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INTRODUCTION

PROFESSOR WING'S BASIC premise—that health care cost increases are a "fundamental problem" which must be addressed by public policy—is irrefutable. This Commentary elaborates on his analysis of the politics of health care cost containment by focusing on Congress. Obviously, Congress is not the only branch of the federal government that makes public policy decisions affecting health care costs; the executive branch, the independent agencies, and the judiciary have all shown more than a passing interest in this matter. Furthermore, the federal government is not the only level of government that concerns itself with health care costs; individual states have become increasingly active in this area in recent years. However, Congress does promulgate the statutes that define federal health care policy, which in turn holds major potential to contain health care costs.

This Commentary reviews the general perceptions of the health care cost problem held by members of the House and the Senate and describes the forces that will shape congressional policy decisions regarding health care costs for the foreseeable future. It appears virtually certain that Congress will reduce the rate of increase in federal expenditures, at least relative to what they would be under current policy. However, it is unlikely that these policy changes will have much effect on the "fundamental problem" of health care cost increases for the economy or for the individual consumers who are not federal program beneficiaries. Indeed, there is a chance that Congress, in addressing the problem of federal cost increases, may compound the problems facing individual consumers.

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I. CONGRESSIONAL PERSPECTIVES ON HEALTH CARE COSTS

There are as many different perspectives on health care costs in the Congress as there are Representatives and Senators. These perspectives are not widely known, however. Only a handful of Members of the House or the Senate focus their personal and staff energies on health policy issues on a regular basis. One reason for this, as a thoughtful House Republican recently observed, is that health has become a "take-away" area — not exactly an ideal foundation for building a political career. Although there are not many clearly articulated individual viewpoints, a few perceptions do appear to be widely held.[1]

One of the most widely held perceptions among members of Congress is that the health care cost problem is attributable to rising federal health expenditures.[2] Members are constantly reminded of increasing health care costs by the media, their constituents, advocacy groups, personal friends and family, who express concern with the increasing financial burden of health care.

This lack of congressional initiative can in part be explained by one basic dynamic: the cost problem is not one that members believed Congress *must* solve. For some, this belief is rooted in the idea that the responsibility for containing health care costs properly rests with the states or with private sector market mechanisms. These members have no incentive to use the federal government's regulatory or taxing policies to address the issue. But even for these members, the high rate of increase in federal health spending remains a concern and the political imperative of reducing the federal deficit, as evidenced by the Balanced Budget and Emergency Deficit Control Act of 1985[3] (generally referred to as the "Gramm-Rud-

1. Iglehart, *Congress, Public Policy, and the Future: A Conversation with Bill Gradison*, 4 HEALTH AFF., Winter 1985, at 41, 42.

2. Federal spending for health care flows primarily through the two major health entitlements, Medicare and Medicaid. However, the federal government also purchases health care for its civilian employees and retirees through the Federal Employees Health Benefits Program (FEHBP), for the dependents of active duty military personnel and retirees and their dependents through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and for the dependents and survivors of certain veterans through the Civilian Health and Medical Program of the Veterans' Administration (CHAMPVA). In addition, the federal government directly operates three separate health care systems: the Indian Health Service, the Veterans Administration Hospitals and Nursing Homes, and the Department of Defense Medical System. Whether as payor or provider, the federal government's health spending is increasing.

3. Balanced Budget and Emergency Deficit Control Act of 1985, Pub. L. No. 99-177, 99 Stat. 1037 (2 U.S.C. §§ 901-922 (Supp. 1986)).

man" Act), has turned the problem of rising federal health spending into an issue Congress now finds itself forced to address.

The Congressional Budget Office (CBO) projected in its February 1986 estimates that federal outlays would exceed federal revenues by $208 billion in the current fiscal year ending September 30, 1986. This amount is equal to five percent of the Gross National Product. CBO also projected that the federal deficit would decline from $181 billion in 1987[4] to $104 billion in 1991 under current revenue and spending policies. While this is encouraging, it is not legally sufficient because, as Table 1 illustrates, the Gramm-Rudman Act requires that the federal deficit be reduced each year for the next five years, from $144 billion in 1987 to $0 by 1991. Even though the Supreme Court has held the automatic spending reduction provisions of Gramm-Rudman unconstitutional,[5] the Act's deficit targets remain in place and, as a practical political matter, compel Congress to make tax and/or spending policy changes to achieve the targets. These deficit targets will force some major restructuring of federal revenue and spending policies, since the amount of "deficit reduction" must increase each year.[6]

