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By Chapin White

Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates

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ABSTRACT Many policy makers believe that when Medicare constrains its payment rates for hospital inpatient care, private insurers end up paying higher rates as a result. I tested this “cost-shifting” theory using a unique new data set that combines MarketScan private claims data with Medicare hospital cost reports. Contrary to the theory, I found that hospital markets with relatively slow growth in Medicare inpatient hospital payment rates also had relatively slow growth in private hospital payment rates during 1995–2009. Using regression analyses, I found that a 10 percent reduction in Medicare payment rates led to an estimated reduction in private payment rates of 3 percent or 8 percent, depending on the statistical model used. These payment rate spillovers may reflect an effort by hospitals to rein in their operating costs in the face of lower Medicare payment rates. Alternatively, hospitals facing cuts in Medicare payment rates may also cut the payment rates they seek from private payers to attract more privately insured patients. My findings indicate that repealing cuts in Medicare payment rates would not slow the growth in spending on hospital care by private insurers and would in fact be likely to accelerate the growth in private insurers’ costs and premiums.

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For many decades the rates used by private insurers for hospital care have exceeded those used by Medicare, and in recent years the gap between these two sets of payment rates has widened. There are two possible explanations for this gap. The first is that Medicare, by setting its payment rates relatively low, is forcing hospitals to charge high payment rates to private insurers in order to keep revenues up—a process known as dynamic cost shifting. The second explanation is that private payment rates are higher, and are rising faster, than Medicare’s rates because of other factors, such as hospitals’ gaining negotiating leverage over health plans and using it to demand higher payment rates from them.

The Affordable Care Act permanently slows the

growth in Medicare payment rates for hospital care, and the Budget Control Act of 2011 will slow it further. In this policy context, it is crucial to test the dynamic cost-shifting theory and the “other factors” theory.

The first theory implies that slowing growth in Medicare payment rates shifts the burden of financing hospitals onto private payers without necessarily reducing total spending on hospital care. It also implies that subsequent premium pressures on the privately insured could be alleviated by increasing Medicare payment rates. The “other factors” theory implies that to slow the growth in private premiums, it is necessary to identify and address those other factors, instead of repealing the Affordable Care Act’s payment rate cuts in the hope of an indirect and costly solution.

Although this topic has been researched extensively, it is still unclear whether or how changes in Medicare hospital payment rates affect private payment rates.¹ Obtaining conclusive evidence has been stymied by various factors. First, the gap between Medicare and private payment rates is sometimes mistakenly treated as proof that low Medicare payment rates are causing higher private rates.²

Second, some studies simply assume that hospitals' costs are fixed and that any reduction in Medicare payment rates automatically results in an increase in private insurers' payment rates.³ This fixed-cost notion lives on, despite decades of research showing very clearly that hospitals respond to a reduction in Medicare payment rates by reducing their overall costs.^{4,5}

Other cost-shifting studies have measured payment rates using profit margins, or the excess of revenues over costs incurred as a share of revenues. These margins-based analyses miss a key point: If hospitals lower their operating costs, margins will appear to increase even if actual private revenues stay the same, thus producing spurious evidence of dynamic cost shifting. As the Medicare Payment Advisory Commission has observed, hospitals that are able to command high payment rates from private insurers will increase their costs, which will drive down their Medicare margin.^{6,7}

Third, data on private payment rates are not widely available, are expensive to purchase, and are released only to researchers with restrictions on how they may be used. Researchers have developed proxies for private payment rates using publicly available data, but they are imprecise at best.⁸

Fourth, many cost-shifting studies have measured payment rate changes over periods of five years or less, some as short as two years. Analyzing payment rates over very short periods is inadequate because private insurers and hospitals typically negotiate multiyear contracts.

Fifth, Medicare payment rates change for many reasons, some reflecting market conditions that also probably affect private insurers, such as nurses' wages, and others that are specific to Medicare, such as the Medicare add-on payments for indirect medical education, which supports physician training programs. Isolating the idiosyncratic components of changes in Medicare payment rates is difficult, but it is important for identifying a causal link between Medicare payment rates and private payment rates.

Finally, because of data limitations, many cost-shifting studies have been based on single states, small surveys, or convenience samples.

