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Medicare at 50: Why Medicare-for-all Did Not Take Place

Theodore R. Marmor & Kip Sullivan*

INTRODUCTION

In the fifty years since Medicare was enacted, Congress has not, with two exceptions in the 1970s, extended Medicare beyond the elderly. In those fifty years Congress has not even engaged in a serious discussion about expanding Medicare beyond the elderly. This disinterest persisted even during those periods when national health insurance was at the top of the national agenda. In other words, even when the conditions for health care reform were promising, Congress did not make Medicare-for-all a prominent option. In recent years, there has been at least as much discussion about raising Medicare's eligibility age as there has been about expanding the program to even a small fraction of the non-elderly.

Why has Congress never seriously debated, and why has the White House never seriously proposed, expanding Medicare? The answer cannot be that Medicare is an unpopular program. Over the five decades since Medicare was enacted, large majorities have supported the program and opposed spending cuts. On rare occasions, Congress has expanded the services Medicare covers. Part D's prescription drug legislation in 2003 is perhaps the most notable example.

Nor can the answer be that the American public has been unconcerned about the threat that rising health care costs—and worsening access to health care—pose to the health and financial welfare of all Americans. Since modern polling began in the 1930s, polls have indicated large majorities of Americans believe access to health care is a right and government should guarantee that right.¹ For the last quarter-century, polls have indicated that a very large majority of Americans believe the US health care system is in crisis and requires fundamental reform,² and a majority support addressing the crisis by expanding Medicare to the nonelderly³ or replacing the current system with a system like Canada's.⁴

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1. See Daniel Yankelovich, *The Debate that Wasn't: The Public and the Clinton Plan*, 14 HEALTH AFF. 7, 7 (1995).

2. See Robert J. Blendon et al., *Satisfaction with Health Systems in Ten Nations*, 9 HEALTH AFF. 185, 185 (1990); Robert J. Blendon & Humphrey Taylor, *Views on Health Care: Public Opinion in Three Nations*, 8 HEALTH AFF. 149, 150 (1989).

3. For example, 65 percent of respondents to an AP-Yahoo poll said yes to this question: "The

Nor can the answer be that Medicare emerged from a reform movement that focused solely on coverage for the elderly. Medicare's enactment in 1965 was the culmination of a half-century of work by activists who sought health insurance for all. In the quarter-century prior to 1965, this aspiration had the support of presidents Roosevelt and Truman, their advisors, and numerous advocates in Congress and among the public at large. Medicare's proponents thought the program was a first step toward universal health insurance.

Nor can the answer be that the movement for universal health insurance died out in 1965. The enthusiasm for universal coverage did wax and wane but never disappeared. For approximately a decade after Medicare was enacted, the movement for what was then called "national health insurance" continued, led prominently by Senator Ted Kennedy and his labor union allies. The movement came back to life again in the late 1980s, subsided after the death of the Clintons' Health Security Act in 1994, and rose again in the mid-2000s.

In this article, we provide an overview of the political and ideological developments that have kept Medicare expansion off the national agenda. We distinguish the explanatory power of short-term conditions, such as the stagflation of the 1970s, from longer-term developments that shaped the policy reform debate, such as the expansion of pro-competitive thinking in health care reform. Short-term circumstances are helpful in explaining particular, important events; for example, why Medicare was enacted in 1965 (and not earlier), why a change in the program occurred when it did, or why national health insurance rose to the top of the congressional agenda in the early 1970s.

Situational factors alone, however, cannot explain why Medicare remains a program only for the elderly, the disabled, and those with renal failure. For a fuller explanation of that puzzle, we turn to factors that prevailed throughout all or most of the last fifty years. Here, we focus primarily on two important developments: the rise of the managed care movement and the resurgence of a longstanding campaign promoting the idea that market competition in health insurance can right the wrongs of American medical care.

The managed care movement contributed to the hemming in of Medicare's expansion primarily through its influence on the proponents of national health insurance. It did so by persuading potential proponents of Medicare expansion to

United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the government and financed by taxpayers." *The Associated Press - Yahoo Poll Wave 2*, KNOWLEDGE NETWORKS (2007), http://surveys.ap.org/data/KnowledgeNetworks/AP-Yahoo_2007-08_panel02.pdf; see *Washington Post-ABC News Poll: Health Care*, WASH. POST (Oct. 20, 2003), <http://www.washingtonpost.com/wp-srv/politics/polls/vault/stories/data102003.html>.

4. Blendon & Taylor, *supra* note 2, at 152; Blendon et al., *supra* note 2, at 185; Patrick Howe, "Citizens Jury" Supports Wellstone's Health Care Proposal Over Clinton Plan, MINNEAPOLIS STAR TRIB., Oct. 15, 1993, at 10A; Michael McQueen, *Voters, Sick of the Current Health-Care System, Want Federal Government to Prescribe Remedy*, WALL ST. J., June 28, 1991, at A4.

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pursue a different reform strategy. Insurance companies practicing managed care, the rhetoric claimed, were more efficient than Medicare. Conversely, because Medicare did not employ managed care policies, it had to be inefficient compared to the “innovative” managed care industry. Managed care robbed Medicare expansion of enough of its proponents, we will argue, to keep it off the congressional agenda.

The rise of what we refer to as the pro-competition movement constituted another significant, long-term political impediment to Medicare’s expansion. It did so by strengthening the belief that market competition among private health insurance firms could be invigorated, largely by shifting more costs back to patients and eliminating tax subsidies for insurance, and that vigorous competition would make the health care sector much more efficient than Medicare could ever be. But because this movement attracted and appealed primarily to conservatives who did not support universal coverage in the first place, its impact on the debate about Medicare’s expansion, although substantial and powerful, was less direct. Unlike managed care, the pro-competition movement did not decimate the ranks of those who supported expanding Medicare beyond the elderly. Instead, it fenced Medicare in by limiting support for government-financed health coverage. This influence has been so pervasive that substantive debate about universal health insurance has been limited to three relatively short periods over the last fifty years: the periods 1970-1973, 1992-1994, and 2008-2010.

The combined effects of the pro-competition and managed care movements were powerful: The pro-competition movement limited the debate about universal coverage to a few “windows of opportunity” and, when those windows arrived, the managed care movement provided a solution at the expense of Medicare-for-all.⁵

In Part II of this paper, we offer a brief narrative of Medicare’s origins and the major developments in the program’s history. Parts III and IV present the conceptual weaknesses of the managed care and pro-competition theories and the role these defects have played in sustaining, rather than dampening, belief in those theories. Each movement, we argue, proceeded from its own particular set of unexamined assumptions, cultivated its own habits of thought, and contributed its own misleading jargon. In short, each movement generated an assumptive world and a mentality that encouraged adherents to discount evidence incompatible with their fundamental assumptions. This attitude toward evidence

5. The success of the pro-competition and managed care movements in blocking the expansion of Medicare was facilitated by structural constraints within the American political system, notably the fragmentation of decision-making authority and a lopsided distribution of resources between the forces supporting and opposing expansion of Medicare. A detailed discussion of these long-term factors is outside the scope of this paper. For further discussion, see THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 171-82 (2000).

is inconsistent with each movement's ostensible embrace of the rules of science and scientific discourse. We offer concluding remarks in Part V.

I. MEDICARE'S ORIGINS AND HISTORY SINCE 1965

In 2015, Medicare will mark its fiftieth birthday. It has played a crucial role in giving millions of elderly Americans—as well as those with disabilities and end-stage renal disease—access to basic medical care. Medicare has been innovative in introducing payment reforms that, compared to private insurance, have moderated the rate of growth in spending on medical care. For many reformers, Medicare's simplicity, low administrative costs, risk pooling, and social insurance arrangements still provide a sensible model for reforming American health care more broadly.

Yet Medicare's fiftieth birthday will take place amidst considerable controversy. Since 1995, there has been open and unusually sharp partisan and ideological conflict over Medicare; its reform has become a recurrent battleground over the proper role of government and markets in health care. That conflict—simmering for decades—was readily visible during debate over the 2003 Medicare Modernization Act (MMA), which added, among other controversial elements, a complicated prescription drug benefit to the program. The MMA was enacted only by the narrowest of margins, leaving behind a deeply polarized Congress divided mainly along partisan lines. That partisan divide is unlikely to end anytime soon. The aging of the baby boomers into Medicare will substantially increase the program's beneficiary population (Medicare enrollment is expected to rise from 54 million in 2014 to 82 million by 2030).⁶ This will raise the political stakes of Medicare reform.

While many liberal reformers still view Medicare as a model for the rest of American medicine, conservative critics typically regard Medicare as evidence of what is wrong with American medical care. The original Medicare program, they believe, should not be expanded, but instead recast to reflect more conservative principles. The debate and controversy over Medicare thus persists almost fifty years after the program's enactment.

Our purpose in this section is to provide an historical and political context for understanding this controversy.⁷ We begin by sketching out Medicare's historical roots in the American campaign for national health insurance that began early in the last century. Next, we describe the sea change in the debate about health policy—from one dominated by the issue of how to improve access to one dominated by the question of how to reduce costs—that occurred in the

6. *Annual Report of 2014*, BOARD OF TRUSTEES OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TR. FUNDS 198 tbl.V.B4, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf>.

7. This section draws substantially from MARMOR, *supra* note 5.

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immediate aftermath of Medicare's enactment. Then, we sketch Medicare's development over the next fifty years, including the reform of its payment policies for medical providers.

A. The Origins of Medicare

Perhaps the best way to understand Medicare's political origins is to appreciate how peculiar the program is from an international perspective. The United States is the only industrial democracy that began compulsory health insurance by covering its elderly citizens only. Almost all other nations began with coverage of their work force or, as in the case of Canada, went from special programs for the poor to universal programs for one service (hospitals) and then to another (physicians). This means that peculiarly American circumstances, rather than some common feature of modern societies, explain why it is that compulsory government health insurance began in the United States with those eligible for Social Security pensions.

The roots of this unique history lie in the United States' distinctive rejection of national health insurance in the twentieth century. First discussed in the years before World War I, national health insurance fell out of favor in the 1920s. When the Great Depression made economic insecurity a pressing concern, the Social Security blueprint of 1935 broached both health and disability insurance as controversial items of social insurance that should be included in more complete schemes of income protection. From 1936 to the late 1940s, liberal defenders of the New Deal repeatedly called for incorporating universal health insurance within America's emerging welfare state. However, the conservative coalition in Congress—comprised of Republicans and conservative, often Southern Democrats—regularly blocked these initiatives.

Leading figures within the movement for American social insurance—Oscar Ewing, Wilbur Cohen, Robert Ball, and Nelson Cruikshank most prominently—were well aware of this opposition and redesigned a reform strategy during President Harry Truman's second term of office. By 1952, they had set out a plan to implement national health insurance in stages. Looking back to a 1942 proposal that called for extending medical insurance to all Social Security contributors, the proponents of what became known as Medicare shifted the category of proposed beneficiaries to elderly retirees while retaining the link to social insurance as well as its contributory, non-means-tested form of eligibility.

Medicare thus became a proposal to provide retirees with limited hospitalization insurance—a partial plan for the segment of the population whose financial fears of illness were as well-grounded as their difficulty in purchasing private health insurance at an affordable cost. With this, the long battle to turn a proposal acceptable to the nation into one passable in Congress began, evolving from its strategic birth in the early 1950s into a fully developed legislative plan

by 1958.

These origins have much to do with the initial design of the Medicare program and the expectations of how it was to develop over time. The incremental strategy assumed hospitalization coverage was the first step in benefits and that more would follow under a common pattern of Social Security financing. Likewise, the strategy's proponents presumed that eligibility would be gradually expanded. Eventually, they believed, Medicare would take in most if not all of the population, extending first perhaps to children. In other words, by the 1960s Medicare was envisioned as the cornerstone of national health insurance in the United States.

All the Medicare enthusiasts took for granted that the rhetoric of enactment should emphasize the expansion of access, not the regulation and reform of American medical practice. Their goal was to reduce the risks of financial disaster for the elderly and their families, not to alter the practice of medicine. They assumed that Congress would demand a largely hands-off posture (following the example of private insurers at the time) toward the doctors and hospitals providing the care that Medicare would finance. Five decades later, that vision seems old-fashioned. It is now taken for granted by most policy makers and health policy analysts that insurers, both public and private, have a responsibility to oversee and influence the practice of medicine. But in the period up to enactment in 1965, no such presumption existed.

The incremental strategy of the fifties and early sixties assumed not only that most of the nation was sympathetic to the health insurance problems of the aged, but also that social insurance programs enjoyed vastly greater public acceptance than did means-tested social programs. Social insurance in the United States was acceptable to the extent it was differentiated from the demeaning world of public assistance. "On welfare," in American parlance, is largely a pejorative expression, and the leaders within the Social Security Administration made sure Medicare fell firmly within the tradition of benefits that are "earned" and not given as a matter of charity. The aged could be presumed to be both needy and deserving because, through no fault of their own, they had on average lower earning capacity and higher medical expenses than any other age group. The Medicare proposal avoided a means test by restricting eligibility to persons over age 65 (and their spouses) who had contributed to the Social Security system during their working life. The initial plan limited benefits to sixty days of hospital care, and physician services were originally excluded in hopes of softening the medical profession's hostility to the program.

