considered a reimbursable cost by rate setters. Health care attracted entrepreneurs, and for-profit hospital chains grew rapidly. Similarly, the nursing home industry and kidney dialysis centers attracted new capital. The medical establishment, which had fought against corporate control of hospitals and other institutions, was relatively helpless. The AMA's stance against Medicare and Medicaid had cost it credibility, and its constituency was now spread out between the AMA, specialty and subspecialty societies, and the academic medical centers, each of which had its own interests.

Costs and Concerns Mount

As health care costs mounted and the health care sector accounted for a much more significant share of the economy, more and more observers expressed concern about the lack of competition in portions of the industry and began suggesting ways to control costs. One suggestion was to promote prepaid group practices, or HMOs, which share some of the cost risk with the employer, thereby inducing reduced costs. The successes Kaiser Permanente and similar organizations had in delivering care at a lower premium cost without evident diminution of quality drew much attention. This led the Nixon Administration to support the Health Maintenance Organization and Resources Development Act of 1973. Although that legislation had little immediate impact, later amendments opened the way for the explosion of HMOs and other vertically integrated health care systems in the 1980s. That expansion continues today under the rubric of administered competition. In 1974, the Nixon administration proposed the Comprehensive Health Insurance Program, which sought to provide health insurance to all employees. Congress debated this and a similar measure, the Kennedy-Mills bill, but did not enact either. Richmond and Fein (2005), writing before enactment of the ACA, argued that 1974 was the closest the nation ever came to universal health insurance, and that those proposals, although eclipsed by the Watergate cover-up and Nixon's resignation, were the basis for successive calls for congressional action by presidents Carter, Clinton, and Obama.

Charges and Cost Shifting

Over time a provider institution must achieve income sufficient to cover its operating and capital costs. Because of the imperfect market for health care, prices are set by marking up estimated costs or by observing what is charged by others in the same market area. When individuals or insurers pay less than the breakeven price, the institution marks up the prices charged to those it figures can pay more or that lack sufficient bargaining power.

Originally, Blue Cross organizations, which were owned by state hospital associations, were interested in a management cost-finding system that fairly allocated the full costs of services among the users of those services. Because they understood that most costs in a hospital system are (1) fixed and (2) joint,[1] they did not attempt to find out the marginal cost of a service (*marginal cost* is the additional cost of producing one additional unit of a product). They established an estimated average direct cost for each unit of service (e.g., bed day, laboratory test, operating room hour, X-ray) and then allocated the overhead costs on the basis of the number of units consumed by the payer's enrollees. The largest expense in the institution, nursing time, was treated as overhead and not allocated to the individual patient. The resulting charges included all the overhead costs, allowing each institution to break even on its Blue Cross patients. If the patients in a health plan used a quarter of the X-rays produced by the radiology department, the plan paid a quarter of the full costs of that department (including allocated overheads). If hospitals and other health care institutions offered discounts, they tended to favor the Blues, not the other insurers, and certainly not the directly paying patients. This resulted in what is called *cost shifting*.

As more patient care costs went uncovered under insurance contracts, hospitals added the cost of this uncompensated care to the overhead rate and increased charges accordingly. It was easy to manipulate charges to mark up costs and either make a profit or provide deeper discounts to preferred customers. First the Blues and then the federal government exerted pressure on providers, obtaining substantial discounts in return for their business. This shifted the costs of uncompensated care to private insurers and the uninsured. Reinhardt (2006, p. 64) observed, "What prevailing distributive ethic in U.S. society, for example, would dictate that uninsured patients be billed the highest prices for hospital care and then be hounded, often mercilessly, by bill collectors?"

Cost Shifting Hits Private Plans

Bills sent to patients and others were typically based on the official price lists of doctors and hospitals. People with no insurance were asked to pay full charges. Commercial insurance companies had contracts that

[1]The cost of a nurse's time is incurred when she or he reports to work; thus, it is *fixed*, regardless of whether there are six patients rounded or three or whether a team approach is used. That time is also *jointly* shared among all the patients the nurse serves. Few systems recorded nursing time by specific tasks.

discounted the charges. The Blues and large HMOs enjoyed even bigger discounts, and the federal government got the biggest discount because it demanded the lowest rate allowed to any customer. Because of the inflated charge figures posted to most bills, the public assumed that unit care costs were a great deal higher than they really were, and that insurers were picking up a higher proportion of the costs of care. Real transfer prices for medical services were kept under wraps. This made deductibles and copayments appear to be a much smaller proportion of actual costs than they really were. Under pressure from the public for greater transparency, this has gradually changed. The public now sees more of what is actually paid and by whom, but real transparency is still lacking. **Table 3-1** shows Medicare charges billed by hospitals and payments made by Medicare and the patients to Miami-area hospitals for a specific procedure type. Making such data available is part of the federal government's efforts to promote price transparency. The payments are the full payments and include added payments such as disproportionate share for the safety net hospitals.