This study attempted to overcome these limi-

tations, testing the dynamic cost-shifting theory by using a very large discharge-level database to measure case-mix-adjusted private payment rates. It also used a long (fifteen-year) panel; isolated formula-driven idiosyncratic changes in Medicare payment rates, such as changes in the formula for indirect medical education payments; and included payment rate data for hospitals in every part of the country.

Although this study is a step forward in the "cost-shifting" literature, it was not designed to address certain important questions, such as whether changes in Medicare payment rates affect the volume of hospital services received by Medicare beneficiaries.

Study Data And Methodology

To study hospital pricing behavior, I first measured Medicare and private payment rates for inpatient hospital care in different hospital markets for each year in the period 1995–2009. Next, I identified markets with high versus low rates of growth in Medicare payment rates and compared trends in private payment rates among those different types of markets.

The national Medicare payment methodology for acute care hospitals includes a number of geographical and hospital-specific adjustments that result in different hospitals' receiving different Medicare payment rates for the same service. Furthermore, changes in that methodology have had different effects on hospitals in different markets, and as a result growth in Medicare payment rates has varied across markets.

According to the dynamic cost-shifting theory, markets with relatively slow growth in Medicare payment rates should exhibit relatively fast growth in private payment rates, and vice versa. I tested that prediction; the results appear below.

Most prior cost-shifting studies analyzed data at the hospital level. In contrast, I measured payment rates and performed my analyses at the market level, with the markets being the *Dartmouth Atlas's* 306 Hospital Referral Regions.⁹ These regions are groupings of ZIP codes clustered around tertiary care hospitals.

I took a market-based approach by necessity. Truven Health Analytics, the source of the data I used, does not permit its MarketScan database¹⁰ to be used to measure hospital-specific payment rates, and other vendors of private claims data apply similar restrictions. The market-level analysis is not necessarily a problem and in fact may be an advantage, because what matters to private insurers is how changes in Medicare payment rates affect their payment rates for an insured population living in a given market.

The main challenge in this analysis was to ap-

appropriately account for factors that affected both Medicare and private payment rates and could create a noncausal positive association between the two. To address that challenge, I measured and accounted for trends in hospital input prices, such as nurses' wages, that would be expected to affect both Medicare and private payment rates. I also performed two-stage least squares regressions that isolated legislative changes, such as adjustments to the Medicare disproportionate-share hospital payment formula, that directly affect only Medicare payment rates. Data sources and methods are described in more detail in the online Appendix.¹¹

PRIVATE PAYMENT RATES Private payment rates were calculated from inpatient hospital claims in the Truven Health Analytics MarketScan Commercial Database,¹⁰ a widely used database that includes enrollees in self-funded employer plans that have data-sharing agreements with Truven Health. Payment rates represent allowed amounts—that is, the amount actually paid, not billed charges—and include insurers' payments and patients' out-of-pocket payments. To account for differential changes in case-mix among markets, private payment rates were adjusted using diagnosis-related groups.

After I excluded Medicare enrollees, health maintenance organization enrollees, and anyone over age sixty-five, there were 6.5 million inpatient claims in the MarketScan database. About 15 percent of the hospital markets were excluded from the regressions because they did not include at least twenty claims in every year of the study period. The final data set consisted of 6.3 million inpatient claims from 257 markets.

MEDICARE PAYMENT RATES I used Medicare hospital cost reports to measure discharges and revenues for Medicare-covered stays in each hospital and year. To calculate Medicare payment rates at the market level, I allocated discharges and revenues from hospitals to markets using a year-specific weighted crosswalk.

REGRESSIONS In the regressions the natural logarithm of the private payment rate was the dependent variable, and the natural logarithm of the Medicare payment rate was the key independent variable. This "log-log" specification produced coefficients that can be interpreted as elasticities, or the percentage change in one economic variable that results from a percentage change in another. For example, a coefficient of 0.5 on the logged Medicare payment rate would imply that a 1.0 percent decrease in the Medicare payment rate was associated with a 0.5 percent decrease in the private rate.

The regressions included dummy variables, or "fixed effects," for each market to capture permanent differences among markets. There were

also dummy variables for each combination of census division and year to control, in a flexible way, for payment rate trends that were specific to each division.

