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CALIFORNIA HEALTH CARE

FROM MEDICARE TO THE MILLENNIUM[a]

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I. INTRODUCTION

This article attempts to present highlights of California's health care history since the enactment of Medicare and Medicaid (Medi-Cal in California) in 1965. Emphasis is placed on hospitals and hospital payment issues. Enactment of the Medicare and Medicaid programs represents the most significant health care financing development in the United States to date. These programs transformed the health industry into a major segment of the economy and one of the most visible sectors from a public-policy perspective. These programs set in motion the chain of events that resulted in the 21st century health system; a system characterized by intense competition, medical miracles, control by managed-care organizations and 44 million uninsured Americans. California, as the largest state, played no small role in shaping these forces.

The next section places in perspective the Medicare and Medicaid legislation. The major events since 1965 are set forth in Section III. This is followed by a discussion of governmental attempts to control costs, and a discussion of attempts to improve access. The last section provides some concluding thoughts.

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II. THE SETTING

Prior to the enactment of Medicare and Medicaid in 1965, the organization and provision of health services were largely in private hands (i.e., hospitals, physicians and insurance companies). Government's involvement in financing and delivering of health care was mainly restricted to public hospitals. By 1965, however, spiraling costs, unequal access and quality problems inspired Congress to end this private domination through enacting more than a score of laws that effectively served to establish health care as a right. A center piece of the 89th Congress's accomplishments were Medicare and Medicaid, which enabled the elderly and major segments of the low-income population unprecedented access to private hospitals and physicians; no longer as charity patients, but with a reasonably profitable payment source. This set in motion a chain of events whose repercussions are still being felt – from federally-imposed cost-control programs, to restrictions on capacity, to state-level cost controls, to dramatic advances in bio-medical technology made possible by infusions of dollars into the health system, to periodic efforts to "shore up" Medicare, to various (largely unsuccessful) initiatives to establish universal access at the federal and state levels, and to the proliferation of managed care, which among other things, has facilitated the movement of the hospital from the hub of the health system to a position much further down the food chain.

Over the last third of a century, the health industry has evolved from a cottage industry to one spending a trillion dollars a year and receiving the lion's share of public policy attention at both federal and state levels. As the population ages, the size of the industry and its public policy implications can only increase.

III. MAJOR EVENTS

Medicare and Medicaid were launched in 1965 in the unrealistic belief that the only barrier that kept the poor and the aged from equal access was inability to pay. The most basic economic principle that "increasing demand without commensurate increases in supply leads to price increases" was largely ignored; probably through wishful thinking. By 1970 the costs of these programs were double the federal actuaries' projections for that year made in 1965. Had, however, the actuaries generated realistic projections in 1965, the programs may not have been enacted. Moreover, had necessary cost-control mechanisms been incorporated in the legislation, it would have been defeated by organized medicine (which received guarantees of fees based on usual, customary and reasonable), and organized hospitals (which were assured cost-based reimbursement).

As the unexpectedly-high bills came pouring in, Congress and successive administrations implemented a variety of actions to control Medicare and Medicaid expenditures. The payment guarantees made to the providers were gradually withered away. During the post-Medicare period, federal and state initiatives involved two, sometimes inconsistent, approaches: (1) reducing or restraining the increase in provider payments; and (2) increasing access. The latter

involved, among other things, expanding Medicare eligibility to the permanently disabled and those with end-stage renal disease, and various efforts to expand the availability of private or public health insurance to low-income groups not eligible for Medicaid.

Regulatory approaches expanded throughout the 1970's, often encompassing efforts to control total hospital revenues, beyond those financed by public funds. This was followed by narrower regulatory limits focusing on public funds only. To prevent private payers from absorbing an increasing cost shift from government underpayments, employer groups and insurance carriers promoted managed care, which at its least intrusive relied on preferred provider organizations (PPOs) based on directing patients to hospitals and physicians with negotiated rates, and in its more aggressive form relied on HMOs, which controlled both payment rates and utilization levels. While PPOs and HMOs are the private sector's market-based alternative to government rate control, the overly restrictive nature of some HMOs have led to regulatory efforts to provide consumers with more provider and medical-procedure choice through "patients' bill of rights" legislation.

