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

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ABSTRACT

After more than five decades of fee-for-service insurance existing as the dominant mode of private medical financing in the United States, what specifically triggered the managed care revolution in the late 1980s and early 1990s? Contrary to popular belief that it was exclusively a free market phenomenon, there is ample evidence that the government actually played the leading role in triggering this paradigm shift. The sequence of domino-like events began with Medicare reform in 1983. Congress had to dramatically revamp Medicare’s reimbursement scheme in the early 1980s or face the possibility of the program going bankrupt by as early as 1987; consequently, it successfully attached a new, prospective payment system (PPS) to Social Security’s 1983 bailout legislation. For the first time, Medicare’s PPS established a general rate schedule of diagnosis-related groups (DRGs) for inpatient hospital procedures and services.

This dramatic change in Medicare’s reimbursement policy greatly altered the power relationship between the government and health care providers. With the program’s new payment system in place, Congress for the first time gained the upper hand in its financial relationship with the hospital industry. Medicare’s prospective payment system became an effective tool in Congress’ annual budget reconciliation process for policymakers to work backwards from a pre-determined amount of deficit reduction to whatever changes in Medicare payment policy were needed to help achieve macro-level budget targets. Due to the increasing pressures from growing budget deficits over the course of the 1980s, Congress annually reduced Medicare’s rate of reimbursement increase (its ‘update factor’) for hospital care in the late 1980s and early 1990s. As a result, hospitals’ Medicare margins became negative between 1990 and 1992, which means that the costs that hospitals incurred treating Medicare patients outstripped the payments they received from the program. Nevertheless, hospitals managed to maintain overall annual profit margins of between 3 and 5 percent during this period. How? Largely through increased cost shifting of un- and under-reimbursed Medicare, Medicaid, and charity care costs to privately insured patients.

As Congress reduced Medicare’s generosity to suit larger budgetary purposes, providers in the country’s patchwork health care system increasingly came to rely on a complex web of financial cross-subsidization—otherwise known as cost shifting—in which, as former Physician Payment Review Commission Chairman Paul Ginsburg explains, “changes in administered prices of one payer lead to compensating changes in prices charged to other payers for care.” Cost shifting from Medicare, Medicaid and charity care for the uninsured to private payers led to significant annual increases in private health insurance premiums. Economists disagree over whether or not cost shifting technically exists or if medical providers are simply exploiting payers through increased price discrimination. Nevertheless, cost shifting became the dominant theory that businesses and employers embraced in the late 1980s and early 1990s as the explanation for the major increases in their private health care costs and insurance premiums. Consequently, each year they responded by switching or encouraging their employees to switch from traditional fee-for-service health insurance to various forms of lower-cost managed care (e.g., HMOs and PPOs). The drafting, proposal and ultimate failure of President Clinton’s Health Security Act in 1994 added substantial momentum to employers’ shift to managed care. In just the six years between 1989 and 1995, the health insurance industry experienced a complete inversion from a 71:29 ratio—of fee-for-service insurance to managed care—to a 30:70 ratio.

Ultimately, Medicare’s innovative payment system triggered the seminal shift in political and economic power away from providers (hospitals and doctors) and to payers (government, insurers, employers)—power that providers had been successfully accumulating and monopolizing from the beginning of the 20th century. Since the late 1990s, medical providers have been attempting to regain this power through mergers, contract renegotiations, and increased professional cooperation. They have largely succeeded.
Introduction

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 paper 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’ 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 and 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, 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.\(^8\) 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).\(^9\) 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.\(^10\)

**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.”\(^11\) But the significance of such factors, he points out, is “frequently distorted when they are taken from their temporal context.”\(^12\) 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).\(^13\) 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.”\textsuperscript{14} The trick, Pierson adds, is to trace the chain of events and test how strong the links are between them.\textsuperscript{15}

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).\textsuperscript{16} The goal is to try to separate the specific order of cause and effect, because sequence analysis is critical for causal analysis.\textsuperscript{17} 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.”\textsuperscript{18} 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.”\textsuperscript{19} 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.”\textsuperscript{20}

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” concerns 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. Inter-fund 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 the state’s experiment worked or not, 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.”

[Table 1 about here]
Changing Medicare payment from a retrospective to a prospective system was revolutionary.\textsuperscript{45} 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 could cost Medicare twice or even three times as much in one location as compared to another. Sheila Burke, a key staff member on the Senate Finance Committee at the time and Senator Bob Dole’s Chief of Staff, explains prospective payment’s unique political appeal:

\textbf{Burke:} There was great sensitivity that we were going down a path that none of us had gone on before, but the cost reimbursement model from before [1983] was insanity. On the face of it, it encouraged people to do more. It \textit{paid} them to do more and not in any particularly rational way. The Section 223 limits that passed in 1972 were the beginning of the government’s efforts to try and get some kind of framework where you could compare similarly sized institutions as a proxy for trying to figure out what the hell we were doing… As I recall it, going to DRGs really was an attempt to try and do a further refinement and frankly, politically, it had all the right things. It was simple, conceptually. So when you said to an average member of Congress—who tended to not want to get into the minuitiae of Medicare policy because it was one of the more boring aspects of their lives—when you said to a member, “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? You know, it was a simple concept that they could buy into.\textsuperscript{46}

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.\textsuperscript{47} 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.\textsuperscript{48} Attaching Medicare reform to critical Social Security reform was a purely opportunistic, but effective, decision.\textsuperscript{49} A veto-proof bill emerged, largely immune from interest-group influence due to its sheer urgency.\textsuperscript{50}