Additional control variables were the percentages of nonprofit, for-profit, and government hospitals in the market; poverty and unemployment rates; and hospital market concentration.

INSTRUMENTS FOR CHANGES IN THE MEDICARE PAYMENT RATE In my two-stage least squares regressions, I used four instruments that isolated changes in specific elements of the Medicare payment formula. Each of the instruments measured the simulated cumulative effects of changes in specific elements of the Medicare payment formula, while holding constant each hospital's patient population, operating costs, and practice patterns. This general approach has been widely used to measure changes in Medicare payment rates and analyze their effects.⁵

ALTERNATIVE SPECIFICATIONS To test the robustness of the main regression results, I performed a number of alternative specifications. Details about them are reported in the Appendix.¹¹

LIMITATIONS The analysis had two major limitations. The first stemmed from the nature of the MarketScan database, which included only claims from employer plans that voluntarily contributed their data. The database was not designed to be nationally or locally representative of all privately insured people, and the number of claims included varied during the study period. However, in an attempt to minimize this weakness, I included market fixed effects and flexible time trends in the panel data analysis. I was also restricted in how I could use MarketScan to measure payment rates, and I was not permitted to use the data to measure hospital-level payment rates, as noted above.

The second limitation was the possibility that trends in Medicare payment rates were driven by some unidentified factor that was not accounted for in the analysis and that was also driving trends in private payment rates. The regression analyses accounted for obvious factors, such as trends in hospital input payment rates.

However, it was difficult, if not impossible, to account for all possible factors. For example, geographically isolated hospitals might have pricing power that they have increasingly used to demand high payment rates from private insurers, and they might have been unusually successful in pressing Congress for changes in the Medicare payment formula that benefited them. I cannot rule out such a possibility, but the robustness of the findings to the many different alternative specifications suggests that I identified the main factors of interest.

Study Results

THE GROWING MEDICARE-PRIVATE GAP IN PAYMENT RATES The payment rate data showed a large and growing gap between private and Medicare payment rates. In 1995 the average Medicare payment rate per discharge was \$7,249, while the average private rate was \$10,504, a gap of 45 percent (Exhibit 1). That gap was not adjusted for case-mix and therefore is almost certainly understated.¹² In 2009 the average Medicare payment rate was \$11,031, while the average private rate was \$17,286—a gap of 57 percent (data not shown).

During the study period the average annual growth rate was 3.00 percent for Medicare payment rates and 3.56 percent for private rates (Exhibit 1). That difference of just over half a percentage point per year may sound small, but the cumulative effect, in terms of total spending on the privately insured, is quite large.

Growth in Medicare payment rates varied geographically. The average annual rate of growth in Medicare payment rates in the markets with the highest growth rate was 1.20 percentage points higher than that in the markets with the lowest

growth rate (Exhibit 1). Slow-growth markets were more likely to be urban, have teaching hospitals with large numbers of medical residents, and be on the East Coast, compared to markets with faster growth rates.

The general trend has been toward convergence: The areas with the highest Medicare payment rates in 1995 tended to have the slowest growth during the study period, and the areas with the lowest payment rates in 1995 tended to have the fastest growth.

About one-third of the 1.20 percentage point difference between the tertiles with the lowest and highest growth rates was explained by changes in the Medicare payment formula. For example, add-on payments for indirect medical education have been trimmed over time; as a result, payment rates in areas with greater concentrations of teaching hospitals grew more slowly than payment rates in other areas.

Similarly, many small hospitals operating in remote areas have been designated as “critical access” hospitals. They are eligible for cost-based reimbursement, which has tended to boost growth in Medicare payment rates in rural areas.

