

MARKET WATCH

Medicare Payment Policy: Does Cost Shifting Matter?

It matters to consumers, who face the ultimate cost shift when prices rise without compensating rises in payment rates.

by Jason S. Lee, Robert A. Berenson, Rick Mayes, and Anne K. Gauthier

ABSTRACT: We examine cost shifting within the context of Medicare payment policy. We briefly review economic theory and available data and discuss the importance of cost shifting for policy. Then we present four central findings on cost shifting based on the views of former high-level policymakers. First, Medicare's early (pre-prospective) payment policy was a boon to hospitals. Second, Medicare payment policy is a "top-down" affair, driven by budgetary and special-interest politics. Third, federal policymakers may not consciously consider cost shifting, but state policymakers do. Fourth, Medicare payment policy requires constant adjustment, but we are "getting it right" most of the time.

FOR AT LEAST THIRTY YEARS there has been no agreement on whether the federal government should develop health care payment policies that address only the costs of public programs, especially Medicare and Medicaid, or whether such policies should broadly address inflationary cost pressures across the health care system. In the early 1970s the Nixon administration placed wage and price controls on the entire economy but kept controls on health care services even after the controls on other sectors of the economy had been withdrawn. A central premise of the Carter administration's hospital cost containment legislation was that cost controls had to be applied to all payers. Indeed, a major reason for its defeat in Congress was the all-payer approach. In enacting the inpatient hospital prospective payment sys-

tem (PPS) for Medicare in 1983, the Reagan administration and Congress went in the other direction, applying a Medicare-specific cost containment strategy for hospital spending. In subsequent years such approaches were adopted for physician services and for most other provider types.¹

A central question raised in evaluating Medicare payment policies is who actually bears the burden of payment reductions: providers alone, whose reimbursement rates are directly reduced, or payers as well, particularly private employers who sponsor health insurance for their employees. In general, do providers "shift costs"—that is, raise prices to one set of payers in response to lower prices from another? And, in the case of Medicare, do hospitals and physicians respond to federally initiated payment reductions by shifting costs to

Jason Lee (Lee-Jason@norc.net) is principal senior adviser at the National Organization for Research at Chicago (NORC) in Washington, D.C., and president of Health Policy Consulting LLC in Bethesda, Maryland. Bob Berenson is senior fellow at the Urban Institute in Washington. Rick Mayes is an assistant professor of public policy at the University of Richmond (Virginia) Department of Political Science. Anne Gauthier is a vice-president at AcademyHealth in Washington, D.C.

private payers? Do those who make Medicare payment policy care?

In this paper we summarize the debate on cost shifting, which economic theory says should not happen but empirical data do not rule out. To illustrate the latter point, we then focus on payment trends for hospitals, a major stakeholder in cost-shifting dynamics.² We do not attempt to resolve the debate empirically. Instead, we reflect on cost shifting from a policy perspective by drawing on the expert opinion of former high-ranking public officials.³ We show that the debate on cost shifting is part of a much broader policy discussion about administered pricing and the role of government in setting health care payment rates. The Medicare program is our central focus. We emphasize four central findings that inform current discussions about cost shifting and Medicare payment policy.

Economic Theory

In his paper on economic theory and cost shifting, which accompanies our paper on the *Health Affairs* Web site, Paul Ginsburg defines cost shifting as “the phenomenon in which changes in administered prices of one payer lead to compensating changes in prices charged to other payers.” He argues there is no “correct” definition of the term and opts for one that is most useful to policymakers.⁴ Although there is nothing inherently unidirectional about the dynamic (initiated by a public payer, affecting private providers and payers), Ginsburg’s definition is consistent with our focus on Medicare payment policy.

In theory, cost shifting can occur only if two conditions are met. First, the provider must have sufficient market power to raise prices to private payers, and second, the provider must not have been fully exercising that power.⁵ Some economists argue, based on economic theory, that cost shifting should not occur. Providers with market power should be profit maximizers, exercising their market power on all payers at all times, and not selectively, based on temporal financial conditions.