IV. GOVERNMENTAL EFFORTS TO CONTROL EXPENDITURES

Following implementation of Medicare and Medicaid, the first major federal cost control efforts were embodied in the Social Security Amendments of 1972 (PL 92-603) and the Economic Stabilization Program (August 1971-May 1974). This was followed by health planning legislation (the National Health Planning and Resources Development Act of 1974 [PL 93-641]); unsuccessful proposals by the Carter Administration to put a limit on all hospital revenue; establishment of hospital financial disclosure in California in 1971; implementation of health planning and certificate of need in California; unsuccessful legislative proposals in California to essentially regulate hospitals as a public utility; California regulatory efforts to control Medi-Cal payments; establishment of the Selective Provider Contracting Program in California, involving hospitals bidding for inpatient Medi-Cal contracts; and implementation of the Medicare inpatient prospective payment system in 1983, and the hospital outpatient prospective payment system in 2000.

The Social Security Amendments of 1972 were aimed at tightening hospital use and reimbursement rates under Medicare and Medicaid. Medicaid payment levels were restricted to not exceed Medicare levels. One provision was particularly problematic for California hospitals. Limits were placed on hospital reimbursement for routine services under Medicare. These limits were on a per-diem basis and were gradually tightened throughout the 1970s. The problem for California hospitals was their generally low length of stay compared to similar hospitals in other parts of the U.S. Since the early days of a typical stay involve greater intensity of care, average cost per day (even routine [i.e., hotel and nursing]) are generally higher for short stays. Thus, while California's low length of stay resulted in program savings on a per-stay basis, its per-diem costs were higher, and thus its hospitals were disproportionately affected by these limits. While some hospitals were granted relief through a cumbersome appeals process and litigation, equity did not occur until the limits were set on a total operating cost per discharge basis in 1982 – Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). This was followed a year later by the

prospective payment system based on diagnosis related groups (DRGs). Another provision of this law established the Professional Standards Review Organizations (PSROs), which attempted to monitor and control utilization at the local level. These were superceded by the Peer Review Organizations. These types of governmentally-mandated organizations no longer exist.

In an attempt to control general economy-wide inflation without raising unemployment levels, the Nixon Administration in 1971 instituted across-the-board price controls through the Economic Stabilization Program (ESP). While most of the economy was decontrolled in later phases of the program, hospitals remained under control until the program was terminated in May 1974. Phase IV of the ESP attempted to control total hospital revenue. While the ESP was in place, the hospital industry believed further control was inevitable, leading to industry-sponsored legislation to establish public-utility-type rate controls on hospitals. California's answer was the Hospital Disclosure Act, which became effective in 1972. At the time, the California Hospital Association (CHA) believed the ESP or a similar program would be permanent. It also believed the best approach to assure adequate Medicare and Medicaid payments was through a public-utilities-type approach. The Disclosure Act established an independent commission, which could in the future become a rate-making body. Since it was independent of the State Medicaid agency, it was viewed as more likely to represent the broader public interest in setting or approving rates. The commission set standards for hospital reporting and accounting for purposes of filing financial reports for public disclosure. CHA viewed a sound disclosure process as a prerequisite to an effective regulatory program. Subsequently, several pieces of legislation were introduced to give the commission rate-making authority. None were successful. The termination of ESP in 1974 resulted in a change of position on the part of CHA, which gradually became opposed to this type of rate regulation. Hospital financial disclosure has been maintained, however. Responsibility for the program was later moved from the California Health Facilities Commission to the Office of Statewide Health Planning and Development (OSHPD).

Several states, most notably Maryland, New Jersey, Connecticut, New York and Washington, established all-payer hospital rate-control programs during the 1970s, with encouragement from the federal government and support by the hospital industry. Federal government and industry support evaporated as the Reagan Administration discouraged such approaches. At this time only one state, Maryland, has maintained its system. It is likely that had such approaches expanded, the competitive pressures that encouraged the proliferation of managed care in the 1980s and 90s would not have materialized.

Health planning and certificate of need attempted to retard hospital cost inflation through restricting unwarranted growth. The National Health Planning and Resources Development Act of 1974 was aimed at strengthening the planning processes among the states. It called for Health Service Areas and corresponding Health Systems Agencies to facilitate planning and certificate of need review. While less comprehensive than the federal law, California enacted its certificate of need law in 1976. This law required all major hospital capital expenditures and increases in capacity to receive a certificate of need as a condition for licensure. While in retrospect it is apparent that California's hospital industry would be in a better competitive position today vis-a-

vis negotiations with HMOs had its capacity been restrained, the program was controversial and unpopular in the Legislature and among segments of the hospital industry. It was repealed in 1987. The national law was repealed even earlier, as its thrust was counter to the philosophy of the Reagan Administration. Health planning and certificate of need, coupled with state-level rate-control programs, had the promise to provide the cost-containment infrastructure for the national health insurance system that never materialized.