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\(^{51}\) 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.”\(^ {52}\)

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.”\(^ {53}\) 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.\(^ {54}\) 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.\(^ {55}\) In 1984, Michael Bromberg, Executive Director of the Federation of American Hospitals (FAH), said as much in his testimony before Congress:

**Bromberg**: The Medicare law that brought us prospective payment for the first time has clearly given us incentives 180 degrees different from any we have ever had, and we have responded. The change in behavior, not to have too many people employed per hospital simply because they are cost reimbursed, not to give extraordinary wage and benefit increases above the national average because [they are] cost reimbursed, to consider capital expenditures for the first time because they do increase operating costs and those are fixed for the first time, all the way down the line to trying to persuade the physicians to cooperate in lowering length of stay, doing more out-patient work, having arrangements with nursing homes and home health agencies and others for less expensive sites, and seeking discounts on supplies, all suddenly became real incentives for the first time. The most important point I can make today is that those incentives that I just outlined, every one of them, helps non-Medicare payers. In fact, those who predicted that we would simply take Medicare’s price, absorb it, and raise our charges to everyone else were wrong.\(^ {56}\)
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 (figure 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 (figure 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, there were hundreds of hospitals that 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’ sizeable 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’.”

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 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.

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 Member on the House Ways and Means Subcommittee on Health until 1993, the key to Congress’
ability to extract huge savings from Medicare was the budget reconciliation process. 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. Rick Pollack, Executive Vice President of the AHA, explains why and points out how Congress used Medicare’s prospective payment system as a deficit reduction device:

**Pollack:** What was going on beginning in the late 1980s and even into the ‘90s was this enormous drive to balance the federal budget. At that time Medicare was, if it wasn’t the biggest program, and/or the fastest growing program, it was pretty close to it. And Medicare was viewed as a deficit reduction device in a big way. Providers, particularly hospitals, were always viewed as an easier target than doing anything that would have ever affected beneficiaries… It was all, “How much money can we save by making this tweak to Medicare’s payment system or that tweak?” For instance, the annual update factor for DRG [payments] was supposed to be based on the annual increase in the “market basket” [of various medical prices, which serves as a measure of medical inflation]. But instead it has always been “market basket minus” some number.

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 they would say, “Ok, we gotta save a billion bucks over three years, so let’s just make it ‘market-basket minus 0.5 percent.’ Or ‘market basket minus 1.5 percent’.” At the end of the day, it was legislated in the back rooms and it was all a budget number.

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.

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.” 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
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:

Reischauer: Medicare was the cash cow! There’s just no question about that. I have a bunch of charts I use in speeches that show the fraction of each of the deficit reduction packages that came from Medicare and it was very, very substantial. And, of course, it peaked with the 1997 deficit reduction bill. There is a very simple reason for this and that is that Congress could get credited for deficit reduction without directly imposing a sacrifice on the public. To the extent that the sacrifice was imposed on the public, it was always indirect. The assumption was that hospitals or providers had the capability of shifting some of the reduction in federal payments on to other payers. 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.

And remember, we were just at the end of phasing in the PPS system and there was a lot of evidence that the payment mechanisms [DRGs] that were adopted were initially excessive and that the hospitals and other providers, with time, were learning how to game the system. There was a lot of “upcoding” going on, so you had DRG-creep. And then on top of that, there was, and still is, a general feeling that hospitals were horrendously inefficient, particularly the not-for-profit hospitals.

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.” 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. 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.
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). 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.” 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).

[Table 3 about here]

Both the business community and commercial insurers had been aware of cost shifting prior long before the PPS’s implementation, but this form of cross-subsidization had traditionally remained modest enough to avoid open conflict. 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 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.

[Table 4 about here]
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 (figure 2).\textsuperscript{91} Hewitt Associates, a benefits consulting firm, identified cost shifting as the single leading source of health plan premium increases in 1987 and 1988.\textsuperscript{92} 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.\textsuperscript{93} 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{94}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure2.png}
\caption{Figure 2: Cost Shifting Scenario}
\end{figure}

Economists debate the technical dynamics of cost shifting,\textsuperscript{95} 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, cost shifting became the dominant explanation among employers for the rapid increase in private health insurance premiums.\textsuperscript{96} Representative John Dingell even initiated hearings in 1991 before the House Energy and Commerce Committee to investigate Humana’s and other hospitals’ “controversial practice of cost shifting.”\textsuperscript{97} 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 summer 1992 by Lewin/ICF, a policy consulting firm headed by Allen Dobson, formerly the Director of HCFA’s Office of Research (1981-1988). In the Lewin/ICF report, rising healthcare 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, “Goddammit, this has to stop!”… What was attracting CEOs’ attention was costs, and they very quickly got animated by their recognition of cost shifting. For many, cost shifting almost seems like cheating. They [employers] were being forced to pay for somebody else’s care…

So they started to say: “Hey, providers are shifting costs to us to pick up the expenses that they had incurred for uninsured and under-insured patients. That’s not fair. That’s the government’s job. The government should pay it and they’ll tax people for it, tax us some, tax citizens some, tax property some, I don’t care. But it’s not fair to make my corporation and my shareholders pay for the care of people outside of our company. The indigents and under-insured are going to get care and there’s no dispute on that. But the costs should not be shifted to the productive parts of the American economy and, particularly, they should not be shifted onto my company.” … And so, as I said before, CEO’s finally began saying, “Goddammit, this has to stop!”

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’.”

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).
“Once 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.” 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.”