The financial reports of health care institutions offer a picture of the size of these discounts. Many institutions book their full charges as revenue and then deduct trade discounts under discounts and "allowances" and reflect charity care costs under bad debt written off and under "uncompensated care." Tomkins, Altman, and Eilat (2006) reported that the ratio of gross revenue (charges) to net revenue (payments received) had grown from 1.1 to 2.6 over a 25-year period. They also reported that cross-subsidization of services and differential pricing might be difficult to change in the current marketplace. In 2009, markups in Atlanta hospitals ranged from 157% to 702%, and the average had moved from 124% to 319% over the preceding 10 years (Pell, 2011). Because insurance companies and governments negotiate substantial discounts, it is the uninsured or those going out of network who are pressed to pay the full amount. Even then, according to the same article (Pell, 2011), an Atlanta hospital offered an uninsured individual a 40% cash discount. In fact, one for-profit hospital with a markup of 702% reported that no patients paid the full markup.

Currently, every hospital has a price list called a *chargemaster*, which may have as many as 20,000 items. These are the charges that the patient usually sees. Terms are not standardized, and some items are really bundles of services, so patients still have trouble comparing prices between institutions (Brill, 2013). In California hospitals, reported charges for the same procedure at one hospital might be four times that of another, but, on average, hospitals received reimbursements for only about 38% of charges from patients and insurers in 2004. Reinhardt (2006) argued that pricing practices would have to change radically if patients were to be able to make

Table 3-1 2011 Medicare Charges and Payments at Selected Miami-Area Hospitals for DRG 470 (Major Joint Replacement or Reattachment of Lower Extremity w/o MCC)

Hospital	City/Suburb	Number Performed	Average Charge	Average Total Payment
Homestead Hospital	Homestead	22	$96,004	$23,250
North Shore Hospital	North Miami	32	$87,579	$16,112
Doctors Hospital	Coral Gables	105	$85,577	$20,280
Kendall Regional Hospital	Kendall	97	$79,080	$16,533
Univ. of Miami Hospital	Miami	72	$78,553	$16,792
South Miami Hospital	South Miami	68	$77,448	$15,506
Palmetto General Hospital	Hialeah	80	$76,868	$17,197
Aventura Hospital and Medical Center	Aventura	82	$74,628	$13,236
Baptist Hospital	Miami	311	$74,610	$20,610
Mercy Hospital	Miami	146	$74,425	$15,116
Jackson Memorial Hospital	Miami	35	$63,537	$24,467
Good Samaritan Hospital	Miami	31	$63,327	$15,068
Memorial Regional Hospital	Hollywood	66	$60,742	$14,891
Mt. Sinai Medical Center	Miami Beach	108	$58,431	$15,805
Memorial Hospital West	Pembroke Pines	44	$56,876	$14,840
Cleveland Clinic	Weston	168	$47,959	$11,969
Westchester General Hospital	Miami	15	$41,215	$19,761

Source: Reproduced from: Inpatient Prospective Payment System (IPPS) Provider Summary for the Top 100 Diagnosis-Related Groups (DRG). https://data.cms.gov/Medicare/Inpatient-Prospective-Payment-System-IPPS-Provider/97k6-zzx3. Accessed 3/7/2014.

rational buying decisions. He seemed to support the recommendation of Porter and Teisberg (2006) that hospitals post one set of bundled prices per disease entity and charge the same to everyone. However, Altman, Shactman, and Eilat (2006) wondered whether transparent pricing and customer sensitivity to pricing might destabilize the hospital sector, bringing average prices down and forcing some into bankruptcy. The ACA provides for a number of demonstrations of bundled pricing, and the Centers for Medicare & Medicaid Services (CMS) appears to be well on the way to implementing this concept for a number of frequently encountered conditions.

