

This is a sample of the instructor materials for *Health Policy Issues: An Economic Perspective*, seventh edition, by Paul J. Feldstein.

The complete instructor materials include the following:

- An instructor's manual featuring chapter overviews, teaching points for the end-of-chapter discussions, and in-class activities
- PowerPoint slides for each chapter
- A test bank

This sample includes the instructor's manual section and PowerPoint slides for chapter 1, "The Rise of Medical Expenditures."

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Chapter 1

The Rise of Medical Expenditures

Chapter Overview

Medical expenditures have climbed steadily and rapidly over the past five decades. This chapter provides a historical perspective and looks at both government and market reactions to growing medical expenditures. Special attention is given to public- and private-sector responses to rising expenditures in the 1980s, a decade in which the medical sector went through dramatic changes as a result of pressure to control costs.

Main Topics Covered

Before Medicare and Medicaid
The Greater Role of Government in Healthcare
 The Relationship Between NHE and GDP
Changing Patient and Provider Incentives
Government Response to Rising Costs
 The 1980s
 The 1990s
 The 2000s
The Affordable Care Act (ACA)

Textbook Discussion Questions

1. What are some of the reasons for the increased demand for medical services since 1965?

The federal government became a major payer of medical services after the Medicare and Medicaid programs were enacted in 1965. These programs reduced out-of-pocket expenses for the aged and the poor, causing demand for hospital and physician services to increase dramatically. Hospitals had to spend more to meet the growing demand for services, which led to rapid rises in expenditures.

Advances in technology also increased the demand for medical treatment. New methods of diagnosis and treatment offered hope of recovery for people with diseases that had previously been considered untreatable. Other factors contributing to the greater demand included rising incomes and the increase in private health insurance coverage, which reduced the cost of medical services to the patient, consequently increasing the demand for services.

2. Why has employer-paid health insurance been an important stimulant of demand for health insurance?

Employer-paid insurance is a form of compensation that is not subject to federal income tax. When employees receive additional income in the form of wages, they pay federal, state, and Social Security taxes and are left with less disposable income. Instead of having their employer pay wage increases in after-tax cash, employees prefer to have their employer spend those same dollars, before tax, to buy additional health insurance. Thus employees can have their out-of-pocket medical expenses paid with before-tax dollars rather than after-tax dollars. The tax subsidy for employer-paid health insurance has stimulated the demand for medical services in the private sector and further increased medical prices.

3. How did hospital payment methods in the 1960s and 1970s affect hospitals' investment policies and incentives to improve efficiency?

The Medicare program paid hospitals their costs plus 2 percent for serving Medicare patients. Because the costs were reimbursed in this manner, hospitals had no incentive to be efficient and reduce expenditures. On the contrary, hospitals actually had an incentive to increase costs. They expanded their capacity, invested in the latest technology, and duplicated facilities and services available in nearby hospitals. Hospital prices rose faster than any other medical service during this period.

4. Why were HMOs and managed care not more prevalent in the 1960s and 1970s?

When Medicare and Medicaid were enacted, federal law prohibited Medicare and Medicaid from contracting with health maintenance organizations (HMOs). Further, providers could only be paid fee-for-service. HMOs, such as Kaiser, also were paid fee-for-service, not an annual capitated amount per Medicare and Medicaid enrollee. The government, under Medicare and Medicaid, was not permitted to enroll Medicare or Medicaid beneficiaries in HMOs; enrollees in the two programs had to have free access to any provider. The American Medical Association (AMA) had lobbied for these provisions.

For many years prior to the passage of Medicare and Medicaid, states had, under pressure from the AMA, enacted restrictions against the development of HMOs (also referred to at that time as prepaid group practices). For example, HMOs could not advertise, they had to be nonprofit, and a majority of the board of directors of an HMO had to be physicians. The purpose of these restrictions was to prevent HMOs from competing with fee-for-service physicians. The state laws discouraged the growth of HMOs and managed care.

5. What choices has the federal government had to reduce greater-than-projected Medicare expenditures?

Medicare Part A was funded by a special payroll tax, and the amount collected was insufficient to pay for Medicare hospital expenditures, which rose faster than expected. Thus the government was faced with the following options: increase the

payroll tax and the wage base to which it applied, pay hospitals less for treating Medicare patients, or increase fees to Medicare patients. The government believed the first two options were politically less costly than increasing the burden on the aged.