EXHIBIT 1

Hospital And Region Characteristics And Medicare And Private Insurers’ Payment Rates, 1995–2009

	All markets	Markets whose annual Medicare payment rate growth rate was:		
		Low	Medium	High
PAYMENT RATE				
Medicare payment rate, 1995	\$7,249	\$7,643	\$7,420	\$6,696
Annual growth in Medicare payment rate, 1995–2009	3.00%	2.43%	2.95%	3.63%
Private payment rate, 1995	\$10,504	\$10,960	\$10,487	\$10,083
Annual growth in private payment rate, 1995–2009	3.56%	3.04%	3.46%	4.15%
Formula-driven annual growth in Medicare payment rate, 1995–2009	2.00%	1.84%	1.94%	2.21%
Annual change in hospital input price index, 1995–2009	0.12%	-0.06%	0.06%	0.36%
HOSPITAL CHARACTERISTICS (2009, WEIGHTED BY MEDICARE ADMISSIONS)				
Teaching (residents per average daily patient census)	0.15	0.18	0.16	0.11
Ownership (%)				
For-profit	15.5	16.0	16.9	13.5
Government	13.4	9.4	14.5	16.3
POPULATION CHARACTERISTICS (%)				
Urban (2000)	79.0	85.4	80.3	71.5
Poverty ^a (2009)	13.4	12.8	13.4	14.0
THOUSANDS OF INPATIENT ADMISSIONS USED TO CALCULATE PAYMENT RATES				
Private				
1995	263	79	97	87
2009	765	244	289	232
Medicare				
1995	9,536	3,308	3,097	3,132
2009	10,199	3,532	3,388	3,279

SOURCE Author’s calculations based on Truven Health Analytics MarketScan® Commercial Database (copyright © 2011 Truven Health Analytics, all rights reserved; see Note 10 in text) and Medicare hospital cost reports. **NOTES** The study included hospitals in 257 markets. The markets were divided into three groups, roughly equally populated, based on average annual growth rate in Medicare payment rates. Payment rate is payment per discharge. Annual growth is the average growth rate over the period 1995–2009. Change is average annual change. The hospital input price index reflects the adjustment for local hospital wages. ^aPeople in households with annual incomes below 100 percent of the federal poverty level.

Another third of the 1.20-percentage-point difference was explained by local differences in trends in wages for nurses and other staff. The remaining third was explained by differences in trends in case-mix; hospital characteristics, such as teaching status; and patient characteristics, such as the proportion of patients with low incomes.

These descriptive analyses led to two conclusions. First, given the role that trends in input payment rates played in explaining differences in Medicare payment rate growth, it was clear that I needed to include the input price index—that is, a measure of prices that hospitals pay for nurse labor and other inputs used to produce hospital care—as a control in the regression models.

Second, the formula-driven changes in Medicare payment rates differed substantially across markets and accounted for a sizable share of the overall variation in payment rate growth. It appeared possible, therefore, to use those elements of the payment formula to predict Medicare payment rate growth in a two-stage least squares model. The results of that model are reported below.

A GRAPHICAL TEST OF THE DYNAMIC COST-SHIFTING THEORY I measured the average annual rate of growth in Medicare payment rates and private rates (both adjusted for input prices) for each hospital market during the study period (Exhibit 2). Contrary to the dynamic cost-shifting theory, I found that the markets with the slowest growth in Medicare payment rates tended also to have the slowest growth in private rates. In addition, the markets with the fastest growth in Medicare payment rates tended to have the fastest growth in private rates.

For example, Philadelphia exhibited relatively slow growth in both Medicare and private payment rates (1.9 percent annually and 2.7 percent annually, respectively), while Binghamton, New York, exhibited relatively fast growth in both Medicare and private payment rates (4.2 percent annually and 5.9 percent annually, respectively). See the Appendix for full results by market.¹¹

The wide dispersion in private payment rate growth makes it clear that many other factors besides Medicare payment rates are in play. But on the whole, the association between Medicare and private payment rate growth is positive.

REGRESSION-BASED TESTS OF DYNAMIC COST SHIFTING The regression models measured the elasticity of the private payment rate with respect to the Medicare payment rate. In other words, if Medicare payment rates were reduced by X percent, by what percent would private payment rates change? In the ordinary least squares model, the estimated elasticity was 0.311, mean-

ing that a 10 percent reduction in the Medicare payment rate was associated with a 3.11 percent reduction in the private rate (Exhibit 3). In the two-stage least squares analysis, the estimated elasticity was 0.773, meaning that a 10 percent reduction in the Medicare payment rate was associated with a 7.73 percent reduction in the private rate.¹³

The coefficients on the control variables suggested that growth in the market share of government-owned hospitals was associated with slower growth in private payment rates, but this relationship was not significant. Similarly, based on the point estimates, increases in hospital market concentration were associated with faster growth in private payment rates, but this relationship was not significant.

