Causal Chains and Cost Shifting: How Medicare’s Rescue Inadvertently Triggered the Managed-Care Revolution

The conventional wisdom on how managed care came to replace traditional fee-for-service reimbursement as the nation’s dominant mode of health insurance is that enlightened businesses and their employers led the way in responding to the emergence of market forces in health care in the 1990s. A common textbook treatment of managed care’s ascendancy puts it this way: “Transformation of the health care delivery system through managed care has been driven principally by market forces, and reinforced by government.” The irony is that the opposite sequence of events is a more accurate portrayal of what actually happened. As this article shows, the transformation of America’s health-care system through managed care was initially triggered—albeit indirectly—by government actions and then driven by market forces. In other words, before business behavior was a cause of managed care’s extraordinary growth, it was largely a response to and an unintended consequence of government policymaking: in this instance, Congress’s reform of Medicare in 1983.

It is intuitively appealing to assume that the paradigm shift from fee-for-service insurance to managed care was solely the result of the business community seeking to reduce costs by increasing managerial control and market mechanisms. “Firms face a very clear incentive structure: they must strive to maximize profits,” as Paul Pierson and Jacob Hacker note. “This conclusion does not rest on assumptions about individual greed, but on the recognition that market systems are powerful mechanisms for inducing decision-makers to adopt profit-maximizing behavior.” But why, then, did the majority of businesses wait so long to begin switching their employees en masse into managed care? Lawrence Brown has explained why
managed care did not thrive in the 1970s, despite concerted government action on its behalf. Nevertheless, why did employers still not begin a big switch to cheaper managed care by the early 1980s or at least by the mid-1980s at the latest? Managed care had been a mandated alternative since 1974, a year after President Nixon signed the HMO Act, which required businesses with more than twenty-five employees that already offered health insurance to make HMOs available to their employees.

Business’ delayed transition to managed care suggests that existing market incentives were necessary but not sufficient for inducing such a major paradigm shift in health insurance. Providers (doctors and hospitals) and patients greatly dislike managed care, relative to fee-for-service health insurance, because it both restricts patients’ access to more expensive medical care provided by specialists and limits physician autonomy. Employers, on the other hand, generally do not care about the specific form of health coverage they provide until its cost becomes a significant issue. Thus, there was no natural incentive or tendency for employers and employees to switch from fee-for-service insurance to managed care.

As the following analysis shows, the critical catalyst for making market incentives sufficiently appealing for this massive paradigm shift came as a result of change to another major actor in the American health-care system, the single largest purchaser of hospital care: Medicare. Since Medicare and employers in the private sector purchase their medical care from the same hospitals and doctors, a dramatic change to Medicare’s payment policy was bound to greatly affect (directly and indirectly) the cost-benefit calculations and policy decisions of private employers. “Medicare is the 800 pound gorilla,” observes David Abernethy, former senior Medicare specialist and staff director of the House Ways and Means Health Subcommittee. “So when it slows its rate of expenditure growth, hospitals’ overall rate of revenue growth slows; and that, in the end, puts the final pressure on private payers.”

By examining the links in the causal chain between the reform of Medicare’s payment policy and the rise of managed care, we find that government policymakers used prospective payment as a powerful tool to help balance the federal budget at the expense of health-care providers, especially hospitals. Instead of increasing the payroll tax for Medicare or making Medicare beneficiaries pay more for their medical care, government leaders increased less visible tax expenditures—tax revenue foregone—by precipitating a significant increase
in health insurance costs for businesses (see Christopher Howard’s *The Hidden Welfare State* for more on this common government approach to fiscal policy). Employers responded, in turn, by ditching more expensive fee-for-service insurance for their workers in favor of cheaper managed care. Ultimately, this linkage shows that nothing can transform an industry more quickly and profoundly than when the government—if it is an industry’s single largest customer—dramatically alters how it pays for goods and services.

**Policy Feedback and Causal Chains**

Social scientists often take a “snapshot” view of political life, explains Paul Pierson. “How does the distribution of public opinion affect policy outcomes? How do individual social characteristics influence propensities to vote? . . . Disputes among competing theories center on which factors (“variables”) in the current environment generate important political outcomes.” But the significance of such factors, he points out, is “frequently distorted when they are taken from their temporal context.” So there is a strong case to be made for shifting from snapshots to “moving pictures,” especially for studying events or phenomena that unfold over longer periods of time (often years). This is particularly true for studying sequences, argues James Mahoney, in which “an event may trigger a chain of causally-linked events that, once itself in motion, occurs independently of the institutions that initially trigger it. This sequence of events, while ultimately linked to a critical juncture period, may culminate in an outcome that is far removed from the original juncture.” The trick, Pierson adds, is to trace the chain of events and test how strong the links are between them.

Accordingly, this article contributes to a growing body of research that focuses on how public policies can be as much of an influence (independent variable) on political and private actors—through the political and economic feedback they generate—as they are an outcome of them (dependent variable). The goal is to try to separate the specific order of cause and effect, because sequence analysis is critical for causal analysis. A parallel goal with this type of inquiry is to try to account for how individuals and institutions respond to changes in public policy, recognizing that government reforms often reconfigure incentives other than those originally intended. According to Pierson, “research on policy feedback has
stressed two arguments: that policy structures create resources and incentives that influence the formation and activity of social groups, and that policies affect processes of ‘social learning’ among major political actors.”¹⁷ For example, Hacker has shown that the parallel growth of public welfare programs (e.g., Social Security) and private welfare (e.g., health insurance) is a classic example of how “private social benefits have ‘policy feedback’ effects that are not all that different from the policy feedback effects that are created by public social programs.”¹⁸ In both instances, “major public policies constitute important rules, influencing the allocation of economic and political resources, modifying the costs and benefits associated with alternative political strategies, and consequently altering ensuing political development.”¹⁹

The paradigm shift from traditional fee-for-service health insurance to managed care is a good example of how policy feedback, within a domino-like sequence of events, can result in a completely unanticipated consequence. In this instance, the entire chain can be summarized as the shifting of costs from one actor in the U.S. medical industrial complex to another—from the government to the hospital industry to privately insured patients and their employers. Congress’s seminal and financially necessary change to Medicare’s reimbursement scheme in 1983 (domino one) allowed Congress to systematically reduce spending on hospital care in the latter half of the 1980s (domino two) in response to massive budget deficits. Hospitals reacted to reduced Medicare funding by increasing their cost shifting to privately insured patients (domino three). By its very definition, cost shifting was simply passed along the payment chain and contributed significantly to large annual increases in private insurance premiums. Responding to the growing imperative for cost control, employers logically switched more and more of their employees into much less popular—but also less expensive—managed-care plans (final domino). The remainder of the article is devoted to explaining this linkage and the mechanisms that fostered it.

