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The Not-So-Sad History Of Medicare Cost Containment As Told In One Chart

Solutions for rising costs do exist, and they work.

by Thomas Bodenheimer

As far as it goes, the argument of Drew Altman and Larry Levitt—that relief from private health spending growth is short-lived—is persuasive. But their history omits a crucial fact about U.S. health expenditures: While growth rates in private health spending per capita have bounced up and down, federal Medicare expenditures per enrollee have shown a consistent downward trend (Exhibit 1).

Why? Because history shows that government regulation works. Through regulatory efforts—prospective payment of hospitals, volume performance standards for physicians, and the (unpopular but effective) Balanced Budget Act (BBA) of 1997—Medicare has slowed its rate of expenditure growth. This trend also holds true when adjusting for increases in gross domestic product (GDP) per capita. Adjusting for inflation using the Consumer Price Index–Unadjusted (CPI-U), annual increases in Medicare spending per capita dropped from 11.2 percent for 1975–1980 to 1.8 percent for 1995–1999. While future Medicare expenditure growth is projected to be about 6 percent per year—rising above the near-zero increases of 1998 and 1999—private health spending is reaching, in Altman and Levitt’s words, “double-digit rates of increase.”

If the federal government becomes unhappy with a 6 percent annual Medicare growth rate, it could ratchet down this rate through a future BBA-2.

While the Medicare data can be criticized for isolating only federal spending and not including beneficiaries’ out-of-pocket spending, the trend is so dramatic that it cannot be ignored. Moreover, many other nations—among them Germany, Japan, Canada, and the United Kingdom—have had success in dampening health care cost increases through governmental regulatory mechanisms.

Painful and painless regulation. Is cost control via government regulation synonymous with rationing? Not necessarily. Cost

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control can be painful (denying appropriate therapies to patients) or painless. Examples of painless cost control include reducing administrative waste (a product that is in abundance in the United States), cutting prices rather than quantities of services and products (particularly applicable to pharmaceuticals), and eliminating unnecessary medical interventions. Such painless cost control has the potential to save more than $100 billion per year in national health expenditures.

The BBA had both painful and painless elements. The reductions in home health spending negatively affected some of the nation’s most disabled citizens. Payment cuts to other providers seemed more painful to the providers than to the patients.

Could effective and long-term government regulation extend to the private health sector? In Altman and Levitt’s history, two of the brief episodes decelerating the rise in private health spending were produced by governmental regulatory (or regulatory-threat) action. Public regulation of health care prices has worked in other nations. There should be no disagreement about the capacity of the government to do the job. Altman and Levitt correctly identify the problem as a lack of political will.

**Political barrier.** One part of the political barrier is the (justified) popular desire for the latest and the best. Medicare may soon be expected to provide a permanent artificial heart pump to each of the five million Americans with congestive heart failure. But the political problem has a second aspect: the health care industry, whose campaign contributions assure a lucrative pricing structure. How much might Medicare pay for each of those five million artificial heart pumps, and how much will the surgeons installing the
pumps be reimbursed? Will private insurance administrative costs continue at their 11.5 percent rate while Medicare is administered at 3.6 percent? Is federal regulation of pharmaceutical prices possible without serious campaign finance reform?

In a plutocracy, Altman and Levitt’s pessimism may have some justification. A true democracy—based on fundamental reform of campaign financing—would improve the chances for long-term governmental regulation of prices, elimination of unnecessary administrative costs, and reduction of inappropriate medical interventions. Altman and Levitt are right that no “easy or magic answers” are available, but the not-so-sad history of Medicare cost containment shows that solutions do exist and they do work.

NOTES
4. Ibid., chap. 8.