Federal and state governments tried additional regulatory approaches to control the rapidly rising expenditures. Medicare utilization review programs were instituted, and controls were placed on hospital investment in new facilities and equipment. However, these government controls proved ineffective; hospital expenditures continued their rapid rise throughout the 1970s.

6. What events during the 1980s in both the public and private sectors made the delivery of medical services price competitive?

To achieve savings in Medicaid, the Reagan administration in 1981 removed the “free choice of provider” requirement for Medicaid enrollees, thus enabling states to require their Medicaid populations to participate in closed provider panels. The states were then able to contract with HMOs—which were beginning to grow at that time—and accept bids from hospitals for care of Medicaid patients. (The “free choice” requirements remained in place for the aged until the mid-1980s, at which time the aged were permitted to voluntarily join HMOs.) In 1983, a new Medicare hospital payment system was phased in. Hospitals were no longer paid according to their costs. Instead, fixed prices were established for each diagnostic-related-group (DRG) admission, and each year Congress set an annual limit on the increase in these fixed prices per admission. Since hospitals could keep the difference between their costs and the fixed DRG price, they now had an incentive to reduce their costs for caring for Medicare patients and to discharge the patients earlier. The length of stay per admission fell, and occupancy rates declined.

In the private sector, businesses struggled to survive the recession of the early 1980s and became focused on reducing labor costs. Because health insurance was the fastest-growing labor expense, businesses put pressure on health insurers to better control both the use and cost of medical services. Pressures from businesses led to more outpatient surgery, increases in deductibles and copayments, prior-authorization restrictions, and utilization reviews to reduce costs. These actions greatly reduced hospital admission rates. Between 1970 and 1998, hospital admissions per 1,000 in Blue Cross plans declined from 127 to 71.

Physician supply, which increased as a result of federal support to medical schools in the 1960s, resulted in physicians having excess capacity and a willingness to join closed provider panels.

With excess capacity among suppliers, and with demanders determined to reduce employees’ medical expenses, the preconditions for price competition were in

place. The applicability of antitrust laws to healthcare, upheld by the US Supreme Court in 1982, removed any anticompetitive barriers to price competition.

7. What are three criteria that have been proposed for evaluating the success of the ACA?

The first criterion for judging the success of the ACA is how it affects the number of uninsured people and the cost per newly insured enrollee. Prior to the ACA, about 50 million Americans were uninsured. The ACA expanded Medicaid eligibility from 100 to 138 percent of the federal poverty level (FPL), federal and state health insurance exchanges were established, premium tax credits and cost-sharing subsidies were provided on a declining scale to those with incomes between 138 and 400 percent of the FPL. The legislation included an individual mandate that required everyone to buy insurance or pay a penalty. An employer mandate was imposed that required employers to offer health insurance to their employees or pay a penalty of \$2,000 per employee. 23 million were expected to gain insurance under the ACA, leaving about 21 million uninsured. By 2016, however, only 16 million people gained insurance, leaving 28 million uninsured.

The second criterion relates to cost. The ACA expected to increase the demand for health insurance and, consequently, the demand for medical services without raising the costs of care. Whether the ACA is able to reduce the rate of increase in medical expenditures, reduce family premiums, and be budget neutral at the end of the decade will determine whether the ACA was able to meet this objective.

The third criterion relates to President Obama's promise that people could keep the coverage they have. What made these promises doubtful was that the ACA made numerous changes to the health insurance market, such as mandating "essential" (i.e., more comprehensive) health benefits, requiring a smaller difference in premiums between older and younger individuals on the health insurance exchanges, establishing gender equality in premium ratings, and initiating a new health insurance tax on premiums for those buying insurance on the exchanges. Additional regulations, as well as subsidies, were imposed on health insurers. As a result, many people who were enrolled in the individual insurance market received cancellation notices from their insurers because their coverage no longer met the ACA's mandated benefit standards. These people were forced to buy more expensive insurance on the new exchanges, which had very limited (low cost) provider networks.