Origins of Prospective Payment: Trust Funds and Medicare’s “Crisis” Politics of Bankruptcy

As Theodore Marmor, Eric Patashnik, Jonathan Oberlander, Julian Zelizer, and others have shown, the politics of Medicare policymaking have often been waged under the auspices of “crisis-oriented” con-
cerns over the solvency of the program’s trust funds. When combined with even larger concerns over federal budget deficits that emerged in the mid- to late 1980s, Marmor notes, Medicare was found to be uniquely vulnerable to major programmatic change in a way that its companion program in Social Security, Old Age and Survivors Insurance (OASI), never was.

The structure of Medicare’s financing with its two trust funds is central to the program’s direct effect on the U.S. federal budget. When Congress passed Medicare in 1965, adding it to Social Security, the public health insurance program was comprised of two parts with separate financing arrangements. Part A, the Hospital Insurance (HI) Trust Fund, pays for beneficiaries’ hospital costs. It is financed from a 2.9 percent payroll tax. Part B, the Supplementary Medical Insurance (SMI) Trust Fund, pays for beneficiaries’ physician and outpatient expenses. It is financed by general tax revenues and premiums paid by Medicare beneficiaries. Because Part A is financed by a payroll tax, it can conceivably go bankrupt by paying out more in expenditures than it receives in tax revenue. Part B, however, is immune to such threats (for all intents and purposes) because its partial funding from general tax revenues operates as an “open pipeline” to the Federal Treasury.

Scholars disagree over whether policymakers, particularly Ways and Means Chairman Wilbur Mills, designed Medicare to be insulated from regular political debate or, rather, to encourage it. Marmor and Oberlander argue that the “bankruptcy crises” that have repeatedly erupted over Medicare are a perverse outcome, unintended by those who designed the program to be a vehicle for smoothly and effectively achieving national health insurance via incremental steps. Conversely, Patashnik and Zelizer see a certain institutional logic to Medicare’s design that, they argue, has “served a valuable social purpose by periodically forcing policymakers to engage in a healthy examination of one of the nation’s largest and most expensive social programs.”

Either way, financial problems with Medicare arose soon after the program began operation. According to a report submitted to the Senate Finance Committee in the spring of 1966, the system for paying hospitals “contains no incentives whatsoever for good management and almost begs for poor management.” Robert Ball, commissioner of the Social Security Administration during Medicare’s development and implementation, agreed: “After-the-fact reimbursement for hospital costs clearly was flawed, and within a couple of
years I and other government officials were calling for some form of prospective payment.”

The core of Medicare’s problem stemmed from its lack of cost-containment incentives; hospitals were neither penalized for cost increases nor rewarded for finding ways to control them. “Medicare gave hospitals a license to spend,” notes Rosemary Stevens. “The more expenditures they incurred, the more income they received. Medicare tax funds flowed into hospitals in a golden stream, more than doubling between 1970 and 1975, and doubling again by 1980.” Medicare’s formula for hospital reimbursement invited abuse, because it operated on a “cost+ 2 percent basis” for all services. Since the 2 percent was a percentage of costs (and added by Congress to reflect the added nursing costs for Medicare patients), it amounted to an open-ended proposition by offering a small bonus for every cost increase. Consequently, Oberlander explains, Medicare “quickly acquired a reputation, as chairman of the Senate Finance Committee Russell Long put it, as a ‘runaway program,’ an image only reinforced by much higher than expected costs in the kidney dialysis benefit added to Medicare in 1972.”

First Domino: Development, Passage, and Phase-in of Medicare’s New Hospital Payment System

By the advent of President Ronald Reagan’s first year in office in 1981, Medicare was predicted to go bankrupt by as early as 1987 or 1988. Interfund borrowing from Medicare’s HI trust fund ($12.4 billion) and the Disability trust fund ($5.1 billion) to the OASI trust fund exacerbated an already deteriorating financial situation for Medicare. Moreover, the structural concessions that policymakers had made to Medicare’s design in 1965, so the program could finally overcome the AMA’s political opposition, led to a very lucrative but ultimately unsustainable system for paying hospitals and doctors.

Ironically, Reagan’s new Republican administration, with its ideological emphasis on pro-market policies and downsizing the federal government, created a unique political context for a Medicare reform proposal that involved increased government regulation. As Oberlander points out, “fiscal exigency simply overwhelmed ideology. . . . Given the administration’s short-term goals for reducing domestic spending, a market approach to Medicare reform was not
viable.” Thus, “federal regulatory authority over medical providers consequently had to be strengthened.”

In rationalizing Medicare’s hospital reimbursement scheme, policy learning came by way of applied federalism. In the 1972 Social Security Amendments, Congress authorized the Department of Health and Human Services (HHS) to conduct statewide experiments with different forms of hospital reimbursement. By 1982, it was monitoring nine individual state experiments. One in New Jersey looked particularly promising with its novel use of diagnosis-related groups (DRGs), designed in the early 1970s by Robert Fetter and John Thompson at Yale University. The definitive report on New Jersey’s experience began by explaining that DRGs grew out of academic “efforts in the 1970s to define a hospital’s product and the use and costs of resources essential to produce it.”

There were other ambitious state experiments in hospital payment reform in New York, Massachusetts, Connecticut, Rhode Island, Maryland, and Washington. But President Reagan’s new Secretary of HHS, Richard Schweiker, came from Pennsylvania and “religiously summered at the Jersey shore,” according to Robert Rubin, assistant secretary of Planning and Evaluation at HHS from 1981 to 1984, who was principally involved in the political negotiations between the administration and key members of Congress over DRGs. “Being in the health care field as a Senator and Congressman for twenty years, Schweiker was well known, so it wasn’t unusual for him to hear about these kinds of things,” adds Rubin. “Actually there were two books on DRGs; he had carefully read both of them and had underlined them. He and I talked about his questions at some length and he became convinced that DRGs made the most sense.”