The form adopted—Social Security financing and eligibility for hospital care, and beneficiary premiums plus general revenues for physician expenses—had a political explanation, not a coherent philosophical rationale. The very structure of the benefits themselves, insuring acute hospital care (Part A of the legislation) and physician treatment as an unexpected afterthought (Part B), was not tightly

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linked to the special circumstances of the elderly. Left out were provisions that would have addressed the problems of the chronically sick elderly—those whose medical conditions would not dramatically improve and who needed to maintain independent function more than triumph over discrete illness and injury. Viewed as a first step, of course, the Medicare strategy made sense. But after fifty years, with holes remaining in Medicare’s coverage of medical services, and with the program having failed to expand to cover the general population, the incremental assumptions behind the Medicare strategy appear somewhat more problematic.

In the next four subsections, we present a short history of Medicare’s first fifty years.

B. 1966-1971: A Half Decade of Accommodation

Medicare’s first period—roughly from 1966 to 1971—was one of accommodation to the medical profession rather than of efforts to change it. To ease the program’s implementation in the face of continued resistance from organized medicine even after the enactment of Medicare, Medicare’s first administrators resisted making any radical changes. This resulted in benefits and payment arrangements that exerted inflationary pressure and hindered the government’s ability to control increases in program costs over time. For example, Medicare’s policy of paying hospitals their “reasonable costs” and physicians their “reasonable charges” prompted many American hospitals and doctors to raise their fees. Unusually generous allowances for hospitals’ depreciation and capital costs were a further built-in inflationary impetus. The use of private insurance companies as financial intermediaries provided a buffer between the government and American physicians and hospitals, but it weakened the capacity of government to control reimbursement. It was left to these intermediaries—Blue Cross/Blue Shield and private commercial health insurers—to determine the reasonableness of hospital costs under Part A and physician charges under Part B.

The truth is that in the early years of Medicare’s implementation, the program’s leaders were not disposed to face the confrontation necessary to restrain costs. They felt they needed the cooperation of physicians and hospitals for Medicare’s implementation to proceed smoothly; vigorous efforts at cost control would have threatened this relationship. Even though they were fully aware of the need for cost control, Medicare’s first administrators were initially reluctant to take effective steps to control costs for fear of enraging Medicare providers.

With the benefit of hindsight, it is easy to criticize this posture of accommodation. At the time of the program’s enactment, however, Medicare’s legislative mandate was to protect the nation’s elderly from the economic burdens of illness without, as noted above, interfering significantly with the

traditional organization of American medicine. It was with this aim in mind that Medicare's leaders ensured a smooth, speedy start to the program by being accommodating.

The result was quite predictable: efficient implementation of Medicare with inflation built in. Between 1965 and 1971, the daily service charges of American hospitals rose by an average of 14 percent per year.⁸ Medicare's deference to physicians in determining reasonable charges paved the way for steep increases in physicians' fees as well. In the first five years of operation, total expenditures rose from \$3.4 billion in 1966 to \$7.9 billion in 1971.⁹

C. The 1970s: Controlling Costs Dominates Health Policy

During the five years after Medicare was enacted, inflation in total national spending on medical care also rose dramatically. During that five-year period, national expenditures on medical care rose at an annual rate of 7.9 percent compared with 3.2 percent during the seven years prior to 1965.¹⁰ By 1970, there was broad agreement among students of American politics and medicine that medical inflation had become a serious problem. Criticism of Medicare was part of this dialogue, and, in the minds of some, Medicare was the cause of what became a pattern of all medical prices rising at twice the rate of general consumer prices (as measured by the Consumer Price Index).¹¹ Total spending by private payers increased sharply. The unexpectedly high cost of Medicare and the acceleration of inflation in the private sector radically altered the health policy debate.

Prior to the enactment of Medicare and Medicaid (Medicaid was enacted in the same legislation that created Medicare), the debate had emphasized access-making insurance available to more Americans. By the late 1960s, cost had become the principal focus. The shift from access to cost dramatically altered the arguments employed by both sides of the health care debate. Neither side had previously felt compelled to couple their position on expanding health insurance with a credible plan for cost containment. Proponents of national health insurance had felt it was sufficient to make fairness and quality-of-life arguments; opponents believed it was sufficient to invoke the specter of "socialism" and "communism." But, by the late 1960s, both liberals and conservatives were under great pressure to offer credible proposals to reduce medical inflation.

Politicians and experts across the political spectrum declared that American

8. See Howard West, *Five Years of Medicare – A Statistical Review*, SOC. SECURITY BULL. Dec. 1971, at 17, 21 tbl.6, <http://www.ssa.gov/policy/docs/ssb/v34n12/v34n12p17.pdf>.

9. *Id.* at 19.

10. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* 396, 384 (1982).

11. See MARMOR, *supra* note 5, at 97.

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medical care was in “crisis.” Richard Nixon said in a 1969 speech: “We face a massive crisis. . .and unless action is taken. . .within the next two to three years, we will have a breakdown in our medical system which could. . .[affect] millions of people. . . .”¹² According to a 1969 report released by the Department of Health, Education and Welfare (HEW, now the Department of Health and Human Services, or HHS), the country faced a “crippling inflation in medical costs.”¹³ The media, especially the business press, echoed this sentiment. In its January 1970 edition, *Fortune* declared, “America’s medical system ... stands on the brink of chaos.”¹⁴ It was this environment that produced the two long-term factors we discuss in later sections—the managed care movement and a stronger and more sophisticated pro-competition movement. By 1970, the Nixon administration was taking the first steps to endorse the “health maintenance organization,” a decision that would give rise to the managed care movement. By the mid-1970s, conservatives were aggressively portraying competition as the solution to the crisis.

With the national debate focused on cost containment in both the public and private sectors, disputes about Medicare took a subordinate political position to discussions about nationwide health reform. That does not mean Medicare was inert. Experimentation with different reimbursement techniques, the expansion of Medicare eligibility to the disabled and those suffering from kidney failure, and the movement of Medicare out of the Social Security Administration and into the newly created Health Care Financing Administration (HCFA) are examples of changes in the program that occurred during the 1970s. They were the subject of intense but low-visibility debates among special interest groups, including the burgeoning medical industry and groups representing the elderly.

By the end of the 1970s, alarm had grown over both the troubles of American medical care generally and the costs of Medicare specifically. The struggle over national health insurance ended in stalemate by 1975, and by 1979 the effort to enact national cost controls over hospitals had also failed. With the failure of these broader reforms, federal cost control attention turned to Medicare.

D. The 1980s: Budget Deficit Politics and Medicare Cost Control

During the 1980s, the politics of the federal budget deficit drove Medicare policy. This had two consequences. The first was that Medicare was no longer an intermittent subject of policy makers’ attention, but instead became a constant target of the annual battles over the federal budget. Second, concerns over

12. See JOSEPH FALKSON, *HMOs AND THE POLITICS OF HEALTH SYSTEMS REFORM* 6 (1979).

13. Robert H. Finch & Roger O. Egeberg, *The Health of the Nation’s Health Care System*, 111 CAL. MED. 217, 217 (1969).

14. *It’s Time to Operate*, FORTUNE, Jan. 1970, at 79.

Medicare's impact on the deficit facilitated far-reaching changes in how the program paid medical providers. In contrast to the accommodating policies of the early years, federal policy makers implemented aggressive measures to hold down Medicare expenditures in the 1980s. They gave priority to the government's budgetary problems over the interests of hospitals and physicians. The result of these changes was a considerable slowdown in the rate of growth in Medicare expenditures that did not compromise the program's accessibility.

While these changes in Medicare payment policy received little public attention, they had enormous consequences for both Medicare and the American health care system generally. Medicare's regulatory transformation began in 1983 with the adoption of the Prospective Payment System for hospitals. Medicare's historic reimbursement formula, which had paid hospitals retrospectively on the basis of their costs, was replaced with a prospective formula that instead paid hospitals fixed sums per diagnosis. While the change was shrouded in technical details, those details could not obscure the policy significance of this change: Medicare had adopted administered pricing and rather than pay providers what amounted to a blank check, the federal government was now limiting its payments to a predetermined fee. In 1989, the federal government adopted the Medicare Fee Schedule for physicians. Medicare's new payment systems were moderately successful in controlling program expenditures. As federal budget deficits persisted through the 1980s and 1990s, Congress used Medicare's prospective payment systems to limit program spending in the name of fiscal discipline. A Congressional Budget Office study found that excess cost growth in Medicare (growth beyond inflation and demographic changes) declined from 5.5 percent during 1975-1983 to 0.9 percent during 1992-2003.¹⁵ Medicare's experience demonstrated that the federal government, if the political will was there, could effectively deploy regulatory strategies for cost containment. But this was never widely appreciated. The promotion of the two panaceas we discuss in this paper—managed care and competition—had much to do with that result.

E. 1995-2014: Medicare and the Market

The payment reforms that Medicare adopted during the 1980s were similar in many respects to those used by national health programs in other countries. Medicare policy, as in other industrialized democracies, emphasized prospective payment, predetermined fee schedules, and budgeting. But in 1995 Medicare politics tacked sharply rightward, a shift that was largely a response to the managed care and pro-competitive movements we will explore at length below.

In the 1994 elections, for the first time in forty years, the Republican Party

15. Chapin White, *The Slowdown in Medicare Spending Growth* (Cong. Budget Office, Working Paper No. 2006-08, 2006), <http://www.cbo.gov/sites/default/files/2006-08.pdf>.

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gained majorities in both the House of Representatives and the Senate. The Republican congressional leadership, led by House Speaker Newt Gingrich, celebrated competitive markets, deregulation, and privatization. Medicare, in their eyes, was an outdated program operating on liberal principles. Not surprisingly, then, in the context of efforts to cut taxes and balance the budget, Republican leaders sought to remake Medicare into a program that more closely expressed their conservative political and ideological commitments. In 1995, Gingrich proposed a series of sweeping reforms, including \$270 billion in proposed cuts in program spending, that aimed to move more Medicare beneficiaries out of traditional Medicare and into private insurance plans.

President Bill Clinton eventually vetoed those reforms, but that did not end the debate. The ensuing two decades in Medicare politics has, in essence, been one long extended struggle over the program's identity. Should the federal government continue to operate Medicare as a federal health program according to social insurance principles, or should it alternatively subsidize the purchase of private insurance by Medicare beneficiaries with vouchers? Should Medicare control costs via its traditional method of regulation and administered pricing, via competition and market forces, or with greater use of managed care tools?

The divisiveness of these questions was readily apparent in the political conflict over adding a prescription drug benefit to Medicare. As enacted in 1965, Medicare did not pay for outpatient prescription drugs. Early efforts to extend Medicare benefits were forestalled by concerns over the program's rapidly escalating costs. In 1988, Congress and the Reagan administration agreed to add prescription drug coverage as part of the Medicare Catastrophic Coverage Act, but in 1989 the bill was repealed amidst a backlash over its financing arrangements (benefits were to be funded entirely by Medicare enrollees, with a surtax assessed on higher-income beneficiaries). The Clinton administration proposed to expand Medicare to incorporate prescription drug coverage as part of its 1993 Health Security Act, but when health reform died so too did that proposal. However, rising drug costs in the 1990s and a budgetary surplus at the end of the decade worked in combination to return Medicare prescription drug coverage to the agenda in the 2000 presidential elections.

The question at the time was how to add drug coverage to Medicare. The position taken by Democrats was that prescription drug coverage should be universally available to all Medicare beneficiaries, with the benefit added to the traditional program and administered in much the same way as the federal government administers hospital and physician insurance. The Republican position, on the other hand, was that drug coverage should be offered by private companies rather than the federal government, and benefits should be limited to lower-income beneficiaries.

The outcome in 2003, named Medicare Part D, was a convoluted form of a prescription drug benefit tied to a series of other Republican reforms that had

nothing to do with prescription drugs. The legislation, entitled the Medicare Modernization Act (MMA), passed the House by one vote and emerged from the conference committee without anything close to a bipartisan consensus. The universality of the drug benefit was a concession to Democratic demands. The funds available were half what the Democrats had insisted upon, a concession to President Bush's budget constraints. The result was a benefit that was both cumbersome (with its unusual "doughnut hole" design)¹⁶ and less generous than what many beneficiaries desired. Moreover, the program attracted criticism both from liberals (who thought the benefits stingy but certain provisions too generous toward drug companies) and conservatives (who thought the insurance program was too expensive and disliked creating a new entitlement).

Republicans had hoped to eliminate the perception that they are less capable of managing Medicare than Democrats. But this hope has not been realized. Ironically, by pushing through such an unwieldy and costly reform, the Republicans added to Medicare's expense and thereby ensured that Medicare would remain a contentious issue in American politics. Some Democrats were hopeful that the MMA would, in the long term, prove to be a stepping-stone to a more workable drug benefit and more sensible, broader Medicare reforms. Making the benefit simpler and more generous, especially for low-income seniors and those with high, near catastrophic drug costs, remains an unfinished reform goal among social insurance advocates.

