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findings brief

A Review of the Evidence on Hospital Cost-Shifting

key findings

- Cost-shifting is but one possible response to reduced public payments.
- In instances of cost-shifting, it is typically at a level far below dollar-for-dollar.
- Cost-shifting is just one of many possible responses to shortfalls in public payments to hospitals (another is cost cutting).
- Cost-shifting can take place only if hospitals both possess market power and have not fully exploited it.

Overview

Medicare payment policy remains an important issue as the Patient Protection and Affordable Care Act (ACA) calls for reduced Medicare payments to health care providers, including hospitals. In the past, certain stakeholders have argued that lower payments to hospitals by Medicare and Medicaid can lead to cost-shifting, charging private payers more to compensate for shortfalls in payments from public programs.[1] In turn, the cost-shifting argument goes, higher hospital payments from private insurers lead to increased premiums and employers' health care costs. But is cost-shifting inevitable, pervasive, and substantial? That is, should we necessarily expect that every dollar (or a large portion thereof) of lower public payments will *cause* an equivalent increase in private payments?

In conjunction with a HCFO-funded grant led by Steven Pizer, Ph.D. at the Boston VA Research Institute, Austin Frakt, Ph.D., of Boston University, undertook the first systematic review of the literature on cost-shifting since the 1990s.[2] Frakt's review updates this earlier work[3] and frames cost-shifting in today's policy context.

"During the debate over health reform, several industry-funded reports repeated the claim that cost-shifting is a large and inevitable consequence of reductions in public payments to hospitals. However, careful analysis by economists over the last 20 years does not support this view. Cost-shifting can occur, and has, but the main result of reduced hospital payments is cost cutting, not cost shifting," says Frakt.

Background

Medicare payments have evolved greatly since the program's inception. Simultaneous changes in the private health insurance market and public policy have created an appearance of cost-shifting over time. In many cases these factors largely or fully explain changes in public and private profit margins for hospitals, leaving less scope for the cost-shifting hypothesis.

Prior to the 1980s, Medicare reimbursed hospitals on a retrospective fee-for-service basis, placing almost no restraint on the amount of reimbursement a hospital would receive. Until the 1990s, private insurers largely reimbursed providers in the same way. In 1983, Medicare switched to a prospective payment system that

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pays hospitals a pre-set rate for each type of admission. The amount a hospital receives is based on average historical costs of treating patients in the diagnosis-related group (DRG) in which the hospital stay falls. By setting reimbursements ahead of time, financial risk was partially shifted from Medicare onto the hospitals themselves, encouraging them to do less during each stay and profit on any surplus payments.

In response to this congressionally introduced Medicare cost control measure, hospitals reduced their costs, not just for Medicare but for all patients. Consequently, private payment-to-cost margins increased as those for Medicare fell. This is often and incorrectly viewed as the signature of cost-shifting, but it is driven by changes in cost, not in prices.

Private insurers eventually introduced their own cost controls by incorporating techniques of managed care. Because insurers had the option to exclude hospitals or other providers from their networks, they had leverage to negotiate reimbursements downward.

Toward the end of the 1990s, providers and the public reacted negatively to the impositions of managed care. Plans began to loosen their networks by paying providers more to participate. At the same time, the Balanced Budget Act (BBA) extended prospective payment models to additional types of Medicare hospital services.[4] Once again, private sector payments increased while public sector reimbursements decreased. However, there is no evidence that these trends were inherently driven by cost-shifting. Private sector payment increases were linked to a shift in market power from plans back to hospitals, and public sector payment decreases were due to policy changes.

Methods

Frakt's literature review included only articles pertaining to cost-shifting from Medicare and Medicaid to private payers, encompassing all such articles since 1996, the year the last such review was published.[5] He did not survey papers on cost-shifting from the uninsured. In order to be included in the final list, articles must have appeared in a peer-reviewed journal and provided a theoretical treatment of cost-shifting or estimated the size of cost-shifting.

Frakt used Google Scholar to compile his initial list, supplemented with other pieces of literature he identified.[6] He placed the studies in two categories: theoretical or empirical. In his review, Frakt also illuminates the non-price factors that could obscure or confound cost-shifting.

