by Lynn Etheredge

Prologue:
The ebb and flow of federal policy action, as well as the election of American political leaders, usually are shaped by larger trends in society. Thus it was no surprise that after Ronald Reagan took office in January, 1981, having successfully campaigned on a platform calling for less government and lower taxes, he would seek to retrench the nation's social welfare enterprise— including public spending for medical care. At the heart of any president's policy-making machinery stands the Office of Management and Budget, a small but powerful agency that develops the budget of the executive branch every year and provides analysis on important federal policy issues. Within the OMB, health policy options are developed by the agency's health branch, a half-dozen career analysts whose names, much less faces, remain anonymous to most interests with a heavy stake in the industry. Lynn Etheredge, an economist and policy analyst, headed the OMB's health branch from 1978 to 1982 and, from 1972 to 1976, worked in the branch as its chief staff member for health financing issues. For the better part of a decade, Etheredge worked at the center of health policymaking in the executive branch. Etheredge, who resigned from the OMB last September and now has joined the Center for Health Policy Studies at Georgetown University, is of the view that the shape of the Reagan administration's health policies was colored not only by the president's conservative political philosophy, but also by the development and analysis of proposals that had been discussed in policy circles throughout much of the 1970s. Thus, in Etheredge's view, the political environment came into alignment with many of the policy notions that had been discussed at the OMB in previous administrations, Consolidating categorical grant programs was a notion expressed by the Ford and Nixon administrations, but never accepted by Congress. Controlling hospital costs on a per-admission basis, as Congress approved in the Tax Equity and Fiscal Responsibility Act, was a feature of Phase IV of the Nixon administration's wage and price control program. The other broad theme that emerges from Etheredge's review of the Reagan administrations first two years in health is that Congress played a central role in reshaping the proposed policies of the executive branch, rather than simply rubber-stamping those policies.
During the Reagan administration’s first two years, Congress enacted substantial changes in federal health programs to restrain budget deficits, provide states with greater authority over government health funding, and use Medicare and Medicaid’s massive purchasing power to create a more managed and competitive health care system.

In total, these actions will result in federal deficit reductions of about $27 billion over fiscal years 1983-85. About $2 billion of these savings are from lower spending for controllable programs, $13 billion results from Medicare and Medicaid changes, and $12 billion are from health-related revenue increases. Expanded state discretion was provided through Medicaid changes and four new block grants; the principal Medicare changes were in hospital reimbursement policies and beneficiary cost sharing.

These major changes were made possible by the Reagan administration’s use of the congressional budget process. Instead of having its proposals considered separately, providing ample opportunity for interest group influences and delays, the Reagan administration focused each year on initial budget resolutions setting revenue and spending targets. These were followed by omnibus reconciliation acts, revenue and continuing resolution bills which sought to conform taxes and spending to these targets through the administration’s specific proposals, but which often required substantial compromises. Through party discipline in the Republican-controlled Senate and coalitions of House Republicans and conservative Democrats, the administration and its congressional allies were able to control the process and beat the House Democratic leadership with “bipartisan” alternatives, for example, the Gramm-Latta bills. Using this strategy, the White House and Office of Management and Budget (OMB) were able to orchestrate the political strategy and negotiations for the total program.

The Controllable Programs

The federal health budget consists of a large number of so-called controllable programs, which require individual annual funding by Congress, and the “uncontrollable” Medicare and Medicaid programs, spending for which results from statutory entitlements. In 1980, Congress provided some $8 billion for the controllable programs; Medicare/Medicaid spending was $49 billion.

A core of controllable health programs has broad bipartisan support. Such programs include biomedical research and research training (for example, the National Institutes of Health), food and drug regulation, and communicable disease surveillance and control. While there are funding level debates about these programs—usually about rates of increase -
rarely have their existence or basic structure been at issue. During the last two years of budget cutting, this tradition of support continued. The strength of the political consensus about these programs was demonstrated in Secretary Schweiker’s widely publicized advocacy of National Institutes of Health (NIH) funding within the administration, and in the widespread media attention last year when the childhood immunization program seemed underfunded. In total, funding for this basic core of health programs will be about $5.0 billion in the current 1983 budget, compared to about $4.4 billion in the 1980 budget, with biomedical research and research training rising from $3.9 to $4.4 billion.