TABLE 1
FEDERAL DEFICIT PROJECTIONS
AND TARGETS, FY 1987-1991
(in billions)

	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
CBO Projections	$181	$165	$144	$120	$104
Gramm-Rudman Deficit Targets	144	108	72	36	0
Required Deficit Reduction	37	57	72	84	104

Federal health programs, particularly the Medicare and Medicaid entitlements, are a major source of growth in federal spending.[7] Table 2 displays CBO projections of outlays for Medicare, Medicaid, and discretionary health programs (including the health block

4. All dates cited herein refer to fiscal years unless otherwise noted.

5. Bowsher v. Synar, 106 S. Ct. 3181, 3192 (1986). In *Bowsher*, the Supreme Court held that the powers given to the Comptroller General under the Gramm-Rudman Act violate the constitutional command that Congress play no direct role in the execution of laws. *Id.* at 3192. *See infra* text accompanying note 21.

6. CONGRESSIONAL BUDGET OFFICE (CBO), THE ECONOMIC AND BUDGET OUTLOOK: FISCAL YEARS 1987-1991 Summary Table 1, at xiv (Feb. 1986).

7. *See supra* note 1.

grants and biomedical research) over the next five years under current policy.[8] It is evident that the rate of growth in Medicare (fifty-seven percent) and Medicaid (twenty-eight percent) outstrips not only the rate for discretionary health programs (twenty percent), but also exceeds the rate for federal spending in the aggregate (twenty-two percent). These numbers—not the increases in national health care expenditures nor the increases in the medical care component of the consumer price index—shape congressional thinking on health care costs.

TABLE 2
FEDERAL HEALTH SPENDING PROJECTIONS
(outlays in billions)

	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
Medicare	$80.2	$90.1	$100.7	$112.5	$125.7
Medicaid	26.0	27.8	29.6	31.4	33.5
Discretionary Health	9.8	10.2	10.7	11.2	11.8
Total Federal Outlays	1025.0	1086.0	1135.0	1188.0	1248.0

Obviously, federal programs with high rates of spending growth are not favored under Gramm-Rudman's declining deficit targets, and open-ended entitlement programs like Medicare and Medicaid, involving large sums of money, are even more suspect. In the zero-sum game created by Gramm-Rudman, if Congress does not reduce the rate of Medicare and Medicaid expenditure increases, then it must cut deeper into defense spending, or into spending for other non-defense programs, or it must raise revenues by a greater amount.

Equally important, but politically less visible in the zero-sum game created by Gramm-Rudman, are the health-related tax expenditures. The largest expenditure of this type is the exclusion from an employee's income of the amount an employer contributes to an insurance plan which provides accident or health benefits, whether the employer is insured or self-insured. Employer contributions to fund such medical benefits are not subject to income, social security, or unemployment taxes. Table 3 shows the amounts of federal revenues foregone as a result of this and other health-

8. *See* CBO, *supra* note 6, at 60, 70.

related tax expenditures.[9]

TABLE 3
FEDERAL HEALTH-RELATED
TAX EXPENDITURES
(in billions)

	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990
Exclusion of Employer Contributions	$23.7	$26.4	$29.0	$32.2	$35.6
Deductibility of Medical Costs	3.5	3.9	4.3	4.8	5.3
Exclusion of Interest on Hospital Bonds	1.9	2.2	2.5	3.0	3.3

In theory, the revenue losses resulting from these tax expenditures could be converted into a program of direct expenditures for health services that is larger in size than the current Medicaid program. Alternatively, these losses could be eliminated and the additional revenue could be used to reduce the deficit. It has also been argued that placing a limit, or "tax cap," on the exclusion of the employer contributions (taxing, for example, contributions exceeding $200 per month for family coverage and $80 per month for individual coverage), would eliminate the open-ended incentive to purchase health coverage beyond the ceiling, and thus reduce demand for health care services and ease the upward pressure on medical care prices.[10]

In practice, however, concern about health care costs does not greatly influence congressional decisions regarding tax policy. Legislative proposals embodying the "tax cap" approach have not been adopted by either the House or Senate tax-writing committees, and are not incorporated in the landmark tax reform legislation enacted by the 99th Congress.[11] Apparently the members do not view the link between health-related tax expenditures and health care costs as being very strong. It is clear that the interests which support the

9. JOINT COMMITTEE ON TAXATION, ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 1986-1990, at 18-19 (Apr. 12, 1985).