In 1977, a marked increase in cost containment efforts occurred. Spurred largely by a projected federal health budget overrun, the Carter Administration proposed capping hospital revenues, and setting an aggregate limit on capital expenditures. This control effort was aimed at revenues deriving from private as well as public sources. This legislation was debated for several years, and was ultimately defeated in 1980. In an effort to defeat this legislation, the American Hospital Association (AHA) proposed a "Voluntary Effort" to control hospital costs. The Voluntary Effort was only successful in defeating the legislation; not in controlling hospital costs in an industry where payment was largely determined by costs (Medicare and Medicaid) and billed charges (private insurance). This was the last effort on the part of the Carter Administration to establish comprehensive revenue controls on hospitals. During the Reagan Administration, all cost-containment efforts focused on Medicare and Medicaid only. While this narrower approach directly focuses on controlling tax funds, the broader approach attempts to go the additional step of protecting the private sector from an expected cost shift (i.e., hospitals cross-subsidizing government payment shortfalls with inflated charges to private payers), and establishing a cost-containment and resource-allocation infrastructure to support future national health insurance; an infrastructure that was not in place when Medicare and Medicaid came on line. Had such an infrastructure been in place, the health system would have been in a better position to accommodate the surge in demand resulting from these huge, new programs.

The early 1980's ushered in a revolutionary change in the way hospitals were paid and regulated, both at the national level and in California especially. At the federal level, as discussed above, the concern was with controlling government expenditures only; i.e. it was believed the federal government should not be reorganizing the health system through planning, capacity controls or controlling private revenues accruing to hospitals. Two major changes in Medicare hospital reimbursement that decoupled payment from an individual hospital's costs were enacted within two years. TEFRA (1982) established new limits on hospital cost reimbursement. While previous limits were generally on routine cost per patient day, the new limits were on a total inpatient cost per discharge basis set at 120 percent of average costs, with additional limits on year-to-year increases. In 1983, the prospective payment system (PPS) based on diagnosis related groups (DRGs) was implemented, fully divorcing reimbursement from operating costs. Over the years, the cost-minimizing incentives inherent in PPS resulted in marked decreases in Medicare length of stay (since payment was on a per discharge basis) and decreases in the rate of increase in hospital costs (hospitals were no longer paid on the basis of their incurred costs). This change, when coupled with the Medi-Cal payment and private payment reforms instituted in California at about the same time, served to transform the California hospital industry in ways that were never imagined; and the repercussions are still being felt, nearly two decades into this "experiment."

In mid-1982, the State of California embarked on a major new, pro-competitive policy in an attempt to reduce Medi-Cal expenditures, prompted by a budget crisis. After nearly a decade of unsuccessful legislative proposals to establish mechanisms to control Medi-Cal, and private health care expenditures, the governor and legislative leaders had no choice but to find an instant solution to the Medi-Cal cost spiral. The central thrust of the reform involved the Medi-Cal program negotiating contracts with hospitals for the provision of inpatient care to Medi-Cal patients. This is in marked contrast to the previous approach, which involved obtaining services from any hospital that wished to participate, and reimbursing that hospital on the basis of its costs. Now the State was free to selectively purchase services based on local market conditions. Physicians were not subject to selective contracting. The perceived likelihood of this scheme resulting in substantially reduced payments to hospitals prompted the insurance industry to insist on also having the ability to selectively contract, to avoid an expected cost shift. Without this legislation, private insurance carriers were not permitted, under state law, to restrict consumer choice of hospitals and physicians. The ability to engage in selective contracting enabled private insurers to establish preferred provider organizations (PPOs), where subscribers are provided incentives in the form of lower cost sharing to obtain care from specified providers.

Medi-Cal contracting has been implemented mainly in urban areas, where the State can take advantage of hospital competition for Medi-Cal business. The California Medical Assistance Commission (CMAC), which administers the program, estimates annual savings in excess of $200 million annually, compared to what would be paid under cost reimbursement. Hospitals in non-contract areas (mainly, but not exclusively, rural hospitals) are still paid on the basis of costs, subject to limits on annual increases and costs per discharge incurred by comparable hospitals. Moreover, non-contracting hospitals in contracting areas are paid only for emergency cases, also on a cost basis subject to limits.

This 1982 reform led to the establishment and proliferation of PPOs in California. This concept later spread to other states. PPOs were later complemented, and many were replaced, by HMOs. In 1982, HMO activity in California was mainly limited to Kaiser Health Plan. At that time Kaiser's approximately 3.5 million members represented 14 percent of California's total population, and nearly 90 percent of statewide HMO enrollment. Today, virtually all privately insured patients are members of PPOs or HMOs, and most are in the latter.