Outside this core, many of the other controllable health activities involving various subsidies or regulation have been frequently debated over the last decade. As a result, David Stockman was able to deliver a revised health budget-preapproved by senior White House staff to Department of Health and Human Services Secretary Schweiker within a few days of taking office, and achieve his concurrence with minor expected modifications in areas of strong Secretarial interest, such as NIH.

The Reagan budget’s “hit list” included several programs which previous administrations had also sought to eliminate as having outlived their basic purpose, notably health professions capitation grants and the Public Health Service (PHS) hospital system. Congress agreed to phase out the health professions capitation programs (MODVOPP and nursing) and several other health professions programs. Similarly, the PHS hospital system and its merchant seaman entitlement-federal programs since 1798 were also ended. Savings from the PHS hospital closure are about $140 million annually; the health professions training levels were trimmed back from $688 million in 1980 to about $270 million in the 1983 budget.

Also on the Reagan administration’s target list were the health planning and Professional Standards Review Organization (PSRO) programs. A number of studies had indicated that, at the least, it was time to clean house of the poor performers. As well, the Reagan administration particularly objected to them as federal regulatory programs which should be eliminated in favor of its promised market-oriented proposals to restrain health costs. These nonregulatory proposals were never forthcoming, but Congress did reduce health planning funding from $167 million in 1980 to $58 million in 1983 (and is still debating major overhauls of the program). The PSRO program was renamed-Professional Review Organizations - and funding was cut from $58 million in 1980 to $15 million in 1983.

Other programs eliminated in the last two years were new grants for health maintenance organization (HMO) start-up, the National Center for Health Care Technology, and most new funding for social science research. On the other hand, Congress did enact a new $10 million “chastity center” program-the Moral Majority’s answer to Planned Parenthood - and a new TB grant program.
The most important controllable program reforms were made by replacing twenty-one separate categorical grant programs with four block grants to states for prevention, mental health, maternal and child health, and primary care. These reforms reversed nearly fifteen years of increasing federal involvement in the direct delivery of services and adopted a key Reagan administration concept that delivery of local health services should be a matter for state and local governments—not the federal government. As with other basic policy changes, the block grants were initiated at OMB and the White House, which also controlled the executive branch’s legislative strategy for their enactment.

The Reagan health block grant proposals addressed the same problems as the Ford administration’s original block grant proposal in the mid-1970s. Even then it was clear that all the separate grant programs, originally essential to bringing health services to underserved populations, had become a serious management problem which frustrated well-intentioned efforts to develop comprehensive health care systems. The Carter administration increased resources for the categorical programs in underserved areas, but its administrative efforts to coordinate the programs made little progress, building the case for legislative reforms. The Reagan administration also sought the block grants as a way of “defunding the left,” on the theory that the categorical grants had been used by the opposition party to build its political constituency. In total, Congress approved reducing funds for the health services grants from about $1.6 billion in 1981 to about $1.4 billion in 1983.

On the whole, Reagan administration officials and Congress agreed on the basic reform and funding issues for the controllable health programs. Most of the enacted changes had been proposed by previous administrations—although not nearly with the same political skill and effectiveness—and a majority agreement was possible on what changes should be made. The budget actions of these past two years—about a 5 percent net reduction in controllable programs—seem to have established a bipartisan agreement for most of the remaining programs, even with $100-$200 billion deficits, as worthy of federal support. Although increases will be difficult to finance, few further cutbacks appear in prospect for the controllable health programs.