10. *See* CBO, REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS 78-79 (Mar. 1986).

11. Tax Reform Act of Oct. 22, 1986, Pub. L. No. 99-514, 1986 U.S. CODE CONG. & ADMIN. NEWS 1 (special tax pamphlet).

current policy of exclusions, and which include business, organized labor and provider groups, are broad-based and highly persuasive.

A second general observation concerns members' perceptions of individuals who face catastrophic health costs. In recent years, for example, a great deal of congressional attention has focused on individuals who need organ transplants but cannot afford them, on individuals who receive organ transplants but cannot afford the necessary post-operative immunosuppressive drugs, on ventilator-dependent children who must live in hospitals or nursing homes because their families cannot afford to care for them at home, on elderly individuals with high drug expenses which are not covered by Medicare, and on victims of Alzheimer's disease who will require costly nursing home care for the rest of their lives. Members of Congress generally recognize that health care costs can pauperize almost any American who is unfortunate enough to experience a catastrophic illness or accident. However, their concern about these sympathetic individual cases has not been translated into federal policy addressing the general problem of rising health care costs. Instead, congressional response is more often directed at solving the problem of the individual, or group of individuals, in question.

The third perception generally held by members of Congress is that vast amounts of money are being earned in the health care field. The health-related political action committees (PACs) are well-financed and generous with their contributions to Democrats and Republicans alike. Although members are most likely unaware that physician incomes are approximately five times that of the average American worker, they do realize that pharmaceutical companies, physicians and most nursing homes, "do not take the vows of poverty."[12] Furthermore, many members of Congress invest their money and are undoubtedly aware of the strong performance of a number of health care company stocks and periodically, the members are reminded by either the General Accounting Office or the Inspector General of the Department of Health and Human Services that profiteering continues at the expense of the federal government's programs.[13] The perceived financial prosperity of health care providers may have made it easier for members to ra-

12. Iglehart, *supra* note 2, at 48.

13. *Hospital Profits under PPS, Before the Subcomm. on Health of the Senate Comm. on Finance* (Feb. 21, 1986) (testimony of Bryan B. Mitchell, Acting Deputy Inspector Gen. of the Dep't of Health and Human Services).

tionalize federal program cutbacks. It has not, however, resulted in a political consensus to bring health care costs under control.

The final observation is that members appear to lack confidence that a clear federal solution to the health care cost problem exists. This is not just a policy disagreement about whether regulatory approaches or market-oriented approaches are preferable; it is more a recognition that the nation's health care system is highly complex, that it varies considerably from state to state and district to district, and that it is undergoing a major change, in part driven by federal policies such as Medicare's shift to a hospital prospective payment system. There is also a disjuncture between the common policy prescriptions for cost containment and the members' personal decisions about health care. A recent informal survey by a McGraw-Hill trade journal found that not one of the key members of Congress and not one top Reagan administration official who have been promoting capitation in Medicare and other federal programs is enrolled in a health maintenance organization.[14]

II. CONGRESSIONAL DEFICIT POLITICS AND HEALTH CARE COSTS

Since the decisive rejection of the Carter administration's hospital cost-containment legislation by the House in 1979, virtually all cost-containment measures enacted by Congress have been included in Medicare or Medicaid legislation. The Reagan administration has, of course, helped to bring about some of these changes through its constant pressure for domestic spending reductions. Ultimately, however, it is the budget process that shapes Medicare and Medicaid policy.[15] The only major Medicare or Medicaid change that occurred outside the budget process was the enactment of the Medicare prospective payment system for inpatient hospital services, which was included in the Social Security Amendments of 1983.[16] However, the political groundwork for this change was laid in the preceding year's budget legislation.[17] The budget process preceded Mr. Reagan's arrival in the White House,[18] and it is almost certain

14. Sorian & Richard, *HMO-Phobia Strikes Administration*, 40 MED. & HEALTH, May 12, 1986, at 6.

15. *See* HOUSE COMM. ON THE BUDGET, THE CONGRESSIONAL BUDGET PROCESS: A GENERAL EXPLANATION (July 1986) (serial number CP-9).