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 organizations 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 markets. 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. Prior this balance of power shifting to payers in the early 1990s, providers had set prices and determined fees in most markets.\textsuperscript{116}

The changes so far described could have been predicates for the development of a single-payer health care system similar to other countries’ approach to providing medical care (see Joseph White’s \textit{Competing Solutions} for elaboration on this point).\textsuperscript{117} 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.\textsuperscript{118} 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.”\textsuperscript{119}

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.

[figure 3 about here]

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 (figure 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-pityingly 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’ 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 consequence, 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 U.S. 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.
### Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHA</td>
<td>American Hospital Association</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>CBO</td>
<td>Congressional Budget Office</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-Related Group</td>
</tr>
<tr>
<td>FAH</td>
<td>Federation of American Hospitals</td>
</tr>
<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health &amp; Human Services</td>
</tr>
<tr>
<td>HI</td>
<td>Medicare’s Hospital Insurance trust fund</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>MedPAC</td>
<td>Medicare Payment Advisory Commission</td>
</tr>
<tr>
<td>OASI</td>
<td>Old Age &amp; Survivors Insurance program</td>
</tr>
<tr>
<td>PPO</td>
<td>Preferred Provider Organization</td>
</tr>
<tr>
<td>PPRC</td>
<td>Physician Payment Review Commission</td>
</tr>
<tr>
<td>PPS</td>
<td>Prospective Payment System</td>
</tr>
<tr>
<td>ProPAC</td>
<td>Prospective Payment Assessment Commission</td>
</tr>
<tr>
<td>RBRVS</td>
<td>Medicare’s Resource Based Relative Value Scale</td>
</tr>
<tr>
<td>SMI</td>
<td>Medicare’s Supplementary Medical Insurance trust fund</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
</tbody>
</table>
### Table 1
**Selected Diagnosis-Related Groups, 1988**

<table>
<thead>
<tr>
<th>DRG Number</th>
<th>Title</th>
</tr>
</thead>
<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>
</tr>
</tbody>
</table>


### 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>
</tbody>
</table>

*80-83 --- | 12.7* | --- | 15.0* | --- | 16.2* |
*84-87 --- | 8.5* | --- | 9.0* | --- | 6.5* |


* Annual average increase over the four-year period

^ First full year of Medicare’s PPS in operation

### Table 3
**Hospitals’ Inpatient Medicare (PPS) “Profit” Margin* and Percentage of Hospitals with Overall Medicare Losses, 1984-92**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals’ Inpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare (PPS) Margin*</td>
<td>14.5</td>
<td>14.0</td>
<td>9.5</td>
<td>6.6</td>
<td>3.9</td>
<td>1.4</td>
<td>-0.5</td>
<td>-2.4</td>
<td>-1.0</td>
</tr>
<tr>
<td>Percentage of Hospitals Losing Money on their Medicare Population</td>
<td>16.8</td>
<td>18.8</td>
<td>32.3</td>
<td>39.8</td>
<td>46.1</td>
<td>51.8</td>
<td>56.7</td>
<td>60.8</td>
<td>60.0</td>
</tr>
</tbody>
</table>


* PPS Margin = (hospitals’ total inpatient Medicare payments – hospitals’ total inpatient Medicare costs) / hospitals’ total inpatient Medicare payments
Figure 1

Hospitals' Inpatient Medicare (PPS) Margin and Overall Margin,* 1984-92

![Graph showing Hospitals' Inpatient Medicare (PPS) Margin and Overall Margin, 1984-92](image)


* PPS Margin = (hospitals' total inpatient Medicare payments – hospitals' total inpatient Medicare costs) / hospitals' total inpatient Medicare payments

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>
</tr>
<tr>
<td>1985</td>
<td>1.01</td>
<td>0.90</td>
<td>1.16</td>
</tr>
<tr>
<td>1986</td>
<td>1.01</td>
<td>0.88</td>
<td>1.16</td>
</tr>
<tr>
<td>1987</td>
<td>0.98</td>
<td>0.83</td>
<td>1.20</td>
</tr>
<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, Greene, “Hospital Cost Growth Down,” 139, fn. 14.
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, February 1995).*

Figure 2
Average Annual Percent Increase in *Fee-For-Service* Health Insurance Premiums, 1984-89

Figure 3
Average Annual Rate of Increase in All Health Insurance Premiums, 1989-2000

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate of CPI Increase</th>
<th>Rate of Change in Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>18</td>
<td>20</td>
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<tr>
<td>1990</td>
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<td>18</td>
</tr>
<tr>
<td>1991</td>
<td>14</td>
<td>16</td>
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<tr>
<td>1992</td>
<td>12</td>
<td>14</td>
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<tr>
<td>1993</td>
<td>10</td>
<td>12</td>
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<tr>
<td>1994</td>
<td>8</td>
<td>10</td>
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<tr>
<td>1995</td>
<td>6</td>
<td>8</td>
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<td>1996</td>
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<td>6</td>
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<td>1999</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2000</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Notes


2 For example, see David F. Drake, “Managed Care: A Product of Market Dynamics,” JAMA, The Journal of the American Medical Association 277, no. 7 (February 19, 1997): 560-564.


