

Hospital Cost Shifting, a Continuing Debate

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Issue Brief

- This *Issue Brief* examines the evidence on hospital cost shifting. It defines cost shifting, explores the incentives facing hospitals and payers, reviews and critiques the new evidence on cost shifting, and discusses the policy concerns that arise from the new learning.
- Cost shifting has a precise and easily understood meaning. It does not mean that some payers pay different prices than others. Different prices are commonplace throughout the economy. Rather, cost shifting exists when the prices faced by one group of payers are higher *because* another group pays less. To be able to cost shift, a hospital must have market power, and it must not yet have fully exercised that power.
- There has been a spate of recent cost-shifting studies. The better known studies focus on industrywide, revenue-to-cost margins by payer. They find that the extent of cost shifting declined in the mid-1990s. The methods underlying these studies have been criticized in the academic literature, with the strong suggestion that the studies overstate any true cost shifting.
- Cross-sectional studies compared measures of prices across individual hospitals. These studies have failed to find evidence of hospital cost shifting. However, they suffer from a potential inability to control for levels of service, quality, and amenities that may simultaneously have changed as well.
- Dynamic studies compare individual measures of hospital prices through time and allow each hospital to serve as its own control. These studies find no evidence of hospital cost shifting. As one analysis concluded: "We found no evidence to suggest that cost-shifting strategies that might protect hospital revenues in the face of financial pressure were undertaken successfully."
- Rather than cost shifting, the existing evidence points to hospital competition limiting the provider's ability to raise prices. Whatever market power hospitals once enjoyed is disappearing—and with it the ability to cost shift.
- This research suggests that Medicare reform or Medicaid restructuring will have little direct effect on the hospital prices that employers and their workers pay for health care. The author argues that cost shifting is dead.
- However, the increased hospital competition necessarily squeezes hospital profits. This reduces the amount of charity care they can provide. Expect to see more and more examples of hospitals unable to provide care to nonpaying patients. This also suggests that care for the indigent will become a more pronounced public issue. This is a form of "cost" shifting, one that the "system" will need to deal with.

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This *Issue Brief* was written by EBRI Fellow Michael A. Morrisey, professor in the School of Public Health at the University of Alabama at Birmingham and director of the UAB Lister Hill Center for Health Policy, with the assistance of the Institute's research and editorial staffs, as well as four referees. Any views expressed in this *Issue Brief* are those of the author and should not be ascribed to the officers, trustees, members, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

Editor's Note: Cost shifting exists in the traditional sense when a health care provider raises its prices to one set of payers because it lowered them to another set. This *Issue Brief* examines the issue of traditional hospital cost shifting. It does not explicitly examine nontraditional forms of cost shifting, such as the effect of lower payments from one set of payers on the level of uncompensated care provided, quality of care, and health insurance premium cost shifting. Cost shifting was touted as one of the key issues during the health care debate of 1994 and continues to have a prominent place in health care debates. Yet, recent empirical studies have not found evidence of cost shifting. The *Issue Brief* concludes that, while hospitals may have been able to shift costs in the past, price sensitive employers and insurers, and excess capacity in the hospital industry, make it virtually impossible for hospitals to shift costs. This view will be the subject of continuing debate. Many policymakers, employers, insurers, consumer groups, and others believe that cost shifting continues to play a prominent role in health care. This *Issue Brief* plays an important role in that debate.

Introduction

of the health care system. It continues to have a prominent place in health care debates.

Consider Medicare. The trustees of the Hospital Insurance Trust Fund project that the Medicare program will not have enough income to pay all the claims of its beneficiaries by 2002. One common element among the proposals to ameliorate the problems tends to be a reduction in the prices paid to hospitals and physicians. This has led to fears that reducing Medicare payment levels will increase the prices paid by private insurers—a concern about cost shifting (Sheils and Ricks, 1995).

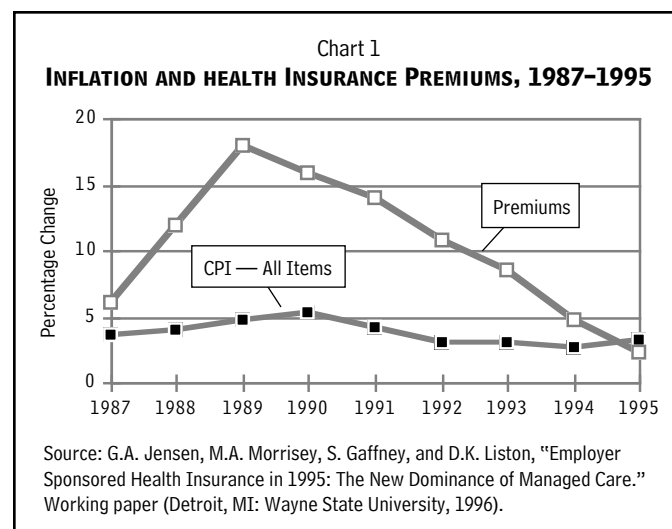
The Medicaid program for the poor is also on the block for reform. Governors complain loudly about the effects that mandated eligibility expansions have had on their state budgets. Some proposals call for the conversion of the program into a state block grant. This would give states much greater flexibility in deciding who is eligible, what services are covered, and how much is paid to providers. One concern is that lower payments to providers will lead hospitals and other providers to shift the costs of caring for Medicaid patients to the privately insured—more cost shifting.