There has been a long-standing debate about whether cost shifting, in fact, exists. Re-

searchers in the mid-1990s, reviewing data from the late 1980s and early 1990s, could not find evidence that hospitals shifted costs from Medicare to private payers.⁶ According to Michael Morrissey, “Cost shifting appears to have died, killed off by new forms of insurance, price competition among hospitals, and greater cost consciousness in health care.”⁷ Other researchers reviewing data from the same time period found that “without exception, for all hospital types during all time periods, lower Medicare prices were associated with statistically significant increases in private pay prices.”⁸

Trends In Hospital Costs And Payments

Following passage of the inpatient hospital PPS in 1983, Medicare’s rate of growth slowed greatly.⁹ From 1986 to 1992 Medicare hospital inpatient PPS margins declined rapidly (Exhibit 1). During this period the annual rate of increase in hospital revenue from Medicare was less than hospital cost inflation (6.3 percent versus 8.6 percent) but was higher from private payers (10.9 percent). Although this trend is consistent with the cost-shifting hypothesis (when public payment declines, private payment increases), it does not prove a causal connection.

With surprising rapidity, managed care (in various forms) came to dominate the private market during the 1990s. Private payment as a source of hospital revenue actually declined each year from 1992 to 1997 (–0.7 percent). Hospital cost inflation also declined during this period, to 1.6 percent annually. Compared with the previous period, the annual change in Medicare payment also declined, but not as sharply as private payment or hospital cost inflation. In fact, the pace of change in Medicare payment (4.7 percent) was almost three times that of hospital cost inflation.

Exhibit 2 displays a twenty-year perspective on change in payment-to-cost ratios by private and public payers. Private payment appears to have cross-subsidized public payment at a steady rate until around 1985.¹⁰ Then, when public payment declined (as the PPS set

**EXHIBIT 1
Medicare Hospital Inpatient Prospective Payment System (PPS) Margins, 1986-1992**



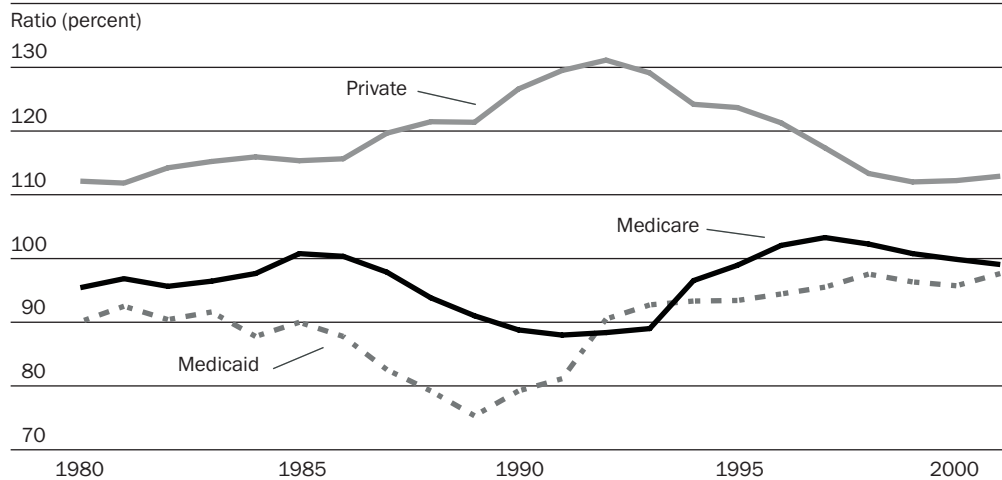
SOURCE: S. Guterman, "What Happens When Medicare Payments Decline? Putting Medicare into Perspective" (Presentation at "When Public Payment Declines, Does Cost Shifting Occur? Hospital and Physician Responses," sponsored by the Robert Wood Johnson Foundation and AcademyHealth, Washington, D.C., 13 November 2002).

in), private payment increased. This phenomenon continued until the early 1990s, when public payment began to increase and private payment declined.

Today, with the return of double-digit health care inflation, there is considerable belt tightening in the public and private sectors.