The issue from 2003 until 2009 was not the expansion of the MMA's benefits (efforts to upgrade the benefit ran headlong into massive budget deficits and the fact that the profligate legislation has no effective cost-control mechanisms), but rather how to make the enormously complex legislation work. In the summer of 2009, Democrats announced legislation that would become the Affordable Care Act (ACA), which would shrink the "doughnut hole." The 2003 legislation did substantially expand Medicare beneficiaries' enrollment in private plans, and the MMA's introduction of income-related premiums set the stage for future debates over the universal nature of Medicare eligibility.

In the latter half of the 2000s, the debate about health care reform shifted back to universal coverage. Every Democratic candidate for president running in the 2008 election felt compelled to have a position on universal coverage, and every Republican candidate felt compelled to offer a solution to system-wide health care inflation. But with the exception of Representative Dennis Kucinich, no candidate proposed expanding Medicare to the non-elderly. Medicare was treated as a separate issue prior both to the 2008 election and during the

16. To minimize the cost of the MMA, Congress required that Medicare beneficiaries who enroll in Part D pay a portion of their drug expenses. The bulk of the portion they pay is defined by the gap in the coverage known as the "doughnut hole." In 2015, the lower threshold of the "doughnut hole" will be \$2,960 and the upper limit will be \$4,700. See *How to Find the Best Medicare Drug Plan*, CONSUMERREPORTS.ORG, <http://www.consumerreports.org/cro/2014/10/best-medicare-drug-plans/index.htm> (last visited Dec. 11, 2014).

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subsequent debate about the enactment of the ACA.

During this period, the issue, broadly defined, was how much to rely on market forces and managed care to reduce both system-wide and Medicare-specific costs. Greater reliance on Medicare's traditional cost-control methods was not on the table, either as an option for Medicare or for the entire system. The disinterest among policy makers and influential organizations in Medicare's traditional methods, and the great interest in managed care and competition testify to the power the managed care and pro-competition movements had acquired. We discuss these movements in the next two sections.

II. THE MANAGED CARE MOVEMENT

In this section we address two questions: Why did the managed care philosophy—its diagnosis and its solutions—spread so rapidly and persist over decades despite there being little evidence to support it? And what role did the success of managed care ideas play in thwarting the expectations of Medicare's founders that Medicare would eventually be extended to all Americans?

We begin by describing the managed care philosophy and its origins in the campaign for the “health maintenance organization” (HMO). We focus on the decision by the first HMO proponents to give the HMO concept a name suggesting it could achieve highly valued outcomes, but to refrain from describing how the HMO was supposed to achieve those outcomes. That decision, and its rapid adoption by leaders of both parties, encouraged—and to some degree, forced—HMO advocates to make their case with hope-based opinion and abstract marketing jargon.

Next, we demonstrate that the 1970-73 debate, raucous and partisan as it was, failed to question the undocumented premises underlying the claims made for HMOs, and failed to reveal how HMOs were supposed to achieve the claims made for them. We conclude that the quick political victories scored by the managed care movement during the 1970-1973 period reinforced the decision by the first HMO proponents to speak in abstractions, to use value-laden labels, and to downplay or ignore evidence.

Next, we offer two examples of subsequent managed care solutions (“pay for performance” and the “accountable care organization”) that also succeeded politically (that is, they were endorsed by Congress and the president) but failed to work as advertised. We demonstrate that proponents of these solutions exhibited the same habits of thought and expression that emerged in the early 1970s: a reliance on hope rather than evidence, abstract rather than concrete language, and labels designed to persuade rather than illuminate. We conclude with a comment on the changing make-up of the managed care movement over the last four decades, and a discussion of the role the movement played in turning leading proponents of universal coverage away from Medicare-for-all.

A. The Managed Care Philosophy

Although the phrase “managed care” did not enter the health policy lexicon until the late 1980s, and despite the phrase’s ambiguity, we will use it to describe the movement and the school of thought that emerged in the wake of the Nixon administration’s quiet endorsement of HMOs in 1970, and the more public endorsements of the concept by leaders of both parties in 1971. The claims made for managed care, as well as the jargon in which those claims are couched, have evolved over the intervening years, but the movement’s diagnosis of the crisis and its principal recommendations for addressing the crisis have remained constant. The diagnosis is overuse—the ordering of unnecessary services and the failure to order preventive services, and the failure to “coordinate”¹⁷ care as a result of the FFS system. The solution is shifting financial risk to doctors and other providers and direct intervention in treatment decisions by third parties.

These premises support numerous secondary or derivative assumptions. Based on their premise that FFS and overuse are the problem, managed care advocates have developed secondary diagnoses such as “fragmentation” and a

17. “Coordinate” is an example of the amorphous, value-laden jargon introduced into the American health policy lexicon by the managed care movement. “Coordinate” is almost never defined but is nevertheless used incessantly. It is frequently used to criticize doctors who are paid FFS (those doctors allegedly fail to “coordinate care”) or to praise managed care (who would want to defend “uncoordinated care”?).

“Coordinate” is such a vague, sprawling term used in so many contexts it is not clear whether it is something only doctors and health care professionals do, only employees of insurance companies do, or is something both insurers and providers do. It apparently means both insurance companies requiring that doctors get prior authorization before providing a service as well as doctors attempting to extract prior authorization from insurance companies. It apparently includes activities, such as giving patients instructions at discharge, for which “coordination” makes little sense and for which more informative labels, such as “patient education,” would be much more appropriate.

Here is an example of the use of “coordinated” from a recent paper promoting “accountable care” (another evanescent concept invented by the managed care movement): “Payment reforms allow accountable care providers to more effectively support the coordination of care and other important patient services that are not well funded under traditional payment mechanisms.” Mark McClellan et al. *Accountable Care Around the World: A Framework to Guide Reform Strategies*, 33 HEALTH AFF. 1507, 1508 (2014).

Note that “coordination” is not the only highly abstract or value-laden phrase packed into this single sentence. “Payment reforms,” “allow,” “accountable care providers,” and “support,” all of which beg for definition, precede “coordination.” Nowhere in their paper do McClellan et al. define “coordination” or refer the reader to a document that does. Nor do they do document their claim that “coordination,” whatever it is, is “important.” The only other statement in the paper that sheds any light on the authors’ understanding of “coordination” is one that claims, “improved coordination of care should allow more task shifting within and between the collaborating provider organizations....” *Id.* at 1512. If the authors had asserted that mergers or hiring more staff “allow more task shifting,” their assertion would be understandable. To attribute “task shifting” to “coordination” is tautological.

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critical view of physician professionalism under the influence of FFS (physicians are alleged to cave in routinely to the desire to make money at their patient's expense by ordering unnecessary services). Based on their premise that the solution is to shift risk to doctors and authorize third-party control over them, managed care advocates have promoted numerous derivative or supporting solutions, the more important of which include:

- preventive services, which allegedly suffer under FFS, flower under capitation;
- quality improvement (including the provision of more preventives services) cuts health care costs;
- monitoring quality for more than a tiny portion of medical services is feasible both technically and financially;
- doctors and hospitals should buy electronic medical records (EMRs) because EMRs improve quality, and because quality improvement allegedly leads to lower cost, the cost of medical care will drop by more than the cost of acquiring and maintaining EMRs; and
- doctors and hospitals should be aggregated into large organizations so that they can bear risk.¹⁸

18. Our summary of the most important assumptions made by managed care proponents is based primarily on inferences we draw from the context in which observers and managed-care proponents speak about managed care. In other words, our summary is not based on a clear, coherent statement of those assumptions by managed care proponents or neutral observers. We are unaware of a description of the principal tenets of managed care that is as detailed as ours. The failure of the managed care movement to define and document its most fundamental assumptions is symptomatic of the mores we criticize in this paper—a penchant for unnecessarily abstract concepts, labels designed to persuade rather than illuminate (who wants to speak up for “unmanaged care”?), and assertions based on little or no evidence. In this footnote we offer four examples of how “managed care” is used in the literature to illustrate our statement that writers who use the term rarely define it, or that when they do, their definitions are so abstract that they are almost useless.

In 1976, Paul Ellwood and George Lundberg (the former editor of the *Journal of the American Medical Association*) urged their readers to reject the widespread anger at “managed care” that erupted in the mid-1990s. Readers might have expected that an article which referred to “managed care” in the title and in the text, and which pleaded with readers to view “managed care” favorably, would have defined the term. It did not. Paul Ellwood & George Lundberg, *Managed Care: A Work in Progress*, 276 JAMA 1083 (1976).

In *Crossing the Quality Chasm*, the Institute of Medicine (IOM), an early and very influential proponent of managed care, urged readers not to blame “managed care” for the defects in quality documented elsewhere in the book. In a section entitled, “How managed care affects quality,” the IOM exonerated “managed care.” INST. OF MED., *CROSSING THE QUALITY CHASM* 238-39 (2001). Given the importance of the question, one might have expected the IOM to define the term. It did not.

In a book entitled *Medicare Prospective Payment and the Shaping of U.S. Health Care*, Rick Mayes and Robert Berenson offered this definition of “managed care”:

The term managed care is problematic because it conflates and confuses two separate forms of organizational behavior: selective contracting to drive down prices, which became the source of most managed care savings, and actual management of treatment, which became the subject

Research did not support these assumptions when they were first asserted or implied in the early 1970s by proponents of the “health maintenance organization,” and research does not support them now.

As we shall explore more fully in the next section, the early HMO proponents relied heavily on opinion to make their case for the HMO. They marshaled very little evidence. As a spokesman for the American Medical Association put it in testimony to Congress in 1971, “At best, what we have are comparisons of the HMO to being ‘something like’ the Kaiser Permanente group.”¹⁹ Two years later Uwe Reinhardt characterized the research on HMOs as virtually non-existent. In a 1973 paper, he wrote, “[F]ar too many of the proposed reorganization schemes—particularly the much touted idea of a national network of presumably competitive Health Maintenance Organizations—appear to have been proffered on the basis of intuition or faith than on the basis of convincing empirical evidence.”²⁰

What little evidence the early HMO advocates presented consisted primarily of anecdotes and claims about Kaiser Permanente. Kaiser was said to save money by reducing hospital use and offering more preventive services, and the cause of this efficiency was allegedly its method of payment. This method of payment was said to be “prepayment,” a vague term which is now rarely used. “Prepayment” appeared in some contexts to be synonymous with “premiums paid to the insurance company known as Kaiser Permanente” (premiums are, after all, “pre-paid”) and in other contexts to mean “capitation paid to doctors who work for Kaiser.”

of most of the managed care hype and hysteria. For the purposes of this book, however, we mean by managed care a payment model that is distinct from the traditional indemnity health insurance by virtue of the fact that it attempts to influence the way health care is provided and often even restricts patients’ access to and choice of medical provider.

RICK MAYES & ROBERT BERENSON, *MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE* 6-7 (2006).

This definition boils down to: Managed care refers to “attempts” to influence “the way” medical care is provided, and does not include using oligopsony power to drive provider fees down.

Finally, we call the reader’s attention to a book by Robert Cunningham III and Robert M. Cunningham, Jr. The authors define “managed care” as “the . . . piecemeal, incremental cost disciplines of the 1970s and 1980s [that] created widening opportunities to apply in new ways the principles underlying the HMO” ROBERT CUNNINGHAM III & ROBERT M. CUNNINGHAM, JR., *THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM* 209-10 (1997). “Piecemeal, incremental cost disciplines” based on “principles underlying the HMO” tells us very little.

Mayes and Berenson and the Cunninghams deserve credit for trying to define this slippery term, but their definitions remain amorphous.

19. *Statement of the American Medical Association on S. 1182—Health Maintenance Organization Assistance Act of 1971, Before the Subcommittee on Health, Committee on Labor and Public Welfare*, 92 Cong. (1971) United States Senate, November 17, 1971, in WILLIAM R. ROY, *THE PROPOSED HEALTH MAINTENANCE ORGANIZATION ACT OF 1972* (1972) at 162, 172.

20. Uwe Reinhardt, *Proposed Changes in the Organization of Health-Care Delivery: An Overview and Critique*, 2 MILBANK MEMORIAL FUND Q. 169, 169 (1973).

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Today, nearly a half century later, research still does not support the assumptions underlying managed care. This is true of the managed care movement's diagnosis and its solutions. It is true of research which addresses managed care's most expansive concepts, such as HMOs, "managed care," "coordination," and "accountable care organizations," as well as research that examines the more specific assumptions itemized above (for example, FFS causes overuse, and quality improvement lowers costs). The failure of the large-scope concepts to work as advertised suggests the more specific assumptions behind them are not accurate. In the remainder of this subsection we offer a cursory review of the evidence with regard to the movement's more overarching concepts, and then a brief review of the research on the assumptions listed above.

The evidence indicates that managed care's most important and encompassing propositions, such as "HMOs" and "managed care," have failed to cut costs, and have at best had a mixed effect on quality. By the early 1990s, by which time tools pioneered by HMOs had spread throughout the insurance industry, evidence still did not support the claim that managed care saved money. In 1993 the US General Accounting Office (now the Government Accountability Office) reported, "Although many employers believe, in principle, managed care plans save money, little empirical evidence exists on the cost savings of managed care..."²¹ Research on the impact of managed care on Medicare's costs demonstrated that managed care either saved no money or raised total costs.²² Research on the effect of managed care on quality shows mixed or negative results when quality is measured by outcome and process measures, and negative

21. *Managed Health Care: Effect On Employers' Costs Difficult To Measure*, U.S. GEN. ACCT. OFF. 3 (Oct. 1993), <http://www.gao.gov/assets/220/218707.pdf>.

