Cost shifting or revenue shifting?

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Common concerns

- Price of private insurance continues to rise
- Part of the reason is increasing hospital prices
  - Health Care Cost Institute reports consistent price growth
  - Prices charged by hospitals rising faster than input prices
- General agreement that hospitals with more market power have higher prices
  - Academic studies of market power
    - Horizontal integration leads to higher prices
    - Limited success slowing integration
    - No efforts to roll back integration
- When will hospitals use their market power?

Why do hospital losses on Medicare patients and private-payer prices go up in tandem?

- Cost shift hypothesis: Hospitals only use their market power when forced to meet rising costs
  - Hospital's input costs are outside of the hospital's control
  - Medicare/Medicaid rates are below costs and force up private prices
  - Conclusion: Medicare losses cause high private prices
- Revenue shift hypothesis: Hospitals will use market power to increase revenue beyond minimum needed for operations (Stensland, Health Affairs 2010)
  - Costs are not fixed
  - Higher revenue leads to higher input costs per unit of output
  - High private profits cause higher hospital spending per case
  - Conclusion: Higher private prices cause losses on Medicare patients
- A middle path is also possible

Graphic of two hypotheses

Cost shift

Revenue shift / Price discrimination

The inverse relationship between commercial margins and Medicare margins fits both stories

- Medicare paid about 94% of hospitals' costs on average during 2021
  - Some hospitals make money on Medicare
  - Most hospitals lose money on Medicare
- Private insurers pay prices that are over 150 percent of hospitals' costs per case on average
- On average, some private-payer revenue pays for Medicare patients

Two tests of the conflicting hypotheses

	Conflicting implications of the two hypotheses	
Questions to test	Cost-shift hypothesis	Revenue-shift hypothesis
Are costs exogenous or do they vary with hospitals' revenue?	Costs are exogenous (Wealthy hospitals will not have higher costs)	Wealthy hospitals will have higher costs
Which hospitals will be under the most financial strain?	Hospitals with high costs and lower Medicare margins will have lowest all-payer margins	Hospitals under financial pressure have lower cost. So low-cost hospitals with higher Medicare margins will have low all-payer margins

Conclusion 1: costs vary with pressure

	Hospitals' standardized 2019 inpatient costs as a share of the national average	
	Low-pressure hospitals (Non-Medicare margin over 5%)	High-pressure hospitals (non-Medicare margin under 1%)
Non-profit	106%	97%
For-profit	96%	88%

High-pressure hospitals had a median non-Medicare margin of less than 1% from 2014 through 2018. In addition, high pressure hospitals would have had equity growth of less than 1% if Medicare profits were zero. Low-pressure hospitals had non-Medicare margins were above 5% suggesting high profits on commercial payers. We examine 2019 data to avoid issues with the pandemic costs and payments.

Conclusion 2: High-cost hospitals tend to be in better overall financial shape

2019 Median values	Low-pressure hospitals (n=1,329)	High-pressure hospitals (n=480)
Non-Medicare Margin	14%	-3%
Standardized costs as a share of the national median	104%	95%
Medicare profit margin (Before relief funds)	-11%	0%
Total (all payer) margin	14%	-2%

Cost-shift/Revenue Shift literature

When Medicare policy changes, do hospitals in markets with low Medicare payment rate growth have below average or above average commercial rate growth?

- Vivian Wu, 2009: 21% of the BBA cuts could be transferred to private payers through higher prices (1996 to 2000 data)
- Austin Frakt, 2011 literature review: A $1 cut in Medicare prices leads to at most a $0.21 increase in private prices
- Chapin White, 2012: Lower Medicare prices lead to lower private prices– opposite of a cost shift (1995 to 2009 data)
- Zack Cooper, 2017: Increased Medicare payments via 508 wage index changes resulted in higher hospital costs.
- General agreement: Lower Medicare rates primarily result in lower hospital costs. Effect on commercial rates is small.

Can hospitals still provide high quality care while keeping costs down to Medicare rates?

MedPAC looks for relatively efficient providers

- Must be in the best third on either risk-adjusted mortality **or** inpatient costs per case **every** year (2017, 2018, 2019), and
- Cannot be in the worst third in **any** year for risk-adjusted mortality, readmission rates, or costs per case

Comparing 2021 performance of relatively efficient hospitals to others

Measure	Relatively efficient hospitals	Other hospitals
Number of hospitals	284	1,672
30-day mortality	11% lower	1% above
Readmission rates (3M)	7% lower	2% above
Standardized costs	10% lower	3% above
Share of patients rating the hospital highly	71%	68%
Overall Medicare margin (excluding relief funds)	0%	-7%
Total margin	11%	9%

Note: medians for each group are compared to the national median
Source: Medicare cost reports and claims data

Conclusions

- Hospitals under financial pressure constrain their input costs
- In contrast, hospitals with strong market power may be under less pressure, have higher non-Medicare profits, and have higher costs
- Higher costs can lead to losses on Medicare patients