**Medicare and Medicaid**

The Medicare and Medicaid programs, which provide about 25 percent of total national health spending and finance health care for about fifty million people, have always represented the most difficult health budget problems. By 1980, federal spending for these entitlement programs—which had been doubling every five years—had reached $49 billion and appeared certain to continue this rapid increase.
The fundamental policy issue in dealing with the Medicare and Medicaid budgets has always been whether to seek comprehensive reforms which address the national problems of health care financing or to restrain the Medicare and Medicaid budgets alone. The Nixon, Ford, and Carter administrations had all sought (at least initially) to enact national health sector reforms, for example, national health insurance and hospital cost containment. The Reagan administration and Congress, facing an immediate need to reduce federal spending and the history of political impasse on comprehensive reform proposals, decided to deal only with Medicare and Medicaid spending.

Over the past two years, Congress enacted some $13 billion of Medicare/Medicaid budget reductions for 1983-85, showing an unexpected willingness to confront politically difficult issues in reshaping the programs. In contrast to the controllable health programs, where the administration and Congress were frequently in agreement, Congress turned down many of the Reagan Medicare and Medicaid proposals and wrote its own basic reform measures. In total, the enacted savings are about 5 percent of projected Medicare/Medicaid spending. Even with the restraint actions, spending for the programs will rise from $49 billion in 1980 to $77 billion in 1983 and over $100 billion in 1985.

The differences between the administration and Congress on the Medicare and Medicaid programs became apparent in actions on the original March, 1981 budget requests. The Reagan administration proposals reflected a view that Medicaid, rather than Medicare, should be the major reform target. An immediate “cap” on federal Medicaid payments was proposed, to be indexed after the first year, with savings of $9 billion over 1983-85, and much greater state management discretion was requested. The Medicare program, although serving a substantially more affluent group, was labelled as one of the “sacred seven” programs constituting the social safety net and no substantial changes were proposed.

Congress did not accept the Reagan Medicare/Medicaid budget priorities, enacting some $4.3 billion of Medicare and Medicaid savings for 1983-85—$2.8 billion from Medicare and $1.5 billion from Medicaid—in the 1981 reforms. Further confounding conventional wisdom of what was politically possible, Congress (while David Stockman and the Reagan administration were still trying to recover from their Social Security fiasco) achieved some $2.4 billion of the $2.8 billion Medicare savings from increased beneficiary cost sharing, primarily higher deductibles for both the hospital insurance and supplementary medical insurance programs.

For Medicaid, however, Congress did agree with the administration’s general approach that across-the-board reductions, plus increased state management discretion, were the best political formula for budget savings. While the Medicaid cap was turned down, Congress did enact a target rate of increase roughly designed to cover inflation (9 percent in 1982,
medical CPI thereafter) and an across-the-board reduction in federal matching payments of 3 percent in 1982, 4 percent in 1983, and 4.5 percent in 1984. States could avoid these reductions to the extent they were below the target rate or through effective hospital rate-setting commissions and fraud and abuse control programs.

The major expansion of state Medicaid management authorities represented the second major Reagan administration accomplishment in providing states a central role in health care for low-income and underserved populations. These reforms were to allow new hospital payment systems different from Medicare, permit waiver of beneficiary rights to freedom of choice of provider, and foster development of a broad range of community-based alternatives to long-term institutional care. Based on agreements with President Reagan before taking office, Secretary Schweiker was able to reject a Medicaid block grant approach and insist on legislation which included continuation of basic services for welfare recipients, as well as fraud and abuse and quality assurance. Combined with the health block grants, these Medicaid changes provided states with the authorities and resources to develop comprehensive, managed systems of care for both acute care and long-term care services.

In its February, 1982 budget proposals, the Reagan administration confounded nearly everyone by reversing course on Medicaid and proposing a full federal takeover as part of a swap whereby states would take over welfare and other grant programs. The flip-flop was all the more puzzling since both the Nixon and Ford administrations aimed to avoid a federal Medicaid takeover at all costs in the belief that a federal Medicare program and a federal Medicaid program would inevitably lead to a nationalized health system. As with other Federalism proposals, the swap proposals were developed at the White House and OMB prior to notification of agency officials.