Employers have been rapidly moving to managed care insurance options for their workers. Recent data indicate that 73 percent of workers in firms offering insurance are in health maintenance organizations (HMOs), preferred provider organizations, or point-of-service plans (Jensen et al., 1996). Furthermore, in some parts of the country, 30 percent to 45 percent of Medicare enrollees are in Medicare HMOs (U.S. General Accounting Office, 1995). Again, there is the worry that this movement into selective contracting arrangements will continue to lead to higher prices for other payers as providers shift costs.

In the early 1990s, cost shifting was touted as one of the key issues necessitating a major overhaul

In contrast, health insurance premiums have actually been increasing much less rapidly in recent years. Chart 1 shows that in 1995 the increase in employers' health insurance premiums was less than the rate of general inflation for the first time in memory (Jensen et al., 1996). Indeed, the increases in private health insurance premiums have been getting smaller each year since 1989. Some large employers report that premiums actually have fallen for them. During this period, Medicare and Medicaid payments, as a percentage of hospital costs, have been falling. This is hardly consistent with cost shifting.

This *Issue Brief* sheds some light on the whole issue of cost shifting. Since the last time the Employee Benefit Research Institute (EBRI) sponsored an examination of the cost-shifting issue in early 1993 (Morrisey, 1993), a number of new studies have empirically examined the existence and magnitude of cost shifting. I believe a consensus among researchers is emerging: whether or not hospitals ever shifted costs in the past, they certainly have not been doing it in any meaningful way lately—even though there has been ample “need to cost shift.” Cost shifting to payers is dead, apparently killed off by price



sensitive employers, aggressive insurers, and excess capacity in the hospital industry.

This report begins with a brief discussion of the nature of cost shifting and the conditions under which it can exist. It presents and critiques the evidence supporting and refuting cost shifting. It examines the direct evidence on the effects of the “need to cost shift” on hospital revenues, profits, and transaction prices and also examines the assumptions about costs that undergird much of the debate.

If not cost shifting, what has been going on in the hospital industry? The answer is price competition, cost cutting, and a reduction in both services and uncompensated care. This *Issue Brief* summarizes the evidence.

What Is Cost Shifting?

Cost shifting is easily defined. It exists when a hospital (or other provider) raises its prices to one set of

payers *because it lowered them* to another set. Thus, if Medicare lowers its payments to hospitals, cost shifting would imply that the hospital *therefore* raised its prices to private insurers. Similarly, if Medicare raises its prices, cost-shifting logic would imply that private prices would be lowered.

Notice that simply charging one group a higher price than another does not necessarily mean that cost shifting is going on. There are many examples of firms charging different prices to different groups. Airlines routinely charge different prices to people on the same plane. Movie theaters routinely charge different prices to adults and children and different prices for different showings. Restaurants give senior discounts; hotels charge convention rates; manufacturers give volume discounts. None of these cases is typically considered cost shifting. They can be understood by one of two explanations: either costs differ or market conditions differ.

The cost-shifting story is different. Not only

must the provider charge different prices to different payers, but it must raise prices to one in response to lower prices from another. To be able to do this basically requires two things. First, the provider must have market power; it must not face stiff competition. If potential patients go down the street for care when a hospital or other provider tries to raise its price, cost shifting cannot occur. Second, and critically important, the provider must not only have market power, but it must not have been fully exercising it!

This last point is most easily seen by revisiting an old movie.¹ Consider Bedford Falls in Frank Capra’s classic movie, *It’s a Wonderful Life*. You recall that old man Potter was the meanest man in town. He owned the bank and almost everything else. Suppose he also owned the only hospital in town.

Mr. Potter would set his prices to maximize profits from the mix of private and Medicare patients. He would take the price that Medicare offered as long as it covered the marginal costs of Medicare patients. He would set the private price at the level that generated the greatest profit. Were Medicare to lower its payment level, Potter couldn’t squeeze more profit out of the private patients; he already has the maximum. (In fact, he would try to shift *capacity* out of the Medicare market into the private market. To sell more private care, he would have to *lower*, not raise, prices.)

If George Bailey ran the hospital, it would undoubtedly be organized as a nonprofit enterprise seeking to do all manner of good works. George, you recall, had big ideas. Many of these good works don’t cover their costs and don’t generate profits. If they did, Potter would have been doing them, too. These good works, of course, include care for the poor.