6 Ibid.

7 David Abernethy interview with the author, June 19, 2002.

8 Many thanks to the anonymous reviewer who pointed this out.


10 Many thanks to the same anonymous who pointed this out.


12 Ibid., 72.

13 Ibid.

14 Ibid., 84.

15 Paul Pierson, “Big Slow-Moving, and . . . Invisible: Macro-Social Processes in the Study of Comparative Politics,” paper presented at the 2000 American Political Science Association Meeting (Washington, D.C.), 5-6: “Causal Chains. We often think of causal processes involving a straightforward, temporally-linked connection where x directly yields y. Yet in many cases the story runs more like the following: ‘x triggers the sequence a,b,c, which yields y’ (Mahoney 2000, Pierson 2000). To the extent that a,b, and c take some time to work themselves out there is likely to be a substantial lag between x and y. . . . Causal chain arguments raise some tricky issues. A key challenge is to show that the links in such chains are strong ones (“tightly-coupled” as Mahoney 2000 puts it). The persuasiveness of a causal chain argument declines quickly if there are many stages, or if the probabilities associated with any particular stage are not high (Lieberson 1997; Fearon 1996). Even if a chain has only three links, and the probability that each link will hold is 80%, there is less than a fifty-fifty chance that the entire chain will operate.”


23 Ibid., 94, 137.


29 Email exchange with Clif Gaus, former Associate Administrator of Policy, Planning & Research, HCFA (2/11/2003).


37 Office of Technology Assessment, “Diagnosis Related Groups (DRGs) and the Medicare Program Working Paper: Using Diagnosis Related Groups in Hospital Payment – The New Jersey Experience,” Congress of the United States (Washington, D.C.: Government Printing Office, December 1983): “Scholars of organizational behavior spent much effort in the 1970s attempting to define a hospital’s product. Like those who studied other ailing industries, they wanted to define the output (product) to understand and justify the use and costs of the resources essential to produce it. Without a satisfactory definition of ‘units of output
upon which selected aspects of hospital performance and costs could be analyzed and monitored,” the reason for threatened hospital bankruptcies in the face of growing payments from multiple sources remained a mystery. After the 1965 enactment of Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act, governments also became increasingly responsible for hospital revenues. Thus, as costs escalated, legislators and public officials also became concerned.

A group of researchers associated with Yale University … developed a computer software program (AUTOGRP) to assign the “customers” of a hospital to diagnostic “product groups. The goal was to classify hospital patients by characteristics their doctors considered medically meaningful and that clustered significantly within some measure of resource consumption. These researchers thought that if a classification system could be found that made sense to clinicians and accountants alike, it might be possible to intelligently assess quality of care, necessity of procedures and resource use, and reasonableness of patient costs. This patient classification system later became known as the DRG system. The fundamental purpose of the DRG approach is to identify in the hospital, acute-care case types, each representing a class of patients with similar processes of care and a predictable package of services [or product] … Using this approach the entire range of [existing] diagnostic codes was initially divided into broad disease areas, such as Diseases of the Eye…. Each of these categories was further subdivided into groups based on values for those variables that demonstrate an effect in predicting output as measure by length of stay.”


40 Ibid.

41 Jack Owen interview with the author, February 17, 2003.

42 Bruce Vladeck interview with the author, August 14, 2002. Ironically, the official report on New Jersey’s hospital payment experiment came out after Congress passed the legislation with DRGs. Consequently, Congress dramatically altered the method by which all the nation’s hospitals received approximately 40 percent of their revenues without ever knowing if the new system would actually work. Bruce Vladeck, who later became Administrator of HCFA (1993–1997), was Assistant Commissioner for Health Planning & Resources Development in New Jersey’s Department of Health from 1979 to 1982. As the Principal Investigator of New Jersey’s DRG experiment, Vladeck had the responsibility for assessing the DRGs’ performance in the state. He recalls how the process of evaluating the state’s experiment, in conjunction with John Thompson and others at Yale, was hindered by the technology limitations of the early 1980s: “The most amazing thing about this experience was that … all of the time we were doing this, the New Jersey Department of Health did not own a computer! The Yale people did some of the work on their computers and then we had to time-share with 1 of the 3 or 4 state mainframe computers in those days, which was controlled by New Jersey’s Department of Transportation.”

43 Louise Russell, Medicare’s New Hospital Payment System: Is It Working? (Washington, D.C.: The Brookings Institution, 1989), 7-9: “The foundation for Medicare’s prospective rates is a patient classification system called Diagnosis-Related Groups (DRG’s), which sorts patients into groups according to medical condition. … Groups were included in the new set only if they made medical sense to an advisory panel of physicians and differed significantly in cost from other groups. … The prospective rate 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.”

44 Ibid.


46 Sheila Burke interview with the author, October 2, 2002.

47 John K. Iglehart, “Health Policy Report,” New England Journal of Medicine 23 (June 9, 1983): 1429: “A remarkable reality of the process in both chambers was how few legislators were actually involved in designing the legislation. For the most part, professional staff members made the key decisions.”


49 For a comprehensive analysis of how Congress devised, passed, and implemented the new reimbursement system, see David G. Smith, Paying for Medicare (New York: Aldine de Gruyter, 1992), 23-120.
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. As a result, Medicare intentionally pays teaching hospitals more than what it technically costs them to provide care to Medicare patients, because policymakers see it as a worthwhile investment. Moreover, forcing teaching hospitals to compete with non-teaching hospitals on a cost basis could lead to an overall reduction in access for the poor and uninsured.

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.

See Smith, Paying for Medicare: The Politics of Reform.

“Health Care Cost Containment Strategies,” Hearing Before the Committee on Labor and Human Resources, United States Senate, 98th Congress 2nd Session (June 21, 1984), 192.