In-Class Discussion Questions—15-20 min

1. Did managed care succeed in reducing medical expenditures?

As managed care spread throughout the country in the 1990s, the rate of increase in medical expenditures slowed. Dramatic reductions were seen in the use of

hospitals, and both hospitals and physicians gave large price discounts to be included in an insurer's provider panel. However, as price competition reduced medical costs, a backlash developed against some of the approaches to cost containment. The public wanted greater access to care, and Congress and the states began to impose restrictions on managed care organizations—mandating minimum lengths of stay in the hospital for normal deliveries, for example.

2. Why are we now seeing another rapid rise in medical expenditures and insurance premiums?

The population is aging, technological advances are improving early diagnosis, and new methods of treatment are becoming available. All of these factors contribute to higher demand for costly medical services. Costs are driven up also by government regulations at the state and federal levels that mandate minimum care requirements and freer access to specialists. New technology is believed to be the most important force behind rising expenditures. More highly trained personnel are needed to handle this technology, and wages must be raised to attract more nurses and technicians to the medical sector.

In response to consumer demands for easier access to providers and specialists, health plans have broadened their provider networks, thereby decreasing their ability to negotiate large provider discounts. In addition, hospital mergers have lessened competition and enabled many hospitals to increase their prices to health plans.

Increased demands and higher costs of providing medical services are causing medical expenditures to rise more rapidly.

HEALTH POLICY ISSUES

An Economic Perspective

CHAPTER 1

THE RISE OF MEDICAL EXPENDITURES

LEARNING OUTCOME

Discuss the underlying reasons for rising expenditures in the medical sector

PRESENTATION

Before Medicare and Medicaid

- [Exhibit 1.1](#)

The Greater Role of Government in
Healthcare

- [Exhibit 1.2](#)

PRESENTATION (CONTINUED)

The Greater Role of Government in Healthcare (continued)

- The Relationship Between NHE and GDP
 - [Exhibit 1.3](#)
 - [Exhibit 1.4](#)

PRESENTATION (CONTINUED)

Changing Patient and Provider
Incentives

Government Response to Rising Costs

- The 1980s
 - Legislative and Government Changes
 - Private Sector Changes
 - Antitrust Laws
 - Consequences of the 1980s Changes

PRESENTATION (CONTINUED)

Government Response to Rising Costs: (continued)

- The 1990s
- The 2000s

The Affordable Care Act

[continue to discussion](#)

Exhibit 1.1

Personal Health Expenditures by Source of Funds, 1965 and 2016

Source of Funds	1965		2016	
	\$ (Billions)	%	\$ (Billions)	%
Total	34.7	100.0	2,834.0	100.0
Private	27.6	79.5	1,479.5	52.2
Out-of-pocket	18.2	52.4	352.5	12.4
Insurance benefits	8.7	25.1	993.8	35.1
All other	0.7	2.0	133.2	4.7
Public	7.1	20.5	1,354.5	47.8
Federal	2.8	8.1	1,093.8	38.6
State and local	4.3	12.4	260.7	9.2

Source: Data from Centers for Medicare & Medicaid Services (2017b).

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Exhibit 1.2

National Health Expenditures, Selected Calendar Years, 1965–2016 (in Billions of Dollars)

	1965	1970	1980	1990	2000	2010	2016
Total national health expenditures	\$42.0	\$74.9	\$255.8	\$724.3	\$1,377.2	\$2,598.8	\$3,337.5
Health services and supplies	37.2	67.1	235.7	675.6	1,289.6	2,456.1	3179.8
Personal healthcare	34.7	63.1	217.2	616.8	1,165.4	2,196.0	2834.0
Hospital care	13.5	27.2	100.5	250.4	415.5	822.3	1082.5
Physician and clinical services	8.6	14.3	47.7	158.9	290.9	512.6	664.9
Dental services	2.8	4.7	13.4	31.7	62.3	105.9	124.4
Other professional care	0.5	0.7	3.5	17.4	37.0	69.9	92.0
Home health care	0.1	0.2	2.4	12.6	32.4	71.6	92.4
Nursing home care	1.4	4.0	15.3	44.9	85.1	140.5	162.7
Drugs, medical nondurables	5.9	8.8	21.8	62.7	152.5	304.3	390.8
Durable medical equipment	1.1	1.7	4.1	13.8	25.2	39.9	51.0
Other personal healthcare	0.7	1.3	8.5	24.3	64.5	129.1	173.3
Program administration and net cost of private health insurance	1.8	2.6	12.0	38.8	81.2	184.4	263.7
Government public health activities	0.6	1.4	6.4	20.0	43.0	75.6	82.2
Research and construction	4.7	7.8	20.1	48.7	87.6	142.7	157.5
Research	1.5	2.0	5.4	12.7	25.5	49.2	47.7
Construction	3.2	5.8	14.7	36.0	62.1	93.5	109.8
National health expenditures per capita	\$210	\$356	\$1,112	\$2,851	\$4,884	\$8,410	\$10,365