Unfortunately for George Bailey, the only way he has to pay for the good works is through retained

¹For an extended discussion of the economics of cost shifting, see Morrissey (1994). The following vignette is drawn from that source.

earnings. He would quickly learn the vernacular and the wisdom of the hospital industry—"No margin — no mission." So, to undertake the range of good works, George Bailey charges the profit-maximizing price to those who can pay. He spends the profits on care for the poor and other good works.

From a business perspective, the only difference between Mr. Potter and George Bailey is how they spend the profits. If Medicare pays George less or if there are more uninsured to care for, George faces the same problem as Mr. Potter. He has already set the profit-maximizing price. He can't "shift costs" to either recoup losses or provide more charity care. By the nature of profit maximization, if prices currently generate maximum profits from private payers, higher prices necessarily will yield *less* profit.

There is one set of circumstances that does allow George Bailey to cost shift. It requires that one of George Bailey's good works is low prices for paying patients. Thus, for many years, Bailey's hospital has been charging paying patients less than it *profitably* could have. In this instance, when faced with more uninsured people and/or lower Medicare payments, George Bailey turns to his private payers and regretfully raises their prices. This is cost shifting as conventionally understood.

The cost-shifting strategy can work only to a point—the point where George finds the profit-maximizing set of prices. Still higher prices will then reduce his ability to do good works.

Three key factors emerge from this vignette:

- **To be able to cost shift, a hospital needs to have market power. If the market becomes more competitive, the ability to cost shift is reduced. In a fully competitive market, cost shifting cannot exist.**
- **To be able to engage in cost shifting, a hospital must have *unexploited* market power. It must have the ability to *profitably* raise prices but not have heretofore done so.**
- **Continued efforts to cost shift are self limiting. Once a hospital sets prices that maximize**

profits, further price hikes reduce profits and reduce the good works that can be performed.

The Evidence

The early studies of cost shifting were considered in the earlier *EBRI Issue Brief* (Morrisey,

1993). In essence, the empirical evidence was split. Two of these studies found evidence that price reductions by one payer resulted in price increases to private payers on the order of 90 percent and 50 percent of the reductions, respectively. Three other studies reached other conclusions. One found no evidence of cost shifting. Another found that the ability to cost shift declined when a hospital had a larger share of privately insured patients. The third found that Blue Cross-Blue Shield plans saved money when Medicare adopted the prospective payment system; it was not cost shifted against.

For the most part, these studies analyzed a period in which hospital payments were dominated by cost-based reimbursement. There were few aggressive purchasers of health care. This increased price pressure, given the *Wonderful Life* story previously described, suggests that any cost shifting should disappear.

The disappearing cost-shifting view has not necessarily been widely held. The Prospective Payment Assessment Commission (ProPAC) argued that the early 1980s, the period analyzed in the early studies, was a period of modest and stable cost shifting. As noted later, it identifies the late 1980s and early 1990s as a period of significant and successful cost shifting (Prospective Payment Assessment Commission, 1995b).

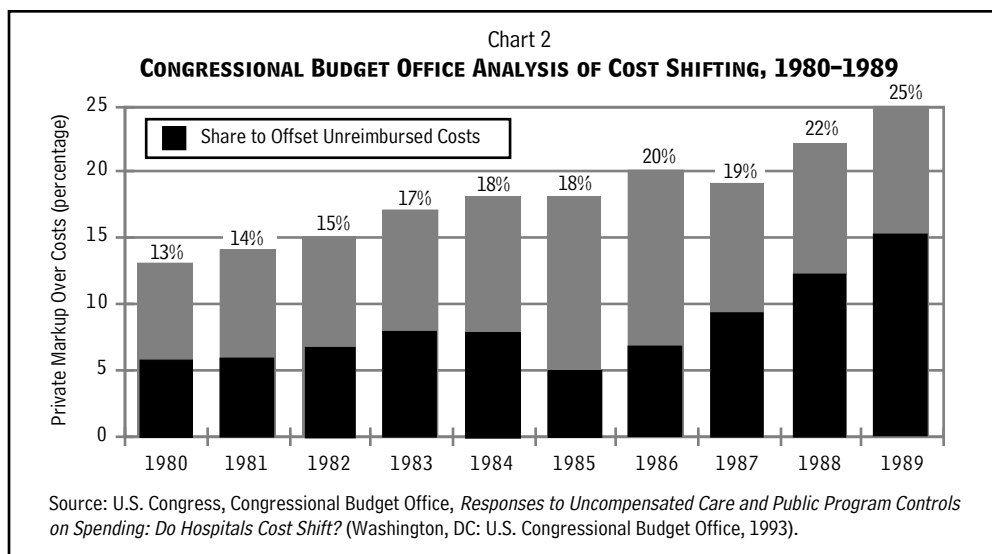
Luckily, there have been a number of empirical studies of cost shifting in the last three years. This research is of three types: industrywide studies, cross-sectional studies, and dynamic studies. The industrywide studies look at aggregates of hospital profitability and revenue-cost

ratios and compare these over time and across

payers. They are the best known of the studies, but they do not test the cost-shifting hypothesis. The cross-sectional studies look at hospital prices or markups. These studies, in principle, can test the cost-shifting claims, but in practice it is difficult to control for hospital- or market-specific factors. They have rightly been accused of yielding statistically biased results. The dynamic studies look at the change in hospital-specific prices and markups. These studies have the best chance of detecting any true cost shifting. The hospital and its market serve as their own controls, and one can directly examine changes in the pricing behavior of specific hospitals. We summarize and briefly critique each set of studies. Interestingly, the findings from each increasingly suggest that cost shifting is not an issue.