Hospital margins are being squeezed from all sides. With increasing frequency and to a greater extent, the individual consumer is experiencing cost shifting.¹¹ We return to this issue in the conclusion of this paper.

**EXHIBIT 2
Hospital Payment-To-Cost Ratios, By Source Of Revenue, 1980-2001**



SOURCES: S. Guterman, "What Happens When Medicare Payments Decline? Putting Medicare into Perspective" (Presentation at "When Public Payment Declines, Does Cost Shifting Occur? Hospital and Physician Responses," sponsored by the Robert Wood Johnson Foundation and AcademyHealth, Washington, D.C., 13 November 2002); and Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, March 2003).

NOTES: The correlation between Medicare and private payment-to-cost ratios is $-.81$ from 1984 (after diagnosis-related groups, or DRGs, were implemented) to 1996 (by which time private-sector managed care had exerted strong downward pressure on price). The Medicaid-private payer correlation during the same period is $.02$.

Why Is Cost Shifting Important?

The cost-shifting debate is important for policy because it raises essential questions about Medicare pricing decisions, which reverberate throughout the health care system. Do concerns about private-sector cost shifting influence Medicare payment policy making? What drives Medicare payment policy? Is Medicare solely intended to pay for senior citizens' medical care, or does it have additional responsibilities? What do current program payment policies tell us about this?

In November 2002 the Robert Wood Johnson Foundation (RWJF) sponsored an invitational meeting to address these questions.¹² Three speaker panels and an audience of research and policy experts convened to consider whether cost shifting occurs when public payment declines. In turn, the panels considered the question theoretically and empirically, operationally, and from the perspectives of former high-level policymakers who held administrative and legislative roles that gave them unique insights into the process and determination of Medicare payment policy and the role of cost shifting in it.¹³

As previously noted, some economists argue that cost shifting should not occur under profit maximization assumptions. Empirically, the cost-shifting question has not been resolved, as Ginsburg discusses in his paper. Research studies present mixed findings that are not obviously reconciled. As we illustrated above, correlational data support cost shifting but do not prove that it occurs. At the conference, experts with extensive experience in hospital financial management, state health care financing and management, physician group practice, and actuarial consulting supported the view that cost shifting occurs, although they agreed that the dynamics are anything but simple.¹⁴ The panel of former high-level policymakers contributed broad, new insights on cost shifting. We take their essential ideas about the questions posed at the outset, supplement them with our understanding of the issues, and present four primary policy implications of the cost-shifting debate.