16. Pub. L. No. 98-21, §§ 601-07, 97 Stat. 65, 149-72.

17. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101, 96 Stat. 324, 331.

18. The budget process first mediated Medicare and Medicaid changes during the last

to continue after his departure.

The enactment of Gramm-Rudman in 1985 has further tightened the control of the budget process over Medicare and Medicaid policy. In the interest of balancing the federal budget, Congress has adopted a set of targets for the federal deficit[19] and an elaborate set of enforcement measures, including rules governing the consideration of bills on both the House and Senate floors.[20] While the Supreme Court overturned one of the enforcement measures—the delegation of authority to the Comptroller General to enforce across-the-board budget reductions—it left all other provisions of the legislation intact.[21] Congress immediately responded by adopting, and sending to the President for signature, the across-the-board reductions that the Comptroller General would have presented to the President. As of this writing, the principal sponsors have proposed what they perceive as a remedy for the constitutional defect in the automatic reduction procedure; whatever the fate of this proposal, which was not adopted by the 99th Congress, it seems extremely unlikely that the Gramm-Rudman deficit reduction targets, or the current enforcement procedures for those targets, will be repealed.

Thus, for the foreseeable future, Congress will be under enormous political pressure to make increasingly difficult fiscal policy choices consistent with the stringent requirements of the Gramm-Rudman Act. These choices will cause policy changes in Medicare and Medicaid which, in turn, will undoubtedly affect health care cost increases in these programs and, perhaps, even have some impact on cost increases in the health care sector generally. As of this writing, Congress has had only nine months of experience under Gramm-Rudman; the budget for 1987, which began October 1, 1986, was finally resolved on October 17, 1986, without a full text of the new Gramm-Rudman procedures. However, enough changes have taken place to illustrate the dynamics of Medicare and Medicaid policymaking within the budget process as modified by Gramm-Rudman.

It is not the need of program beneficiaries, the interest of participating providers, nor the increase in health care costs generally that

year of the Carter administration. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, §§ 900-66, 94 Stat. 2599, 2609-55.

19. *See supra* Table I.

20. *See* Congressional Budget and Impoundment Control Act of 1974, Pub. L. No. 93-344, §§ 901, 902, 88 Stat. 297, 426, *as amended by* Pub. L. No. 99-177, 99 Stat. 1037 (1985).

21. *See supra* note 3.

were the principal determinants of Medicare and Medicaid policy in 1986; it is the Gramm-Rudman deficit target of $144 billion for fiscal year 1987. The question was — and will in future years remain — to what extent must Medicare and Medicaid contribute to the mix of defense and non-defense spending reductions and revenue increases to meet this target?

The budget process, within which this question is resolved, has two basic steps. First, Congress adopts a budget resolution, which is a blueprint for federal spending and taxing policy intended to achieve the Gramm-Rudman targets for the upcoming fiscal year.[22] Budget resolutions are not public laws; they are adopted by the the House and the Senate and are binding on both Houses, but they are not signed by the President. To effect program changes assumed in the budget resolution, the budget reconciliation bill must first be enacted. Only after this legislation has been signed into law by the President may any expenditure reductions or tax increases be implemented. The following brief summary describes the impact of this process during 1986 on Medicare policy.

In January of 1986, the President submitted his budget for 1987 which purported to meet the Gramm-Rudman target with a deficit of $143.6 billion.[23] The President's proposals were designed to achieve reductions in federal outlays by shifting costs to program beneficiaries, states, and providers; they did not address the cost problem in the health sector as a whole.

In February, the non-partisan CBO submitted its statutorily mandated annual report on budgetary options to the House and Senate Budget Committees.[24] While some of these options—such

22. S. Con. Res. 120, 99th Cong., 2d Sess. (1986).

23. The CBO re-estimated the President's budget and projected the deficit at $159.7 billion due to a lower rate of real economic growth and a higher spending rate for defense than the President had projected. CBO, AN ANALYSIS OF THE PRESIDENT'S BUDGETARY PROPOSALS FOR FISCAL YEAR 1987, at vii (Feb. 1986). The President proposed: (1) to reduce federal outlays by $10 billion over the next five years by putting a cap on federal Medicaid matching payments to states, effectively converting the entitlement into an indexed block grant; (2) to reduce federal outlays by $4.9 billion over the next five years by freezing public health and discretionary health program spending at 1986 levels; and (3) to reduce federal outlays for Medicare by $52.8 billion between 1987 and 1991. The major Medicare savings would result from an increase in Part B premiums from 25% to 35% of program costs ($18 billion over five years), from a cut in payments to hospitals for operating and capital costs ($22.2 billion over five years), and from a reduction in payments for the direct and indirect costs of medical education ($12.8 billion over five years). *See id.* at 85-91.