Results

Cost-Shifting Theory: Market Power and Profit Maximization

According to basic economic theory, market power has significant influence over hospital price setting among private payers. In a market with many competing hospitals and providers, private payers have the option to exclude providers who will not meet their desired price points. Conversely, in highly concentrated hospital and provider markets, plans cannot afford to exclude a major provider from coverage. Market power is also directly linked with the ability of hospitals to cost-shift. In order to cost-shift, hospitals must have the market power to do so (i.e., unexploited market power) or else plans would simply drop hospitals from coverage as prices increase. This idea, which is referred to as the "market power hypothesis," suggests that hospitals with more privately insured patients shift more costs because of the bargaining leverage they hold with payers. However, there is a ceiling to market power implied by profit maximization. If hospitals are profit maximizers, any shift in prices would cause profits to go down. Therefore, a necessary condition for cost-shifting is that hospitals have not maximized profits and retain untapped market power that can be exploited to shift costs.

Not all studies agree that causality can only run from public prices to private ones. Sometimes public prices respond to private payments. Jacob Glazer and Thomas McGuire[7] argued that by strategically underpaying hospitals, public payers could enjoy the same quality demanded by private payers without having to pay the full cost for that quality. As private payers pay more for the quality demanded in the commercial market, public payers could pay less. The extent of this "reverse shift" would greatly depend on the payer mix at each hospital. This theory, the "strategy hypothesis," contradicts the "market power hypothesis" by suggesting that hospitals with more private patients shift fewer costs because they are not as affected by or dependent upon public payments.

Cost Shifting Theory: Utility Maximization

Just because a hospital is non-profit does not mean it will not maximize payments in order to provide better quality or more charity care. Conversely, for-profit hospitals are also motivated by more than the bottom line and can forgo some financial profits in order to provide better quality or less profitable community services. The literature shows that utility (as opposed to profit) maximization does allow for a certain degree of cost-shifting, but there may be other confounding factors. For example, David Cutler[8] provided an intuitive, graphical depiction of a theory of hospital price setting under utility maximization, which shows that both cost shifting and cost cutting are expected when public payments to hospitals are reduced. The extent of each depends on the plans' power to exclude hospitals from their networks.

Review of Empirical Literature

The preponderance of evidence suggests that cost-shifting cannot completely offset the loss of revenue from lower public sector payments. Only one of the empirical articles reviewed[9] found a dollar-for-dollar shift between public and private sector payments (and even there, it was only found for one time period, 1985-1990). The rest found either no evidence of cost-shifting, or found evidence that increases in private revenues only offsets a small portion of declines from public payers.

Cutler[10] examined cost cutting in relation to lower Medicare payments. His results showed dollar-for-dollar cost-shifting in the late 1980s (a rate much higher than any

other study conducted during the same time period). Once managed care became popular during the 1990s, shortfalls in Medicare payments were addressed by cost-cutting as opposed to cost-shifting.

According to Frakt, the strongest empirical study available on cost-shifting in something like the modern era of health plan-hospital market competition was conducted by Vivian Wu in 2009.[11] She examined the consequences of reduced Medicare payments due to the BBA on private prices. Using an instrumental variables approach, Wu found that, on average, 21 cents of every dollar of lost Medicare payments were shifted to private payers. She found evidence that hospitals with higher market power had a slightly increased level of cost-shifting (approximately 33 cents of every dollar lost to Medicare payments). Additionally, markets with high numbers of for-profit hospitals had slightly less cost-shifting.

Policy Discussion

The question of hospital cost-shifting has been a major topic for policymakers since the introduction of the first cost controls in Medicare in 1983. In the late 1980s and early 1990s, its potential existence became central to arguments for and against lower public sector hospital payments. Proponents argued that the ability to shift costs would allow hospitals to make up budgetary shortfalls, and therefore they should not be unduly concerned about lower public payments. Others argued that this practice unfairly burdened private sector payers.