Industrywide Studies of Cost Shifting

The best known cost-shifting analyses have come from the Congressional Budget Office (CBO), ProPAC, and Lewin-VHI. They examine both industrywide profit margins and payments to hospitals as a proportion of average hospital costs. During the late 1980s through the early 1990s, they found substantial cost shifting. The CBO analyzed American Hospital Association annual survey data over the period 1980-1989 (U.S. Congressional Budget Office, 1993). They found that Medicare and Medicaid payments, relative to average costs, declined. The markup from private sources increased and, indeed, the share of private payer profits going to pay for uncompensated care increased (chart 2). In 1980, hospital revenue from private payers was 13 percent above estimated costs. By 1989, it had risen to 25 percent above estimated costs. Over the same period,



the share of private profits estimated to have been paid for uncompensated

sated care went from 38.4 percent in 1980 to 60 percent in 1989. From this evidence they argue that hospitals must have raised prices to private payers to make up for the losses incurred from the government payers.

ProPAC concluded that over the 1986-1991 period, cost shifting was a major factor in hospital pricing behavior (Prospective Payment Assessment Commission, 1995a, 1995b). Hospital losses from Medicare and Medicaid rose from 5.9 percent of costs to 11.1 percent. However, overall hospital profit margins remained at about 4.0 percent. ProPAC (and CBO) argue that hospitals necessarily accomplished this by means of raising prices to the private sector. Again, the implication is that hospitals must have raised prices to private payers.

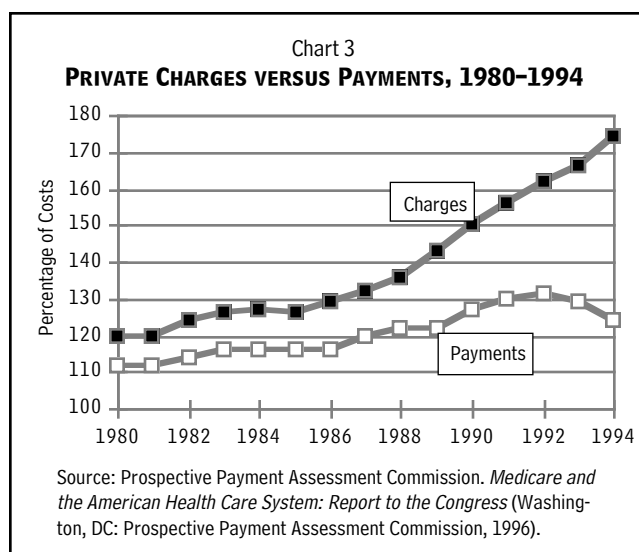
However, ProPAC revisited the cost-shifting issue using data through 1994 (Prospective Payment Assessment Commission, 1996). They now conclude that private payers are increasingly unwilling to pay higher hospital prices. The ratio of private payments to costs dropped from a high of 1.31 percent of costs in 1992 to 1.24 percent in 1994. The 1992-1994 period saw the first decline in the private-sector payment ratio since at least 1980 (chart 3). They also argue that Medicare and Medicaid programs have been aided by these private market changes, because hospital costs have declined. ProPAC neatly summarizes the pricing problems (at least some) hospitals face:

Surprisingly, public major teaching hospitals had among the highest payment-to-cost ratios for private payers, almost 34 percent over the cost of care. But this produced little benefit due to their inability to attract privately insured patients; their private payer share of costs was only half that of the other groups. Private major

teaching hospitals had the converse problem. Their privately insured patient share was the largest of the teaching-related groups, but they apparently had to make substantial pricing concessions to obtain that level of volume. This left their private payer payments only 19 percent above costs (Prospective Payment Assessment Commission, 1996).

Finally, a recent report by Lewin-VHI is typical of the way the industrywide cost-shifting analysis is applied in the policy arena (Sheils and Ricks, 1995). It essentially takes ProPAC analysis and simulates the effects of governmental program changes. Based on ProPAC analysis, Lewin-VHI estimated that, in 1991, 47 percent of hospital uncompensated care and Medicare/Medicaid shortfalls were paid for through cost shifting. By 1992, the share of losses made up by cost shifting had dropped to 40 percent. Lewin-VHI then assumes that cost shifting will continue to drop as a source of revenue from 40 percent in 1994 to 30 percent by 2002. As a consequence, they conclude that proposed reductions in Medicare and Medicaid spending as then proposed in Congress would lead to \$62.5 billion in additional cost shifts between 1996 and 2020. They report additional cost shifting from nonhospital providers as well.