Jack Owen, vice president of the American Hospital Association (AHA) beginning in 1982, previously had run the New Jersey Hospital Association for twenty years and was instrumental in securing the cooperation of New Jersey hospitals in the state’s experiment with DRGs. As vice president of the AHA, he urged Secretary Schweiker to adopt New Jersey’s innovative form of reimbursement and then persuaded Senator Bob Dole that the AHA would support the move to a prospective payment system.

Building on New Jersey’s model, albeit without a formal evaluation indicating whether or not the state’s experiment worked, the foundation for Medicare’s new prospective reimbursement method was DRGs. As a patient classification system, DRGs sorted patients into groups according to medical condition (Table 1). Medicare’s
payment for any specific DRG, Louise Russell explains, “is the same for every patient in a given group, regardless of how long the patient stays in the hospital or what else is done during the stay.” The crucial features of Medicare’s prospective payment system “are that payment is prospective—rates are set before services are delivered—and that a single lump-sum rate pays for the entire hospital stay. . . . If the hospital can take care of the patient for less than the fixed rate, it keeps the profit. If not, it absorbs the loss.”

Changing Medicare payment from a retrospective to a prospective system was revolutionary. Previously, doctors and hospitals often charged patients different rates for the same procedure based on their ability to pay or how long they stayed. This meant that the same hospital procedure would often cost Medicare twice or even three times as much in one location as compared to another. “The cost reimbursement model from before 1983 was insanity. On the face of it, it encouraged people to do more, it paid them to do more and not in any particularly rational way,” according to Sheila Burke, a key staff member on the Senate Finance Committee at the time and Senator Bob Dole’s chief of staff. “Going to DRGs, therefore, had all the right things going for it politically and conceptually. . . . In effect, you could say to the average member of Congress, who tended to not want to get into the minutiae of Medicare policy be-

Table 1. Selected Diagnosis-Related Groups, 1988

<table>
<thead>
<tr>
<th>DRG Number</th>
<th>Title</th>
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<tbody>
<tr>
<td>106</td>
<td>Coronary bypass with cardiac catheterization</td>
</tr>
<tr>
<td>127</td>
<td>Health failure and shock</td>
</tr>
<tr>
<td>176</td>
<td>Complicated peptic ulcer</td>
</tr>
<tr>
<td>236</td>
<td>Fractures of hip and pelvis</td>
</tr>
<tr>
<td>317</td>
<td>Admit for renal [kidney] dialysis</td>
</tr>
<tr>
<td>433</td>
<td>Alcohol or drug abuse or dependence, left hospital against medical advice</td>
</tr>
<tr>
<td>470</td>
<td>Ungroupable</td>
</tr>
<tr>
<td>474</td>
<td>Tracheostomy</td>
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</table>

cause it was one of the more boring aspects of their lives, “Why should it [a particular hospital service or procedure] cost anything different between L.A. and San Francisco or San Francisco and Chicago, or Chicago and Detroit?”

The government’s fiscal priorities so dominated the development of Medicare’s PPS in 1982 and 1983 that there existed little interest-group influence or congressional and media debate. Most members of Congress did not understand exactly how the PPS worked. They voted for it, however, because Medicare was approaching insolvency and because congressional leaders piggy-backed the plan onto even more vital Social Security legislation that had to pass for monthly OASI checks to continue uninterrupted. Attaching Medicare reform to critical Social Security reform was a purely opportunistic, but effective, decision. A veto-proof bill emerged, largely immune from interest-group influence due to its sheer urgency.

The PPS’s four-year phased-in approach had profound effects on hospital administration. In order to cushion their transition from traditional cost-reimbursement to a prospective system, first-year DRG payments were based on each hospital’s historical costs. Hospitals quickly reduced their patients’ average length-of-stay and in the process, according to Robert Coulam and Gary Gaumer, reaped huge windfall payments: “Widely conceded ‘overpayment’ in the first year of PPS created a situation in which margins were increasing as expenses per case were dropping, due to large reductions in length of stay. This not only made the first year a somewhat aberrant intervention, but also armed most hospitals with an unanticipated source of disposable funds, and probably altered expectations as well.”

Hospital administrators transformed their medical records departments—where accurate coding of patient records determined how much hospitals got paid or whether they got paid at all—with more personnel and improved technology. The cliché of choice became “PPS brought medical records out of the basement.” In addition, hospitals that had a teaching mission or served a disproportionate share of poor patients successfully persuaded Congress to have Medicare pay them more generous DRG rates because of their special status. Significant change ensued. The Medicare hospital payment reforms “were the most drastic and far-reaching changes in Federal health policy since the passage of Medicare itself,” notes David G. Smith. In 1984, Michael Bromberg, executive director of the Federation of American Hospitals (FAH), said as much in his testimony before Congress: “The Medicare law that brought us prospective
In 1985, Bromberg reiterated his claim that Medicare’s “Prospective Payment System is the most effective cost containment program ever enacted, successful beyond anyone’s expectations.”

Everyone was initially pleased with Medicare’s PPS. Medicare’s rate of expenditure growth slowed dramatically in 1985, with Part A payments to hospitals providing the bulk of the program’s reductions (Table 2). At the same time, hospitals profited handsomely. Their positive Medicare margins—which reflected the total amount of Medicare inpatient payments they received relative to the total inpatient costs they incurred treating Medicare patients—were almost 15 percent in 1984 and 1985 (Fig. 1). Such large Medicare PPS margins helped to offset hospitals’ regular losses on both Medicaid and charity care patients, which left them with an average overall profit margin of slightly more than 5 percent (Fig. 1).

For the first time ever, though, Medicare's new method of reimbursement separated hospitals into financial “winners” and “losers.” Each year’s average Medicare PPS margin masked an enormous amount of variation around the mean. Even with a positive overall average of almost 15 percent Medicare PPS margins in the early years, hundreds of hospitals had significantly higher margins. Meanwhile, there were hundreds of hospitals that either were so inefficient or had such an unpredictable mix of Medicare cases (often small rural hospitals) that they still managed to lose money on their Medicare patients (see Table 3).