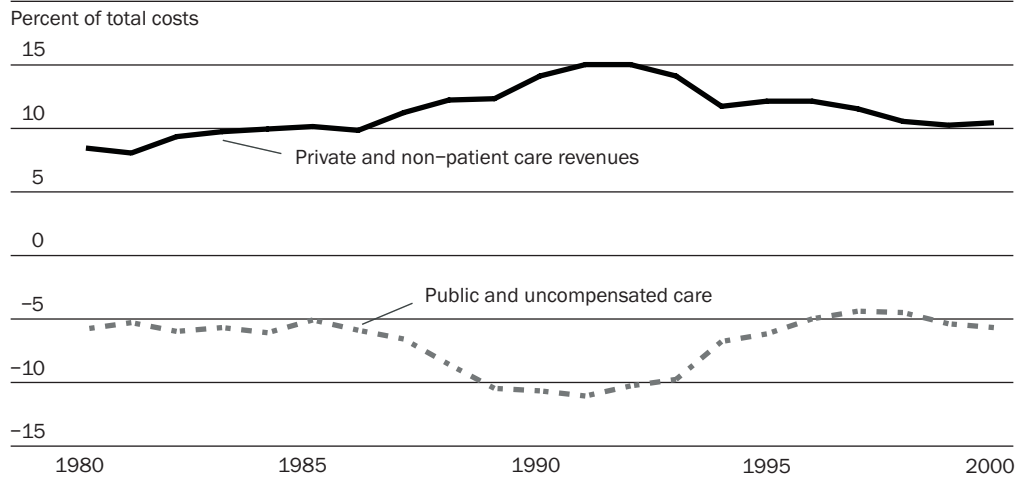
Policy Implications

■ Early Medicare payment policy put hospitals in the pink. For many years Medicare's payment model was a boon to providers, especially hospitals, as it reimbursed them all of the costs they incurred treating beneficiaries. This changed during the 1980s, when aggregate Medicare payment varied from a few percentage points below hospital costs to slightly above costs to about 10 percent below costs late in the decade (see Exhibit 2). During the same period aggregate private-sector payments changed in the opposite direction, thereby enabling hospitals to maintain stable profit margins. Clearly, change occurred in the 1980s in the relative contribution of public and private payments to hospital margins, but the net effect was general equilibrium (Exhibit 3). Over time, Medicare's inpatient hospital PPS transformed the hospital industry economically.

In addition, the program's new payment policy became a powerful tool for managing the federal budget. According to Robert Reischauer, who directed the Congressional Budget Office (CBO) between 1989 and 1995, prior to the Balanced Budget Act (BBA) of 1997, Medicare "was viewed as a 'cash cow' that was there to be milked for deficit reduction purposes...Congress by and large believed that you should and could cut Medicare payments as long as access was not compromised. And access, from the standpoint of institutional providers, really had to do with what [hospitals'] overall margins were." As long as hospital margins were positive, Reischauer argued, policymakers were not concerned with the relative contributions of public versus private payers.

■ **Medicare payment policy is a top-down affair driven by budgetary politics.** Medicare's PPS made it possible for policymakers to generate sizable budgetary "savings." By restraining the annual increase in diagnosis-related group (DRG) payment rates below the "market basket" rate of medical inflation, the difference between what Medicare actually paid and what it would have paid had payment increases actually matched the market basket was counted as budgetary savings

EXHIBIT 3 Hospital Gains And Losses, By Source Of Revenue, 1980–2000



SOURCE: S. Guterman, "What Happens When Medicare Payments Decline? Putting Medicare into Perspective" (Presentation at "When Public Payment Declines, Does Cost Shifting Occur? Hospital and Physician Responses," sponsored by the Robert Wood Johnson Foundation and AcademyHealth, Washington, D.C., 13 November 2002).

NOTES: The correlation between public and private sources of revenue is $-.80$ from 1980 to 2000, and $-.83$ from 1984 (after diagnosis-related groups, or DRGs, were implemented) to 1996 (by which time private-sector managed care had exerted strong downward pressure on price).

by the CBO.¹⁵ Congress could then count these savings toward deficit reduction or increased spending in other parts of the federal budget. From the mid-1980s to 1997, when sizable budget deficits were an annual occurrence, Congress repeatedly adjusted Medicare's payment policy in this manner as part of its effort to exert greater control over federal finances.

Budgetary politics is a top-down affair that has subordinated Medicare policy to larger budgetary issues. After the federal budget's overall expenditures and revenues are negotiated between senior congressional leaders and administration officials, committees in Congress are given the task of making changes to the programs for which they have responsibility. In effect, a committee works backward from a target amount of deficit reduction to the policy changes and cuts that achieve the target. As former House Ways and Means Committee Chief Health Counsel Charles N. Kahn III put it, "At the end of the day...you get a 'number' from above and then you work up a menu [of policy options]...that gets you to where you need to be."

The 1997 BBA exemplifies policymakers'

subordination of Medicare payment policies to larger budgetary goals. Nancy-Ann DeParle, former administrator of HCFA, now the Centers for Medicare and Medicaid Services (CMS), noted that top administration officials looked at multiple factors in adjusting payment policy when the BBA was negotiated. However, they did not focus on the adequacy of or interaction between private and public health care spending. Instead, DeParle said, the primary driver behind Medicare payment policy changes enacted in the BBA was the overall level of the federal budget deficit.

■ **Cost shifting differs by level of government.** Given policymakers' willingness to adjust Medicare's reimbursement system for larger budgetary purposes, the question naturally arises whether payment policy decisions are based in any sense on the assumption that a shortfall—resulting from Medicare's underpayment—will be compensated for by private payers through hospitals' use of cost shifting. Do policymakers assume that hospitals shift costs, set public payment rates artificially low, and expect that private payers will make up the difference? Neither DeParle nor Kahn be-

believes that high-level decisionmakers consciously factor cost shifting into their determination of payment rates. Indeed, reflecting on the BBA experience, DeParle said they did not have “good enough data to...consider cost shifting explicitly.”

