payment rates, prospective payment would virtually force hospitals to increase efficiency and productivity and, in the process, lower their costs.¹³⁰ And lower hospitals costs, proponents argued, would translate into lower Medicare expenditures.¹³¹

128. *Ibid.*, 44-45.

129. Gold, Chu, Felt, Harrington, and Lake, "Effects of Selected Cost-Containment Efforts: 1971-1993," 193-94.

130. Robert Rubin oral history interview with Edward Berkowitz, 16 August 1995: "DRGs were an example of [using] financial or economic incentives for getting people to do the correct thing versus coercing them, the difference between the carrot and the stick."

131. *Ibid.* See also Richard Averill and Michael Kalison, "Prospective Payment by DRG," *Healthc. Financ. Manage.*, 1983, 13, 12-16; Richard Averill and David Sparrow, "TEFRA's Two-Part Strategy Will Reduce Medicare's Financial Liability to Hospitals," *Healthc. Financ. Manage.*, 1983, 13, 72-77.

PIGGY-BACKING ON SOCIAL SECURITY'S BAILOUT AND BUYING
OFF THE OPPOSITION

Financial necessity, particularly the specter of imminent bankruptcy, is often the mother of all kinds of major programmatic invention. Policymakers' seminal reform of both Social Security and Medicare in 1983 is a classic example. According to Don Moran, Reagan's Associate Director for Budget and Legislation, Social Security's approaching insolvency provided the perfect vehicle for changing Medicare's Part A hospital program to a prospective payment system with DRGs:

Ideas like DRGs have an intellectual life of their own . . . but at some point these ideas hit their nexus to the real world, tactical political situation and they either do or do not adhere. So, yes, DRGs had an independent life of their own quite without regard to what anybody in the Reagan administration thought about them *per se*. But we just pulled them off the shelf as a "plug" to solve the short-term solvency problem with Social Security. Inter-fund borrowing had sprung a temporary leak in Medicare's HI [Hospital Insurance] Trust Fund, so we needed some kind of magic asterisk to stick in the Social Security deal to say, "Notwithstanding the fact that we are currently bankrupting the HI Trust Fund, we have a fig leaf [prospective payment] to stick in as a plug when inter-fund borrowing expires on June 30th, so that we can lower the five-year forecast outlays in the HI Trust Fund and, in so doing, prevent its bankruptcy over the next five years."¹³²

Obviously there was more momentum and technical development behind prospective payment's ascendancy than Moran's statement suggests. But his argument that extraordinary political and fiscal circumstances opened a rare window of opportunity for a major policy change is undeniable.

Ironically, the first person to suggest the possibility of strategically attaching Medicare's prospective payment proposal to Social Security's bailout bill was Dan Rostenkowski, chair of Ways & Means, who had played the leading role in defending the hospital industry from Carter's hospital cost containment plans.¹³³ Rostenkowski contacted Secretary Schweiker about the idea. He was initially surprised but quickly supported it.¹³⁴ Shortly thereafter, as John Iglehart has

132. Don Moran, oral history interview with the author, 28 October 2002.

133. John Salmon, oral history interview with the author, 28 June 2002.

134. Smith, *Paying for Medicare*, 50.

chronicled, Rostenkowski's Chief Counsel, John Salmon, asked Schweiker's Assistant Secretary for Policy & Planning, Robert Rubin, "How fast can you do prospective payment?"¹³⁵ Rubin responded, "In six weeks." Salmon said, "How about 11 days?" and then explained to him the merits of "one of the greatest legislative engines we'll ever see—the Social Security bill."¹³⁶ Bob Dole, Rostenkowski's counterpart as chair of the Senate Finance Committee, objected to the idea at first but eventually agreed after receiving a personal guarantee from the AHA's Jack Owen that "we will get the hospitals to go for it."¹³⁷ According to Owen, "My job was not to stop it, but just to help it and go along with it."¹³⁸