Ultimately, Medicare’s new PPS was a huge but not an immediate change for the hospital industry. The four-year phase-in period allowed hospitals to make minor adjustments and technological coding improvements, which significantly increased most hospitals’ financial margins and created the term “DRG creep.” The vast majority of hospitals found themselves much better off financially during the early years of Medicare’s new PPS than they were under cost reimbursement. But the AHA’s Jack Owen knew that the good financial times would not last. He believed that Congress would come to view hospitals’ sizable profits as potential budgetary savings: “I told my member hospitals to put their money in the bank. . . . ‘It won’t continue,’ I said. ‘You’re going to get reduced.’”
Table 2. Total Medicare and National Health Expenditures (in billions), 1980–87

<table>
<thead>
<tr>
<th>Year</th>
<th>National Health Expenditures</th>
<th>Percentage Change</th>
<th>All Medicare Expenditures</th>
<th>Percentage Change</th>
<th>Medicare Hospital Payments</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>$249.1</td>
<td>—</td>
<td>$36.4</td>
<td>—</td>
<td>$25.4</td>
<td>—</td>
</tr>
<tr>
<td>1981</td>
<td>288.6</td>
<td>15.9%</td>
<td>43.7</td>
<td>20.0%</td>
<td>30.6</td>
<td>20.3%</td>
</tr>
<tr>
<td>1982</td>
<td>323.8</td>
<td>12.2%</td>
<td>51.2</td>
<td>17.3%</td>
<td>35.7</td>
<td>16.5%</td>
</tr>
<tr>
<td>1983</td>
<td>356.1</td>
<td>10.0%</td>
<td>58.1</td>
<td>13.5%</td>
<td>39.9</td>
<td>11.8%</td>
</tr>
<tr>
<td>1984</td>
<td>387.0</td>
<td>8.7%</td>
<td>64.8</td>
<td>11.5%</td>
<td>44.5</td>
<td>11.7%</td>
</tr>
<tr>
<td>1985^</td>
<td>420.1</td>
<td>8.5%</td>
<td>69.8</td>
<td>7.8%</td>
<td>47.1</td>
<td>5.7%</td>
</tr>
<tr>
<td>1986</td>
<td>452.3</td>
<td>7.7%</td>
<td>75.8</td>
<td>8.5%</td>
<td>49.2</td>
<td>4.6%</td>
</tr>
<tr>
<td>1987</td>
<td>492.5</td>
<td>8.9%</td>
<td>82.0</td>
<td>8.2%</td>
<td>51.3</td>
<td>4.2%</td>
</tr>
<tr>
<td>'80–83</td>
<td>—</td>
<td>12.7%</td>
<td>—</td>
<td>15.0%</td>
<td>—</td>
<td>16.2%</td>
</tr>
<tr>
<td>'84–87</td>
<td>—</td>
<td>8.5%</td>
<td>—</td>
<td>9.0%</td>
<td>—</td>
<td>6.5%</td>
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* Annual average increase over the four-year period
^ First full year of Medicare’s PPS in operation
Second Domino: Medicare Policy's Increasing Subordination to Budget Policy

The mutual admiration between Congress and the hospital industry over the success of the PPS deteriorated when Congress turned to Medicare in 1986 as a means of addressing the nation's growing budget deficits. The same Michael Bromberg, who just a year earlier had effusively praised federal policymakers, now accused Congress and the Reagan administration of operating in “bad faith” and violating the PPS “contract.” Hospitals started withholding requested financial information from Congress concerning their finances, particularly their overall margins. They concluded that politicians only
**Table 3.** Hospitals’ Inpatient Medicare (PPS) “Profit” Margin* and Percentage of Hospitals with Overall Medicare Losses, 1984–92

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospitals’ Inpatient Medicare (PPS) Margin*</th>
<th>Percentage of Hospitals Losing Money on their Medicare Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>14.5</td>
<td>16.8</td>
</tr>
<tr>
<td>1985</td>
<td>14.0</td>
<td>18.8</td>
</tr>
<tr>
<td>1986</td>
<td>9.5</td>
<td>32.3</td>
</tr>
<tr>
<td>1987</td>
<td>6.6</td>
<td>39.8</td>
</tr>
<tr>
<td>1988</td>
<td>3.9</td>
<td>46.1</td>
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<tr>
<td>1989</td>
<td>1.4</td>
<td>51.8</td>
</tr>
<tr>
<td>1990</td>
<td>-.05</td>
<td>56.7</td>
</tr>
<tr>
<td>1991</td>
<td>-2.4</td>
<td>60.8</td>
</tr>
<tr>
<td>1992</td>
<td>-1.0</td>
<td>60.0</td>
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* PPS Margin = (hospitals’ total inpatient Medicare payments – hospitals’ total inpatient Medicare costs) ÷ hospitals’ total inpatient Medicare payments
meant to use the information to justify further Medicare rate reductions. By 1988, members of Congress and the hospital industry were openly trading angry accusations of lying, fraud, and deceit.\textsuperscript{63} Congress ignored the hospital industry’s complaints and annually reduced the rate of increase to Medicare’s DRG payments. According to Bill Gradison, the ranking Republican on the House Ways and Means Subcommittee on Health until 1993, the key to Congress’s ability to extract huge savings from Medicare was the budget reconciliation process.\textsuperscript{64} Leon Panetta, chair of the House Budget Committee in the 1980s, observed that the reconciliation process “scared the hell out of” the hospital and other industries.\textsuperscript{65} Moreover, “providers, particularly hospitals, were always viewed by Congress as an easier target than doing anything that would have ever affected Medicare beneficiaries,” according to Rick Pollack, executive vice president of the AHA. “I don’t know how many people on the Hill would be up front in admitting this, but they would sort of have a hole in the budget target to reconciliation . . . and they’d save the PPS update factor to be the last thing to be determined and say, ‘Ok, we gotta save a billion bucks over three years, so let’s just make this tweak to Medicare’s payment system or that tweak.’ At the end of the day, it was legislated in the back rooms and it was all a budget number.”\textsuperscript{66}

Many policymakers, including senior staff and members of Congress, have admitted to using prospective payment for larger budgetary purposes. According to Lisa Potetz, senior hospital analyst at ProPAC from 1984 to 1989 and senior Medicare analyst on the Senate Finance and House Ways and Means Committees from 1989 to 1995, congressional leaders came to view prospective payment as a valuable and effective tool for reducing the deficit.\textsuperscript{67}