24. *See* Congressional Budget and Impoundment Control Act of 1974, *supra* note 20, at § 202(f), 88 Stat. at 300. This report set forth a number of health-related options for lowering the federal deficit. These options involved increasing federal revenues by (1) taxing some employer-paid health insurance; (2) raising the Medicare hospital insurance payroll tax;

as taxing employer-paid health insurance and eliminating tax-exempt bond financing for hospitals—would arguably have an impact on cost increases in the health care sector of the economy, the primary purpose and effect of most of the options was to reduce federal outlays or increase federal revenues.

On May 2, the Senate approved a budget resolution for 1987,[25] that fixed the deficit at $144.65 billion for that year.[26] Of the $27.55 billion in deficit reductions contained in the Senate version, $900 million was to be cut from Medicare and $260 million from Medicaid.[27]

On May 15, the House adopted a budget resolution[28] that established a deficit of $137.3 billion for 1987. Of the $34.9 billion in deficit reductions, $300 million was to come only from Medicare. Instead of reducing Medicaid outlays, the House resolution proposed an increase of over $200 million in Medicaid spending for 1987.[29]

The House-Senate conference agreement, affirmed on June 26, 1986, called for a 1987 deficit of $142.6 billion, which is below the Gramm-Rudman target of $144 billion. The conferees agreed to $450 million in cuts in Medicare and approved an increase of just over $100 million in Medicaid spending.[30] Table 4 summarizes the

(3) taxing a portion of Medicare benefits; (4) eliminating private-purpose tax-exempt hospital bonds; and (5) imposing through the tax system an income-related premium on Medicare beneficiaries for Part B services. The options also included reductions in federal outlays which were sought to be achieved by (1) reducing Medicare payments for indirect medical education costs and for direct medical education expenses; (2) lowering Medicare reimbursement for capital expenditures; (3) adopting a fee schedule for paying physicians under Medicare Part B; (4) raising the Medicare Part B deductible; and (5) limiting Medicaid payments for long-term care services. *See* CBO, *supra* note 10, at 78-101, 256-59.

25. S. Con. Res. 120, 99th Cong., 2d Sess. (1986).

26. Figures for Senate and House versions and the conference agreement are taken from the Table entitled "Functional Comparison," 132 CONG. REC. H4408-09 (June 26, 1986).

27. "Deficit reductions" refers to the difference between the CBO-projected deficit of $172.2 billion and the Senate's final deficit of $144.65 billion. The difference between the initial CBO estimate of $181 billion and its mid-year estimate of $172.2 billion is largely explained by the intervening enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, on April 7, 1986.

28. H. Con. Res. 337, 99th Cong., 2d Sess. (1986).

29. The considerable difference between the Senate and House resolutions derived largely from the allocations for national defense; the House proposed outlays $5.75 billion below those of the Senate.

30. At this stage of the budget process Medicare, Medicaid, and, where applicable, income tax laws, are actually amended to achieve the net reductions called for by the budget resolution. The proposed statutory changes are typically combined into an omnibus bill and then follow the regular legislative route, taking effect only if passed by the House and Senate and signed by the President. However, the CBO remains the final arbiter of the amount by which a proposed policy changes federal outlays.

President's budget proposals, the Senate and House versions, and the conference agreement.

TABLE 4
FISCAL YEAR 1987 HEALTH BUDGET
(outlays in billions)

Reductions	Medicare	Medicaid	Total Deficit
President's Budget	- $ 4.7	- $ 1.3	- $ 21.6
Senate-passed Budget Resolution	- 0.9	- 0.3	- 27.5
House-passed Budget Resolution	- 0.3	+ 0.2	- 34.9
Conference Report	- 0.45	+ 0.1	- 29.6

The budget resolution approved by both the House and Senate on June 26 contained "reconciliation" instructions to each of the authorizing committees. These instructions directed the committees to report, by July 25, 1986, any changes in the laws within their jurisdictions that would achieve the reductions in Medicare outlays agreed to in the resolution.