22. For example, in a 2012 report, the Congressional Budget Office concluded that "coordination" and disease management (the labels for the activities HMOs were alleged to engage in because they were "prepaid") either saved no money or raised Medicare's costs. Here is an excerpt:

This paper summarizes the results of Medicare demonstrations of disease management and care coordination programs. Such programs seek to improve the health care of people who have chronic conditions or whose health care is expected to be particularly costly, and they seek to reduce the costs of providing health care to those people. In six major demonstrations over the past decade, Medicare's administrators have paid 34 programs to provide disease management or care coordination services to beneficiaries in Medicare's fee-for-service sector. All of the programs in those demonstrations sought to reduce hospital admissions by maintaining or improving beneficiaries' health.... On average, the 34 programs had no effect on hospital admissions or regular Medicare expenditures (that is, expenditures before accounting for the programs' fees)... After accounting for the fees that Medicare paid to the programs, however, Medicare spending was either unchanged or increased in nearly all of the programs.

Lyle Nelson, *Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination* 1 (Cong. Budget Office, Working Paper No. 2012-01, 2012), http://www.cbo.gov/sites/default/files/WP2012-01_Nelson_Medicare_DMCC_Demonstrations.pdf.

results when quality is measured by patient satisfaction.²³

The managed care movement's diagnosis has always consisted of two related assumptions: overuse is rampant and is the primary cause of the high cost of American health care, and overuse is caused by the FFS system. Neither assumption has ever been supported by research. At least four types of evidence contradict these assumptions:

- Evidence that citizens of many other industrialized nations consume medical services at or below American rates, and yet per capita spending on medical care in these countries is far below the American level;²⁴
- research showing that underuse of medical care in the US is far more common than overuse, even among the insured;²⁵
- evidence that research demonstrating overuse of specific medical services is virtually non-existent compared with the myriad goods and services delivered by clinics and hospitals and other providers in industrialized nations;²⁶ and
- evidence that overuse occurs as often among providers paid FFS as among providers subject to the restrictions and incentives of managed

23. See Kip Sullivan, *Managed Care Plan Performance Since 1980: Another Look at Two Literature Reviews*, 89 AM. J. PUB. HEALTH 1003 (1999).

24. See Gerard Anderson et al., *It's the Prices, Stupid: Why the United States is So Different from Other Countries*, 22 HEALTH AFF. 89 (2003).

25. See Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635 (2003).

26. Here are three quotes from the literature on this issue: "The robust evidence about overuse in the US is limited to a few services." Deborah Korenstein et al., *Overuse of Health Care Services in the United States: An Understudied Problem*, 172 ARCH. INT. MED. 171, 171 (2012).

What is most striking about this report is how hard the authors searched for data on overuse of health care and how little they found. They viewed 21 years of the medical literature and evaluated 114,831 publications, yet found only 172 articles that addressed overuse of health care.

Mitchell H. Katz, *Overuse of Health Care: Where Are the Data?*, 172 ARCH. INT. MED. 178, 178 (2012). (Referring to Korenstein et al. *supra*)

One factor that has often been cited as a probable cause of overuse is ... FFS payment....

In fact, a direct association between FFS payment and overuse has never been established. No study has used formal appropriateness criteria for specific procedures to compare rates of overuse in FFS financing versus other forms of payment.

Elise C. Becher & Mark R. Chassin, *Improving the Quality of Health Care: Who Will Lead?*, 20 HEALTH AFF. 164, 166-67 (2001).

Demonstrating the overuse of specific goods and services is complicated by the fact that uncertainty plays a role in many medical decisions. Many services, for example hospitalization and additional tests, are ordered to rule out a diagnosis or to otherwise reduce uncertainty. The fact that the patient turned out not to be so sick as to need hospitalization, or did not have the suspected disease, is not evidence of overuse.

Over the last decade, the evidence most often invoked by those who claim overuse is rampant are studies that show regional variation in the utilization rates of medical care. But this research does not tell us how much of the variation is due to overuse and how much to underuse.

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care.²⁷

Taken together this evidence indicates the managed care movement's assumptions about FFS and overuse are at best undocumented, and at worst contradicted by the evidence. We turn now to the more specific assumptions about solutions that follow from the managed care movement's FFS-overuse diagnosis.

Managed care advocates have long asserted that HMOs, and later "managed care organizations," provide more preventive services because (a) preventive services allegedly save money and (b) the HMO or insurance company (or the doctors who work for them; it is not clear which was intended) are paid capitation fees rather than FFS, and being paid capitation creates an incentive to save money. But the premise that preventive services save money is not accurate. A review of the literature on this question concluded, "Although some preventive services do save money, the vast majority reviewed in the health economics literature do not."²⁸

Even the minority of preventive services that save money may not save money for a particular insurer or provider. Preventive services take time to pay off, and during that time many patients leave the insurance company that paid for the service or the provider who administered it.

With this evidence in mind, it is not surprising that there is little support within the literature for the claim that HMOs or managed care providers deliver more preventive services than FFS doctors.²⁹

It is routinely claimed by managed care proponents that quality improvement saves money. It appears this assumption is based on the same faulty logic behind the claim that prevention saves money. Just as preventive services cost money to administer, so the interventions that bring about quality improvement cost money. And just as the return-on-investment in prevention is often not high enough to offset the cost of the preventive service, so the return-on-investment in quality improvement (foregone medical costs due to improved health) may not offset the cost of the intervention that improved quality. Donald Berwick dismissed this claim out of hand a decade ago. "Right from the start, it has been one of the great illusions ... that quality and cost go in opposite directions," he

27. Salomeh Keyhani et al., *Overuse and Systems of Care: A Systematic Review*, 51 MED. CARE 503 (2013).

28. Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW. ENG. J. MED. 661, 662-63 (2008). Preventive services raise rather than lower costs for three reasons: (1) Preventive services must be administered to many people who would never have caught or developed the targeted disease; (2) some preventive services, notably cancer screens, reveal disease, which in turn triggers tests and in some cases expensive treatment, which can in turn create side effects that require more treatment; and (3) like most other forms of medicine, preventive medicine is not 100 percent effective.

29. Kathryn A. Phillips et al., *Use of Preventive Services by Managed Care Enrollees: An Updated Perspective*, 19 HEALTH AFF. 102 (2000).

said in an interview with *Health Affairs*. “There remains very little evidence of that.”³⁰ Research confirms Berwick’s impression.³¹

A third critical assumption made by managed care proponents is that the quality of insurance companies and clinics can be measured and reported to the public and to regulators, and can be used to reward and punish providers, and that these uses will induce improvements in quality and lead to lower costs. But proponents of medical “report cards” have never articulated what portion of the thousands of medical goods and services must be measured in order to avoid “teaching to the test,” nor have they estimated the cost of measuring even the relatively small handful of conventionally accepted quality measures. The cost of reporting on a single procedure can run into the millions of dollars.

There is little evidence that report cards improve quality and some evidence they damage quality.³² This is true both of report cards that are published in the hope they will induce patients to choose “high quality” providers, and those that are used internally by payers to reward and punish providers. Given this evidence, and the evidence that quality improvement does not always lower costs, we may conclude that report cards are probably raising costs.

The managed care movement has enthusiastically recommended EMRs on the assumption that they will lower costs and improve quality. The research does not support either claim.³³ Because EMRs are expensive to buy and maintain, the failure of EMRs to improve quality on balance almost certainly means the spread of EMRs is raising total health care costs.

The last assumption on the itemized list above is that providers should join large horizontal and vertically integrated groups or corporations. This recommendation is more often implied than stated. Paul Ellwood and colleagues, to take an early example of the endorsement of this assumption, asserted their “HMO strategy” would lead to “a course of change ... that would have some of the classical aspect of the industrial revolution,” including “conversion to larger units of production.”³⁴ Ellwood et al. predicted this outcome presumably because they understood that small organizations cannot bear insurance risk. Proponents of the successor to the HMO, the ACO, have offered an additional rationale:

30. Robert Galvin, *Interview: “A Deficiency of Will and Ambition”: A Conversation with Donald Berwick*, HEALTH AFF. W5-1 (2005).

31. See Peter S. Hussey et al., *The Association between Health Care Quality and Cost*, 158 ANNALS INT. MED. 27 (2013).

32. David Dranove et al., *Is More Information Better? The Effects of “Report Cards” on Health Care Providers*, 111 J. POL. ECON. 555, 577 (2003).

33. David U. Himmelstein et al., *Hospital Computing and the Costs and Quality of Care: A National Study*, 123 AM. J. MED. 40 (2010); Sumit R. Majumdar & Stephen B. Soumerai, *The Unhealthy State of Health Policy Research*, 28 HEALTH AFF. w900, w904-05 (2009); Max J. Romano & Randall S. Stafford, *Electronic Health Records and Clinical Decision Support Systems: Impact on National Ambulatory Care Quality*, 171 ARCH. INT. MED. 897 (2011).

34. Paul M. Ellwood, Jr. et al., *Health Maintenance Strategy*, 9 MED. CARE 291, 298 (1971).

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Measurement of ACO quality and cost by third parties requires large numbers of patients in order for measurement to be accurate.

But the assumption that consolidation should be tolerated or encouraged rests on several of the previously discussed assumptions, notably the FFS-overuse diagnosis and the assumption that the solution to FFS is to shift insurance risk to doctors and hospitals. It also rests on another assumption that cannot be justified—that consolidation does not create its own negative effects, or that the negative effects are so trivial they are outweighed by the benefits of shifting insurance risk to providers.

However, from 1970 on, proponents of HMOs and later iterations of managed care asserted or relied on all of the unexamined assumptions we have just discussed, almost always without reference to research. From the earliest days of the managed care movement, its participants have consistently displayed a tendency to diagnose and to prescribe without evidence or on the basis of evidence that can at best be described as inconclusive. This casual attitude toward evidence is also revealed in the movement's disinterest in identifying the mechanisms that are supposed to cause HMOs and kindred entities to function as advertised, and to ignore or minimize side effects of its proposals. This includes denial of necessary services to patients, the deprofessionalization of medicine, rising administrative costs, the risks electronic medical records pose to patient safety and patient privacy, and, as we just mentioned, consolidation.

Because of the movement's reliance on unexamined assumptions as well as its affinity for abstract and value-laden marketing jargon ("health maintenance organization," "managed care," "coordinated care," "integrated care," "silos," "medical home," "accountable care organization," "patient-centered," "transformation," etc.), it is very difficult to create testable hypotheses for the movement's fundamental premises and, therefore, very difficult to engage in scientific discourse. It is, in short, very difficult to hold the movement accountable. If we view the managed care movement as a political phenomenon, that has worked to its advantage. But as a source of policy, it has been a serious defect.

B. The Origins of the Managed Care Movement: The Birth of the HMO

As we saw in Part II, the acceleration of medical inflation in the late 1960s forced policy makers and activists across the political spectrum to develop positions on cost containment. Neither liberals nor conservatives looked to Medicare for answers. With Medicare still in its accommodationist phase, Democrats felt compelled to look outside of Medicare for solutions to the cost crisis. For Republicans, Medicare was part of the cost crisis, not part of the solution. A proposal first marketed by Paul Ellwood in 1970 under the label "health maintenance organization" gave both parties the solution they were

looking for. Between 1970 and 1973, both parties viewed the HMO as a promising reform option.

The partisan motivations supporting the conception of health maintenance organizations differed. The possibility that the medical cost crisis would soon lead to national health insurance worried Republicans and prompted attention to new policies. Their worries were not unfounded. The decades-old movement for national health insurance had been reinvigorated in 1968 by the formation of the Committee of 100 by the United Auto Workers and Senator Ted Kennedy. In September 1969 the National Governor's Conference endorsed New York Governor Nelson Rockefeller's national health insurance proposal.³⁵ In 1970, Senator Kennedy introduced what would today be called a single-payer bill.

For conservatives, the enactment of Medicare and Medicaid and the resurrection of the national campaign for national health insurance were red flags. In a 1968 speech to doctors in his congressional district organized by the president of the Marshfield Clinic, Republican Representative Melvin Laird warned that the "federal government is going to nationalize medical care within the next few years unless the profession itself takes responsibility for controlling runaway medical costs."³⁶ Within months of taking office in 1969, Nixon administration officials began searching for a solution that might thwart both medical inflation and the threat of national health insurance. A report prepared by Health, Education and Welfare officials Robert Finch and Roger Egeberg in 1969 made this clear: it claimed that what is at stake "is the pluralistic, independent, voluntary nature of our health care system. We will lose it to pressures for monolithic, government-dominated medical care unless we can make the system work for everyone."³⁷ In early 1970, Ellwood, who coined the phrase "health maintenance organization," came to the administration's rescue with his "HMO strategy."³⁸ Ellwood's arguments appealed directly to conservatives' opposition to national health insurance.³⁹

Democrats' support of the HMO concept was driven by an entirely different motive. HMOs, or "prepaid group practices" as they were generally known before 1970, were in large part the creation of populist organizations and labor. Because the American Medical Association (AMA) so vociferously opposed HMOs, and because other organizations with a history of supporting national health insurance were enthusiastic about HMOs, leading Democrats, including

35. See STARR, *supra* note 10.

36. See JAN GREGOIRE COOMBS, *THE RISE AND FALL OF HMOs: AN AMERICAN HEALTHCARE REVOLUTION* 14 (2005).

37. Finch & Egeberg, *supra* note 13, at 219.

38. See STARR, *supra* note 10, at 394-95; FALKSON, *supra* note 12, at 13-43.

39. For example, in the closing paragraph of a 1971 paper, Ellwood et al. wrote: "Most important, the health maintenance strategy offers a common cause for . . . the health industry in alleviating the medical care crisis in a rational and timely manner, as a feasible alternative to a nationalized health system." Ellwood et al., *supra* note 34, at 298.