Stuart Altman, who chaired the Prospective Payment Assessment Commission (ProPAC, now subsumed into the Medicare Payment Advisory Commission, or MedPAC) for twelve years, maintained that state policymakers knowingly account for cost shifting when setting Medicaid rates. State officials are much more willing to underpay hospitals than nursing homes. Why? “Because they know [Medicaid] is only 10 percent of hospitals’ revenues on the patient side, but it’s 60, 70, 80 percent of nursing homes’ revenues,” Altman said. “Ultimately,” he continued, “the big cost shifter is Medicaid.”¹⁶

Altman pointed out that Medicare does explicitly subsidize two hospital sectors whose missions often overlap: teaching hospitals and hospitals that constitute the nation’s safety net of providers.¹⁷ In the teaching hospital sector, Medicare provides two additional payment types to hospitals with graduate medical education (GME) programs to compensate for their higher costs.¹⁸ The indirect medical education (IME) adjustment, \$3.7 billion in 1999, pays the costs of treating sicker patients and additional tests needed for training purposes. Teaching hospitals also receive a direct medical education (DME) adjustment, \$2.2 billion in 1999, for training medical residents.¹⁹ As a result, Medicare explicitly pays teaching hospitals more than what it technically costs those hospitals to provide care to Medicare patients. Policymakers continue to see this as a worthwhile investment in part, said Altman, because making teaching hospitals compete with nonteaching hospitals on a cost basis could lead to an overall reduction in access for the poor and uninsured:

If we forced the teaching adjustment down to what technically the regression equation suggests we should pay them, we could force teaching hospitals into very serious financial shape. And we count on them to provide a disproportionate amount of uncompensated care. We

[also] count on them...to be subsidizing teaching and education in different ways.

Similarly, Medicare’s disproportionate-share hospital (DSH) program has, since 1986, increased payment rates to safety-net hospitals that provide a disproportionately large share of health care to the poor, whose conditions are often more severe than those of average patients and yet who are less able to pay. This explicit adjustment costs approximately \$5 billion a year.²⁰ In both cases—DSH and GME payments—the public sector pays the costs of care not otherwise covered by private payers. However, these subsidies are illustrations of a public program’s paying for public goods rather than cost shifting per se.

■ **“We are getting it about right.”** The cost-shifting issue raises fundamental questions about the purpose of Medicare payments.²¹ Specifically, should these narrowly cover only the cost of care incurred by Medicare beneficiaries, or should they help subsidize care of non-Medicare patients, provide resources for public goods (such as GME), and, most generally, support health care delivery systems for the entire community?

The Medicare Act explicitly required payments to providers to include both the indirect and the direct costs of providing those services, so that “the costs with respect to individuals covered by the insurance programs established under this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.”²²

As noted above, over time Congress did provide explicit payments for specific other purposes. In the case of support for GME, Medicare subsidizes functions of teaching hospitals that go beyond educating and training interns and residents; IME payments compensate teaching hospitals for the higher costs associated with their urban location, their more severely ill caseload, and their disproportionate share of low-income patients.²³

Nevertheless, except where there were specific statutory exceptions, Medicare payment policy has been predicated on the principle

that payments should cover only the costs of care incurred by Medicare beneficiaries. Further, until recently, almost all courts had found—or at least had assumed—that Congress enacted the Medicare program solely to assist elderly and disabled beneficiaries.²⁴

However, in 2000 the Supreme Court greatly modified that traditional view in *Fisher v. United States*, a fraud case that offered the Court the opportunity of opining whether participating hospitals receive actual benefits from the Medicare program and not merely compensation for services rendered.²⁵ The Court concluded in a 7–2 decision that Medicare “payments are made not simply to reimburse for treatment of qualifying patients but to assist the hospital in making available and maintaining a certain level and quality of medical care, all in the interest of both the hospital and the greater community.”²⁶

What should Medicare pay providers? The official position, according to Reischauer, now vice-chairman of MedPAC, is that the program ought to pay “the approved costs in full that are incurred by efficient providers when they offer necessary and appropriate care to Medicare beneficiaries...What this means in short is that Medicare should not consider the level of payments relative to costs that other purchasers are paying providers. And it should set rates as if it were in a sense the only payer.”