Adjusting hospital payment rates as part of the budget reconciliation process had a noticeable impact on Medicare’s financial condition. According to the CBO, it reduced the “growth rate of real [Part A] spending from 5.4 percent annually between 1980 and 1985 to just 1 percent annually between 1985 and 1990.”\textsuperscript{68} As Patashnik notes, “This extended the HI Trust Fund’s projected date of exhaustion from 1991 in the 1981 Trustees report to 2005 in the 1991 report.”\textsuperscript{69} Robert Reischauer, CBO director from 1989 to 1995, explains why it was so attractive (politically and fiscally) for Congress to manipulate Medicare payment policy for larger budgetary purposes: “Medicare was \textit{the} cash cow! There is a very simple reason for this and that is that Congress could get credited for deficit re-
duction without directly imposing a sacrifice on the public. . . And to the extent that the reduction actually led to a true reduction in Medicare services, it would be difficult to trace back to the Medicare program or to political decision-makers.70

Medicare's new payment system successfully restrained the program's rate of expenditure growth. “Though Medicare's cost savings may not have been impressive on an international scale,” Oberlander explains, “compared to the inflationary American private insurance market they were downright remarkable.”71 One result of Medicare's major cost savings, however, was that more and more hospitals lost money on their Medicare patients (particularly those with complicated diagnoses), largely because they did not restrain their cost growth. Hospitals' costs-per-case increased at an average annual rate of 8.6 percent between 1986 and 1992, more than twice the rate of general inflation.72 With increasing financial pressures, hospitals began to include operational efficiency measures and program closures to try to save money at the margins. But more than anything else, according to Stuart Altman, former chair of Medicare's Prospective Payment Assessment Commission (ProPAC), hospitals felt pressure to increase revenue by cost shifting to private payers.73

Third Domino: Hospitals' Increased Cost Shifting to Privately Insured Patients

By the late 1980s, the majority of hospitals were losing money on their Medicare patients (Table 3).74 According to ProPAC, while hospitals' overall cost growth returned to its “historical rate throughout the remainder of the 1980s, Medicare's PPS margin steadily fell, dropping below zero in 1990 and to -2.4 percent in 1991.”75 As Altman suggests, hospitals responded largely by turning to privately insured patients to make up for these losses, as well as for an increasing share of their Medicaid losses and unreimbursed charity care (Table 4).76

Both the business community and commercial insurers had been aware of cost shifting long before the PPS's implementation,77 but this form of cross-subsidization had traditionally remained modest enough to avoid open conflict.78 From 1984 to 1993, however, the average annual increase in the per capita cost of private health insurance for medical services was 22.7 percent more than the rate of
Table 4. Hospitals’ Overall Payment-to-Cost Ratios* by Payer, 1980–92

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Medicare</th>
<th>Total Medicaid</th>
<th>Total Private Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>0.96</td>
<td>0.91</td>
<td>1.12</td>
</tr>
<tr>
<td>1981</td>
<td>0.97</td>
<td>0.93</td>
<td>1.12</td>
</tr>
<tr>
<td>1982</td>
<td>0.96</td>
<td>0.91</td>
<td>1.14</td>
</tr>
<tr>
<td>1983</td>
<td>0.97</td>
<td>0.92</td>
<td>1.16</td>
</tr>
<tr>
<td>1984</td>
<td>0.98</td>
<td>0.88</td>
<td>1.16</td>
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<td>1985</td>
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<td>1987</td>
<td>0.98</td>
<td>0.83</td>
<td>1.20</td>
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<tr>
<td>1988</td>
<td>0.94</td>
<td>0.80</td>
<td>1.22</td>
</tr>
<tr>
<td>1989</td>
<td>0.91</td>
<td>0.76</td>
<td>1.22</td>
</tr>
<tr>
<td>1990</td>
<td>0.89</td>
<td>0.80</td>
<td>1.27</td>
</tr>
<tr>
<td>1991</td>
<td>0.88</td>
<td>0.82</td>
<td>1.30</td>
</tr>
<tr>
<td>1992</td>
<td>0.89</td>
<td>0.91</td>
<td>1.31</td>
</tr>
</tbody>
</table>


* Medicare's payment-to-cost ratio in this table contrasts with the PPS margins in Table 3 and Figure 1. This is attributable to the broader scope of the payment-to-cost ratio, which reflects payments and costs for all Medicare services (inpatient and outpatient acute care, medical education programs, and hospital-based post-acute care). Payments for outpatient services, medical education, and post-acute tend to be below reported costs because of the use of fee schedules, discounts from cost-based rates, and payment limits. In addition, the payment-to-cost ratio reflects Medicare's share of all hospital costs, whereas the PPS margin is calculated using only Medicare-allowable costs, which are believed to be 3–5 percent lower. See Guterman, Ashby, and Greene, “Hospital Cost Growth Down,” 139 n. 14.

Increase in the per capita cost of Medicare beneficiaries for the same services. Private payers’ payment-to-cost ratio peaked at 131 percent in 1992 (see Table 4). And smaller businesses were particularly vulnerable to the negative effects of cost shifting because they were far less able to obtain strong bargaining positions in negotiating their health insurance contracts.

In more competitive markets without a large government presence, David Drake argues, cost shifting of this magnitude would not
and could not occur. But as current CMS administrator and former president of the FAH, Tom Scully, observes, medical providers are second only to defense contractors in their dependence on government payments, which provide approximately 40 percent of their total revenues. In addition, hospitals basically treat all patients alike. Hence, it is difficult, if not impossible, for them to separate public and private patients into various parts of the hospital that might have different cost structures.

Evidence of hospitals’ extensive use of cost shifting even came in the form of confession. In a written reply to a series of questions posed by the Senate Labor and Human Resources Committee, the American Hospital Association admitted that hospitals routinely shifted some of their costs to privately insured patients, who then paid inflated bills. James Mongan—currently CEO of Partners HealthCare in Boston and formerly president of Massachusetts General Hospital, senior staff member of the Senate Finance Committee, and deputy assistant secretary for Health in the Carter administration—argues that hospitals have to cost shift to private payers or risk bankruptcy. Michael Bromberg of the FAH, which represents the nation’s investor-owned, for-profit hospitals, admitted that hospitals regularly increase charges to private patients to compensate for reduced reimbursement for public patients. And Rick Pollack, senior vice president of the AHA, argues that cost shifting was standard operating procedure for most hospitals until managed care made it increasingly difficult by negotiating significant discounts with medical providers.