Once senior congressional leaders and the administration were in agreement, attention turned to buying off any opposition from the hospital industry. It helped that TEFRA's stringent cost controls were set to begin later that same year. Hospitals were looking for anything to avoid TEFRA.¹³⁹ Besides the prevailing sense that reform was unavoidable, a major factor that contributed to the hospital industry's relatively receptive attitude about reform was the unprecedented potential for significant profits. "That was one of the things you could sell, because there was a lot of financial slack in the hospital business," acknowledges Owen. "Once they started pulling back on their slack, the hospitals could really start making some money."¹⁴⁰

Hospital representatives, however, were still divided in their opinion of prospective payment. The Federation of American Hospitals, which represented for-profit hospitals, was enormously enthusiastic.¹⁴¹ The AHA was comparatively less so but was still eager to avoid the effects of TEFRA.¹⁴² Representatives of the nation's teaching hospitals, however, were strongly opposed to the plan.¹⁴³ Due to the fact that they train residents, employ academic physicians, and conduct medical research, academic medical centers

135. Paul Rettig, oral history interview with Edward Berkowitz, 14 August 1995.

136. Iglehart, "Medicare Begins New Prospective Payment of Hospitals," 1430.

137. Owen, oral history interview with the author.

138. *Ibid.*

139. Rubin, oral history interview with the author; Pollack, oral history interview with the author; Owen, oral history interview with the author.

140. Owen, oral history interview with the author.

141. Demkovich, "Who Says Congress Can't Move Fast?," 705.

142. *Ibid.*

143. Iglehart, "Medicare Begins New Prospective Payment of Hospitals," 1429.

are less efficient than community hospitals. At the same time, they serve a unique and essential need: advancing medical progress. Moving to a national prospective rate system, therefore, would have put them in the impossible situation of competing financially with hospitals that could and would consistently beat them on price.

Consequently, staff members in HCFA and on the Ways & Means Committee recommended increasing DRG payment rates to teaching hospitals as a “cushion.”¹⁴⁴ Different economic simulations of this increase, though, produced different results. The issue was critical, because adjusting the payment rates involved massive swings in the total amount of money that teaching hospitals would receive. Too low of an adjustment and teaching hospitals would be severely harmed financially; too high of an adjustment and the hospitals would receive absurd financial windfalls at Medicare's actuarial expense. Robert Rubin ultimately pushed for a generous doubling of the “resident-to-bed” adjustment in DRG rates to teaching hospitals.¹⁴⁵ “It was a bribe, pure and simple,” says Allen Dobson. “It was a bribe and it worked.”¹⁴⁶ Teaching hospitals relented and became supportive of prospective payment with DRGs. As Rubin explains,

Were we overly generous on the teaching adjustment? Sure. I've said publicly innumerable times that the real number was not 2 [a doubling]. I mean, any fool would know that 2 is a totally made-up number, but it was close to 2. . . . That made the teaching hospitals reasonably happy and it gave us a very important part of New York's political delegation, including [Pat] Moynihan and Charlie Rangel. That was not a trivial issue. We also got the Mayo Clinic exemption, which made Senator [David] Durenberger [R-MN] happy. And we had exemptions for the cancer hospitals, which made the folks in Texas happy.¹⁴⁷

The Ways and Means and Senate Finance Committees made a few other important adjustments to account for “outlier” cases and to exclude various items from being factored into the DRGs, namely hospital capital and direct medical education. The latter two items would continue to be reimbursed on a traditional cost basis.¹⁴⁸

144. Smith, *Paying for Medicare*, 52.

145. Rubin, oral history interview with the author.

146. Dobson, oral history interview with the author.

147. Rubin, oral history interview with the author.

148. Smith, *Paying for Medicare*, 55.

Having bought off the hospital industry's opposition, members of both committees were able to pass the legislation quickly and easily. Attaching Medicare reform to critical Social Security reform was a purely opportunistic, but effective, decision. It produced a veto-proof bill that was immune to any single or collective interest-group veto due to its sheer urgency.¹⁴⁹ Most members of Congress did not even understand how prospective payment worked.¹⁵⁰ They voted for it, however, because Medicare was approaching insolvency and even more so because the Social Security legislation had to pass for the program's millions of monthly checks to continue uninterrupted.¹⁵¹ "There was no serious debate [about prospective payment] of any consequence," notes Paul Rettig. "It was so overwhelmed by the Social Security rescue that it received very little political attention."¹⁵²