Finally, subsequent to the 1982 reforms, in an effort to benefit from the proliferation of HMOs, the Medi-Cal program greatly expanded its involvement in managed care through three models:

(1) County Organized Health Systems (COHS), where designated county governments assume responsibility, on a capitation basis, for the entire Medi-Cal population within their jurisdictions. Five COHSs are now operational -- Santa Barbara, San Mateo, Solano, Orange and Santa Cruz. Under current federal law, no additional COHSs can be designated in California. The COHS represented the first major plunge by the Medi-Cal program into the managed care arena, with the

Santa Barbara County program established in the1982, San Mateo in1987 and the others in the mid-90's. In addition, the geographic coverage of the Santa Cruz COHS has recently been expanded to include Monterey County, and that of the Solano COHS to include Napa County;

(2) The Two-Plan Model has been implemented in12 counties. Under this model, all Aid to Families with Dependent Children (AFDC), and no-share-of-cost Medically-Needy Families and Children are required to sign up with one of two local HMOs. The major HMO is envisaged as a consortium of each county's safety-net providers – the "Local Initiative" – organized by the county boards of supervisors. The other HMO is to be a single, commercial HMO ("Commercial Plan") selected by the State. The former is to be comprised mainly of disproportionate-share hospitals, community clinics and "traditional" providers (i.e., physicians and hospitals which have traditionally served Medi-Cal patients). This model was intended to protect disproportionate-share hospitals, the most important of which in terms of Medi-Cal and indigent volume are county hospitals, and other safety-net providers that are dependent on Medi-Cal revenue. Local Initiative health plans are required to be Knox-Keene-licensed HMOs. The Two-Plan Model was implemented over the period 1996 through 1998; and

(3) Geographic Managed Care (GMC) is operational in two counties – Sacramento and San Diego. In Sacramento, it was implemented in April 1994. Implementation in San Diego began in 1998. While GMC covers the same beneficiary mix as the two-plan model, here beneficiaries choose from among a variety of commercial plans. Health plans are encouraged to contract with safety-net providers.

Under these programs, providers contract with the health plans in their geographic area to provide care to covered enrollees. The rates paid to the providers are set by the negotiation process. The health plans are paid capitation rates set by the State. For those beneficiaries not covered by the managed-care plans, providers are paid directly by the Medi-Cal program (i.e., Selective Provider Contracting or cost-based for inpatient care, and the State fee schedule for outpatient care). Approximately half the State's 5 million Medi-Cal beneficiaries are enrolled in a managed-care plan.

This section traced the major governmental efforts to control expenditures in California and nationally since the mid-1960's. During the 1970's, policy makers attempted to respond to the unanticipated cost increases generated by the post-Medicare/Medicaid influx of health services demand through a combination of direct limits on program reimbursement and broader efforts to re-design the entire health system. By the end of that decade, public policy generally gave up on the latter goal, preferring to focus only on the publicly-supported portion of health expenditures. To fill the void, managed-care strategies were pursued in the private sector, aided and abetted by an oversupply of hospital capacity, with hospitals hungry to fill their growing number of excess beds. The decade of the 1990's witnessed the shift in economic power from

hospitals to managed-care organizations, which have successfully reduced demand for hospital services.

V. GOVERNMENTAL EFFORTS TO INCREASE ACCESS

Efforts to increase access range from providing more provider choice to HMO enrollees, to enabling health insurance subscribers to change jobs without losing coverage, to increasing funds for safety net providers to maintain access for the uninsured, to government subsidized health coverage for certain groups (e.g., low-income children), to universal coverage for all groups.

Six times over the course of the 20th century (1910's, 1930's, 1940's 1960's, 1970's and 1990's) Congress considered government financing of health care for all, or large categories of, Americans. All these efforts, with the exception of Medicare and Medicaid, were unsuccessful. The earlier efforts encountered the vigorous opposition of the powerful medical lobby, fearing that government intrusion would interfere with how physicians practice medicine and thus limit their incomes. As discussed above, promising not to disrupt the physician payment system was the price that had to be paid to pass Medicare. Interesting, the most recent attempt to provide health care for all (the 1994 Clinton Plan) was not vigorously opposed by organized medicine. Its failure is attributed to the plan's complexity combined with a coalition of health insurance companies, small business, anti-government activists and Congressional Republicans seeing the Plan's defeat as an opportunity to capture Congressional majorities in the next election. It is unlikely the universal coverage issue will be revisited any time soon, no matter who is elected president this November.

In California, statewide health-insurance coverage was debated in the Legislature in the late 1980's and early 1990's, and through two voter initiatives during the mid 1990's. All the proposals were based on an employer mandate, where employers would be required to provide a minimal set of benefits to their employees. Both the physician and hospital trade associations supported this concept. Because of conflicting interests (providers, businesses that do not provide coverage, health insurers, and consumers) and lack of gubernatorial leadership during this period, there was little progress in addressing the growing problem of populations without health insurance. Currently, over 7 million Californians are not covered by private or public health insurance.

