WHAT DO WE WANT?
EVIDENCE-BASED CHANGE
WHEN DO WE WANT IT?
AFTER PEER REVIEW
Lemonade prices, per cup

- Joggers: $1.00
- Residents: $0.50

Your cost:
- $0.25
Lemonade prices, per cup

Cost shift?

Your cost

Joggers

Residents
When someone without health coverage gets urgent—often expensive—medical care but doesn’t pay the bill, everyone else ends up paying the price.

—healthcare.gov, 2014
Controlling Prescription Drug Costs: Regulation and the Role of Interest Groups in Medicare and the Veterans Health Administration

Austin B. Frakt
Steven D. Pizer
Ann M. Hendricks
VA Boston Healthcare System and Boston University School of Public Health

Abstract  Medicare and the Veterans Health Administration (VA) both finance large outpatient prescription drug programs, though in very different ways. In the ongoing debate on how to control Medicare spending, some suggest that Medicare should negotiate directly with drug manufacturers, as the VA does. In this article we relate the role of interest groups to policy differences between Medicare and the VA and, in doing so, explain why such a large change to the Medicare drug program is unlikely. We argue that key policy differences are attributable to stable differences in interest group involvement. While this stability makes major changes in Medicare unlikely, it suggests the possibility of leveraging VA drug purchasing to achieve savings in Medicare. This could be done through a VA-administered drug—only benefit for Medicare-enrolled veterans. Such a partnership could incorporate key elements of both programs: capacity to accept large numbers of enrollees (like Medicare) and leverage to negotiate prescription drug prices (like the VA). Moreover, it
“And we all lived profitably after.”
The Cost-Shift Payment ‘Hydraulic’: Foundation, History, And Implications

Hospital cost shifting is alive and well, but its premature demise could have negative effects on all hospital patients.

by Allen Dobson, Joan DaVanzo, and Namrata Sen

ABSTRACT: The cost-shift payment “hydraulic” is an integral component of the fragmented U.S. health care financing system. If private payers’ acceptance of the cost-shifting burden were to erode, our system of health care financing could become unstable. This is especially true for the hospital industry. In this paper we provide a series of examples of cost shifting and a historical profile of the cost shift in the hospital industry since 1980, noting that cost-shifting pressures seem to fluctuate over time and across health care markets. Cost shifting need not be dollar per dollar, as hospitals can absorb some degree of cost-shifting pressure through increased efficiency and decreases in service provision. [Health Affairs 25, no. 1 (2006): 22–33]

During the past twenty years, documentation of hospital cost shifting has accumulated in the health services research literature; at the same time, some economists have maintained that cost shifting either does not exist or is “dead.” Several researchers have defined the cost shift and described the history of the debate in both conceptual and empirical terms.¹

Those who advocate for the existence of cost shifting point to differential hospital payment-to-cost ratios across payers and to increased premiums paid by private-sector payers at the same time public payers receive rate reductions.² In 1992 the Prospective Payment Assessment Commission (ProPAC) estimated that

As some pay less, others must pay more.
If you clamp down on one side of a balloon, the other side just gets bigger.

—Karen Ignagni, 2009
Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage

PricewaterhouseCoopers

October 2009
How A New ‘Public Plan’ Could Affect Hospitals’ Finances And Private Insurance Premiums

A new government-run plan could produce sharply higher private insurance premiums if hospitals prove unable to cut their costs.

by Alien Dobson, Joan E. DaVanzo, Audrey M. El-Gamil, and Gregory Berger

ABSTRACT: Two key health reform bills in the House of Representatives and Senate include the option of a “public plan” as an additional source of health coverage. At least initially, the plan would primarily be structured to cover many of the uninsured and those who now have individual coverage. Because it is possible, and perhaps even likely, that this new public payer would pay less than private payers for the same services, such a plan could negatively affect hospital margins. Hospitals may attempt to recoup losses by shifting costs to private payers. We outline the financial pressures that hospitals and private payers could experience under various assumptions. High uninsured enrollment in a public plan would bolster hospital margins; however, this effect is reversed if the privately insured enter a public plan in large proportions, potentially stressing the hospital industry and increasing private insurance premiums. [Health Aff (Millwood). 2009;28(6):w1013–24 (published online 15 September 2009; 10.1377/hlthaff.w1013)]

Current discussions around health reform have centered on two seemingly conflicting goals: extending insurance coverage, and reducing the amount spent on health care. Proponents argue that introducing a
[P]ricing reflect[s] the need to offset losses because many programs, including Medicare, reimburse less than the cost of delivering services.

—Elizabeth Rosenthal in the NYT on a Princeton, NJ hospital, 2014
Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid

- Medicare
- Medicaid(1)
- Private Payer

(A) 1980-1984
(B) 1985-1990
(C) 1991-1996
(D) 1997-2008
Source: Clemens, Gottlieb, Shapiro (2014)
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.