The one control variable that was strongly associated with trends in private payment rates was the share of the population in poverty, which was strongly associated with increases in private hospital payment rates. That result was surprising: Private hospital payment rates would be expected to grow relatively slowly in areas with rising poverty rates. The link between poverty and private hospital payment rates could be because Medicare payment rates tend to increase with the poverty rate (as a result of disproportionate-share hospital payments), and increases in Medicare payment rates appear to lead to increases in private rates.

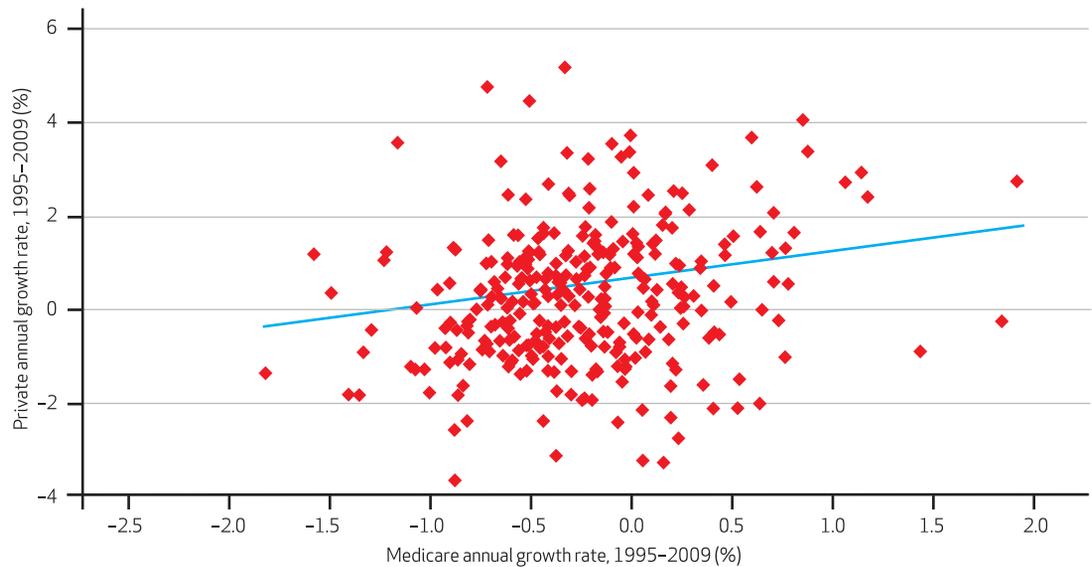
Additional results are shown in the Appendix.¹¹ They generally support the validity and robustness of the main estimates of the effect of Medicare payment rates on private rates.

TWO MODELS OF HOSPITAL PRICING BEHAVIOR Prior cost-shifting studies have offered two competing models to explain hospital pricing behavior: the mixed-motives model and the maximizing-margins model. In the mixed-motives model, dynamic cost shifting might occur, but only under very limited conditions.¹⁴ Those conditions are that hospitals must be seeking to increase volume, must have negotiating leverage over private insurers, and—prior to cuts in Medicare payment rates—must be charging private insurers payment rates below the level that would maximize profits so as to boost private volume. Under these conditions, hospitals facing Medicare cuts might choose, because of their weakened financial condition, to raise private payment rates and give up some private volume.

My results clearly support the maximizing-margins model instead, which differs from the mixed-motives model in one key respect: It assumes that hospitals maximize the profit margins earned on privately insured patients, in that they do not boost private volume by intentionally setting payment rates below the profit-maximiz-

EXHIBIT 2

Annual Payment Rate Growth Rates Per Discharge For Medicare And Private Insurers, Adjusted For Input Costs, 1995–2009



SOURCE Author’s calculations based on Truven Health Analytics MarketScan® Commercial Database (copyright © 2011 Truven Health Analytics, all rights reserved; see Note 10 in text) and Medicare hospital cost reports. **NOTES** Each diamond represents a Hospital Referral Region (see Note 9 in text). The blue line represents the slope (0.49; $p < 0.01$; $R^2 = 0.033$) from a population-weighted regression of changes in private insurers’ payment rates on changes in Medicare payment rates, both adjusted for changes in hospitals’ input payment rates during 1995–2009. Complete findings for all Hospital Referral Regions are available in the online Appendix (Note 11 in text).

ing level (see the Appendix for a graphical illustration of the maximizing-margins model).¹¹ This model predicts that a cut in Medicare payment rates will lead to a reduction in private rates, a reduction in total hospital admissions, and an increase in the number of private admissions.