However, there are several problems with industrywide type analyses. First, the methodology doesn't necessarily imply cost shifting; it doesn't establish that private prices actually rose, much less that they rose as a result of losses from other payers. If hospitals had been setting private prices below the profit-maximizing levels, then raising them, as CBO and ProPAC allege, hospitals could maintain their profit margins. However, the same results are also consistent with a hospital that has become more efficient. Mr. Potter's profit-maximizing hospital would respond to a cost-



saving innovation by *lowering* his prices to private payers and *increasing* his profits. George Bailey would also lower his private

prices—and spend the profits on more good works. Such a result is consistent with price discrimination but not necessarily with cost shifting. Indeed, a problem with the CBO-ProPAC analysis is that any such cost-saving behavior is interpreted as an increase in cost shifting.

A more fundamental problem is that the analysis views costs as an average rather than a marginal concept. Hospitals have substantial fixed costs. In the long run, hospitals must cover these fixed costs as well as the extra operational costs associated with caring for additional patients. However, in an industry commonly regarded as having excess capacity and low occupancy, a hospital is better off accepting any price that covers the marginal costs of care rather than refusing a patient. In the absence of these additional patients, the fixed costs continue; in a literal sense there may not be any losses from treating government patients; indeed, these programs are making a contribution to the fixed costs.

Early work by Friedman and Pauly (1983) suggests that short-run marginal costs were only about 50 percent of total costs. Even if they are closer to 75 percent of average costs, the prices paid by Medicare and Medicaid over the period typically covered the marginal costs of care. From this perspective, there were no losses from either Medicare or Medicaid and, therefore, there was no need to cost shift.

A third problem is also methodological. Most studies of cost shifting have no direct evidence of the (marginal) costs of treating patients of different payers. Are Medicaid patients as costly to treat as Medicare or private patients? Most industrywide studies, as well as cross-sectional and dynamic studies, tend to assume that hospital costs per day are equal across payers.² More

²This is based on some empirical work conducted in the early 1980s. See Morrissey (1994) for a review.

Higher prices, in part, reflect more services provided, not necessarily cost shifting, and hospitals can and apparently do respond to lower prices by reducing services and costs—reducing the “need to cost shift.”

sophisticated studies attribute costs in proportion to full billed charges. There is little evidence that such a linkage is reflective of true costs.

A new study by Dor and Farley (1996) addresses this issue. Using 1985-1987 data from 331 hospitals nationwide, they estimate the costs of care by payer, carefully controlling for patient severity and input prices. They found that results differ significantly by payer source. At the mean of the data (and in 1987 dollars), Medicare inpatients cost \$2,006, private inpatients \$1,635, Medicaid \$907, and other inpatients (largely the uninsured) had an average inpatient cost of \$715.

These findings have two important impacts on the cost-shifting debate. First, they suggest that the typical cost basis used in cost-shifting analyses is flawed. If Medicaid patients actually cost much less than other patients, then when the government pays less on their behalf, there are no true losses incurred by a hospital. Analogously, if Medicare patients cost more, then comparisons of Medicare payments to average costs will understate the size of a loss.

Second, the results raise (and answer) basic questions about how hospitals set prices and respond to price changes. Dor and Farley argue that their results demonstrate that hospitals can and do respond to financial incentives and allocate resources accordingly.

They are able to target their resource use on a case-by-case basis, at least within the range of what is clinically acceptable . . . This is entirely consistent with the discharge planning process, which is under the administrative prerogative of hospital professionals assigned to each case.

In short, higher prices, in part, reflect more services provided, not necessarily cost shifting, and hospitals can and apparently do respond to lower prices by reducing services and costs—reducing the “need to cost shift.”

A final critique of the CBO-ProPAC type analy-

sis is raised by Hadley, Zuckerman, and Iezonni (1996) (and implicitly by Dranove and White (1996)). Cost shifting is fundamentally a dynamic issue. Comparing trends is not the same as dynamic analysis. A direct

test of cost shifting would examine how hospitals *changed* their private pricing behavior as a result of a *change* in government payments or other need to cost shift.

Cross-Sectional Studies of Cost Shifting

Cross-sectional studies do test the cost-shifting hypotheses, at least in principle, because they seek to determine whether some measure of private prices are higher among hospitals that receive lower Medicare and/or Medicaid payments than among those that do not. Cost shifting would be said to exist if the former hospitals had higher private prices than did the other hospitals, other things equal. The problem with the cross-sectional work is that it is difficult to separate hospital or market-specific factors from potential cost shifting. The hospitals with the higher private prices, for example, may offer higher quality and amenities for which the study was unable to adequately control.