After roughly two months of legislative consideration, most of it focused on adjustments to the OASI program, Congress passed the Social Security bill on 24 March 1983. President Reagan signed it into law one month later, on 20 April.¹⁵³ The single biggest change to the American health care system since Medicare and Medicaid's passage in 1965 went largely unnoticed outside a small group of hospital representatives and health policy leaders.

CONCLUSION

Following a decade of development, experimentation, and analysis, the passage of Medicare's new prospective payment system with DRGs represented nothing short of an administrative revolution. It

149. See Timothy Clark, "Congress Avoiding Political Abyss By Approving Social Security Changes," *Natl. J.*, 1983, 15, 611-15. See also Paul Light, *Still Artful Work: The Continuing Politics of Social Security Reform* (New York: McGraw-Hill, 1995), 1: "This is a story about a legislative miracle. Under extreme time pressure in 1983 (and largely because of it), Congress and the President finally passed a Social Security rescue bill. Two years in the making, the legislation arrived just moments before the Social Security trust fund was to run dry. Without the \$170-billion package of tax increases and benefit cuts, millions of checks would have been delayed."

150. Iglehart, "Medicare Begins New Prospective Payment of Hospitals," 1429: "A remarkable reality of the process in both chambers was how few legislators were actually involved in designing the legislation. For the most part, professional staff members made the key decisions."

151. For more on the Social Security crisis, see Joseph White and Aaron Wildavsky, *The Deficit and the Public Interest* (Berkeley, Calif.: University of California Press, 1989), ch. 14, "A Triumph of Governance: Social Security"; Paul Light, *Artful Work: The Politics of Social Security Reform* (New York: Random House, 1985).

152. Rettig, oral history interview with Edward Berkowitz.

153. Iglehart, "Medicare Begins New Prospective Payment of Hospitals," 1430.

altered the power relationship between Medicare and health care providers. Key to policymakers' success was the strange political attraction of prospective payment. Hospital industry representatives were already desperate for any alternative to TEFRA, but they quickly became keen on the opportunity to make significant profits under the new reimbursement system. Congressional leaders of both parties and Reagan administration officials wanted more control of Medicare to restrain the program's rate of growth, despite the fact that prospective payment required significantly increased government regulation and control of health care. And with Social Security literally on the verge of bankruptcy in 1983, policymakers finally had a legislative vehicle for comprehensive Medicare reform that was unstoppable.

Following the rapid passage of Medicare's new reimbursement system, a new set of concerns arose: Would the system actually work? Would Medicare's rate of expenditure growth subside? How would hospitals respond to the new incentives? Would any particular set of hospitals be wiped out financially by the new system? How would patients be affected, if at all? "There was great sensitivity that we were going down a path none of us had gone down before," notes Sheila Burke:

There had been some rough sort of testing on the state-level, but nothing on the scale of Medicare. We all knew only too well the impact of any change in Medicare could lead to seismic changes in the industry, because Medicare was such a big purchaser. So we were all enormously sensitive to that, and also enormously sensitive to not really knowing how to defend or describe what appeared to be real differences between hospitals, their costs and their mix of cases. We knew far less than one would have hoped about what would occur after making these changes.¹⁵⁴

The only thing policymakers did know for sure was that, with a program as immense as Medicare, it was impossible to change just one thing.¹⁵⁵ The ripple effects of moving to a prospective payment system were bound to be extensive and, as history reveals, they were.¹⁵⁶

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154. Burke, oral history interview with the author.

155. Morone and Dunham, "The Waning of Professional Dominance," 74.

156. Rick Mayes, "Causal Chains and Cost Shifting: How Medicare's Rescue Inadvertently Triggered the Managed Care Revolution," *J. Policy Hist.*, 2004, 16, 144-74.