George W. Whetsell, “The History and Evolution of Hospital Payment Systems: How Did We Get Here?” Nursing Administration Quarterly 23 (Summer 1999): 1-10: “First, the prospective payment rates were to be blended with cost reimbursement during a four-year phase-in period. Second, capital costs and outpatient services (as well as a wide range of other non-hospital services) were not included in PPS initially and cost reimbursement was still provided for these services. Third, PPS provided special adjustments and exemptions for sole community providers (typically small rural hospitals), for-profit hospitals, hospitals with graduate medical education programs, and hospitals that serve a disproportionate share of Medicaid patients and patients who had no means of payment (typically inner-city hospitals).… Because the data used to develop the DRGs and establish the original payment rates were pre-DRG data, as hospitals improved their data collection and coding processes to optimize Medicare reimbursement, their case mix changed—generally becoming slightly more complex. The original payment rates were based on older, less complex data that essentially understated case mix. As hospitals improved their data, their case mix complexity increased and their Medicare payments would up being higher than HCFA anticipated. This phenomenon is often referred to as DRG creep…

In addition, PPS created a new array of opportunities to maximize Medicare reimbursement. In the original DRG system, determining which DRG a patient should be assigned to required several steps and depended on the patient’s diagnoses, surgical procedures, age, and complications. As it turned out, the sequence in which diagnoses and procedures were recorded and the completeness of the data influenced the DRG assignment. Obviously, hospital managers wanted their patients assigned to the highest payment rate DRGs allowable, so coding processes were improved to ensure that the data used to assign patients to DRGs were correct and that the coding process itself resulted in the best payment option. Just as with cost reimbursement, computer programs were developed to automate the coding process and optimize DRG assignments.”
Ibid.

61 Jack Owen interview with the author, February 17, 2003:

Owen: And I meant it. I think some of them did… I had the chief executive of a big hospital come to me in the year or two after DRGs went into effect, and he said, “I’ve got almost a $50 million dollar surplus this year! What do I do?” I said, “Put it in the bank and be awful careful of it because you’re not going to have it that long. It won’t continue. You’re going to get reduced.”


63 “1987 Medicare Budget Issues,” *Hearing Before the Subcommittee on Health of the Committee on Ways and Means*, House of Representatives, 99th Congress, 2nd Session (March 6, 1986), 338-339:

Bromberg: “[We were] willing to accept our fair share of responsibility in any attempt to reduce the Federal Deficit. However, the cuts for the Medicare program proposed by the Administration once again go far beyond any sense of fairness and proportion. Consequently, health care providers will be asked to absorb much more than their fair share of the reductions. The Administration and Congress should note that the Medicare Hospital Insurance Trust Fund does not contribute to the Federal deficit. Payments to hospitals under Medicare do not come from general revenues; they are financed by a payroll tax. The pending bankruptcy of Medicare can no longer be held out as a legitimate reason for drastic cuts in the program… If we had frozen payments to hospitals over the last 10 years what improvements would we have sacrificed? How many life-saving Intensive Care Units, or Cardiac Care Units or Neonatal Units would not exist today? What about technological advances like the CAT Scanner and MRI? Would we have the same quality and quantity of health care we enjoy today? Absolutely not!!… Hospitals understood the prospective payment law to be a contract. We have kept our part of the contract, and the system is working. However, if Congress unilaterally changes this contract by freezing or reducing hospital payments, then hospitals can hardly be expected to endorse the program.”

64 “Status of the Medicare Hospital Prospective Payment System,” *Hearing Before the Subcommittee on Health of the Committee on Ways and Means*, 100th Congress, 2nd Session (March 1, 1988), 83-84:

Stark: I suspect that based on the [hospitals’] inability, supposed inability, to provide data, that they are way behind all the other industries in this country that provide us data. The railroads provide us better data than the hospitals. Think about that one for a minute!

Owen: I think the record will show that we have provided you with data in your committees whenever we could, on the basis of what is proprietary and what is not from the standpoint of the hospitals themselves.

Stark: There is no such thing as propriety when you are asking for Federal dollars, my friend. That is when, as I say, if you do not like the system, you can drop out…

Owen: I think the basic problem, though, is that it is not that no one wants to divulge it or let it go; it is just as you said earlier, you had some concern about the lack of trust, I guess. And I think there is a lack of trust in what has happened in this program well before you became chairman of the subcommittee. It started out in one fashion, and we hadn’t even gone a year, and it was changed. There is a feeling by hospitals that all you really want data for—not you, personally, but all Congress wants data for—is so that they can take out more money to offset the budget deficits on the other side, and we are left with a patient who is lying in the hallway or who is bleeding and needs to be taken care of. That is a legitimate, I think, reason for being very cautious. If you want more data, then let’s see something that indicates that we will be recognized for it, not rewarded for it, but recognized for it. It hasn’t happened.

Stark: I suspect that is the concern, and if we were not providing the funds, that concern would bother me. But when we are constantly pressured by the same folks for more money—and you have seen the letters in my office, mostly from California hospitals, they just lie. They tell us they are going broke. And you and I both know that is just an unvarnished fabrication. So you go in the same door you came out. The hospitals are concerned that we may use this data to cut funds. We are concerned that they may, in the most unconscionable way, use the data to create and fabricate situations which do not exist, in an effort to get more of the taxpayer’s dollar.
Gradison: The Ways and Means Committee was given the responsibility for achieving most of the deficit reductions year-by-year as the budget process developed with Gramm-Rudman-Hollings, reconciliation, and so on. The reason why Ways and Means got this responsibility was that we had jurisdiction over essentially all the revenue-raising and a very substantial amount of expenditures.... Now, the critical thing was that during that period of time the Ways and Means Committee, so far as I can recall, without exception, always met its responsibilities under whichever budget resolution was adopted. In other words, we were given a number from the Budget Committee—and to say “given” sounds like we had no role in it, which is not precisely correct. But, in any event, they would come up with a number and it would be in the resolution... So we’d go through these annual exercises of having to come up with a number. And it is in that context that Medicare became very important, because it was usually an important—if not the most important—element in terms of where we looked for the savings to meet our assigned reconciliation budget number or instructions. I mean, that’s just how it was.