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Senator Kennedy, had little doubt that HMOs deserved the claims made for them by their proponents.⁴⁰ Whereas endorsement of HMOs turned out to be a brief love affair for Republicans (an affair they would resume in the late 1990s), for many Democrats the endorsement of HMOs was deeply felt and long-lasting.

The Nixon administration had reduced its support for HMOs by 1973, thanks primarily to the opposition by the AMA. The temporary alliance of Nixon and big business conservatives with congressional Democrats and unions, however, legitimized the managed care movement's diagnosis of and solution to the health crisis. The HMO Act of 1973, produced by the brief liaison between liberal and conservative proponents, was a mere shadow of the massive program originally proposed by Nixon and congressional HMO supporters.⁴¹ But that legislation, as well as the 1972 legislation authorizing HMOs to participate in Medicare, were beachheads upon which the newly formed managed care movement would build in decades to come.

C. The Managed Care Movement's Habits of Thought

The habits of thought within the managed care movement that we are examining—disregard for evidence, and the use of highly abstract concepts with manipulative labels—emerged at the very beginning of the movement. The label chosen for the movement's first and most formative proposition—the “health maintenance organization”—was deliberately constructed to be ambiguous. The decision by a handful of influential men to promote a concept as ambiguous as the HMO and to bestow upon it such a presumptuous label, and the immediate political success of that strategy, set a precedent that deeply influenced the managed care movement for decades.

The HMO label was invented at a meeting held at the Washington Plaza Hotel on February 5, 1970 at which Ellwood presented his “health maintenance strategy” to three representatives of the Nixon administration: HEW Undersecretary John Veneman, Assistant Secretary Lewis Butler, and an assistant to Veneman. Ellwood initially argued that Kaiser Permanente should be the model for the HMO, but Butler objected to defining any feature of an HMO. As Butler stated in a 1973 interview:

Why should we specify how to put it together? Let the doctors—let everybody do it, figure out how to put it together. *Let's specify what we want it to do.* And we don't give a damn how they put it together Let's describe the thing by what we want it to do, not how it's formed (emphasis added).⁴²

As Falkson reported later, “By leaving the specification of the organizational

40. See FALKSON, *supra* note 12, at 123.

41. See COOMBS, *supra* note 36, at 51.

42. See FALKSON, *supra* note 12, at 31.

structures to the delivery system itself but defining incentives designed to accomplish particular objects, it could be argued that the federal government was removing itself from interference in the direct delivery of health care and confining itself to the role of catalyst and purchaser. The idea could be sold . . . as a market reform strategy rather than yet another federal program requiring a large bureaucracy . . . to manage it.”⁴³

Thus, at the dawn of the HMO movement, making the concept more attractive was invoked as justification for manipulative language. The HMO would be defined by what its proponents hoped it would accomplish, not according to how it operated or what empirical evidence said it could do.

Defining something by “what we want it to do” is ordinarily not a promising first step in generating a useful debate. Consider a medical analogy. If a drug company defined a pill to reduce arthritis pain not by describing its ingredients and its mechanism of action, but by what “we want it to do,” how does the Food and Drug Administration evaluate the pill? Or, consider an engineering analogy: What if a bridge-building firm defined its bridge not by its dimensions, the materials to be used and the mechanisms used to ensure strength, but instead by “what we want it to do”? Unless that approach—presenting one’s aspirations for something as a substitute for a definition of it—is abandoned at some point, that approach guarantees that the proponents of the idea in question will have to speak at a high level of abstraction. And, worse, they will have to defend the original wishful thinking with more wishful thinking. But conservative and liberal proponents of HMOs inside and outside Congress swiftly adopted this linguistic convention. Ellwood, for example, in a paper published a year later, defined the HMO as an entity that “agrees to provide comprehensive health maintenance services to its enrollees in exchange for a fixed annual fee.”⁴⁴ Similarly, in response to a letter from the Senate Finance Committee asking the Nixon administration for a definition of “HMO,” Veneman replied that “an HMO is one [*sic*] which assumes responsibility for the maintenance of health of a defined population.”⁴⁵ According to these “definitions,” an HMO can be defined by what it “agrees to” or “assumes responsibility for.” This definition tells us nothing about who the HMO is “agreeing with,” whether the HMO will or can live up to its agreement, and by what mechanisms it will attempt to do so. The same can be said of other hope-based claims that were made by HMO proponents—that HMOs would provide “comprehensive services,” “emphasize prevention,” implement “quality assurance” and “accept prepayment.”

Ellwood and the other participants in the 1970 meeting debated what to call the thing that would be defined by their hopes for it. Ellwood recommended

43. *Id.* at 31-32.

44. Ellwood et al., *supra* note 34, at 295.

45. Letter from John Veneman, Under Sec’y of U.S. Dep’t of Health, Educ., & Welfare, to Tom Vail, Chief Counsel, Senate Fin. Comm. (Sept. 13, 1971), in ROY, *supra* note 19, at 261, 264.

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putting “health maintenance” in the name because “health maintenance” implied that HMOs would make greater use of preventive services. The group endorsed this choice and the biases it implied (prevention and high-quality care wither under FFS and flourish when doctors bear insurance risk and are supervised by third parties), and then discussed what noun to tack on to “health maintenance.” They settled on “organization” because that word did not imply any particular structure. The three words together—health maintenance organization—“was a politically nebulous and, therefore, desirable phrase,” according to Falkson, and therefore “not immediately assailable from either the left or the right.”⁴⁶

Before the meeting broke up Ellwood agreed to write a paper summarizing the case for HMOs. He submitted the paper to the Nixon administration in March 1970 and published a version of it in *Medical Care* in 1971. That paper, influential for decades after it was published, confidently asserted the fundamental assumptions that would fuel the managed care movement for decades to come. And yet Ellwood’s paper contained not a single footnote.⁴⁷ Patricia Baumann noted in a 1976 article, “Ellwood’s rhetoric is more important in explaining why HMOs were initially denoted as a major strategy by the Nixon administration than is the substance of the concept.”⁴⁸ The same could be said about the willingness of Democrats to endorse the HMO. Leaders of both parties eagerly accepted the idea that the HMO could be defined by the aspirations of its proponents. Rhetoric trumped scientific discourse.

Once it was clear the ambiguously defined HMO had bipartisan support, grandiose claims for HMOs—claims which often implied severe criticism of FFS doctors—became commonplace. President Nixon, for example, stated that HMOs “keep their clients healthy.”⁴⁹ Similarly, Dr. Merlin Duval Jr., Assistant Secretary for HEW, claimed: “It is reasonable to expect that with this [prepayment] incentive, HMOs are most likely to immunize members’ children, rather than have them contract a disease . . .”⁵⁰

Legislation subsequently introduced by both parties perpetuated the novel idea of defining an important concept according to the aspirations of its

46. FALKSON, *supra* note 12, at 32.

47. Ellwood et al., *supra* note 34.

48. Patricia Baumann, *The Formulation and Evolution of the Health Maintenance Organization Policy, 1970-1973*, 10 SOC. SCI. & MED. 129, 132 (1976).

49. *Id.* at 133.

50. *Testimony before Subcommittee on Health, Senate Committee on Labor and Public Welfare*, in ROY, *supra* note 19, 103, at 103. Some wishful thinking about HMOs verged on the outlandish. Dr. Harry C. Stamey, a psychiatrist affiliated with Geisinger Clinics, asserted that HMO doctors would become responsible for eliminating hunger in their patients: “Say we get a child in the clinic who is undernourished. Because we are now oriented toward crisis intervention, once the child leaves, the cause of the undernourishment is not our responsibility.... But under the HMO it will be.” *Health Maintenance Organizations: What They Will Mean to Doctors in Quality, Hours, Dollars*, MED. WORLD NEWS, Oct. 29, 1971, at 39, 45.

proponents. The Nixon Administration's 1971 HMO bill (HR 5615) defined HMOs as organizations that would meet a half-dozen aspirations of HMO proponents.

HR 5615 . . . was purposely general in specifying types of organizational entities that could qualify as HMOs Six conditions were established. The entity must: (1) provide service on a per capita prepaid basis; (2) provide or arrange for a prescribed range of services; (3) provide physicians' services . . . ; (4) demonstrate financial and operational competence; (5) ensure access, prompt services, and quality, and (6) have open enrollment⁵¹

Democrats adopted the same strategy. As Representative William Roy, the chief HMO proponent in the House of Representatives said, his bill sought "to describe what HMOs must do (provide comprehensive health services, with quality assurance, etc.) but not to say how these general characteristics are to be achieved by any given organization."⁵²

What did "operational competence," "ensure access," and "comprehensive services" mean, how would we know it if we saw it, and what mechanisms in HMOs were supposed to produce these outcomes? What did it mean to say HMOs were different from insurance companies because they were "prepaid"? Was it not true that premiums paid to insurance companies were also "prepaid," that is, paid prior to the provision of medical services?⁵³ How did the phrase "assume responsibility for a defined population" distinguish the legal liability that HMOs assume from the liability traditional insurers assume? How did the phrase "defined population" or "enrolled population" distinguish the finite "populations" insured by HMOs from the finite "populations" insured by

51. See FALKSON, *supra* note 12, at 108.

52. Roy's definition of "HMO" was as abstract as Nixon's. In his 1972 book explaining his HMO bill, he wrote: "The general characteristics which would make an organization an HMO regardless of its particular make-up include:

1. Open enrollment of a defined, heterogeneous population which receives its health services from the HMO;
2. Assumption by the HMO of the responsibilities and risks involved in caring for the enrolled population;
3. Prepayment by the enrolled members. . . .;
4. Provision by the HMO of . . . comprehensive health services. . . .;
5. Quality assurance programs. . . .;
6. Provision of health education, health maintenance and preventive health services. . . .;
7. Provision of meaningful grievance procedures and policy-making roles for members; and
8. Evaluation of its performance in key areas."

ROY, *supra* note 19, at 32.

53. HMO proponents were deliberately vague about whether "prepayment" described how HMOs were paid, how clinics and hospitals were paid, or how both HMOs and providers were paid. Referring to the Nixon Administration's proposal as of 1971, Baumann wrote, "[T]he method of provider reimbursement . . . is not specified." Baumann, *supra* note 48, at 129.

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traditional insurance companies?⁵⁴

The congressional debate that took place during 1971-1973 failed to refine the definition of HMOs. The debate focused on these questions:

- Whether HMOs would be required to limit patient choice of provider to “closed panels,” or would be allowed to let enrollees see providers outside HMO networks;
- whether subsidies and loan guarantees for HMOs would be limited to non-profits;
- whether enrollment had to be “open” during a certain period (that is, whether HMOs would have to accept all applicants) if the same requirement was not imposed on other insurers;
- whether employers would be required to offer HMOs along with traditional insurance (a mandate known as “dual choice”);
- how broad the required coverage should be; and
- whether to eliminate state laws that outlawed the “corporate practice of medicine,” an impediment to the formation of HMOs.⁵⁵

None of these issues forced HMO proponents to describe specific mechanisms (as opposed to abstract concepts such as “coordination” and limiting patient choice of provider) that HMOs would use to lower costs and “maintain health” and otherwise raise quality of care. Consequently, proponents were not forced to abandon abstraction and value-laden jargon, and, most importantly, they were not forced to defend their optimistic predictions of what HMOs would do.

And yet, the emerging managed care movement notched two significant legislative victories: the 1972 legislation permitting HMOs to enroll Medicare beneficiaries, and the HMO Act of 1973.⁵⁶ The lesson was clear: Being vague, using marketing-like labels, and exaggerating or ignoring evidence paid off politically. These habits of thought and argumentation became deeply ingrained in the culture of the managed care movement. We illustrate this statement with two examples from the more recent past—“pay for performance” (P4P) and “accountable care organizations” (ACOs).

54. The Senate Finance Committee posed thirty-four similar questions in a July 20, 1971 letter to HEW Under Secretary John Veneman. The questions included: “Exactly what is the difference between a premium payment and a capitation payment...?”; “How do ‘health maintenance’ services differ from what are ordinarily regarded as diagnostic and therapeutic services?” and, not surprisingly; “[H]ow is a health maintenance organization defined?” Veneman *in* ROY, *supra* note 19, at 272, 279, 264.

55. See COOMBS, *supra* note 36, at 39-57; FALKSON, *supra* note 12, at 89-164.

56. The HMO Act of 1973 subsidized the formation or expansion of HMOs, and required employers with more than 24 employees to offer HMO coverage if they offered insurance coverage of any kind.