For the authorizing committees, the challenge was to develop politically acceptable and programmatically sound policy changes that yield outlay reductions which would meet the reconciliation instructions. This already complex and difficult task was made even more formidable because these changes had to reduce outlays almost immediately; fiscal year 1987 began less than four months after the House and Senate agreed upon a budget which incorporated the Gramm-Rudman targets. This compressed time-frame effectively precluded any policy changes which might reduce federal health outlays by moderating price inflation in the health sector. Even if the CBO were willing to quantify any such changes, it would be several years before the effects of major structural reforms would be felt by federal programs. Furthermore, because virtually any major cost-containment reform is likely to face serious political opposition from some quarter, and because an authorizing committee earns no credit against its reconciliation target for proposing such changes, the budget process does not produce legislative changes that address the "fundamental problem" of health care cost increases. Instead, it produces cuts in provider reimbursement rates, increases in beneficiary cost-sharing obligations, and reductions in federal matching payments—changes that are concrete, readily quantifiable, and immediate in their effect.

The response of the authorizing committees to the 1987 Medicare reconciliation instructions illustrates how the budget process shapes congressional health care cost containment. The two House committees sharing Medicare jurisdiction made the following major recommendations for Medicare outlay reductions: (1) elimination of periodic interim payments to hospitals; (2) reductions in payments for inpatient hospital services; (3) reductions in capital payments to hospitals; (4) limitations on payments for cataract surgery; and (5) modifications in payments for oxygen therapy.[31] The Senate authorizing committee reported comparable but not identical recommendations on issues (1), (2), and (3), and also proposed to achieve further outlay reductions by providing that Medicare be the secondary payor for all Medicare beneficiaries who elect to be covered by employment-based health insurance as a current employee of a large employer. (The Senate committee also proposed to extend Medicare coverage, and the corresponding hospital insurance payroll tax, to all state and local employees hired before April 1, 1986, raising nearly $5 billion in revenues over 3 years).[32]

Several points are worth noting about these House and Senate authorizing committee recommendations. First, they are far narrower in scope than either the President's proposals or the options outlined by CBO. Second, with the exception of the Senate Medicaid secondary payor proposal, each of these proposals represents a reduction in reimbursement to a particular class of providers participating in the Medicare program. The proposals do not affect those providers' payments which are derived from other payors; consequently, the providers are free to try to transfer their Medicare "losses" to some other purchaser. The recommendations are not primarily meant to use Medicare's leverage to make providers behave in a more cost-effective manner toward non-Medicare patients. Finally, although the House committees recommended other Medicare policy changes in connection with their reconciliation proposals, few of these recommendations are likely to have any impact on cost increases in the health care sector.

This does not mean, however, that the budget process will never result in generalized cost savings. One House proposal, directing the Secretary of Health and Human Services to research the effectiveness of selected medical treatments and surgical procedures among the Medicare population, is intended to provide the basis for

31. Omnibus Budget Reconciliation Act, H.R. 5300, §§ 4506, 4527, 4530, 10202, 10203, 10221, 10233, 99th Cong., 2d Sess. (1986).

32. S. REP. No. 348, 99th Cong., 2d Sess. (1986).

long-term reductions in inappropriately high utilization rates of some treatments and procedures.[33] Such reductions, if implemented, could yield substantial savings to the Medicare program and, to the extent that such reductions influence physicians' practice styles, they may yield savings to non-Medicare patients and payors as well. Reductions in inappropriately high utilization rates may also improve the quality of care. Unfortunately, because such initiatives do not achieve outlay reductions and may even be considered "extraneous" to a reconciliation bill under Senate rules, the merits of such proposals are often overlooked.[34]

The way in which Congress eventually resolved the differences between the House and Senate Medicare reconciliation policies offers a classic illustration of the vagaries of the budget process. On August 20, 1986, the directors of the Congressional Budget Office and the Office of Management and Budget issued their "snapshot" of the federal budget, as required by the Gramm-Rudman law.[35] The directors estimated that the deficit for fiscal year 1987 would be $163.4 billion, or $19.4 billion over the Gramm-Rudman target of $144 billion. In the absence of a reconciliation bill or other spending reductions or revenue increases, across-the-board reductions of $9.7 billion in both defense and non-defense programs would be required. Of even greater importance to Medicare, the CBO revised its baseline assumptions regarding Medicare, converting many of the House and Senate committee savings recommendations into spending provisions.[36] Thus, when the House and Senate reconciliation conferees finally began negotiating in September, both Houses, according to CBO, *increased* Medicare outlays over the fiscal year 1987 through 1989 period.[37]

The final Medicare conference agreement, as passed by the House and the Senate on October 17, 1986, included the following major cost-saving provisions: (1) reductions in payments for inpa-

33. *Id.* at § 4503.

34. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 20001(d), 100 Stat. 82, 390 (1986).

35. 51 Fed. Reg. 29,829 (Aug. 20, 1986).

36. For example, savings in the House bill from the periodic interim payment proposal, which had been certified in writing by CBO on July 28, 1986, as saving $1.6 billion over 3 years, were transformed into costs of $2.5 billion under the August 20 baseline — a swing of $4.1 billion in less than a month. The change is attributable to the promulgation by the Health Care Financing Administration on August 15, 1986, of final regulations eliminating periodic interim payment.

37. According to CBO, net Medicare outlays in the House bill over the 3-year period were $600 million; in the Senate bill, $1.3 billion. The Senate proposal to bring uncovered state and local employees into Medicare was treated as a revenue measure.

tient hospital services; (2) reductions in capital payments to hospitals; (3) establishment of Medicare as a secondary payor; and (4) limitations on payments for cataract surgery.[38] However, according to CBO, the savings resulting from these measures were overwhelmed by the increased outlays resulting from other provisions, such that, on net, the reconciliation conference agreement *increased* Medicare outlays by nearly $500 million in fiscal year 1987, and by over $1 billion in the fiscal year 1987 to 1989 period. Table 5 displays the estimated budget effect of the reconciliation bill passed in October; a comparison with Table 4, setting forth the reconciliation instructions contained in the fiscal 1987 budget resolution passed by the House and Senate in June, shows that, in crafting program changes, Congress does not always strictly conform to its own budgetary blueprints. It is instructive that, less than 3 weeks after voting for the reconciliation bill, all of the members of the House and one third of the Senate stood for reelection.

TABLE 5
BUDGET EFFECT OF FY 1987
RECONCILIATION PROVISIONS
(outlays in billions)

	FY 1987	FY 1987-1989
Medicare	+ $ 0.495	+ $ 1.086
Medicaid	+ .170	+ 1.083

The Medicare spending in the reconciliation bill did not prevent the Congress from meeting its Gramm-Rudman target, however. Other savings measures and revenue increases contained in the conference agreement offset this Medicare spending, yielding net outlay reductions of $11.7 billion in fiscal year 1987. These reconciliation savings, combined with an estimated increase of $11.4 billion in fiscal year 1987 revenues from the Tax Reform Act and smaller amounts of savings or revenue increases from other bills, enabled Congress to come under the $154 billion "trigger" for an across-the-board sequestration, effectively meeting the $144 billion Gramm-Rudman deficit target for fiscal year 1987.[39]

38. Sections 9302, 9303, 9319, and 9334 of the Omnibus Budget Reconciliation Act of 1986, P.L. 99-509.

39. See statement of Senator Domenici, 132 Cong. Rec. S16,922 (October 17, 1986). The Gramm-Rudman law allows a $10 billion margin of error in any given fiscal year for avoiding a sequestration order.

III. CONCLUSION

What does all this arcane congressional procedure have to do with the "fundamental problem" of health care cost increases? A good deal and then again, not much at all. On the one hand, the budget process has a good deal to do with the health care cost increases because it is, as a practical matter, the only way in which Congress acts on health care cost-containment issues. On the other hand, the budget process has very little to do with solving the problem of rising health expenditures because it has as its sole objective the development of a federal budget that meets the Gramm-Rudman deficit targets. As this Commentary has demonstrated, the incentives in the budget process all work to develop short-term, quantifiable cost-containment strategies that are limited in scope to Medicare and Medicaid instead of encouraging the development of proposals that address the fundamental problem of increasing costs which faces society.

The budget process is certainly not the only influence on congressional health policy decisions. Good old-fashioned partisan politics, the new political action committees, state and regional geopolitics, and other familiar factors are also at work. Moreover, the budget process has been changed in the past and will inevitably be changed in the future. For the time being, however, it has a powerful effect on congressional health policy. Although it may work to reduce the rate of increase in federal health care expenditure, it is unlikely to solve the "fundamental problem" of health care costs.