Congress never considered the swap proposal because the administration was unable to reach agreement with states’ representatives on a mutually acceptable design. Under the Reagan approach, states and localities—rather than controlling their spending and enjoying an open-ended federal matching of 50 percent or more—became concerned they would be responsible for 100 percent of what the federal government decided not to spend. Such worries only increased as misunderstandings seemed to develop about the administration’s long-term funding plans, and major features of the suggested program, involving federal funding but state administration, began to look suspiciously like a block grant.

While comprehensive Medicaid reform discussions were going nowhere, the administration and Congress proceeded with further Medicaid reforms in the budget process. Again Congress agreed to significant changes ($0.8 billion of new 1983-85 savings on top of the $1.5 billion enacted the previous year), but far less than the $8.1 billion of new cuts Reagan had
The enacted savings, however, came primarily from changes requiring further political actions and the estimates could thus be questioned (for example, state options for nominal copayments and recovery of long-term care costs from relatives and estates). In view of the nature of these changes, further federal Medicaid cutbacks of major consequences do not appear likely.

The most far-reaching changes of the Reagan administration’s first two years came in the second round of Medicare program changes last year, primarily in hospital reimbursement reforms. The February, 1982 Reagan budget called for $9.3 billion in legislative savings for 1983-85; the congressional reductions are now estimated at $8.0 billion.

The major Medicare difference between Congress and the administration was hospital reimbursement policy. Reagan had proposed a 2 percent across-the-board reduction in Medicare hospital payments, that is, a “reasonable cost minus 2 percent” policy for all hospitals, regardless of their cost level or inflation rates, with three-year savings of $2.5 billion. In contrast, Congress adopted a prospective payment system which allowed all hospitals the “market basket” inflation in their costs per admission plus 1 percent, as well as modest financial rewards for being under this target. The Section 223 maximum reimbursement limits were revised by including all (not just routine) hospital costs, with case-mix adjustments, and tightened over three years. These approaches to hospital reimbursement reform built on the experience of the Cost of Living Council 1971-74 control period, state hospital rate-setting programs, earlier Section 223 limits, and the Carter hospital cost-containment proposals. Total federal savings from Congress’s version, which allowed well-managed hospitals to escape any penalty, are now estimated at $4.5 billion over 1983-85.

As reported at the time, leading hospital industry representatives, enlisting the support of Secretary Schweiker, encouraged the administration’s short-lived hospital reimbursement proposals from concern that a Medicare prospective payment system could too easily evolve into national hospital regulation. As well, to a Reagan administration still trying to develop a market-oriented health strategy, a new, complex set of hospital payment regulations did not seem desirable. In the final analysis, the administration was brought to realize its preferred solution was going nowhere. Procompetitive reforms which might be proposed would never produce much short-term savings, and Congress was convinced of the need for a prospective system by the failure of the hospital industry’s voluntary efforts to contain costs.

The Medicare hospital reimbursement amendments will substantially increase competition in the health sector. Under these changes, Medicare will be a more aggressive purchaser by reducing the range in pay-
ments to different providers for the same services—and by limiting the rate of increase in these payments. Within three years, for example, maximum hospital payments will be limited to only 10 percent more than the hospital industry’s average costs, adjusted for case-mix and area wage rates. Such restraints move away from a cost-based reimbursement system toward a price-based purchasing system. These economic pressures will be strengthened by assistance to business health groups and insurers which are starting to implement improved utilization reviews, preferred provider plans, and switching business from higher cost hospitals.

Health sector competition will also be fostered by other policy changes for more uniform reimbursement of in-hospital and out-of-hospital services. In the past, Medicare has used “reasonable cost” reimbursement policies for most in-hospital services and paid similar out-of-hospital services on a different “reasonable charge” basis or subject to different reimbursement limits. The administration and Congress have been gradually changing these policies toward providing the same reimbursement for the same services regardless of their provider or location. The 1981 and 1982 amendments continued major restructuring along these lines for outpatient surgery, preadmission diagnostic testing, renal dialysis, hospital-based skilled nursing and home health payment limits, routine nursing services (the 8.5 percent in-hospital nursing differential), and compensation for several types of in-hospital physician services and hospital-based physicians. These changes will increase competition for hospitals, particularly from new physician-operated enterprises such as free-standing dialysis and ambulatory surgery centers, and may lead to substantial reorganization of the health services industry. About $1.7 billion of the three-year savings are targeted from these reimbursement changes.