Source: Data from Centers for Medicare & Medicaid Services (2017b).

*Except where otherwise noted.

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Exhibit 1.3

Changes in National Health Expenditures and Gross Domestic Product per Capita, 1965–2016



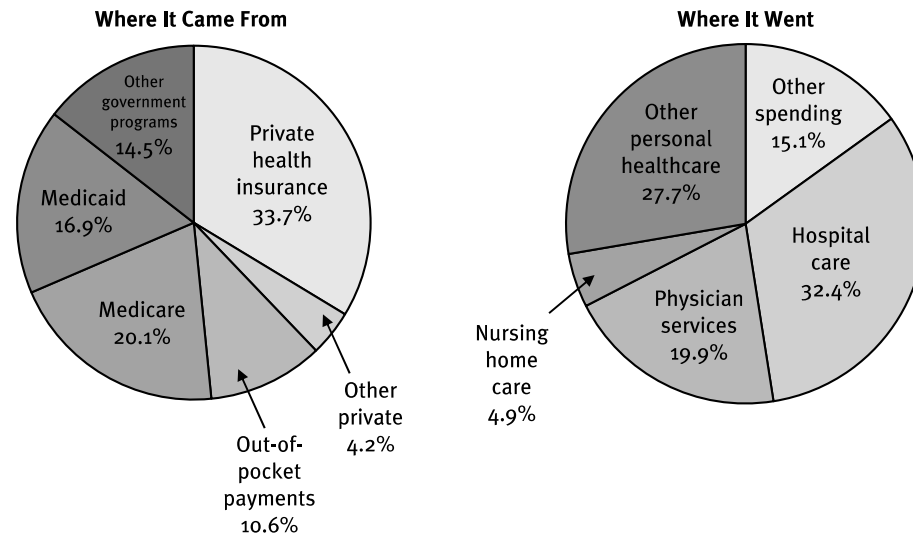
Note: Five-year moving averages.

Source: Data from the Centers for Medicare & Medicaid Services (2017b).

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Exhibit 1.4

The Nation's Healthcare Dollar, 2016



Notes: "Other personal healthcare" includes dental care, vision care, home health care, drugs, medical products, and other professional services. "Other spending" includes program administration, net cost of private health insurance, government public health, and research and construction.

Source: Data from the Centers for Medicare & Medicaid Services (2017b).

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DISCUSSION

The textbook explains several reasons for the increased demand for medical services since 1965. Which do you believe to be most significant, and why? Are there any other reasons you can add? What are some positive—and negative—aspects of this increased demand, in your opinion?

SUMMARY

The forces increasing demand and the costs of providing care include:

- An aging population
- Technological advances that enable early diagnosis
- New methods of treatment
- Need for more highly trained medical personnel

SUMMARY (CONTINUED)

The forces increasing demand and the costs of providing care include: (continued)

- Wage rate increases to attract more nurses and technicians to the medical sector
- The ACA
- The developing shortage of physicians

SUMMARY (CONTINUED)

Innovative approaches to reducing healthcare costs are more likely to be taken in a system that has price incentives to do so.

SUMMARY (CONTINUED)

A scarcity of funds to provide for all of our medical needs and population groups exists, and choices must be made.

- How much we as a society should spend on medical care
- The best way to provide medical services

SUMMARY (CONTINUED)

A scarcity of funds to provide for all of our medical needs and population groups exists, and choices must be made. (continued)

- How rapidly medical innovation should be introduced
- How much should be spent on those who are medically indigent and how their care should be provided

SUMMARY (CONTINUED)

Economics clarifies the implications of different approaches to these decisions.