With the growth of cost shifting and the directly associated increase in insurance premiums, businesses concluded that their benefit-cost ratio for involvement in health insurance had fundamentally changed. The problem of escalating private insurance premiums was not new, but cost shifting greatly exacerbated it and contributed significantly to unprecedented annual premium increases—often in excess of 20 percent—in the late 1980s (Fig. 2). Hewitt Associates, a benefits consulting firm, identified cost shifting as the single leading source of health plan premium increases in 1987 and 1988. Similar studies in the early 1990s found cost shifting to be the single largest factor in the rise of private health insurance premiums, more than increased utilization, technology improvements, and deductible erosion combined. According to Rashi Fein, “as Medicare (and Medicaid) tightened their reimbursement policies, they paid hospitals less than the hospitals believed was a fair share of total hospital
expenses. Hospitals reacted by increasing charges to other payers, especially to commercial insurance carriers, in order to cover the shortfall in total receipts. In turn, private insurers had to raise their premiums in order to, as they would put it, 'subsidize' patient care only partly paid for by government.\textsuperscript{93}

Economists debate the technical dynamics of cost shifting,\textsuperscript{94} but arguably what is most important about the concept is the extent to which employers believed it largely explained their rapidly increasing health-care costs and then subsequently made their health insurance decisions based on their beliefs. Due in part to ProPAC's reports on Medicare in the late 1980s and early 1990s, which repeatedly maintained that the phenomenon was large and growing,

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{image2}
\caption{Average annual percent increase in fee-for-service health insurance premiums, 1984–89.}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{image3}
\caption{Graph showing the rate of change in premium over years.}
\end{figure}

cost shifting became the dominant explanation among employers for the rapid increase in private health insurance premiums. Representative John Dingell (D-Mich.) even initiated hearings in 1991 before the House Energy and Commerce Committee to investigate Humana’s and other hospitals’ “controversial practice of cost shifting.” David McFadden argued that the notorious “$7 aspirin,” like the $200 military toilet seats from the decade before, had become the infamous symbol of cost shifting. Malcolm Gladwell, a leading health-policy journalist at the time, maintained that cost shifting was the biggest reason for the rapid increase in private health insurance costs.

Employers’ concerns over cost shifting peaked following the publication of an influential report to the Healthcare Financial Management Association in the summer of 1992 by Lewin/ICF, a policy consulting firm headed by Allen Dobson, formerly the director of HCFA’s Office of Research (1981–88). In the Lewin/ICF report, rising health-care costs “were being allocated unevenly because some stakeholders are better than others at insulating themselves from paying their fair share of the costs,” according to Dobson and HFMA president, Richard Clarke. “Stakeholders with significant purchasing power and those who purchase coordinated care are moving to protect themselves from what they believe is an untenable situation, leaving others, particularly small business and non-group purchasers, to fend for themselves. An important aspect of this interplay of stakeholders is the cost-shifting phenomenon.” As Dobson and Clarke argued, businesses and employers were essentially paying a “sick tax” to cover the additional costs that providers were shifting to them.

As chairman of the Prudential Insurance Company and head of the Business Roundtable’s Health Care Task Force between 1988 and 1994, Robert Winters had a unique vantage point from which to observe cost shifting, given his position as the head of a major company that sold health insurance policies. The Business Roundtable is an association of chief executive officers of the country’s biggest companies with a combined workforce of more than 10 million employees. Thus, the extent to which its members believed that cost shifting was primarily to blame for the nation’s rapidly increasing private health-care costs reflects how widespread the explanation had become throughout the entire U.S. business community. According to Winters, “What happened in the late 1980s and in the early 1990s, was that health care costs became such a
significant part of corporate budgets that they attracted the very significant scrutiny of CEOs. . . . More and more CEO's [were] saying, ‘Goddamnit, this has to stop!’ What was particularly attracting their attention was costs, and they very quickly got animated by their recognition of cost shifting.”102

Ultimately, America’s health-care system stumbled when double-digit increases in health insurance premiums coincided with the recession of the early 1990s. As Uwe Reinhardt notes, “Eventually, the increasingly desperate American employers began to reevaluate the open-ended social contract they had written and supported for so long, and they looked around for an alternative deal. That deal was known as ‘managed care.’”103

Final Domino: Employers’ Shift to Managed Care

There was a pronounced change in the health delivery system in the U.S. that began in the late 1980s. Cost control in the public sector with Medicare reform contributed significantly to medical inflation in the private sector, which triggered the private sector’s response: a massive switch to managed care (Table 5).104

“Onece employers discovered the cost-saving potential of the managed care system,” note Karen Titlow and Ezekiel Emanuel, “they rapidly turned away from traditional indemnity plans. This trend was spearheaded by Allied Signal Inc., which in 1988 moved all its employees from indemnity insurance into a Cigna health maintenance organization (HMO). By 1991, Allied Signal demonstrated the cost-saving potential of managed care when it reported a 23 percent cut in health insurance expenditures.”105 Fein adds that “as the number of HMOs grew, employers discovered that just as they negotiated the price of steel, paper, or other ‘inputs’ (including labor), they could negotiate prices for health insurance. This became advantageous when, as a result of the ability of HMOs and capitated plans to control physician behavior, restrict expensive hospital utilization, and limit patient choice of providers, competing managed-care delivery/insurance organizations were often able to offer employers premiums substantially lower than those available from traditional indemnity plans.”106

The initial shift to managed care in the late 1980s and early 1990s had a self-reinforcing quality to it that fed back into the momentum away from fee-for-service insurance. Managed-care organi-
zations initially attracted and enrolled low-risk individuals who were least likely to object to restrictions on utilization of services and physician choice. These low-risk individuals also tended to be healthier than the general population, so they did not increase operating costs; on the contrary, they increased the profitability of managed-care organizations. So although the rates of change in health insurance premiums generally moved in tandem, premiums for fee-for-service indemnity insurance grew substantially more than managed-care premiums between 1986 and 1991. Moreover, according to Mark Pauly and Sean Nicholson, the private health insurance market in the post–World War II era up to the mid-1980s essentially had been a “pooling equilibrium” in which the risk of covering an individual patient’s medical costs was spread out over a large pool of individuals who all paid generally the same, community-rated insurance premiums: “Over 90 percent of employees had indemnity insurance, mostly with Blue Cross and Blue Shield, which experience rated only reluctantly. This pooling equilibrium unraveled between 1984 and the early 1990s when [managed care] quadrupled its share of the large employer market.”