D. The Managed Care Culture at Work: Wishful Thinking About Pay-for-Performance and “Accountable Care Organizations”

The HMO experiment, which by the 1980s had become the managed care experiment, was badly damaged by a hailstorm of negative publicity in the latter half of the 1990s. The damage was so severe that observers in the professional and lay media questioned whether the managed care revolution was “dead” or “over”.⁵⁷ The managed care movement, which by now included virtually the entire health insurance industry, searched for cost-control tactics that were less visible and less provocative than those pioneered by HMOs, but which would be equally effective at shifting risk to providers.

Within the first decade of the 2000s, managed care advocates from both the public and private sectors cooperated to develop two seemingly new concepts that held the promise of shifting financial risk to providers without infuriating patients—P4P and the ACO. Unlike utilization review, gate-keeping and pre-authorization, P4P could be administered in back offices out of sight of patients. And, unlike capitation, P4P could be described as an attempt to improve quality.⁵⁸ Unlike the HMO, the ACO would not require enrollment and would not limit patient choice of provider.

P4P emerged first. Between 2000 and 2003 it was endorsed by, among others, the Leapfrog Group (a creation of the Business Roundtable),⁵⁹ the Integrated Healthcare Association (an association of eight insurers in California),⁶⁰ the Medicare Payment Advisory Commission (MedPAC), and a group of prominent managed care advocates, including Donald Berwick, Paul Ellwood, and Alain Enthoven.⁶¹ As was the case with HMOs, this wave of endorsements of P4P by the health policy elite was not supported by evidence that P4P in medicine was safe, effective, or affordable. For example, in the paper mentioned above by Berwick et al., the authors did not cite one study supporting their assertion that “payment for performance should become a top national priority.”⁶² To take another example, MedPAC’s justification for recommending P4P in its June 2003 and March 2005 reports to Congress was that the private

57. See, e.g., James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001).

58. Robert Galvin, an executive at General Electric, a co-founder of the Leapfrog Group, and an advisor to the Institute of Medicine, attributed the rise of P4P in part to “the collapse of managed care.” Robert S. Galvin, *Evaluating the Performance of Pay for Performance*, 63 MED. CARE RES. & REV. 126S, 126S (Supp. Feb. 2006).

59. *Fact Sheet*, THE LEAPFROG GROUP (Feb. 2007), http://www.leapfroggroup.org/media/file/leapfrog_factsheet.pdf.

60. *California Pay For Performance Overview*, INTEGRATED HEALTHCARE ASS’N (2014), http://www.ihc.org/p4p_california.html.

61. Donald M. Berwick et al., *Paying for Performance: Medicare Should Lead*, 22 HEALTH AFF. 8 (2003).

62. *Id.* at 9.

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sector was doing it. MedPAC cited no research supporting its claims for P4P.⁶³

P4P proponents did not justify their policy reform with evidence because there was none to invoke. As the three guest editors put it in a 2006 edition of *Medical Care Research and Review* devoted entirely to P4P, “P4P programs are being implemented in a near-scientific vacuum.”⁶⁴ As the Institute of Medicine stated in 2007 in the course of restating its support for P4P, “most studies have failed to demonstrate any significant effects on processes of care.”⁶⁵ The justification for P4P boiled down to, “the status quo is terrible; P4P can’t be worse than the status quo.”⁶⁶

Today, a sizable body of research on P4P has been published, and it does not support the claims made for P4P.⁶⁷ Nevertheless, P4P—like the HMO—gathered so much support from the health policy elite that the concept quickly made its way into federal law. The ACA mandates the implementation of P4P in the Medicare program.

The ACO emerged on the heels of the P4P fad. Like the HMO concept, the ACO rocketed to fame overnight. The ACO label was invented at a November 2006 meeting of the MedPAC commissioners; the first paper about the ACO appeared a month later in *Health Affairs*;⁶⁸ by 2009, Democrats in both houses were supporting it; and in 2010, the ACO concept was written into federal law with the enactment of the ACA.

63. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: VARIATION & INNOVATION IN MEDICARE 107-22 (2003); MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 183-214 (2005).

64. Dan Berlowitz et al., *Introduction*, 63 MED. CARE RES. & REV. 11S, 11S (Supp. Feb. 2006).

65. INST. OF MED., REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE 46, (2007), quoted in Ruth McDonald et al., *Paying for Performance in Primary Medical Care: Learning about and Learning from “Success” and “Failure” in England and California*, 34 J. HEALTH POL., POL’Y & L. 747, 769 (2009).

66. Glenn Hackbarth, chairman of MedPAC, offered the “the status quo is terrible” rationale in a 2006 paper:

Why is MedPAC confident that P4P is the proper thing to do, especially given the limited amount of hard evidence on its impact? Two reasons. First, there is overwhelming research documenting the poor performance of our health care system The status quo is unacceptable Second, there is abundant evidence that health care providers respond to incentives. For people with substantial experience in health care delivery and policy, like the MedPAC commissioners, it does not seem like much of a leap to conclude that P4P is a step in the right direction.

Glenn Hackbarth, *Commentary*, 63 MED. CARE RES. & REV. 117S, 118S (Supp. Feb. 2006).

67. See Ashish K. Jha et al., *The Long-Term Effect of Premier Pay for Performance on Patient Outcomes*, 366 NEW ENG. J. MED. 1606 (2012); Grace M. Lee et al., *Effect of Nonpayment for Preventable Infections in US Hospitals*, 367 NEW ENG. J. MED. 1428 (2012); Andrew Ryan et al., *The Early Effects of Medicare’s Mandatory Hospital Pay-for-Performance Program*, HEALTH SERVS. RES. (2014), <http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12206/abstract>.

68. Elliot Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. W44 (2007).

Like the early HMO proponents, the inventors of the ACO concept deliberately refrained from defining the ACO's structure and mechanisms. They chose a name for the concept that manipulated rather than enlightened (who would want to be for "unaccountable care?"). Like the HMO, the definition of the ACO is aspirational. ACOs are said to "take responsibility" for improving quality and lowering costs for a "defined population," etc.⁶⁹ As was the case with the HMO, the ACO is said to counteract the alleged negative consequences of the FFS system, including overuse and "fragmentation."⁷⁰ And, as was the case for HMOs, the claims made for ACOs could not be substantiated at the time they were first made and were subsequently contradicted by research.⁷¹

69. See Ed Adashi & Elliott S. Fisher, *An ACO Visionary Talks Implementation, Healthcare Reform*, MEDSCAPE, Jan. 25, 2012, <http://www.medscape.com/viewarticle/757056>.

70. Here is a typical aspirational definition of "ACO":

ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.

ACOs may involve a variety of provider configurations, ranging from integrated delivery systems and primary care medical groups to hospital-based systems and virtual networks of physicians such as independent practice associations.

Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFF. 982, 983 (2010).

This definition contains the ingredients common to virtually all ACO definitions, notably, language depicting a (poorly defined) group of providers being "held accountable" (by unidentified means by unidentified parties) for "measured improvements" (measured at an unknown cost to providers and the measurer) in the "cost and quality" of health care delivered to a "population."

71. The Physician Group Practice Demonstration, which ACO proponents themselves acknowledged was a test of the ACO concept, failed to cut Medicare's costs but did demonstrate that ACOs engage in upcoding to create the illusion that they cut costs. Carrie H. Colla et al., *Spending Differences Associated with the Medicare Physician Group Practice Demonstration*, 308 JAMA 1015 (2012). Similarly, preliminary second-year results from the Medicare ACO programs mandated by the Affordable Care Act indicate ACOs achieved tiny savings for Medicare. Jordan Rau, *One-quarter of ACOs Save Enough Money to Earn Bonuses*, KAISER HEALTH NEWS (Sept. 16, 2014), <http://capsules.kaiserhealthnews.org/index.php/2014/09/one-quarter-of-acos-save-enough-money-to-earn-bonuses>. According to MedPAC, the ACO program is raising the costs of participating providers by "one to two percent" and cutting Medicare expenditures by only 0.3 to 0.5 percent. Transcript of Medicare Payment Advisory Commission Public Meeting, MEDICARE PAYMENT ADVISORY COMMISSION 118, 123, 133 (Sept. 11, 2014), http://www.medpac.gov/documents/092014-medpac_transcript.pdf. (statement of David Glass & Jeff Stensland on Medicare Accountable Care Organizations (ACOs), Public Meeting of Medicare Payment Advisory Commission). Neither Colla et al., *supra*, nor Glass & Stensland, *supra*, reported on the administrative costs to Medicare of running the PGP Demonstration and the ACO programs. These results suggest ACOs are raising total health care costs.

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E. The Effect of the Managed Care Movement on Liberals

Managed care was a response to, and came of age during, a time when policy makers and payers had fallen under unprecedented pressure to reduce health care costs. That pressure made them vulnerable to the message presented by the managed care movement, namely, that there was widespread consensus among experts that managed care would work, and that this consensus was based on evidence, not mere opinion or ideology. At the same time, the growing influence of the pro-market movement put pressure on lawmakers and activists to turn away from the cost-control tools that Medicare eventually developed—low administrative costs and negotiated fees and prices. The managed care message—“You don’t need to endorse Medicare-for-all, and thereby annoy conservatives, to contain costs”—was music to the ears of legislators who supported universal coverage (that is, liberal legislators) but who knew they had to appear to be interested in cutting costs if they wanted to expand coverage.

This was the principal mechanism by which the rise of the managed care movement played a significant role in keeping Medicare-for-all off the nation’s agenda during the 1970s. The influence of this mechanism became even greater in the 1980s and 1990s with the addition of the health insurance industry and many large corporations to the ranks of the managed care movement. It did so by inducing leaders and groups that supported universal coverage to abandon Medicare-for-all as a solution in favor of the “win-win” managed care vision—costs would go down because quality would go up. If the feel-good managed care vision had not existed, the people and groups who were pulled into the managed care movement might otherwise have overcome their anxiety about anti-government rhetoric from the right differently. They might have examined more closely the cost-containment tools of the traditional Medicare program, and, having done so, they might have endorsed an expansion of Medicare.

Senator Ted Kennedy and Presidents Bill Clinton and Barack Obama are prominent examples of political leaders who might well have endorsed Medicare-for-all but did not because they were misled by managed care rhetoric. All three men were passionate proponents of universal coverage, and all three felt keenly the need to restrain health care inflation. All three men held powerful positions during those rare moments in American history when universal coverage had a chance of being enacted. But none of them endorsed the obvious benefits of a Medicare-for-all system. Instead, they became powerful advocates of managed care.

Kennedy’s conversion to managed care’s diagnosis and solution occurred early in the 1970s, thanks to widespread support for it within the labor movement and other liberal groups supporting universal coverage.⁷² The legislation

72. See FALKSON, *supra* note 12, at 123.

Kennedy introduced with Representative Griffiths—legislation which is often characterized as a single-payer bill—would have subsidized non-profit HMOs. Kennedy would later throw his support behind the ACA, a bill that promoted numerous unproven managed care nostrums, including the ACO.

By the early 1990s, when President Clinton developed his position on health care reform, the managed care movement had become larger and more powerful. It had evolved from a relatively small coalition of policy entrepreneurs, politicians, and liberal groups committed to universal coverage into a much richer and more influential coalition led by large employers and the health insurance industry. (As we shall see in the next section, the pro-competition movement had also become more influential by the early 1990s.) By the time Clinton began formulating his response to the health care crisis, the influence of the managed care movement was no longer based primarily on the exaggerated claims made for it. By then, the movement's influence was based as well on the immense political muscle it acquired during the 1980s and 1990s.

Candidate Bill Clinton seemed to entertain the Medicare-for-all proposal briefly, then rejected it in favor of a version of managed competition. In 1991 he invited one of the authors (Marmor) to a meeting at the Washington Court Hotel in Washington, DC to present the case for a single-payer system. He also invited Ron Pollack, then and now the director of Families USA, to present the case for relying on a multiple-payer solution. After a two-hour debate, Clinton told Marmor, "Ted, you win the argument," but then gesturing to Pollack he said, "but we're going to do what he says."⁷³ Barely a year later, candidate Clinton endorsed "managed competition." In 1993 President Clinton built his universal coverage legislation, the Health Security Act, on the managed competition theory.

Candidate Obama followed a path much like the one Senator Kennedy followed: Encouraged by large labor unions, Families USA, and a long list of other groups that supported universal coverage, many of whom joined the Herndon Alliance and Health Care for America Now, Obama turned away from Medicare-for-all and endorsed a grab-bag of managed care concepts, including P4P and ACOs. Like Kennedy and Clinton, Obama enthusiastically promoted the basic premises of managed care.

III. THE PRO-COMPETITION MOVEMENT

During the 1970s, competitive reforms became a dominant feature of policy debates about American medicine. Although Medicare was largely insulated in the 1980s from these newer ideological currents, the genesis of those pro-competitive ideas and how they came to be applied to American medicine proved

73. See Tom Hamburger et al., *What the Death of Health Reform Teaches Us About the Press*, WASH. MONTHLY, Nov. 1994, at 35, 35.

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to be crucial to Medicare's fate in the late 1990s, and will continue to be important. In this section we describe the rise of pro-competitive ideas in American medicine over the last quarter of the twentieth century.