Several provisions of the ACA may create conditions seemingly favorable to cost-shifting. In an effort to curtail the growth in health care spending, the ACA reduces future updates of Medicare hospital payments, makes some payments partially based on quality measures, and reduces payments for preventable hospital readmissions and hospital-acquired infections. Medicaid eligibility expansions are expected to cover an additional 16 million people. If this expansion causes individuals to move from private coverage to Medicaid coverage (a crowd-out effect), the drop in Medicaid payments could create an opportunity for cost-shifting. At the same time, incentives in the ACA for providers to integrate (to form Accountable Care Organizations) may increase provider market power, providing leverage to increase private prices.[12]

While some stakeholders continue to argue that cost-shifting is a negative consequence of the ACA, the literature reviewed in Frakt's article suggests that cost-shifting is not likely to be a pervasive, substantial, and inevitable outcome. In fact, the literature shows that cost-shifting is but one possible response to reduced public payments, and, when it does occur, it is typically at a level far below dollar-for-dollar. While the new Medicare payment provisions in the ACA will have some consequences, the preponderance of hospitals' response will likely be to cut costs rather than shift them onto the private sector payers. The literature also suggests that payment changes are caused by many factors and cannot always be linked to cost-shifting.

"It's well-known that our health system has many costs that can and should be reduced or eliminated. We spend a great deal to achieve far less than other wealthy nations. This does not mean we should cut costs indiscriminately. We must be smart about it. But it does mean that we should not be afraid to spend less for things that are demonstrably less effective. In doing so, we should not fear the cost-shift. The literature shows that it largely won't occur," says Frakt.

Conclusion

As policymakers prepare for the implementation of the ACA, theoretical analyses may predict that there could be shifting costs from the public payers such as Medicare to the private sector payers. However, the literature available on cost-shifting is relatively consistent in suggesting that it will not be substantial, if it occurs at all. Although changes in payments in the private and public sector are likely to occur, this systematic review suggests they will largely not be the result of cost-shifting.

For More Information

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Endnotes

1 Frakt, A.B. "How Much Do Hospitals Cost Shift? A review of the Evidence." *Milbank Quarterly*, Vol. 89, No. 1, March 2011, pp. 90-130. Also see http://www.ncbi.nlm.nih.gov/pubmed/21418314

2 For complete findings see Frakt, A.B. "How Much Do Hospitals Cost Shift? A review of the Evidence." *Milbank Quarterly*, Vol. 89, No. 1, March 2011, pp. 90-130. Also see http://www.ncbi.nlm.nih.gov/pubmed/21418314

3 In 1994, Michael A. Morrisey published *Cost-Shifting in Health Care: Separating Evidence from Rhetoric*, as well as similar articles and issue briefs. Similarly, Robert Coulam and Gary Gaumer published a critical appraisal of the Medicare prospective payment system in 1998. Complete references available in Frakt, A.B. "How Much Do Hospitals Cost Shift? A review of the Evidence." *Milbank Quarterly*, Vol. 89, No. 1, March 2011, pp. 90-130. Also see http://www.ncbi.nlm.nih.gov/pubmed/21418314

4 The BBA eliminated retrospective cost-reimbursement for post acute care, long-term hospital services, and hospitals' outpatient departments.

5 Morrisey, M. "Hospital Cost Shifting, a Continuing Debate." EBRI Issue Brief, Employee Benefits Research Institute, December 1996. Also see http://www.ncbi.nlm.nih.gov/pubmed/10163864

6 A complete list of the articles reviewed can be found in Table 1 and Table 2 of Frakt, A.B. "How Much Do Hospitals Cost Shift? A review of the Evidence." *Milbank Quarterly*, Vol. 89, No. 1, March 2011, pp. 90-130. Also see http://www.ncbi.nlm.nih.gov/pubmed/21418314

7 Glazer, J. and T. McGuire. "Multiple Payers, Commonality and Free-Riding in Health Care: Medicare and Private Payers." *Journal of Health Economics*, Vol. 21, No. 6, November 2002, pp. 1049-1069. Also see http://www.ncbi.nlm.nih.gov/pubmed/12475125

8 Cutler, D. "Cost Shifting or Cost Cutting? The Incidence of Reductions in Medicare Payments." *Tax Policy and the Economy*, Vol. 12, 1998, pp. 1-27. Also see http://ideas.repec.org/h/nbr/nberch/10911.html

9 *Ibid.*

10 *Ibid.*

11 Wu, V. "Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997." *International Journal of Health Care Finance and Economics*, Vol. 10, No. 1, March 2010, pp. 61-83. Also see http://www.ncbi.nlm.nih.gov/pubmed/19672707

12 Frakt, A. "The Future of Health Care Costs: Hospital-Insurer Balance of Power." *Expert Voices,* National Institute for Health Care Management, November 2010. Also see http://nihcm.org/pdf/EV_Frakt_FINAL.pdf