There have been two cross-sectional studies that bear on the cost-shifting issue. Both tend to refute the notion. Lynk (1995) used 1989 California hospital data to examine the effects of hospital mergers on full billed charges and net prices (i.e., billed charges less discounts) paid by nonMedicaid and nonMedicare payers for 10 common diagnosis related groups. He found that hospitals with larger Medicare and Medicaid shares had lower full billed charges and lower net prices. The paper arguably has some of the best measures of prices found in this literature. However, as Lynk notes, the price measures do have problems. They implicitly have bad debt and charity care embedded in them, and this may have imposed some negative correlation between “private price” and Medicare and Medicaid shares. Lynk also

finds that mergers between investor-owned hospitals were associated with higher prices, while mergers of nonprofit hospitals were associated with lower prices. This has implications for cost shifting because it suggests that pricing behavior is different between nonprofit and for-profit hospitals. Since the theory implies that investor-owned hospitals will never cost shift and nonprofit ones may do so in some circumstances, this finding is relevant.³

A second cross-sectional paper is by Showalter (1995). While this paper does not deal with hospitals, its analysis of physician pricing is instructive. It has been alleged that doctors shift costs; however, there has been virtually no empirical research on the issue.⁴ Showalter examined a national sample of private prices reported by physicians for: (1) an office visit for an established patient, (2) a followup visit in a hospital, and (3) a number of specialty specific services. He found that, controlling for other factors, higher Medicaid payment rates for these same services were associated with higher, not lower, private patient prices. The results, statistically significant for virtually all the services, are wholly inconsistent with cost shifting. They suggest that physicians were setting prices in a fashion consistent with what Mr. Potter would do in the *Wonderful Life* vignette. However, the positive correlation between public and private prices may be the result of other unmeasured factors that confound the analysis.

Dynamic Studies of Cost Shifting

The dynamic approach to cost shifting seeks to examine the change in some measure of private price as a result of a change in government payments or the “need to cost shift.” The strength of this approach is that it uses the hospital as its own control. Thus, many of the differences

that are hard to control for in a cross-sectional analysis wash out because they have not changed at the hospital over time.

There have been two studies of this sort. Hadley, Zuckerman and Iezzoni (1996) used a national sample of AHA and Medicare cost report data on 1,435 community hospitals to examine the effects of financial pressure and competition on the change in hospital revenues, costs, and profitability, among other things, between 1987 and 1989. Their regression model controlled for hospital size, ownership and teaching status, and changes in demand and input costs. The hospital’s profits (i.e., revenues received minus costs) in 1987 served as the measure of the hospital’s financial pressure and, therefore, the need to cost shift. If hospitals cost shift, lower profits should lead to higher revenue growth over the period, controlling for other factors.

They found that financial pressure had statistically significant effects on hospital expense growth, profit rate, use of inputs, and efficiency. Hospitals with smaller profits in the base year increased costs less and increased their efficiency. The least profitable hospitals constrained their growth in total expenses to one-half that for the most profitable hospitals by limiting the growth of their staffs and their total assets.

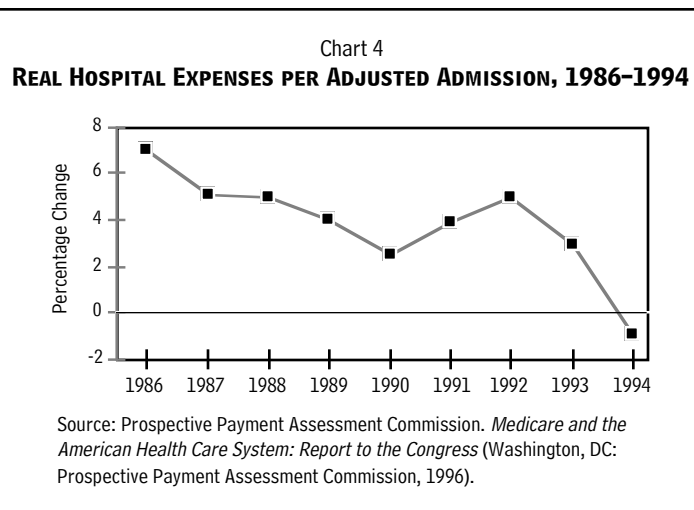
However, there was no statistically significant effect of financial pressure on total revenues. That is, there was no evidence that hospitals were able to increase their revenues as a result of the need to cost shift. As the authors say:

We found no evidence to suggest that cost-shifting strategies that might protect hospital revenues in the face of financial pressure were undertaken successfully. There was no relationship between base year profits and ... revenue growth....

Hadley and colleagues do attempt to measure the effects on prices directly; however, this effort is not completely satisfying. They, and most other researchers, have no clean measure of the transaction prices paid by

³ Dranove and White (1996) note that they too found differences in hospital pricing behavior in 1983, but these differences were not present in 1992. The Dranove-White paper is discussed in the section on dynamic studies.

⁴ Sheils and Ricks’ arguments (1995) are typical of physician cost-shifting allegations. See Morrissey (1994) for a review of the limited early evidence.



privately insured patients. They argue that at least some patients and insurers still pay billed charges.