As we saw in Part 2, Ellwood's vague HMO proposal stirred up enough support among conservatives to ensure enactment of the HMO Act of 1973, but by that year conservative support for HMOs was already waning. Simultaneously, conservative support for universal coverage reverted to the traditional conservative position, which was to promote more cost-sharing for patients and to oppose universal health insurance, either explicitly or implicitly by blaming the health care system's defects on government regulations and public programs, namely Medicare and Medicaid. At least three factors contributed to the resurgence of conservative interest in pro-competition theory during the 1970s. The first we have already discussed in Parts I and II: the dramatic shift in the focus of the health care reform debate from access to cost during the five years after the enactment of Medicare. This put pressure on both liberals and conservatives to adopt credible cost-containment policies.

A second factor was the general ascendance in academic writing of a particular microeconomic approach to analyzing public policy. This phenomenon reflected the influence of "neoclassical economics," a school of thought that distinguished itself from "classical economics" by its assumptions about the ability and willingness of human beings to attach prices or "utility" to their choices. Economists who subscribed to these assumptions tended to argue that any action by government that constrained individual choice reduced society's ability to maximize society-wide "utility" or welfare. Politicians and regulators, they argued, could not possibly guess accurately how millions of people would choose, for example, between an extra unit of housing and an extra unit of food, or an extra unit of hospital coverage and an extra unit of drug coverage. These questionable assumptions led many economists who subscribed to them to a variety of proposals designed to reduce government influence, including proposals to rescind regulations and reduce taxes.⁷⁴ The anti-government, free market enthusiasms of economists identified with the University of Chicago represented this development, but others who would hardly be associated with that movement, like Brookings economist Charles Schultze, were also influential.⁷⁵ Indeed, it is fair to say that the neoclassical training of most

74. "Neoclassical economics" became the dominant school of economic thought during the last century. The primary difference between "classical" and "neoclassical economics" is that the latter relies heavily on the assumption that human beings can and do calculate the value in dollar terms of virtually any decision and compare that value to the value of other decisions. Moreover, in calculating the values of various options, neoclassical economics assumes human beings do so "at the margin," that is, they calculate the value of one additional unit of item A versus one additional unit of items B through Z before deciding to buy one more unit of A.

75. See E.M. Melhado, *Competition Versus Regulation in American Health Policy*, in *MONEY, POWER & HEALTH CARE* 145 (E. M. Melhado et al. eds., 1988).

American economists of this period made the growth of economic analyses of public policy a factor in this shift. All of this provided the intellectual groundwork for making pro-competitive reforms more plausible in medical care.

A third factor bolstering the pro-competition movement was the spread of the anti-government, anti-regulatory sentiment to the wider political arena. Although for many this development is synonymous with Ronald Reagan's presidency, it in fact had earlier roots. Richard Nixon's two presidential victories celebrated the limits of government and the appeal of market competition even if his administration's domestic policy actions actually expanded federal social policy significantly. During the mid-1970s, big business greatly increased its influence in American politics, indirectly by contributing money to conservative groups and candidates, and directly by traditional lobbying methods. Commentators often forget the extent to which Jimmy Carter ran for president on an anti-Washington, anti-government platform, portraying himself as a down-home farmer who, with pitchfork in hand, was headed to the nation's capital to slay the federal leviathan. The increased legitimacy of this general political ideology—most obviously consequential in traditional areas of governmental regulation like trucking, airlines, and finance—made its application to medical care less difficult than would have been the case at the time of Medicare's birth.

The pro-competitive ideology that arose out of the ashes of the 1970s came to have considerable political and rhetorical appeal. The simplest version of the "competitive" answer to social problems was that all public institutions needed to be restructured to accommodate market incentives. Proponents of competition in medical care confidently claimed that a return to the market would lead to lower costs, a more equitable allocation of scarce medical resources, the creation of a more rational delivery system, and the delivery of more appropriate (and perhaps better) medical care. The acceptability of these pro-competitive presumptions had become broad enough by 1980 that the *Report of the President's Commission for a National Agenda for the Eighties* could un-self-consciously assert:

An expansion of the role of competition, consumer choice, and market incentives rather than government control is more likely to create the much needed stimulus toward greater efficiency, cost consciousness, and responsiveness to consumer preferences so visibly lacking in our present arrangements for providing medical care.⁷⁶

Similar claims received widespread coverage in trade journals, in the popular press, and on Capitol Hill.⁷⁷

76. PRESIDENT'S COMM'N FOR A NAT'L AGENDA FOR THE EIGHTIES, REPORT OF THE PRESIDENT'S COMMISSION FOR A NATIONAL AGENDA FOR THE EIGHTIES 78-79 (1990).

77. See, e.g., J.B. Christianson & W. McClure, *Competition in the Delivery of Medical Care*, 301 NEW ENG. J. MED. 812 (1979) (for trade journals); L. E. Demkovich, *Competition Coming On*, 12 NAT'L J. 1152 (1980) (for coverage in the popular press and on Capitol Hill).

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The pro-competition movement shares with the managed care movement a fascination with financial incentives and a belief that changing those incentives will lead to lower utilization and higher quality. Whereas the managed care movement focuses on the financial incentives affecting *doctors* created by the FFS method of payment, the pro-competition movement focuses on incentives affecting *patients* created by “excessive” health insurance and the tax subsidies that allegedly encourage the purchase of “too much” health insurance. As the managed care movement recommends shifting risk from insurance companies to doctors, so the pro-competition movement recommends shifting risk from insurance companies to patients via greater out-of-pocket payments. As the managed care movement assumes, without evidence, that shifting risk to doctors will cause doctors to eliminate only unnecessary services, so the pro-competition movement assumes, without evidence, that when patients are forced to pay more of their own medical bills they will eliminate only unnecessary services.

The most fundamental premise underlying the claims made for competition is that health insurance and medical care are no different from household appliances, restaurant meals, entertainment services, and myriad other goods and services sold in this country with minimal government assistance to buyers and minimal government regulation of sellers. Pro-competition enthusiasts assume that patients could and would restore competition to the health insurance and medical markets if they were exposed to the same incentives to shop that they are exposed to in other markets. But, according to pro-competition theory, this incentive is missing in the health insurance markets because patients lack “cost consciousness.”

This problem is caused by tax subsidies which artificially lower the real price of insurance and thus encourage patients to buy richer coverage than they need; “excessive” coverage in turn reduces “cost consciousness” or sensitivity to price in patients when they are “shopping” for medical care. The net result of this reduced sensitivity to price is that patients demand surgery and other medical services they do not need and would not pay for if they had to pay for it out of their own pockets.

Most pro-competition advocates, then, called for ending or reducing the tax subsidies for private health insurance, resisting any further expansion of Medicare and Medicaid in their traditional form, and encouraging the sale of insurance that exposed patients to large out-of-pocket costs. By the 1990s conservatives were regularly calling for “transparency,” by which they meant the publication of accurate information on the price and quality of medical services. Transparency will help the newly cost-conscious consumer shop intelligently for insurance and medical care, and when millions of consumers begin to shop intelligently, competition will be restored and prices will drop without damaging patients, says the theory.

But as was the case with the fundamental premises underlying the diagnosis

and solution endorsed by the managed care movement, the basic premises underlying the diagnosis and solution promoted by the pro-competition movement were assumed. The most fundamental premise, that medical care is like the markets for food, entertainment, and myriad other goods and services, is obviously wrong much of the time. It is wrong in two respects: (1) The role that price plays in influencing the demand for medicine is nowhere near as powerful as the role it plays in other markets, such as the markets for food and entertainment; (2) “consumers” of medical care have nowhere near the expertise to evaluate the appropriateness and quality of medical care ordered by their doctors that they have to evaluate food, entertainment, and myriad other consumer items.

Let us consider the first mistake. For example, while it is true that people will consume a lot more chocolate if it is given away for free or is sold at a price below its production costs, the same cannot be said about most medical goods and services. Unlike chocolate etc., many medical goods and services put patients at risk of death, pain and prolonged side effects. The demand for medical services with those risks clearly does not respond to price signals the way the demand for chocolate does. To take an obvious example, if the price of gall bladder surgery fell to zero for the entire American population, demand would, at most, increase by a small amount among that small portion of the population that badly needed it and had managed to put it off. Even medical services that entail little pain and minimal side effects, such as blood draws to check for cholesterol, are viewed by most patients as the equivalent of chores.

This characterization of patient attitudes is supported by a large body of research. Patients, even well insured patients, have so little attraction to medical care that they avoid seeking it for a wide variety of serious symptoms. According to the well-known RAND Health Insurance Experiment, eighty percent of patients with first-dollar coverage failed to see a doctor after experiencing “serious symptoms” such as loss of consciousness, shortness of breath, and unexplained bleeding.⁷⁸ As we noted earlier, other research indicates underuse of medical care is rampant, so common in fact that it exceeds overuse, even among the insured.⁷⁹ In short, the pro-competition movement’s most fundamental assumptions—that underuse is so trivial it can be ignored, that overuse drives health care inflation, and that overuse is caused by “overinsurance”—are not consistent with a large body of research on the role that price plays in patient demand for medical services.

The pro-competition movement has had little to say about these fundamental defects in its argument. It appears leading proponents found the analogy to other goods and services irresistible, and rather than examine their attraction to the

78. Martin F. Shapiro et al., *Effects of Cost-Sharing on Seeking Care for Serious & Minor Symptoms*, 104 ANNALS INT. MED. 246 (1986).

79. See MCGLYNN, *supra* note 25, at 348.

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analogy, they built an entire health policy on it. Mark Pauly's 1968 paper on "moral hazard" is an early and prominent example of a leading pro-competition scholar who claimed insurance induced overuse even while he ignored the difference between consumer demand for chocolate and demand for colonoscopies. "The quantity of medical care an individual will demand depends on his income and tastes, how ill he is, and the price charged for it," Pauly wrote. "The effect of an insurance which indemnifies against all medical care expenses is to reduce the price charged to the individual at the point of service from the market price to zero."⁸⁰ That statement is true—insurance which covers all medical expenses reduces the effective, or point-of-service charge, to zero—but it begs the essential question: Do patients want to use—much less overuse—medical care just because the price is zero or below its cost of production? Pauly and his followers simply assumed the answer was yes.⁸¹

80. Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 532 (1968).

81. Pauly wrote the paper cited in the previous footnote in response to Kenneth Arrow's influential 1963 paper on the role that uncertainty plays in weakening competition in the insurance and medical care sectors. Pauly took issue with Arrow's statement that the economic argument "for insurance policies of all sorts is overwhelming" and that "government should undertake insurance," including health insurance, when markets fail to do so. Kenneth Arrow, *Uncertainty and the Welfare Economics of Medicare Care*, 5 AM. ECON. REV. 941, 961 (1963). Total social "welfare" is maximized, wrote Arrow, when government provides services, such as health insurance, that people want but which markets have not provided or have provided in insufficient quantities.

Pauly made the opposite argument. He claimed that because all forms of insurance, including health insurance, create "moral hazard," national health insurance would lower, not raise, total welfare. "Moral hazard" is the economist's more technical term for cost unconsciousness or insensitivity to price induced by insurance. Pauly defined "moral hazard" as the "increase in usage" that occurs when health insurance lowers "the marginal cost of care to the individual." Pauly, *supra* note 81, at 535. To illustrate his undocumented assumption that the demand for medical care responds to price just as the demand for all other consumer goods and services does, Pauly presented the graph familiar to every economics 101 student: "price or cost" on the vertical axis, "quantity of medical care" on the horizontal axis, and a straight line with a downward slope of about 45 degrees indicating the consumption of medical care rises steadily as price falls. *Id.* at 533.

But Pauly made no effort to document his claim that the consumption of medical care bears such a strong correlation with price. He simply asserted that medical care is subject to the usual rule that demand for a good or service rises as its prices falls, and vice versa. Here is how he articulated that assumption: "[T]he response of seeking more medical care with insurance than in its absence is a result not of moral perfidy, but of rational economic behavior. Since the cost of the individual's excess usage is spread over all other purchasers of that insurance, the individual is not prompted to restrain his usage of care." *Id.* at 535. But is this true? Is it in fact "rational" to purchase an unneeded colonoscopy, prostate exam, mastectomy, or dose of radiation just because the cost will be "spread over all the other purchasers of the insurance?" Pauly assumed, without any explanation, that it is.