Finally, the 1982 amendments took a first step toward an Enthoven-model Medicare system by assuring enrollees of the right to HMO enrollment with a federal voucher of 95 percent of average Medicare costs. Similarly, Medicare was made a secondary payer for working aged persons with employer health insurance plans. Similar reforms were proposed by the Carter administration.

In retrospect, it is somewhat surprising that Congress and different administrations held off limiting Medicare hospital reimbursements during fifteen years of extraordinary inflation, until Medicare/Medicaid costs rose to the $50 billion level and federal deficits reached $100-$200 billion. Having failed to reach agreement in the past on hospital regulation or to make its Voluntary Effort a success, the hospital industry is now faced with the prospect of an increasingly chaotic and competitive health care market. The only consolation for hospitals is probably that the federal actions of the last two years are restrictive enough, for example, market basket plus 1 percent, that major further cuts are not immediately in prospect. On the other hand, neither is the Reagan administration likely
to agree to protect the hospital industry from competition through regulation. The recent HHS prospective hospital reimbursement proposals would move from cost reimbursement to a far more competitive price system.

The major 1982 amendment directly affecting Medicare beneficiaries was again a congressional initiative to maintain the premium for the physician’s insurance program at 25 percent of program costs. Originally set at 50 percent of program costs, the premium had been allowed to rise only as fast as the Social Security cost-of-living adjustments since 1972, thus increasing the federal share of the program each year. Three-year savings of about $600 million are anticipated. For the future, gradual raises of the premium, perhaps with income testing, have been discussed as possible savings. Other cost-sharing changes reportedly on the Reagan drawing board include reforming the hospital insurance cost sharing so that there would be some coinsurance from the second to sixtieth hospital day, which is now free, but with catastrophic protection, for example, a $2,500 out-of-pocket cap now lacking in the program. Similar reforms were proposed to Congress by the Ford administration.

Since most Medicare reductions, however they are devised, ultimately come from hospitals, physicians, or beneficiaries, it is interesting to note that virtually all of the enacted savings in the first two years of the Reagan administration were from hospitals and beneficiaries. Only a few in-hospital physician services were affected, for example, a limit of $150,000 to $200,000 may be set on pathologist incomes. With Medicare physician payments now $18 billion rising 15-20 percent annually, a growing physician oversupply in most areas, and the recent Supreme Court ruling and congressional action on advertising creating the ideal market conditions for competitive purchasing, physician reimbursement policies clearly seem the major untapped opportunity for Medicare budget savings.

In retrospect, Congress's Medicare and Medicaid reform actions over the past two years were truly remarkable, both in terms of the federal spending changes enacted as well as in redirecting federal health policies to use Medicare’s massive purchasing power to restrain health care costs and create a more competitive health industry, while also freeing states to act as even more aggressive purchasers and managers of health services for their Medicaid programs. The reforms are all the more remarkable when one considers the extent to which they were devised independently of the Reagan administration’s proposals—and frequently in opposition to its preferences. These changes can be expected to have decisive effects on the health sector over the next few years, providing an opportunity to see if such a “competitive” health system seems desirable for the long term.
Taxes

The health-related taxes enacted in 1982, raising federal revenues by some $12 billion over the 1983-85 period, included an administration proposal to require federal employees to pay the Medicare (HI) payroll tax on the same basis as other workers, for which they would receive Medicare benefits. This action set a possible precedent for bringing federal workers into the entire Social Security system as a way of helping to finance its long-range deficit. As well, the Congress approved a doubling of the cigarette tax, which had not been raised since 1952, over which period the Consumer Price Index (CPI) had more than tripled. Three-year revenue enhancements from these actions will be about $2.4 billion and $6.8 billion respectively. A tripling of the alcohol tax, also on the same basis, was not adopted. Congress did act to limit federal tax subsidies by eliminating deductions for individual insurance premiums and restructuring some other deductions, with three-year revenue increases of about $2.7 billion. Further reforms in alcohol and tobacco taxes—and particularly the tax subsidy of employer health insurance contributions, now $19 billion annually—appear to be leading contenders for future budget actions, both for health policy reasons and as revenue raisers which do not fall on earned income.