However, all of the former policymakers agreed that it doesn't appear to work this way in practice. Instead of having rational analysis driving Medicare payment policy debates, it often comes down to budgetary and special-interest politics, where the overall financial well-being of providers, not just their Medicare margins, are invoked in political discourse and decision making. As Kahn explained, “The issue is what can the political market bear... and how does that play out to all of the individual payments?” He argued that very little of “the great work that ProPAC, PPRC [Physician Payment Review Commission], and ultimately MedPAC have done over the years...actually plays through to ultimate decisions” about payment policies. Nevertheless, he acknowledged that although payment policy decisions

are budget-driven, “public purpose is a piece of it [too]...Special interests get involved, and whether it's the people that are pushing DSH payments or indirect medical education...if they push hard enough and are smart enough, they affect the ultimate whole.” In short, Kahn argued that the determination of Medicare payment policy has little to do with market prices and everything to do with politics.

In the end, Altman argued, “Medicare is doing about right.” Reischauer agreed: “On average, I think we feel that Medicare...is paying about right most of the time.” Reischauer and DeParle observed that the program sets millions of prices and that there will inevitably be mistakes. But, they concur, it is important to keep an eye on mistakes around the margins and make sure they don't cause larger problems. DeParle concluded that policymakers hope “there is an ability to make adjustments and to get as many [payment decisions] as close to being right as possible over time.” She continued, “I guess you do assume some rational behavior on the part of providers.”

DOES COST SHIFTING MATTER? The answer varies, depending on the power and position of actors in the health care system. To date, the answer for policymakers appears to be that payment policy matters more and that as long as other actors are not harmed, it need not be a central concern. The answer for private payers and hospitals (and other providers) depends on both their market power and the level of money in the system. The answer for consumers, with the least power, is that cost shifting matters increasingly.

In the foreseeable future, greatly increased Medicare compensation is unlikely, given the most recent budget estimates of “deficits as far as the eye can see.”²⁷ In addition, states are experiencing their worst fiscal crises in years and are straining under their Medicaid programs. Employers face escalating premiums and a limp economy and, by and large, are not absorbing the latest round of escalating health care costs. Instead, they are reducing their level of coverage, asking employees to share

more costs, and some are ceasing to provide coverage altogether.²⁸

When providers' prices rise and neither public nor private payers' compensation follows suit, consumers pay more. The result is that people lose coverage.²⁹ This appears to be the ultimate cost shift, and the issue deserves more public and private attention and action than current politics are likely to allow, at least for now.

.....
This paper was funded by the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative. The authors gratefully acknowledge the able research assistance of Lisa Fleisher.