The habit of assuming that the demand for medical care is like the demand for food or clothing and that reduced price sensitivity guarantees overuse, and offering no documentation for those assumptions, persisted long after Pauly published his influential paper. In a 1994 paper advocating high-deductible policies known at the time as "medical savings accounts (MSAs)," former Texas Senator Phil Gramm made the case for MSAs by asking readers to contemplate what would happen

Consider now the second mistake in the assumption that medical care is like other goods and services: That patients know as much as their doctors about what services they need, and if costs are shifted to patients, patients will know the difference between necessary and unnecessary care and will cut back only on the latter.⁸² Common sense tells us that cannot be true, and numerous studies confirm common sense. The RAND Health Insurance Experiment, often cited by market enthusiasts as evidence that cost-sharing does not harm patients,⁸³ demonstrated that patient cost-sharing aggravates the underuse of preventive services,⁸⁴ causes patients to forgo necessary and unnecessary services in roughly equal measure,⁸⁵ and damages the health of sicker and poorer people.⁸⁶ Other research demonstrates that even a small increase in co-payments causes insured patients to reduce their use of prescription drugs⁸⁷ and preventive services.⁸⁸

Another important but infrequently mentioned premise underlying the claims for competition is that the supply sides of the insurance and medical markets are

to food prices if “we all carried grocery insurance.” Gramm claimed, “In my case, not only would I eat better but so would my dog. In fact, if every American had grocery insurance, no grocery store in the country would sell dog food. Nothing less than steak would do Very soon the cost of grocery insurance would begin to climb.” Phil Gramm, *Why We Need Medical Savings Accounts*, 330 NEW ENG. J. MED. 1752, 1752 (1994).

82. The immense difference between the patient’s and the physician’s expertise in medicine played a central role in Arrow’s critique of the claim that the conditions for a competitive market are met in the insurance and medical sectors. Arrow, *supra* note 82. This knowledge imbalance is often referred to as “asymmetry of information.” In his 1968 paper, Pauly completely ignored this issue. He ignored as well as the possibility that making patients more sensitive to price might lead to underuse. Focusing on the patient’s role and ignoring or downplaying the asymmetry-of-information issue continued to be standard practice within the pro-competition movement thereafter. By contrast, the managed care movement has always focused on the physician’s role in medical decision-making. Like the pro-competition movement, the managed care movement blames overuse for medical inflation. But unlike the pro-competition theorists who blame overuse on patients exposed to “moral hazard,” managed care theorists attribute overuse to doctors exposed to the FFS method. (As we noted earlier, the evidence indicates both movements exaggerate the role of overuse in medical inflation.)

83. See John F. Cogan et al., *Making Markets Work: Five Steps to a Better Health Care System*, 24 HEALTH AFF. 1447 (2005).

84. See Nicole Lurie et al., *Preventive Care: Do We Practice What We Preach?*, 77 AM. J. PUB. HEALTH 801 (1987).

85. See Kathleen N. Lohr et al., *Effect of Cost-Sharing on Use of Medically Effective and Less Effective Care*, 9 MED. CARE S31 (1986); Shapiro et al., *supra* note 79, at 247; Albert L. Sui et al., *Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans*, 315 NEW ENG. J. MED. 1259 (1986).

86. See Shapiro et al. *supra* note 79, at 246, 251; Emmett B. Keeler et al., *How Free Care Reduced Hypertension in the Health Insurance Experiment*, 254 JAMA 1926 (1985); Willard Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 AM. ECON. REV. 251 (1987).

87. See Haiden A. Huskamp et al., *The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending*, 349 NEW ENG. J. MED. 2224 (2003).

88. See Amal N. Trivedi et al., *Effect of Cost-Sharing on Screening Mammography in Medicare Health Plans*, 358 NEW ENG. J. MED. 375 (2008).

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populated by numerous small suppliers no one of which is so big it can set, or influence the setting of, its own prices. This condition—an atomized supply side—is implied in the phrases “consumer choice,” “consumer power,” and “consumer-driven.” These phrases are frequently invoked by market enthusiasts even though choice is in fact severely limited throughout much of the markets for insurance and medical goods and services.

Despite these seemingly obvious defects in competition theory, it began to attract more attention during the health care reform debate of the early 1990s, and drew even more attention after the failure of the Clintons’ Health Security Act in September 1994 and the Republican takeover of Congress in the elections two months later. By the early 1990s, Republicans were promoting high-deductible policies known first as “medical savings accounts” and later as “health savings accounts” (HSAs).⁸⁹ By the late 1990s Republicans had linked these high-deductible policies with the notion of vouchers and tax credits. These two ideas—high-deductibles and either vouchers or tax credits—are the main planks in the most prominent pro-competition proposals today, including those put forth by Representative Paul Ryan,⁹⁰ the Cato Institute,⁹¹ and Avik Roy.⁹²

The pro-competition movement’s endorsement of high-deductibles, vouchers, tax credits, and “transparent” cost and quality data has forced at least some within the movement to endorse the requirement that some third party (government is the obvious candidate but is not always mentioned) adjust deductibles, vouchers, tax credits, prices and “grades” on quality measures to reflect patient health and income, a process known as “risk-adjustment.” Without accurate risk-adjustment, competition becomes a race to the bottom as providers and insurers seek to avoid sicker and poorer patients. But those who promote risk-adjustment as a solution to the “adverse selection” problem fail to address the question of whether accurate risk-adjustment will ever be technologically and financially feasible. The treatment of this issue by Mark Pauly and John Goodman, two of the most prominent HSA proponents, is typical. In the following excerpt from a 1995 paper, they concede risk-adjustment is essential to their reform proposal, and then they walk away from the issue.

Some critics fear that increased use of catastrophic insurance coverage protected by MSAs will worsen a serious social problem of risk segmentation

89. See Harris Meyer, *GOP Reformers Push Medical IRA Plans*, AM. MED. NEWS, Jan. 3, 1994, at 1.

90. Letter from Douglas W. Elmendorf, Director, U.S. Cong. Budget Office, to Rep. Paul Ryan (Jan. 27, 2010), <http://www.cbo.gov/sites/default/files/01-27-ryan-roadmap-letter.pdf>.

91. Chris Edwards & Michael Cannon, *Medicare Reforms*, CATO INST. (Sept. 2010), <http://www.downsizinggovernment.org/hhs/medicare-reforms>.

92. Timothy Jost, *Transcending Obamacare? Analyzing Avik Roy’s ACA Replacement Plan*, HEALTH AFF. BLOG (Sept. 2, 2014), <http://healthaffairs.org/blog/2014/09/02/transcending-obamacare-analyzing-avik-roys-aca-replacement-plan>.

and adverse selection in the private health insurance market. ... The natural tendency in competitive insurance markets is for premiums to reflect risks. To the degree that this process creates unreasonable burdens for some people, government interventions such as tax-financed risk pools and or risk-related tax credits for unusually high risks are the correct solutions.... A full treatment of this *exceedingly complex and confusing issue* is beyond the scope of this paper.⁹³

As is the case with the pro-competition movement's assumption that medicine is like food and other consumer goods, the movement's assumption that accurate risk-adjustment is technologically and financially feasible is not based on anything resembling rigorous evidence. Accurate risk-adjustment cannot be done without rich information on patient health, which is to say without access to the medical records of the American population. Accurate risk-adjustment requires information on patient income as well.⁹⁴ Even assuming that someday electronic medical records become universal and interoperable, it is extremely unlikely America, or any other country, will ever be able to afford the cost of adjusting vouchers, tax credits, deductibles, prices, and quality measures for either patient health status or income.

But without risk-adjustment of vouchers and the other variables mentioned above, competition-based proposals cannot work well, and may not work at all. For example, without risk-adjustment of vouchers for seniors to buy private insurance, insurers will be under great pressure to refuse to accept sicker seniors, and to chase away those sicker seniors they cannot avoid enrolling. If they fail to ward off a sufficient number of sicker seniors, they could be forced to withdraw from the Medicare program or go bankrupt. Similarly, if report cards on physician services are not adjusted to reflect differences in the health and incomes of the patients physicians treat, the "grades" will misrepresent the true quality of the services. Physicians who treat sicker and poorer patients will be unfairly portrayed as inferior doctors.

The pro-competition movement's willingness to gloss over the assumptions that have to be true for the medical "market" to function like other markets gives it its appeal, especially to citizens and policy makers who favor reducing

93. Mark V. Pauly & John C. Goodman, *Tax Credits for Health Insurance and Medical Savings Accounts*, 14 HEALTH AFF. 126, 136 (1995). In *A Roadmap for America's Future*, Representative Paul Ryan treats the risk-adjustment issue in the same manner. He acknowledges that risk-adjustment of premiums is essential to his proposals for the non-elderly and Medicare, and he implies risk-adjustment of medical price and quality measures is necessary to make "data on the pricing and effectiveness of health care services widely available." But he offers no information on how any of that is to be done, whether it can be done accurately, and what it might cost.

94. *Risk Adjustment for Socioeconomic Status or Other Socioeconomic Factors: Technical Factors*, NAT'L QUALITY FORUM (Aug. 15, 2014), http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx.

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government's role. But when the glossed-over assumptions are pulled up for examination, it becomes clear that the reformed market imagined by competition theorists either cannot function as advertised, or can function only with considerable assistance from and regulation by the government. The irony of this posture is obvious: to address and eliminate "market failures" that arise in any unregulated medical environment, defenders of competition must offer programs and regulations administered by the very public administrators they deride.

CONCLUSION

Many countries that now have universal health insurance programs built those programs in increments. Germany at first covered only workers in certain high-risk industries, and Canada at first covered only hospital services in one province. It was not unreasonable, therefore, for the architects of the American Medicare program to anticipate that Medicare would eventually be expanded, possibly in stages, to cover all Americans. True, phasing universal coverage in first for the elderly was unorthodox by international standards, but there was no obvious reason why phasing in by age should be any more difficult than phasing in by occupation, geography, or type of service.

However, fifty years later, it has not happened. The rapid increase in Medicare's costs in its first half decade (a period we have referred to as a period of accommodation) took Medicare-for-all off the table during the early 1970s when Congress was seriously considering extending universal health insurance to the non-elderly. In the decade after Medicare's enactment, even advocates of national health insurance did not propose expanding Medicare. They proposed insuring the non-elderly through a program that was separate and substantially different from Medicare.

But the disinterest in expanding Medicare persisted long after Medicare brought its expenditures under control. Since the late 1980s, the traditional Medicare program has operated more efficiently than the insurance industry. Its annual inflation rate has been, on average, slightly below that of the private sector,⁹⁵ and it has insured its enrollees at a cost per enrollee that is lower than that of the insurance companies that participate in the program known today as Medicare Advantage.⁹⁶ But despite this track record, Congress has expressed no

95. Christina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades*, 22 HEALTH AFF. 230 (2003); *The Facts on Medicare Spending and Financing*, KAISER FAMILY FOUND. (2014), <http://kaiserfamilyfoundation.files.wordpress.com/2014/07/7305-08-the-facts-on-medicare-spending-and-financing.pdf>.

96. Fred J. Hellinger, *Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence*, 9 HEALTH CARE FINANCING REV. 55 (1987); PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS 255-79 (1996); *Changes to HMO Rate Setting Method are Needed to Reduce Program Costs*, U.S. GEN. ACCT. OFF. (1994).

interest in Medicare-for-all, not even during the 1992-1994 and 2008-2010 periods when national health insurance was debated. In fact, Congress has moved in the other direction: Over the last two decades it has accelerated the expansion of the relatively inefficient Medicare Advantage program, and it has passed numerous bills that require the relatively efficient traditional Medicare program to experiment with managed care schemes, the vast majority of which either saved no money or raised costs.⁹⁷

The unexpectedly high cost of the Medicare program during its first five years is the obvious explanation why Medicare-for-all was not seriously considered by Congress during the first decade or so after Medicare was enacted. But what accounts for lawmakers' disinterest in expanding Medicare over the last four decades, a period in which the traditional Medicare program has proven to be a relatively efficient program?

We attribute that disinterest primarily to the two movements we have discussed in this paper. The primary contribution of the pro-competition movement has been to render Congress reluctant to debate universal coverage at all. The primary contribution of the managed care movement has been to induce influential liberals to promote managed care rather than Medicare-for-all during those rare periods when national health insurance has been seriously debated by Congress. We attribute the success of these movements in large part to their willingness to promote questionable assumptions as fact, and to compare their dream worlds with the real world—the Medicare program. The acquisition of enormous resources by both movements over the last quarter century has greatly enhanced their power. Those resources dwarf the resources available to the groups and individuals who support the expansion of Medicare to the non-elderly.

The irony is that these movements came to life shortly after Medicare was enacted, thanks in part to the rapid inflation that Medicare suffered during its first five years. As we have seen, Medicare's first administrators decided it was more important to win the cooperation of providers than to control costs. It is instructive to ponder these questions: What if Medicare's costs had not soared so unexpectedly in its early years? What might have happened if Congress had given Medicare's original administrators the authority to control spending? Would Medicare-for-all have remained on the table? Would a managed care movement have materialized, much less gone on to dominate the health care

Medicare operates at a lower cost for two reasons: Its overhead costs are small compared with those of the insurance industry. Kip Sullivan, *How to Think Clearly about Medicare Administrative Costs: Data Sources and Measurement*, 38 J. HEALTH POL., POL'Y, & L. 479 (2013); CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTH CARE INDUSTRY MARKET UPDATE: MANAGED CARE (2003). Additionally, since it acquired the authority to regulate payments to hospitals (1983) and physicians (1989), it has paid providers substantially less than private insurers pay. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 81 (2006).

97. Nelson, *supra* note 22.

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reform debate for the next fifty years? Would the pro-competition movement have had as much ammunition to use against expanding Medicare?

It is possible that the answer to the last three questions is no. But it is also possible that if the authors of the Medicare legislation had attempted to bestow upon the program the tools it needed to control spending, the bill might never have passed and we would not be celebrating Medicare's fiftieth birthday next year.