Panetta: I think there was a recognition not only by hospitals, but also by a lot of other constituencies, that when they saw the impact that the reconciliation tool could have, that it scared the hell out of them [chuckling]. Before reconciliation, the constituencies could basically fight these battles in separate pieces of legislation and in separate committees. And while they could continue to fight these issues, the problem was that these committees had to come up with a level of savings that were required. So, in the context of reconciliation, when that package went to the floor it was just much tougher for these separate constituencies to take those battles on. I think that was true for the hospitals and it was true, obviously, for other issues in the Medicare area and the health care area.

Pollack: Back then the victories were determined by how much you were able to limit the cuts. And each of these deficit reduction packages ended up being a bipartisan effort that was very hard to oppose. You would go through the budget process at a macro-level trying to limit the amount the committees of jurisdiction would be asked to extract. Then once you got into the committees of jurisdiction, they had to come up with this savings number. And the way the budget system worked, if that savings number wasn’t achieved, then there would be this sequestration kick-in. So if you didn’t play ball in trying to come up with a policy that was damage control, you were going to get hit with an automatic cut that could be much worse than the damage control effort.

Potetz: Do you remember Medicare policy becoming fairly budget-driven on the Senate side?

Potetz: Oh, God, yes! I mean we had these huge deficits. People may learn again in a few years what that was like... But, yes, it’s absolutely true that the PPS offered a means for achieving some significant cost savings. And hospital spending was the bulk of Medicare spending, with inpatient care being the bulk of that.... Now you had a system in place, the PPS, where you had a lot of levers that you could pull in order to generate a tremendous amount of savings. By just reducing the DRG update factor, by making small changes to the teaching adjustment—which we always did on the Senate side, partly because some of these rural senators really didn’t care so much about teaching hospitals/academic medical centers and partly because it was a great negotiating position to have when dealing with the House side—you could generate a tremendous amount of savings. So for a number of years there was sort of this ritual that included tweaking Medicare’s update factor....

The other thing to keep in mind was that if you had a kind of pure bill that consisted only of tax increases and budget cuts to meet the deficit reduction targets, everyone would have been miserable. But these bills—partly because they were operating under expedited rules, which in the Senate is extremely helpful to have these type of reconciliation bills—offered the opportunity to legislate in other areas as part of a bigger package. So there was a lot of legislation that was done in addition to budget cutting. And there was even quite a bit of spending that was done. We did a lot to increase Medicaid coverage in those years. And a lot of that was done by saying, “Well, if you have to cut X dollars out of Medicare, why not cut X+ something and do some good things that you would want to vote for.
Robert Reischauer interview with the author, August 16, 2002:

Author: When I interviewed Michael Bromberg [President of the FAH], he has a very different take on this obviously. He says that Congress simply lied to them and broke their promises; that the original promise was: “If we, the hospitals, become more efficient and more productive, then we get to keep the savings, not the government.” He and his members would say to Congress, “It’s our money. I mean, the Medicare portion of the payroll tax should not be used as a deficit reduction device. It’s supposed to be used for paying for hospital services for Medicare beneficiaries. So, fine, maybe the first two years of DRGs, you overpaid us. But by the late ‘80s, you’ve taken it all back and then some and that’s not fair.” Were you sympathetic to that kind of argument or did you leave that more for ProPAC to decide?

Reischauer: No, I mean, as CBO Director, that wasn’t something that I would opine on. But, personally and having done a lot of health economics, I would not be particularly sympathetic to that. I mean, it’d be one thing if we were talking about a truly competitive industry, but we aren’t. We’re dealing with a set of administered prices that not only the government takes, but also large insurers who are often in the situation where they have to pay the charges that the sole community hospital dictates to them.


Stuart Altman interview with the author, July 22, 2002:

Altman: There is absolutely no question about it: hospitals cost-shift. The not-for-profit hospitals are dominated by people whose view of life and hospitals is this: they first look at what their costs are and then they look at where they are going to get the revenue from to pay those costs. They don’t look at maximizing revenue or profits first. They look at their costs first. And their job as hospital administrators is to generate the revenue to equal those costs. It is absolutely NOT to decrease costs! You lose your job if you decrease costs. You’re going to piss somebody off, some doctor group, or patients. You’re going to lose your prestige in the community, because you don’t have something: a piece of medical equipment, a particular medical specialist, whatever it might be. I mean, lowering costs is not on any not-for-profit administrator’s agenda. They only lower costs when they can’t find the revenue. It’s the same thing at a university. Which president of a university or a dean gets credit for whacking faculty salaries or for cutting the size of the faculty? I was a dean and you don’t win games with that. The only way you can afford to cut costs is if the market or the legislature won’t give you the necessary revenue. And hospitals are the same way.


MedPAC, Report to the Congress: Medicare Payment Policy, 52.


See Karl Pozer, “Strategies to Contain Health Care Costs,” *Business & Health* (September 1990): 35:

“Many employers may be saving health care dollars at the expense of society as a whole, claims political economist Reinhardt. One result of cost shifting is a growing population of Americans—currently estimated 37 million—without health insurance. Uwe Reinhardt predicts that for the next three to five years the American health system will ‘muddle through’ without major reforms. Administrators of the Medicare and Medicaid programs are likely to continue their tough bargaining. Because government purchasers probably will pay prices below what providers seek to cover their overhead and profit, providers will be even more aggressive in bargaining with the private sector. While large businesses and third-party payers may be able to resist this ‘cost shift,’ insurers and small businesses may not.