Indeed, those that do would seem to be the most susceptible to cost shifting. However, to use billed charges, they must adjust for the services provided to each patient. Hadley and colleagues use Medicare data to construct the billed charge that the average case-mix adjusted Medicare patient would have paid had his or her insurer paid billed charges. When they run the regression on the change in case-mix adjusted charges per case, they find that hospitals with higher base year profits increased their charges more. This statistically significant result is the opposite of what traditional cost shifting would lead one to expect. On the face of it, this refutes the cost-shifting hypothesis. However, the synthetic nature of the price makes the story less than fully convincing.

Dranove and White (1996) provide strong evidence against cost shifting from the California market. They examine changes in price/cost margins and services offered between 1983 and 1992. Their principal test of cost shifting is an examination of the effects of Medicaid and Medicare on the price/cost margin. Between 1983 and 1992, Medicaid payments declined from 78 percent of average costs to 59 percent; Medicare payments declined from 91 percent to 83 percent. They argue that, if cost shifting exists, one should observe that hospitals with larger Medicaid and Medicare loads in 1983 increased their overall price/cost margins the most over the ensuing decade. These hospitals, under the cost shifting story, must raise prices to private payers to pay for the cuts in these governmental programs. In fact, they find negative and statistically significant effects of Medicaid and Medicare loads on the price/cost margins. This is wholly inconsistent with cost shifting.

Summary

Thus, the research evidence, while never perfect, strongly suggests that cost shifting is not a serious

issue, at least in the mid-1990s.

Industrywide studies of aggregates have re-

cently found that price/cost ratios of private payers have been declining. Cross-sectional studies have failed to find evidence of cost shifting. The dynamic studies don't find hospital cost shifting. Thus, I conclude that cost shifting is a nonissue.

The Alternative

If hospitals are unable to deal with lower Medicare and Medicaid payments by

cost shifting, what can they do? They do what firms in other industries do: they cut costs and reduce output—particularly to those who pay less. Hospitals have indeed been cutting costs (chart 4). The rate of increase in inflation-adjusted hospital expenses per adjusted admission (adjusted for outpatient volume) has been declining, for the most part, since the mid-1980s. In 1994, the most recent year for which data are available, hospital costs actually declined in real terms.

The previously discussed Hadley, Zuckerman, and Iezzoni study (1996) suggests that much of this cost-reducing behavior was going on even early in the period. They examined changes in costs and input use between 1987 and 1989 and found that the least profitable hospitals in 1987 constrained their growth in total costs to one-half that of the most profitable hospitals. They accomplished this by limiting the growth of their staffs and their total assets to rates significantly below those of the most profitable (base year) hospitals. The hospitals that were least profitable in 1987 improved their efficiency by over 11 percent, compared with a slight reduction in efficiency by the most profitable hospitals.

Zwanziger et al. (1994) found that California hospitals in more competitive markets (over the 1982-1988 period) had inflation-adjusted rates of cost increases that were 17 percent below those in less competitive areas.

The Dranove and White (1996) California study also found cost-cutting behavior among hospitals faced with more competition. They found that a high Medicaid hospital (one that had a MediCal caseload that was two standard deviations above the mean in 1983) reduced services per admission to Medicaid patients by about 9 percent more than did the average hospital. Indeed, they conclude that these reductions in services were enough to offset the reductions in revenues from Medicaid.^{5,6}

One might also expect that, when public or private payers reduce their payment levels, hospitals respond by reducing the level of uncompensated care they provide. If George Bailey generates less profit from various paying patients, he has less profit and can't do as many good works. Recent empirical literature supports this view. Campbell and Ahern (1993) examine the amount of bad debt and charity care provided by California hospitals over the 1983-1987 period. They find that increases in contractual adjustments (i.e., discounts) reduced the amount of uncompensated care provided by hospitals. Furthermore, all types of nonprofit hospitals reduced the amount of uncompensated care provided when their profit margins declined.

Jonathan Gruber (1994) examined the effects of hospital profitability on the provision of uncompensated care. He examined the 1984-1988 period. Controlling for other factors in a detailed multi-equation econometric model, Gruber finds that lower hospital profits resulted in less uncompensated care being provided. A 1 percent

reduction in hospital net income led to a 0.43 percent reduction in the amount of uncompensated care. Gruber also notes that his estimate is statistically no different from 1.0—suggesting that the true effect of reduced hospital net income could be a dollar for dollar reduction in uncompensated care. He also finds that much of this reduction takes place in the outpatient setting.

Price Competition

Cost shifting can only exist when providers have market power. In the earlier Issue Brief

(Morrisey, 1993) we summarized the evidence that price competition in the hospital market was increasing. Managed care firms were able to negotiate lower prices with hospitals based on traditional sorts of market factors: multiple hospitals in the market and available excess capacity. HMOs were found to enter into contracts with hospitals based on some measures of quality. The volume of admissions went to those contracted hospitals that had lower prices. We won't revisit those studies. However, there has been recent research on the effects of hospital competition on hospital prices.