Intuitively, when Medicare cuts its payment rates, Medicare patients become relatively less financially attractive, and private patients be-

come relatively more financially attractive. Hospitals then seek to increase private volume, and the way to do that is by lowering the private payment rate.

The maximizing-margins model fits well with my findings, but it would be premature to embrace it as fact. Researchers have not yet tested whether hospitals actually manage to boost private volume by lowering private payment rates following Medicare rate cuts.

EXHIBIT 3

Estimated Effect On Private Payment Rates Of A 10 Percent Reduction In The Medicare Payment Rate

	Model	
	Ordinary least squares	Two-stage least squares
Dependent variable	Private payment rate (logged)	Private payment rate (logged)
Unit of observation	Market-year (1995–2009)	Market-year (1995–2009)
Estimated effect (standard error)	-3.11%*** (1.07)	-7.73%*** (2.33)
R squared	0.027	0.012
Number of observations (market-years)	3,855	3,855
Sum of weights (number of claims used to calculate private payment rates)	6,256,500	6,256,500

SOURCE Author’s calculations based on Truven Health Analytics MarketScan® Commercial Database (copyright © 2011 Truven Health Analytics, all rights reserved; see Note 10 in text) and Medicare hospital cost reports. **NOTES** Estimated effects were based on panel data regressions that included Hospital Referral Region (see Note 9 in text) fixed effects, census division year fixed effects, and other market controls. Estimated coefficients, including first-stage coefficients, are shown in the online Appendix (see Note 11 in text). *** $p < 0.01$

Discussion

I found that a reduction in Medicare payment rate growth led to a spillover reduction in private rates. This result raises two important questions. First, can it be reconciled with previous research claiming to find evidence of dynamic cost shifting, in which cuts to Medicare payment rates seemingly resulted in higher private rates? Second, what are the mechanisms by which changes in Medicare payment rates might move private rates in the same direction?

Four well-known articles have reported evidence of dynamic cost shifting.^{7,15-17} Notably, each of these articles either measured private payment rates using markups—the difference between the cost of producing a good or service and its selling price—or included hospitals' operating costs per discharge as a control variable. The payment rates considered in those articles, therefore, were measured relative to the resources that hospitals expended on patient care, including labor costs, equipment purchases, and interest payments. If hospitals expended fewer resources, then the payment rate, as measured in these articles, would appear to rise even if the actual transaction amount per discharge did not change.

I took a conceptually different approach, controlling for input prices but not for the level of resources that hospitals chose to expend. The difference in approach could explain the difference in findings. Reductions in the Medicare payment rate have been shown to lead to a reduction in input intensity.¹⁸ In that situation, private payment rates measured relative to operating costs would appear to rise even if there was no change in private insurers' actual payment rates.

The difference in methodology reflects a difference in how to think about hospital output. If the metric of hospital output is the amount of resources spent by the hospital, then it makes sense to measure payment rates relative to the resources used. But that approach embodies a very old-fashioned notion: Everything that hospitals do is valuable, and it is appropriate to reimburse hospitals for whatever resources they expend.

From the perspective of a person paying premiums or a private insurer monitoring its balance sheet, however, the relevant metric of hospital output is the set of treatments provided during a hospital stay. Therefore, the relevant payment rate is the amount paid for that discharge. That perspective is the one embedded in my approach.

The mechanisms by which changes in Medicare payment rates spill over to private rates probably differ, depending on how the private

insurer pays the hospital. Private health plans pay for inpatient hospital care using a mixture of three methods. Some payments are based on discharges adjusted for diagnosis-related groups, some are based on daily rates (per diems), and some are based on discounted charges.¹⁹

For private plans using diagnosis-related groups to set payment rates, the spillover mechanism is fairly clear. In some systems based on diagnosis-related groups, private payment rates are set as a multiple of Medicare payment rates,²⁰ which means that a change in Medicare rates will have a direct, proportional effect on private rates. In other systems, private payment rates are not set as a multiple of the Medicare rate but still incorporate some elements from Medicare, such as local wage indexes and inflation adjustments.²⁰

For plans using daily rates or discounted charges, the payment rate spillover mechanisms are less obvious. A close examination of the contracts between private plans and hospitals could clarify the nature of these mechanisms, but those contracts are closely held trade secrets. One possible mechanism is that hospitals might be limiting their operating costs in response to constraints on Medicare payment rates.