‘Small business, whose health care costs per employee have been rising much faster than those of large firms, are likely to respond to this pressure by refusing to offer their employees health insurance or by canceling the insurance policies hitherto offered their employees,’ says Reinhardt. ‘Thus, they are likely to bump more Americans into the pool of uninsured, which will put pressure on the hospital sector, to which American politicians have traditionally looked as insurers—and tax collectors—of last resort.’ … According to Joseph Duva, small employers should band together to gain greater bargaining leverage. ‘I believe small employers should look to be big in purchasing power,’ he says. ‘If the small employers can’t do it, then it will be a big problem. If small businesses become priced out of the health insurance market, the number of uninsured could double.’”

See David Drake, “Managed Care: A Product of Market Dynamics,” *Journal of the American Medical Association* 277, no. 7 (February 19, 1997): 560-64.

Scully interview with the author, October 24, 2002.

Scully: If you’re a nursing home, if you’re a doctor, or you’re a hospital, fundamentally a big chunk of your business is as a government contractor. And your expectation, I think, when dealing with the government, whether you’re in the Pentagon or in health care … is boring consistency, decent margins that don’t go up or down or flop around. If you’re Boeing, you don’t want to have a 25% margin one year and a negative two percent the next year. I think that’s what health care providers want. Unfortunately, because health care policy is frequently driven by budget deals and the policy is so complicated, for many years it was driven by “how much money do we need to save for the budget” and not by what the right health policy is. Thus, you get these huge up and down roller coasters, which I think is unfortunate.

Marilyn Moon interview with the author, August 2, 2002:

Author: Do you remember there being any evidence that you were convinced of that there was cost-shifting going on by the late ‘80s/early ‘90s, cost shifting to private payers by the hospitals because they were not, in their opinion, getting sufficient reimbursement from Medicare?

Moon: I think there has been cost shifting. I’m a believer in cost-shifting from the standpoint that I think that hospitals find it very hard to segregate out their patients and medically treat their patients all that differently. And when they’re being pushed in one area, they push back in another area if they can. And they change slowly. So if the cuts are really deep in Medicare and if there were excess payments, as I believe there were, in the other private areas then, yes, in a sense hospitals are subsidizing Medicare by pushing costs off onto other payers. But that’s not necessarily because they had to. It’s just because it was a lot easier for hospitals than making other kinds of changes that they didn’t want to make. …

They [the hospitals] try very hard to push on whomever is easier to push on at that moment and, at first, since private payers were largely ignoring the whole issue of cutting back on payments to hospitals and weren’t very serious about it, it was very easy for hospitals to push on them. … One way or the other, the hospitals want revenue that is as high as they possibly can get and they will respond in terms of their behavior to that revenue. I don’t think they’re very discriminate in terms of where it goes in the sense that, you know, if they needed it in the X-ray area, they’ll put it in the X-ray area. And so I think it’s very difficult to parse out the way we’d like to and say, “What are you doing for Medicare patients versus what are you doing for other patients?”

“Options for Health Insurance,” 187:
**Senate Finance Committee:** How do hospitals finance uncompensated care?

**American Hospital Association:** The vast bulk of under- and uncompensated care is financed through charges paid by private insurers and individual patients. . . . A substantial part of the “cost shift” is the private sector’s contribution to the cost of treating those individuals not covered—or inadequately covered—by public programs.

86 James Mongan interview with the author, October 3, 2002:

**Author:** What’s your view of the debate over cost shifting.

**Mongan:** You know, you can take a malignant view of it and say the hospitals are just sitting there spending every dollar as fast as it comes in. You can also take a more benign view, and obviously I’ve been in this business, we try very hard to put together as tight a budget as we can. You negotiate with the nurses; you cut what costs you can, etc. And then you see your costs have gone up 5%; you see that Medicare’s going up 2%. You’re either going to go under or you’re going to get it from your private payers. So there was that cost shift, but managed care clearly came in and made that cost shift tougher.

87 Michael Bromberg interview with the author, July 23, 2002:

**Author:** Did you think cost-shifting was a viable alternative or perhaps the only alternative for hospitals when Medicare reimbursement rate increases actually became negative between 1989 and 1992? I mean, do hospitals even cost shift at all?

**Bromberg:** Yes, absolutely! Except HMOs took that away from us. I mean, before HMOs, you could cost-shift, sure, and insurance companies would just pass it on to employers. But when HMOs came into the picture and started squeezing, then you couldn’t cost-shift anymore.

88 Rick Pollack interview with the author, October 29, 2002:

**Author:** So do hospitals cost shift or…?

**Pollack:** Oh, yes, there’s no question that we do. We’ve always been very up front in saying that there’s no free lunch here. And that’s how we’ve tried to get the business community focused on helping us on some of these government shortfall issues. But Medicare and Medicaid are way below cost, and then you add in charity care and that has to come from somewhere.

**Author:** I’m looking at the period around 1990. I’m sure you remember these years...’90, 91, 92… Medicare’s inpatient margin was absolutely negative, relative to the years before. Its payment-to cost-ratio bottomed out at about 88 cents on the dollar in 1991. At the same time, Medicaid’s payment-to-cost ratio is even below that of Medicare’s. So is that the impetus for hospitals’ cost shifting to private payers?