Employers’ shifting of their workers away from fee-for-service health insurance was further facilitated by the maturation and improved infrastructure of the managed-care industry by the late 1980s. Between 1987 and 1993, in particular, managed-care organizations responded to employers’ demands for more cost control by consolidating and applying extensive utilization review and guideline development to their more traditional fee-for-service insurance offerings. The traditional managed-care organizations, such as staff- or group-model HMOs (e.g., Kaiser Permanente), required significant expenditures in “bricks and mortar” when entering new mar-

Table 5. Enrollment in Indemnity Insurance and Managed Care, 1989–95

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>1989</th>
<th>1993</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity (fee-for-service)</td>
<td>71%</td>
<td>49%</td>
<td>30%</td>
</tr>
<tr>
<td>Managed Care (HMO, PPO)</td>
<td>29%</td>
<td>51%</td>
<td>70%</td>
</tr>
</tbody>
</table>

*Source: Employee Benefit Research Institute, Sources of Health Insurance *(Washington, D.C., February 1995).*
kets. This served as a major barrier to entry because they were vertically integrated organizations that operated their own physical facilities in different geographic locations, and whose physicians worked solely for the managed-care organization. But beginning in the late 1980s, many new for-profit HMOs experienced rapid growth because they were “virtual organizations” or “organizations without walls,” built largely on contractual (paper) relationships with community providers.

By expanding their provider base and involving in their systems more physicians whose predominant practice was fee-for-service, managed-care organizations developed to the point that employers took them more seriously and found them significantly more attractive. Why? Because by increasing their number of affiliated medical providers, managed-care organizations essentially became more effective “managed cost” plans, which could negotiate lower prices on behalf of larger numbers of patients and then pass the savings on to employers. Before this balance-of-power shifting to payers in the early 1990s, providers had set prices and determined fees in most markets.

The changes so far described could have been predicates for the development of a single-payer health-care system similar to other countries’ approaches to providing medical care (see Joseph White’s Competing Solutions for elaboration on this point). The private sector could have responded to increased cost shifting the way many leaders from the employer community began to respond in the early 1990s—in favor of national health insurance and a greater role for government financing. President Bill Clinton’s proposal for comprehensive health-care reform in the fall of 1993 represented a major political attempt to capitalize on just such sentiments. His election in 1992, after twelve years of Republican control of the presidency, dramatically changed the political context for consideration of comprehensive health-care reform. As Jacob Hacker notes, “For a brief moment in the early 1990s, the strains on public programs and the erosion of private benefits shared the spotlight, as President Clinton sought to tackle the problems in American health insurance by putting in place the biggest missing piece of the American welfare state. The resounding failure of the Clinton health plan demonstrated not just the fiscal barriers such efforts face, but also the powerful ongoing hold of antigovernment ideas and interests in American politics—the last of the intertwined pressures that have placed the welfare state under siege.”
The death knell for the Clinton proposal, according to Sallyanne Payton (who was legal counsel to the Clinton White House for health care and a member of the Clinton Health Care Reform Task Force), came when top officials of the largest corporations—whose health and benefit officers earlier had been supportive of Clinton’s efforts—did their own cost-benefit analysis of what would happen if Clinton’s comprehensive insurance reform plan went into effect. They concluded it would cost them more than they would gain. In effect, staying with managed care or shifting to it made more sense than changing to national health insurance.

The switch to managed care did succeed in significantly reducing the annual increase in health insurance premiums during the first half of the 1990s. But overall cost control proved to be relatively short-lived as double-digit annual increases in health insurance premiums returned in the late 1990s (Fig. 3). What did not prove to be short-lived was the enormous public backlash against managed care, which became one of the country’s most hated industries.

Managed-care executives essentially became the “flak catchers” for rationing medical care in much the same way that Clinton proposed government would do in his managed-competition plan. Opponents of Clinton’s proposal complained loudly at the time that his plan would force government rationing of medical care. How ironic it was, then, as Uwe Reinhardt observes, that “only half a decade after embracing the idea of ‘managed competition with managed care,’ America’s ‘rugged individualists’ [began] to show their more tender side, as self-pitifully and pitifully they pleaded with the White house, with the Congress, with their state governments and with the courts to jump right back onto their backs, to protect them from the forces of the private markets that, in their more rugged moments, they had professed to adore.”

Conclusion

The reform of Medicare’s payment policy in 1983 appears to have been the initial catalyst that triggered a series of interconnected events resulting in an unintended consequence: the managed-care revolution. Congress’s changing of Medicare to a prospective method of hospital reimbursement in 1983 proved effective in slowing the program’s rapid rate of cost increase. But as an unintended conse-
Fig. 3. Average annual rate of increase in all health insurance premiums, 1989–2000.

quence, much of Medicare’s cost containment came at the expense of hospitals’ increased cost shifting to private patients, which became a primary motivation for businesses to shift their workers into various managed-care plans in order to restrain their health-care spending. Ultimately, the rapid and revolutionary paradigm shift in the United States from fee-for-service health insurance to managed care is a striking example of how the radical adjustment of a public program (Medicare) can inadvertently trigger the transformation of an entire industry (the U.S. health-care system), as individuals, institutions, and organizations strategically readjust their behavior in response to changing incentives and regulations.