—Michael Morrisey, 1996
How Much Do Hospitals Cost Shift?  
A Review of the Evidence

AUSTIN B. FRAKT

VA Boston Healthcare System; Boston University

Context: Hospital cost shifting—charging private payers more in response to shortfalls in public payments—has long been part of the debate over health care policy. Despite the abundance of theoretical and empirical literature on the subject, it has not been critically reviewed and interpreted since Morrisey did so nearly fifteen years ago. Much has changed since then, in both empirical technique and the health care landscape. This article examines the theoretical and empirical literature on cost shifting since 1996, synthesizes the predominant findings, suggests their implications for the future of health care costs, and puts them in the current policy context.

Methods: The relevant literature was identified by database search. Papers describing policies were considered first, since policy shapes the health care market in which cost shifting may or may not occur. Theoretical works were examined second, as theory provides hypotheses and structure for empirical work. The empirical literature was analyzed last in the context of the policy environment and in light of theoretical implications for appropriate econometric specification.
The End of Hospital Cost Shifting and the Quest for Hospital Productivity

Austin B. Frakt

Although perennially relevant, investigation of the effect of Medicare hospital payment changes on hospital and health system performance has heightened salience today. The 2010 Patient Protection and Affordable Care Act (Public Law 111–148; hereafter, ACA) will permanently reduce the Medicare payments hospitals would otherwise receive. Its “productivity adjustment” will scale payments downward by the average rate at which private nonfarm businesses’ productivity increases. That rate has been estimated to be 1.1 percentage points per year (Shatto and Clemens 2011), larger than historical, annual hospital productivity gains (Cylus and Dickensheets 2007–2008). Unless hospitals become more productive, they will have to find other ways to handle lower growth in Medicare payments. How will the industry respond?

Some observers do not believe all hospitals will be able to adequately respond, or at least not in ways Congress will tolerate (Antos 2013). Actuaries for the Centers for Medicare and Medicaid Services (CMS) have estimated that by year 2040, Medicare payment rates to hospitals will be half those of
## Results from Selected Hospital Cost Shifting Studies

<table>
<thead>
<tr>
<th>Years; Region</th>
<th>Finding</th>
<th>Lead Author</th>
</tr>
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<tbody>
<tr>
<td>1985-1990; nat’l</td>
<td>Dollar for dollar cost shifting</td>
<td>Cutler</td>
</tr>
<tr>
<td>1983, 1992; CA</td>
<td>No cost shifting</td>
<td>Dranove</td>
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<tr>
<td>1990-1995; nat’l</td>
<td>No cost shifting</td>
<td>Cutler</td>
</tr>
<tr>
<td>1993-2001; CA</td>
<td>Cumulative 12% private increase from pub price decrease</td>
<td>Zwanzinger</td>
</tr>
<tr>
<td>1996, 2000; nat’l</td>
<td>$0.20 private price increase for $1 public price decrease</td>
<td>Wu</td>
</tr>
<tr>
<td>1995-2009; nat’l</td>
<td>Private prices decrease when public prices do—spillover</td>
<td>White (x2)</td>
</tr>
<tr>
<td>2000-2007; TX</td>
<td>No cost shifting</td>
<td>Ho</td>
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</tbody>
</table>
Lemonade prices, per cup

- **Spillover**

Your cost:

- Joggers: $0.75
- Residents: $0.25
Private-Payer Profits Can Induce Negative Medicare Margins

ABSTRACT A common assumption is that hospitals, which are privately insured, should have lower costs and must charge high rates to pay for their costs. Medicare rates are lower than hospital costs, and this contradicts that common assumption. Higher private-payer and lower Medicare rates create power and pressure to constrain their costs. The pressure to constrain their costs per unit of service, which can lead hospitals under more financially sustainable conditions to charge higher prices, is the ability to charge higher private-payer rates to generate profits on Medicare payments.

Hospitals’ profits have risen dramatically over the last 5 years, while profit margins for Medicare patients have declined. Payment and cost data gathered by the American Hospital Association (AHA) reveal that the negative margin for Medicare patients has been driven by payments. Other factors from the hospital’s experience, such as occupancy and discharges, have not generated the profit increase seen in private-payer margins.

REPORT TO THE CONGRESS

Medicare Payment Policy

MARCH 2011
Percent of office-based physicians accepting new patients, nationally (2013)

Source: CDC, March 2015
Percent of office-based physicians accepting new patients, Wisconsin (2013)

Source: CDC, March 2015
[One] study ... found higher mortality rates among those using hospital services with lower profits from Medicare payments. Yet another study found that hospitals in the most financial stress experienced higher mortality for some types of patients.

—Austin Frakt, NYT, 2015
Source: Romley et al, Health Affairs, Feb 2015.
Efficiency

Timeline of progress toward an efficient health system

- Change in site of care
- Eliminating errors
- Process redesign
- Administrative savings
- Prevention; Patient engagement

Changes within institutions

1-2 years: Change in site of care
3-5 years: Process redesign, Eliminating errors, Administrative savings
5-10 years: Prevention; Patient engagement

Source: Adapted from Cutler, The Quality Cure, 2014
[D]ynamic cost-shifting theory is hereby put to rest.

—Chapin White, 2013
Cost Shifting and Provider Payments

Austin Frakt, PhD

Artwork credit: Christopher Brand