The defeat of comprehensive health reform in 1994 led to incremental efforts in Congress to make it easier for some groups to obtain private health insurance, and to provide government subsidized coverage to children in low-income families not otherwise eligible for Medicaid. In 1996 the Health Coverage Portability and Accountability Act was passed. While it does little to expand health coverage, it did produce some improvements in health insurance, through placing some limits on coverage exclusions that are based on pre-existing conditions and it makes it possible for people to change jobs without losing coverage. Prior to this law, people with ongoing health problems (pre-existing conditions) were either denied coverage, or whatever

coverage they bought excluded benefits for those illnesses. This act also allows people to change jobs without losing the ability to keep insurance.

In 1997, a more significant gap in health insurance coverage was dealt with. Through extensive pressure by the President, Congressional Democrats and children's advocates, a law was enacted extending health insurance coverage to low income, uninsured children. New cigarette taxes of $24 billion were set aside to finance this program. Depending on parents' income levels, government subsidies are provided to enable purchase of health insurance for their children. Some 10 million children are targeted by this program. The program is administered by the states, with the federal government matching state contributions on a two-to-one basis. California's program, the Healthy Families Program, was implemented in 1998. Currently, approximately 300,000 children are enrolled.

Since 1998, again after considerable prodding by the President and strong support by Congressional Democrats, Congress has been debating "Patient's Bill of Rights" legislation. This is aimed at giving subscribers of managed-care insurance plans safeguards from abuses by these plans. The Bill of Rights is intended to enable a managed-care patient to have a wider choice of physicians. It also allows the patient to sue the insurance company if denial of a service by the managed-care plan harmed the patient's health. California has already enacted similar legislation.

Another action to increase access involves the use of federal Medicaid funds to protect safety net hospitals. These hospitals, primarily county hospitals, treat a disproportionate number of Medi-Cal and other low-income patients. This payer mix precludes these hospitals from subsidizing losses incurred by treating this population with profits from other payer classes. Moreover, should these hospitals be forced to close, access for many low-income consumers would be greatly restricted. These "disproportionate share" hospitals are provided supplemental payments tied to their Medi-Cal patient volume. These funds are derived from leveraging transfer payments from public entities operating hospitals against federal Medicaid funds. Since the program was implemented in California in 1991, hospitals have received in excess of $1 billion annually in these supplemental payments, all provided through federal funds. This funding source is intended to subsidize Medi-Cal payment shortfalls as well as the costs incurred in treating unsponsored patients.

Since the enactment of Medicare and Medicaid in 1965, most major additional expansions did not occur until fairly recently. This reflects public officials' primary concern with dealing with the unanticipated Medicare and Medicaid cost explosions, so that these programs could be put on a realistic path from a budgetary perspective. Expansion beyond these programs was, for the most part, not seriously addressed until the 1994 Clinton Plan was debated. Where we go from here somewhat depends on future elections. At a minimum, however, it is likely that the Medicare program will be expanded to include coverage for some seniors for outpatient drugs. It is also possible more children will be made eligible for health insurance coverage.

VI. SOME CONCLUDING THOUGHTS

The modern health system is largely a product of the aftershocks of introducing the massive Medicare and Medicaid programs onto a fragmented health system ill-equipped to accommodate the surge in new purchasing power. Efforts to put some form of lid on the system to control federal and state budgets absorbed much of the two and one-half decades immediately following the enactment of these programs. These efforts involved narrow attempts to conserve only public funds, as well as broader efforts to redesign the entire health system, through health planning initiatives and comprehensive cost containment. The broader efforts were largely abandoned as the public and the health industry became disenchanted with large-scale government programs and regulation. What we have now is an industry that is still heavily regulated – with hospitals receiving over half their revenue from tax funds, this is to be expected – yet facing strong market forces, due to the growth in managed-care programs.

California has played an important role in getting these programs under control, through its Medi-Cal contracting program and the associated initiatives that spurred the tremendous expansion of managed care.

Now that, at least from the cost side, things have appeared to level off, new challenges have emerged. One is a desire on the part of providers and consumers to create a more level playing field between HMOs, providers and consumers through initiatives such as a patient's bill of rights. Another is to address the problem of the 44 million Americans (7 million Californians) lacking public or private health insurance. To date, this issue is being addressed in an incremental way, starting with low-income children, and maybe their parents. The bigger challenge, providing universal health coverage, is not on the radar screen.