NOTES

1. D.G. Smith, *Paying for Medicare: The Politics of Reform* (New York: Aldine de Gruyter, 1992); L.D. Brown, "Political Evolution of Federal Health Care Regulation," *Health Affairs* (Winter 1992): 17-37; G. Wilensky and J. Newhouse, "Medicare: What's Right? What's Wrong? What's Next?" *Health Affairs* (Jan/Feb 1999): 92-106; N. McCall et al., "Medicare Home Health before and after the BBA," *Health Affairs* (May/June 2001): 189-198; and S. Guterman, "Putting Medicare in Context: How Does the Balanced Budget Act Affect Hospitals?" (Washington: Urban Institute, July 2000).
2. Physicians are another important stakeholder in this debate; however, the dynamics are different. Moreover, data on physicians' responses to declining public payments are more sparse.
3. Much of this paper draws on data and opinions presented at "When Public Payment Declines, Does Cost Shifting Occur? Hospital and Physician Responses," an invitational meeting sponsored by the Robert Wood Johnson Foundation under its Changes in Health Care Financing and Organization (HCFO) Initiative and conducted by AcademyHealth, Washington, D.C., 13 November 2002. Unless otherwise acknowledged, direct quotes throughout this paper were taken from comments made at that conference.
4. We acknowledge, with Ginsburg, that cost shifting is not necessarily synonymous with price discrimination, wherein different payers are charged different amounts. Price discrimination occurs when airline passengers are charged different amounts for the same class of travel, but differential pricing in the airline industry typically is not an example of cost shifting.
5. M. Morrissey, *Hospital Cost Shifting: A Continuing Debate*, EBRI Issue Brief no. 180 (Washington: Employee Benefit Research Institute, 1996).
6. Ibid.; and J. Hadley, S. Zuckerman, and L. Iezzoni, "Financial Pressure and Competition: Changes in Hospital Efficiency and Cost-Sharing Behavior," *Medical Care* (March 1996): 205-219.
7. Morrissey, *Hospital Cost Shifting*, 12.
8. J. Zwanziger, G. Melnick, and A. Bamezai, "Can Cost Shifting Continue in a Price Competitive Environment?" *Health Economics* (April 2000): 211-225. We acknowledge that cost-shifting dynamics differ for hospitals and physicians. On the physician side, recently published studies examining data from the late 1980s and early 1990s found a complex set of physician responses that varied by specialty and service. J.M. Mitchell, J. Hadley, and D.J. Gaskin, "Physicians' Responses to Medicare Fee Schedule Reductions," *Medical Care* (October 2000): 1029-1039. In an efficiently functioning marketplace, a business would minimize its share of lower-paying clients and maximize its share of higher-paying clients. Although this motive exists in health care, providers vary in the degree to which they can (or desire to) achieve this efficiency. Some physicians can adjust their Medicare involvement by accepting more or fewer beneficiaries. But it is not financially feasible for hospitals to greatly restrict access to Medicare beneficiaries. In 2001 Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) paid for close to 50 percent of all hospital spending and just under 30 percent of physician and clinical services. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington: MedPAC, March 2003), 9. See also J.P. Clement, "Dynamic Cost Shifting in Hospitals: Evidence from the 1980s and 1990s," *Inquiry* (Winter 1997/98): 340-350.
9. R. Mayes, *Universal Coverage: The Elusive Quest for National Health Insurance* (Lanham, Md.: Lexington Books, 2001), 86. The new reimbursement system paid hospitals flat rates for specific sets of related conditions, known as diagnosis-related groups (DRGs). If the hospital managed to provide a patient's care for less than the DRG payment, it kept the "savings" as profit. If the cost to the hospital was more than the DRG payment, it absorbed the difference as a loss.
10. Even though Medicare hospital payment-to-cost ratios were below 100 percent prior to implementation of DRGs, the trend was upward. The trend was also upward for private payers. (The correlation between Medicare and private hospital payment-to-cost ratios is .47 between 1980 and 1984.) Generally speaking, it is not clear to what extent more generous Medicare payments induce hospitals to increase capital investments and otherwise raise expenses; however, such re-