In review, the last two years have seen fundamental changes in federal programs and policies which will reshape the health system in the years ahead. While the Reagan administration generated the political momentum and legislative tactics for budget reductions, it is clear that the health reforms were certainly a cooperative effort—and that, for Medicare and Medicaid, Congress has increasingly taken the lead in determining the substance and scope of the changes. The Reagan administration now faces far tougher fights on domestic program reductions than in its first two years and the loss of its working majority on the House floor, which allowed use of the reconciliation act process for budget packaging and behind-the-scenes negotiations. As well, in enacting the changes of the last two years, the Reagan administration and Congress were also able to draw on many years of work by the executive branch, Congress, and outside experts in evaluating government programs, devising and debating ways in which they could be reformed to work better. Much of that intellectual capital has been used up in the enacted reforms. For the next few years, the health sector (except physicians) will have a great deal to handle in accommodating to the enacted changes—and program and budget analysts can start seeing how well the reforms work, and building an agenda for future changes.
## Reagan 1984 Health Budget Overview (millions)

<table>
<thead>
<tr>
<th></th>
<th>Fiscal Years</th>
<th>Change 1983/1984</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1982</td>
<td>1983</td>
</tr>
<tr>
<td><strong>Major Discretionary Programs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Budget Authority)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research and research training</td>
<td>$4,036</td>
<td>$4,439</td>
</tr>
<tr>
<td>Prevention (CDC/FDA)</td>
<td>556</td>
<td>598</td>
</tr>
<tr>
<td>Health services grants</td>
<td>1,336</td>
<td>1,362</td>
</tr>
<tr>
<td>Health professions</td>
<td>302</td>
<td>270</td>
</tr>
<tr>
<td>Health planning</td>
<td>57</td>
<td>58</td>
</tr>
<tr>
<td>Professional Review Organizations</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td><strong>Entitlements</strong> (Outlays)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>46,568</td>
<td>53,031</td>
</tr>
<tr>
<td>(proposed legislation)</td>
<td>-</td>
<td>(+2.6)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>17,391</td>
<td>19,326</td>
</tr>
<tr>
<td>(proposed legislation)</td>
<td>-</td>
<td>(-7)</td>
</tr>
<tr>
<td><strong>Tax Subsidies</strong> (Revenue Loss’)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion of employer health insurance contributions</td>
<td>16,365</td>
<td>18,645</td>
</tr>
<tr>
<td>(proposed legislation)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>5,870</td>
<td>5,150</td>
</tr>
</tbody>
</table>

### Key Points

- For discretionary programs, the budget request is roughly level from 1983 to 1984. Within this total, small increases are provided for biomedical research and prevention; health services grants remain level; health professions training continues to be phased down and health planning and PROs would be eliminated.
- Medicare and Medicaid spending would grow from $72.4 billion in 1983 to $80.6 billion in 1984, with $2.0 billion in savings. Most of the federal savings would come from shifting costs to Medicare beneficiaries, e.g., through copayments on hospital care (raising required cost sharing from $350 to $630 for an average stay, with a maximum of $2,324 per year) and increasing the premiums and out-of-pocket expenses for physicians’ insurance.
- Tax subsidies would be limited by capping tax-free employer health insurance premium contributions at $2,100 per couple and $840 for a single person, with a revenue increase of $2.3 billion.

### NOTES

1. Three-year estimates were used for Reconciliation Act accounting since some impacts grow rapidly.