Hadley, Zuckerman, and Iezzoni (1996) examined changes in hospital revenues, costs, and profits between 1987 and 1989. They used several alternative measures of the hospital market. In every case, they found that hospitals in more competitive markets had smaller increases in expenses, smaller increases in staff and assets, smaller increases in revenues, and lower profit rates. Hospitals in highly competitive markets controlled their expenses but not by enough to offset their lower revenue growth. This led to a substantial relative decrease in profits among hospitals in highly competitive areas.

Brooks, Wong, and Dor (1996) examined the

⁵ It is also worth noting that, in their study, hospitals with a base-year one Medicaid load that was one standard deviation higher than average were nearly nine times more likely to have closed by 1992 than was the average hospital.

⁶ There is earlier evidence as well that hospitals have cut back on services to Medicaid recipients as a result of lower payment levels. See Morrissey (1994) for a review.

payments made by over 760 self-insured firms for appendectomies. Using 1988–1992 data from 10 states for this single set of inpatient clinical services, they found that firms in communities with less hospital concentration, i.e., more competition, paid lower prices. The study also found that hospital prices declined over time, suggesting that the market power of hospitals was eroding.

Competition is also having an impact in the managed care market. Wholey, Feldman, and Christianson (1995) examined the effects of both greater market penetration by HMOs and a larger number of HMOs in a market, given their combined market share. Using 1988 and 1991 HMO premiums, they conclude that higher penetration rates were associated with lower HMO premiums. More HMOs in the market was associated with still lower premiums, particularly among staff/group model HMOs. **Care should be taken in considering the effects of competition in the managed care market. Competition among managed care firms should drive their premiums down to marginal costs. This increased price competition may spill over to the indemnity side of the market. However, increased managed care penetration may increase the premiums for traditional insurers if they tend to disproportionately retain the subscribers with the poorest health status. When these individuals are no longer subsidized by healthier members of the insurance pool, the premiums associated with their utilization will rise.**

Conclusion

The evidence is increasingly clear. Whether or not hospital cost shifting existed in earlier periods, the recent literature suggests that it is not a major policy issue today. Cost shifting appears to have died, killed off

by new forms of insurance, price competition among hospitals, and greater cost consciousness in health care.

This suggests that any programmatic changes that are in the offing for Medicare and Medicaid will have only minor effects on private payers. I believe that reductions in the amounts that government programs pay for health care will not lead to higher prices for employers. However, we should expect that such reductions will affect the elderly and the poor. Some hospitals will drop out of the Medicaid program in the face of cuts in payments; some may even drop out of Medicare.

Care for the uninsured will become a more explicit issue as well. Because hospitals are now in price competitive environments, they will no longer get the large profits they once enjoyed. The George Bailey hospitals of the world will no longer have the profits to spend on the uninsured. This will draw attention to the meaning of distinctions between investor-owned and nonprofit hospitals. It will draw attention to the role of public hospitals, to the potential for health vouchers for the poor, and more generally, to a discussion of what role, if any, society will play in caring for the uninsured.

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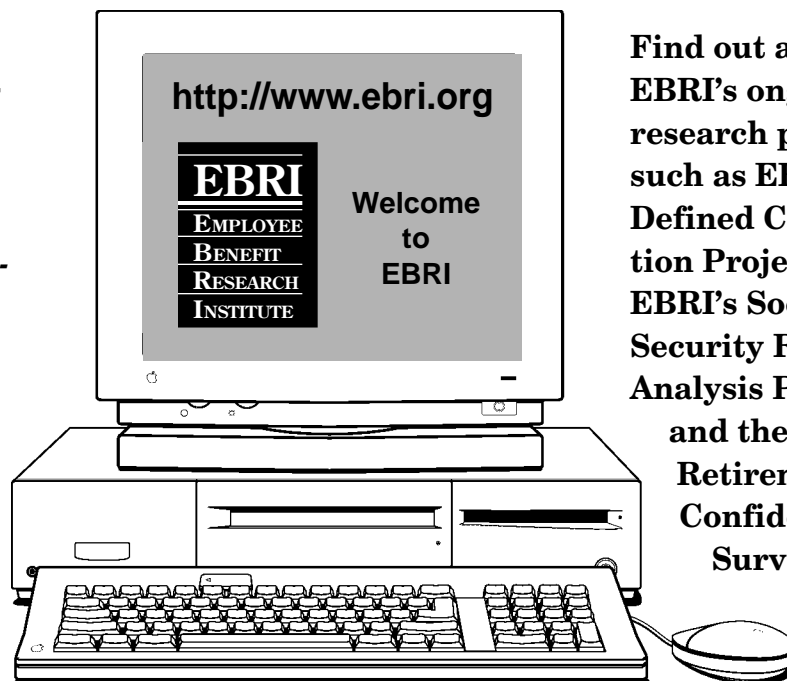
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