- source expansion seems to occur, at least for some periods. See also R. Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, 2d ed. (Baltimore: Johns Hopkins University Press, 1999), 284–320.
11. J. Gabel et al., “Job-Based Health Benefits in 2002: Some Important Trends,” *Health Affairs* (Sep/Oct 2002): 143–151; D. Barkholz, “Health Costs Hit Hard: Trend Is Asking Employees to Pay More,” *Business Insurance* (20 September 1999): 48–50; Towers Perrin, “2003 Health Care Costs Register Biggest Increase in More than a Decade,” November 2002, www.towers.com/towers/enews/monitor/Nov_02/Nov_02_article1.htm (17 September 2003); and J. Lee and L. Tollen, “How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing,” 19 June 2002, www.healthaffairs.org/WebExclusives/Lee_Web_Excl_061902.htm (17 September 2003).
 12. See Note 3.
 13. Presenters on the empirical panel were Allen Dobson, Paul Ginsburg, Stuart Guterman, Thomas McGuire, and Michael Morrissey. Presenters on the operational panel were Deborah Chang, Donald Fisher, Richard Showalter, and Joan Trauner. Presenters on the policy panel were Stuart Altman, Nancy-Ann DeParle, Charles Kahn, and Robert Reischauer.
 14. Conferees generally agreed that, economic theory aside, hospitals act as if they are shifting costs. Unlike many physicians, hospitals cannot drop out of the Medicare program. A large share of the typical hospital’s revenue derives from public sources. Thus, when public payment declines, do hospitals increase prices to private payers? According to Kahn, hospital administrators think about revenue streams from retail payments, from wholesale payments (negotiated with private payers), and from administered payments (from Medicare and Medicaid): “Theirs is a balancing act to make sure they...keep the institution’s doors open...[I] don’t think they’re thinking about cost shifting per se. They’re just thinking about maximization of revenue...within the parameters of retail price, which is paid by few people; wholesale price, which is paid by many people; and government price that is imposed on them.” Hospital administrators might not use the term “cost shifting” to describe their accounting techniques, but their actions reflect cost shifting in practice.
 15. Inflation in the medical “market basket” is the rate of increase for a basket of medical goods and services. See A. Wellevier, “The Area Wage Index of the Medicare Inpatient Hospital Prospective Payment System: Perspectives, Policies, and Choices,” 27 August 2000, www.rupri.org/publications/archive/reports/P2000-12 (17 September 2003).
 16. Allen Dobson of the Lewin Group concurred, noting that “in practice...cost shifting, especially at the state level, is a widespread phenomenon as public payers often do not pay full costs.”
 17. Medicare also provides special treatment under the PPS for certain kinds of rural hospitals, including “sole community hospitals,” rural referral centers, and critical access hospitals.
 18. S. Guterman, “Financing Graduate Medical Education: A Federal Perspective,” in *Medical Education Meets the Marketplace: What Mix of Tradition and Innovation Can We Afford?* ed. H. Greenberg and S. Raymond, conference proceedings published by the New York Academy of Sciences, www.nyas.org/books/medicaled/conference.pdf (17 September 2003).
 19. J. Greene, “MedPAC Advises Ending GME Training Payments,” *amednews.com*, 23/30 August 1999, www.ama-assn.org/sci-pubs/amnews/pick_99/gvta0823.htm (17 September 2003).
 20. J.P. Newhouse, “Medicare Policy in the 1990s,” NBER Working Paper no. 8531 (Cambridge, Mass.: National Bureau of Economic Research, October 2001).
 21. D.M. Harris, “Beyond Beneficiaries: Using the Medicare Program to Accomplish Broader Public Goals,” *Washington and Lee Law Review* (forthcoming).
 22. 42 U.S. Code, sec. 1395x(v)(1).
 23. U.S. General Accounting Office, *Medicare: Graduate Medical Education Payment Policy Needs to be Re-examined*, Pub. no. GAO/HEHS-94-33 (Washington: GAO, 1994).
 24. Harris, “Beyond Beneficiaries.”
 25. 529 U.S. 667 (2000).
 26. Justices Thomas and Scalia voiced the two dissenting opinions.
 27. J. Weisman, “CBO Worsens ’03, ’04 Deficit Projections,” *Washington Post*, 29 January 2003. See also Congressional Budget Office, “The Uncertainty of Budget Projections,” chap. 5 in *The Budget and Economic Outlook: Fiscal Years 2004–2013*, January 2003, www.cbo.gov/showdoc.cfm?index=4032&sequence=6 (17 September 2003).
 28. Gabel et al., “Job-Based Health Benefits in 2002.”
 29. U.S. Census Bureau, “Health Insurance Coverage: 2001” (Washington: Census Bureau, 30 September 2002); J. Elswick, “Analysts Mull Best Means of Cost Shifting,” *Employee Benefit News* (1 October 2002); J. Elswick, “Most Plans Seen Shifting Costs,” *Employee Benefit News* (1 November 2002); and J. Elswick, “Higher Costs, More Cost Shifting Seen in Employer Health Plans,” *Employee Benefit News* (18 December 2002).