Responding to Cost Shifting

As employers and private insurers became increasingly aware of the effects of cost shifting, they adopted a number of measures to counter it and combat the overall inflation in the costs of care. As early as the 1970s, employers demanded that insurance companies begin to control premiums (Starr, 1982; Mayer & Mayer, 1985). These measures fit under the general heading of *managed care*. Most of these measures spread slowly until the 1980s. Employers moved away from contracts that accepted provider-established fees from any provider, and instead signed up with HMOs. **Figure 3-2** illustrates the roughly 60% decline in market share for traditional indemnity

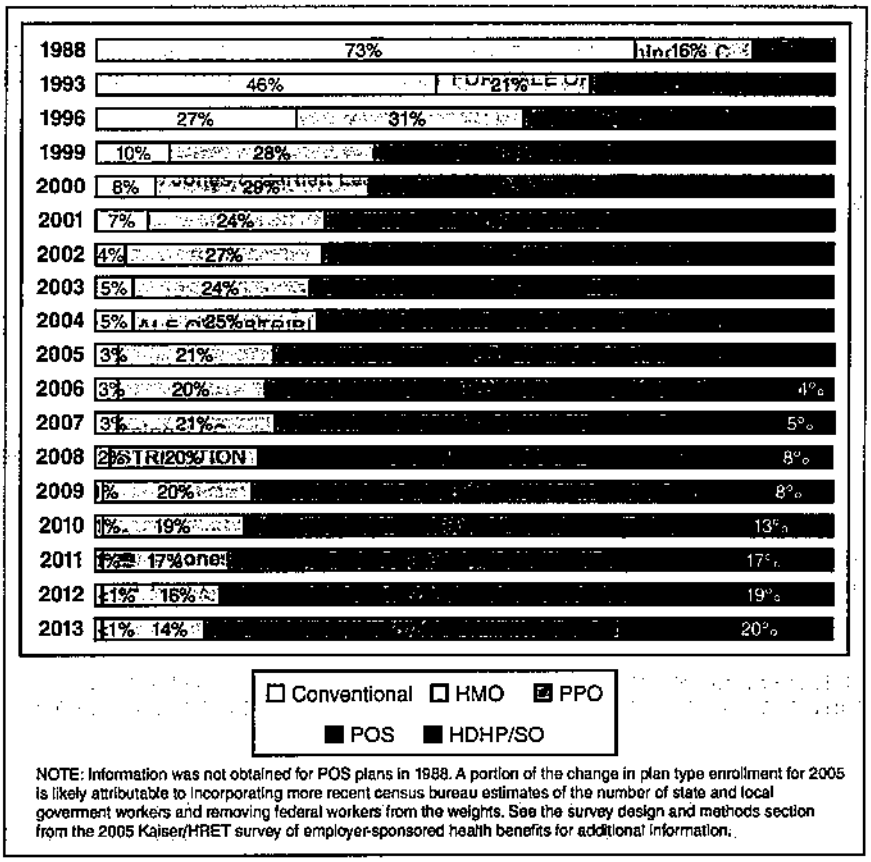

Figure 3-2 Health plan enrollment for covered workers by plan type, 1988–2013.

Source: Reproduced from: Employer Health Benefits 2013 Annual Survey – Chartpack, (8465), The Henry J. Kaiser Family Foundation and Health Research & Educational Trust

plans from 1988 to 1998. The HMO/POS (health maintenance organization plus point-of-service) and PPO (preferred provider organization) plans appeared much better able to control health care costs by exacting their own discounts and by constraining what patients and providers would be able to do.

The Blues began to shed their nonprofit identities and their focus on being community-based cooperative organizations as they competed with the newer for-profit insurers. They often developed their own HMO organizations. The concept of the HMO was no longer a prepaid group practice. It had become an organization that managed the insurance risk and the delivery of care either directly or through a designated provider network. HMOs (for profit and nonprofit) continued to negotiate with individual providers, group practices, hospitals, pharmaceutical companies, and all other types of providers for deeper and deeper discounts.

THE CURRENT "ERA" EMERGES

Fox (2001) described three eras of managed care:

- Pre-1970, the early years
- 1970 to 1985, the adolescent years
- 1985 to 2001, the years when managed care came of age

We would add the following:

- 2001 to present, mixed administered and oligopolistic competition comes of age

Richmond and Fein (2005) described the period 1965 to 1985 as a time of emerging tensions between regulation and market forces and called the period after 1985 the "Entrepreneurial Revolution." Bodenheimer and Grumbach described the 1970s as a period of developing tension, the 1980s as the "Revolt of the Purchasers," and the 1990s as the breakup of the provider–insurer pact. The changeover to managed care slowed the growth of premiums from the mid-1990s into the first years of the new century, but then premiums took off again. In the meantime, both providers and patients expressed displeasure with HMO constraints on treatment choice and provider choice. New state laws sprang up limiting the ability of insurers and HMOs to control professionals and patients. Some thought managed-care control mechanisms had already picked the low-hanging fruit and had stopped the most egregious cases of inappropriate utilization. One control mechanism, *capitation* (a fixed payment per enrollee per time period), had been promoted because it shifted the cost risk from