Cuts in Medicare payment rates have been shown to both reduce length-of-stay for Medicare and non-Medicare patients²¹ and to reduce treatment intensity.²² For private plans that use daily rates, any drop in length-of-stay will reduce the payment rate per discharge. Similarly, for private plans that use discounted charges, any reduction in length-of-stay or treatment intensity more generally will reduce the payment rate per discharge.

Another possible mechanism is that pricing by private insurers might be based on markups, meaning that payment rates are set so that they are equal to a multiple of hospitals' costs. Private plans have been reported to take hospitals' costs into account when negotiating discounts.²³ If an insurer negotiates payment rates with a target markup in mind, then anything that reduces hospitals' operating costs will reduce the payment rate that the insurer pays. The impact of markup-based pricing on private rates would probably show up only after several years because it would take one or more rounds of negotiations to take hold.

The fourth possible mechanism, which would probably occur only over the long run, is that there might be strategic repricing in the maximizing-margins model as hospitals seek to boost the share of their services that they provide to private patients. It is possible to test for effects of changes in Medicare payment rates on length-of-

stay and Medicare and private volume, but such a test is beyond the scope of this article.

Conclusion

Private payment rates for hospital care are clearly higher than Medicare rates and are rising more rapidly, contributing to the unsustainable rise in private health insurance premiums.^{24,25} Some analysts have blamed those increases in payment rates on hospitals' consolidation and increasing leverage over insurers.²⁶ Others have blamed a scarcity of nurses, resulting in higher labor costs; regulatory burdens, such as quality reporting requirements; and underpayment by Medicare and other public payers.²⁷

My results indicate that cuts in Medicare payment rates have not caused the rapid rise in private rates. In fact, private rates might have grown even more rapidly if Medicare had not kept its rates in check.

The Affordable Care Act permanently slowed the growth in Medicare hospital payment rates, producing large savings for the federal government. One criticism of those rate cuts is that private insurers will get stuck with the tab. My results indicate the opposite: Private insurers may actually see the growth in their payment rates slow as a result of the act, though probably not enough for that growth rate to be considered sustainable. Repealing the cuts in Medicare payment rates would not only increase federal spending but would also accelerate the growth in private insurers' costs and premiums.

My hope is that the dynamic cost-shifting theory is hereby put to rest. If so, then future research can focus on identifying the real drivers of increases in private hospital payment rates, quantifying any volume shifts resulting from changes in Medicare payment rates, and testing for broader impacts on access and quality of care. ■

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In this month's *Health Affairs*, Chapin White lays to rest the popular theory of hospital cost shifting: the notion that when Medicare constrains its hospital payment rates for inpatient care, private insurers' payment rates end up rising as a result. He tested this cost-shifting theory using a unique new data set that combines MarketScan private claims data

with Medicare hospital cost reports. Contrary to the theory, White found that hospital markets with relatively slow growth in Medicare hospital payment rates also had relatively slow growth in private hospital payment rates in 1995–2009—and that a 10 percent reduction in the Medicare payment rate led to an estimated reduction in the private payment rate of 3 percent or 8 percent, depending on the statistical model used. The findings suggest that repealing the cuts in Medicare payment rates put in place under the Affordable Care Act would not slow the growth in spending on hospital care by private insurers and would in fact be likely to accelerate the growth in private insurers' costs and

premiums.

White is a senior health researcher at the Center for Studying Health System Change. His recent research has focused on the effects of coverage expansions on the use of physician services, geographic variation in health spending, Medicare spending trends, and the effects of Medicare payment cuts on the privately insured. White is a committee member of the Health Economics Interest Group at AcademyHealth and a member of the National Academy of Social Insurance. He earned a master's degree and a doctorate in health policy from Harvard University.