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Glossary of Terms

AHA American Hospital Association
AMA American Medical Association
CBO Congressional Budget Office
CMS Centers for Medicare & Medicaid Services
DRG Diagnosis-Related Group
FAH Federation of American Hospitals
HCFA Health Care Financing Administration
HHS U.S. Department of Health & Human Services
HI Medicare’s Hospital Insurance trust fund
HMO Health Maintenance Organization
MedPAC Medicare Payment Advisory Commission
OASI Old Age & Survivors Insurance program
PPO Preferred Provider Organization
PPRC Physician Payment Review Commission
PPS Prospective Payment System
ProPAC Prospective Payment Assessment Commission
RBRVS Medicare’s Resource-Based Relative Value Scale
SMI Medicare’s Supplementary Medical Insurance trust fund
SSA Social Security Administration

Acknowledgments

I want to thank several individuals who critiqued previous versions of this article or offered helpful comments and suggestions along the way, including: Martha Derthick, Rashi Fein, Christopher Howard, David Karol, Jennifer Mayes, James Morone, Paul Pierson, Uwe Reinhardt, Deborah Stone, Margaret Wein, four excellent anonymous reviewers, and especially Mark Peterson and Joseph White.
Notes

1. For example, see David F. Drake, “Managed Care: A Product of Market Dynamics,” JAMA, The Journal of the American Medical Association 277, no. 7 (19 February 1997): 560–64.
5. Ibid.
7. Many thanks to the anonymous reviewer who pointed this out.
9. Many thanks to the same anonymous who pointed this out.
11. Ibid., 72.
12. Ibid.
13. Ibid., 84.
22. Ibid., 94, 137.
28. E-mail exchange with Clif Gaus, former associate administrator of Policy, Planning & Research, HCFA (11 February 2003).
35. For more on the origins of DRGs and how New Jersey's plan became the national model, see Robert Fetter, David Brand, and Dianne Gamache, DRGs: Their Design and Development (Ann Arbor, 1991); Health Care Finance Administration, A Prospective Reimbursement System Based on Patient Case-Mix for New Jersey Hospitals, 1976–1981 (Washington, D.C., 1981); Health Care Finance Administration, Diagnosis-Related Groups: The Effect in New Jersey—The Potential for the Nation (Washington, D.C., 1984); Leah Curtin and Carolina Zurlage, eds., DRGs: The Reorganization of Health (Chicago, 1984); Mohan L. Garg and Barbara M. Barzansky, eds., The Medicare System of Prospective Payment (New York, 1986); and Howard Smith and Myron Fortler, Prospective Payment (Rockville, Md., 1985).
39. Ibid.
41. Bruce Vladeck interview with the author, 14 August 2002.
43. Ibid.
44. See Stevens, In Sickness and in Wealth, 322–27.
45. Sheila Burke interview with the author, 2 October 2002.
48. For a comprehensive analysis of how Congress devised, passed, and implemented the new reimbursement system, see David G. Smith, Paying for Medicare (New York, 1992), 23–120.


52. David Burda, “What We Have Learned from DRG’s,” Modern Healthcare (4 October 1993): 44.

53. Traditionally, there have been two hospital sectors—whose missions often overlap—that policymakers have explicitly used Medicare to subsidize: (a) teaching and (b) indigent safety-nets. In the first sector, teaching, Medicare provides two types of extra payments to hospitals with graduate medical education programs to compensate them for their higher institutional costs. The indirect medical education (IME) adjustment, which accounted for $3.7 billion in 1999, pays the costs of treating sicker patients and additional tests needed for training purposes. Teaching hospitals also receive a direct graduate medical education (DGME) adjustment, which accounted for $2.2 billion in 1999, for training medical residents. In the second hospital sector, indigent safety-nets, Medicare provides what are known as “disproportionate share” payments to hospitals that treat a large number of Medicaid and uninsured patients. Initiated by policymakers in 1986, the Medicare Disproportionate Share (DSH) program increases payment rates to hospitals that provide a disproportionately large share of health care to the poor whose conditions are often more severe than average patients and, yet, are less able to pay. This explicit adjustment costs the government (Medicare) approximately $5 billion per year.


59. Ibid.


61. See Dennis S. Ippolito, Uncertain Legacies: Federal Budget Policy from Roosevelt Through Reagan (Charlottesville, 1990), chaps. 6 and 7; White and Wildavsky, The Deficit and the Public Interest, chaps. 19 and 21.


64. Bill Gradison interview with the author, 12 June 2002.

69. Patashnik, *Putting Trust in the U.S. Budget*, 104.
70. Robert Reischauer interview with the author, 16 August 2002.
73. Stuart Altman interview with the author, 22 July 2002.
81. See Drake, “Managed Care: A Product of Market Dynamics” (as in note 1).
82. Tom Scully interview with the author, 24 October 2002.
83. Marilyn Moon interview with the author, 2 August 2002.
86. Michael Bromberg interview with the author, 23 July 2002.
88. For more on the role of cost shifting, see George W. Whetsell, “The History and Evolution of Hospital Payment Systems: How Did We Get Here?” *Nursing Administration Quarterly* 23 (Summer 1999): 9–15.
RICK MAYES

93. Rashi Fein, Medical Care, Medical Costs: The Search for a Health Insurance Policy, 2d ed. (Cambridge, Mass., 1999), 95.
100. Ibid.
108. Ibid.
113. Ibid.
117. Thanks to Mark Peterson for showing me this line of argument.
121. For example, see Titlow and Emanuel, “Employer Decisions and the Seeds of Backlash,” 941–47.
123. Oberlander, The Political Life of Medicare, 199.
124. Personal communication with Jack Ashby, MedPAC Hospital Research Director (7 August 2003): “The 14% PPS margins [in Fig. 1] come from ProPAC publications and are based on Medicare cost report data. The 0.98 to 1.01 payment-to-cost ratios [in Table 4] are, of course, from the AHA annual survey. The first and perhaps primary difference between the two measurements is that the cost report figure is an inpatient margin, while the AHA numbers cover all services hospitals provide for Medicare beneficiaries. Medicare inpatient margins have always been, and still are, much higher than Medicare outpatient margins. Besides that, though, the two data sources are fundamentally different in two ways. First, the cost report measure is based on Medicare-allowable costs while the AHA measure captures all costs per the hospitals’ books. This difference also leads to a higher margin value for the cost report data. Second, the cost report measure reflects a complex method for allocating costs among payers, while the AHA data reflect a simple application of an RCC to charges by payer to produce costs by payer. While the proof has been illusive to date, we have anecdotal evidence that hospitals over the years have set their charges so as to maximize the allocation of costs to Medicare, which then biases the AHA payment to cost ratio downward. Charges are used in the cost report allocation also, but to a lesser degree than in the AHA data. This factor also leads to a higher value for the cost report data, and this manipulation of charges was at its zenith in the first few years of the PPS. The net result of all this in our minds [at MedPAC] is that the AHA data are quite useful for monitoring trends (which includes providing evidence that there has been cost shifting), but are much less useful in establishing the level of margins or payment/cost ratios.”