**Pollack:** Exactly. And when the pressure for the hospital field got real tight was with the advent of managed care. It became much harder to cost-shift. And that’s what made things very difficult because where do you make up the difference?

89 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.

90 David Burda and Cathy Tokarski, “Hospitals are Under Pressure to Justify Cost Shifting: But Some Payers are Rejecting Hospitals’ Excuses and are Demanding Data,” *Modern Healthcare* (November 12, 1990), 28-36


98 D. McFadden, “The Legacy of the $7 Aspirin,” *Management Accounting* 71 (April 1990): 38-41: “The accounting practice of cost shifting in the hospital industry has been a significant contributor to the rapid increase in health care costs... Cost shifting spreads around, and in some cases hides, the charges for certain items. To stay within the guidelines of reasonable and customary charges for such things as room rates, operating rooms, and intensive care units, hospitals have been breaking those charges into smaller units that can be regularly multiplied across the entire patient population under the category of ancillary charges. The price of an innocuous item such as aspirin can include a portion of hospital costs for such things as labor, supplies, and shared and shifted costs.”


“At the root of the problems faced by White Memorial Hospital and others … is the arcane way that hospitals are financed in the United States. Hospitals do not sell goods like department stores and supermarkets do, with every customer paying the same price for the same product. Instead, each hospital strikes a separate deal with each of the dozens of insurers in its community. Those prices may have very little to do with a hospital’s actual costs and a lot to do with the kind of bargaining a hospital does with insurers. The prices vary widely. A hospital makes money at the end of the day if the profitable contracts it has struck outnumber the money-losing ones.

The difficulty for many hospitals comes in large part from the bulk of patients who are insured by Medicare or Medicaid. In most cases, government insurers do not bargain with hospitals over prices; they dictate prices to hospitals. And in recent years, in the face of rapidly rising budgets, government payers have become increasingly thrifty. While it was once common for hospitals to make money treating Medicare patients, a recent federal report estimated that, on average, every U.S. hospital now loses more than $1 million a year treating the elderly. Medicaid provides even less....

The hospital industry has responded to this steady decrease in reimbursement in part by becoming leaner.... The second step the industry has taken is raising its prices for private patients. In the early 1980s, hospitals charged private insurance companies an average of 10 percent above costs; now, that figure has climbed to 40 percent or more. This practice of cost-shifting is one of the biggest reasons health insurance premiums to employers continue to rise every year by as much as 25 percent.”


101 Dobson and Clarke, “Shifting No Solution to Problem of Increasing Costs”:

“Employers in their role as health insurance purchasers fund the cost shifting. (Employees also fund cost shifting through higher cost-sharing requirements; business customers pay their share through higher product prices.) Employers cover not only the healthcare costs of their employees, but also a portion of the costs of the uninsured and of public payers whose payments do not meet costs. This is a major reason private sector employer premium payments rise faster than underlying healthcare costs. Hewitt Associates has estimated that 27 percent of insurance costs increases are due to cost shifting.

Governments are perhaps the major beneficiaries of cost shifting. As Medicare and Medicaid pursue policies of marginal (variable) cost payment (as opposed to average cost payment), the costs of treating government beneficiaries are shifted to private pay patients. This paper has shown that this “sick tax” is increasing.
The politics of cost shifting may become the politics of health care as remaining payers resist government underpayment policies.

For instance, an October 1991 proposal introduced by House Ways and Means Committee Chairman Dan Rostenkowski (D-Ill.) would give private payers the option of using payment rates based on Medicare methodologies. ProPAC estimates that this proposal would drive down hospital total margins from 3.5 percent to –5.7 percent during the first year of operation. This type of proposal would clearly disrupt the current system of cost shifting that enables hospitals on average to maintain positive total margins.”

See http://www.brtable.org/newsroom.htm

Robert Winters interview with the author, August 28, 2002:

**Winters:** There was also a private-to-private form of cost-shifting going on, which incensed some employers. Bob Crandall of American Airlines is perhaps the most vivid example. He was infuriated, and understandably, that his cabinet attendants—largely women—were insuring their husbands under the American Airlines plan, because their husbands were working without coverage. And there was a lot of that private-to-private kind of cost-shifting going on. It tended to occur in companies that had a lot of covered female employees. It was not uniquely that. It could work the other way as well. But employers had always been at ease with the notion that their male employees would cover their dependents. The reverse, although one ought to be in a gender-neutral society, was new. So along came this cost-shifting phenomenon, which added an element of unfairness to what was already a rapidly escalating area of expense for corporations, and so, as I said before, CEO’s finally began saying, “Goddammit, this has to stop!”

Reinhardt, “The Predictable Managed Care *Kvetch* on the Rocky Road from Adolescence to Adulthood,” 903.


Gabel, “Ten Ways HMOs Have Changed During the 1990s,” 134-145.

Gold, “DataWatch: HMOs and Managed Care,” 192-193.


118 Thanks to Mark Peterson for showing me this line of argument.


122 For example, see Titlow and Emanuel, “Employer Decisions and the Seeds of Backlash,” 941-47.

123 Reinhardt, “The Predictable Managed Care Kvetch on the Rocky Road from Adolescence to Adulthood,” 908.

124 Oberlander, Medicare and the American State, 199: “During the 1980s, Congressional and executive branch budgeters saw Medicare as a fiscal target.  Medicare regulation of payments to [hospitals] consequently occupied a central position in the annual budgetary process; omnibus reconciliation bills became a familiar vehicle for reductions in Medicare spending.”

125 Personal communication with Jack Ashby, MedPAC Hospital Research Director (August 7, 2003): “The 14% PPS margins [in figure 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.”