From The Field

Cost Shifting: New Myths, Old Confusion, And Enduring Reality

Instead of focusing on the symptom of cost shifting, we should be focusing on the causes.

by Michael A. Morrisey

ABSTRACT: The papers by Paul Ginsburg and Jason Lee and colleagues make it clear how far we have come on the issue of cost shifting and how far we still have to go. We have created some new myths, persisted in some old confusion, and largely ignored an enduring reality. That enduring reality is that lack of competition in the health care sector permits cost shifting to occur. Instead of focusing on this causal condition, public discussion has been centered on the symptoms. A number of steps can be taken to deal with causes; this paper discusses several of these steps.

Some twenty years have passed since the specter of cost shifting was loosed upon the land. Over that time hospitals have passed from the golden age of cost-based reimbursement through the fearful era of managed care to the new millennium of rapidly rising health care costs. These forces set the stage well for the Robert Wood Johnson Foundation and AcademyHealth to have sponsored a conference on cost shifting in November 2002. The paper by Paul Ginsburg served as the keynote address; that by Jason Lee and colleagues summarizes much of the discussion by the health care experts in attendance. Both papers accompany this one on the *Health Affairs* Web site.

The papers and the much broader discussion at the conference make it clear how far we have come on this issue and how far we still have to go. We have created some new myths, persisted in some old confusion, and largely ignored an enduring reality. The optimists among us, however, take heart at the progress.

New Myths

The ongoing discussion of cost shifting has led to a new myth: that economic theory says cost shifting is impossible. One seldom hears a discussion of cost shifting nowadays that does not include, and often begin with, this or a related comment. In one sense, this is some measure of success for those who have rigorously pressed the issue. Unfortunately, more often than not, this "impossibility theorem" is meant in the context of the old joke about economists: "Economists are those who see something in reality and then try to see if it can exist in theory."

In fact, as a matter of economic theory, cost shifting can exist. It belongs to that group of actions, like predatory pricing, that can exist but for which the underlying costs and benefits make most economists skeptical that an organization could successfully make it work. In the case of predatory pricing, a dominant firm lowers prices to drive its rivals from the market. It then raises it prices above the com-

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petitive level to capture the subsequent monopoly gains. The problem is that the dominant firm incurs the most losses when prices are low, and it typically has a hard time keeping the old (and new) competitors from reentering the market once prices have risen.

In the case of cost shifting, a firm has to have market power that heretofore it had not exploited. When Medicare, for example, cuts its payment level, the provider turns to its private insurers and raises prices to them to compensate for the Medicare cut. What makes economists uneasy is that most models of firm behavior lead one to expect that the provider has already charged the private insurer the most profitable prices permitted by the market. If so, efforts to raise prices further are self-defeating. Higher prices mean less, not more, revenue. If providers have market power and, indeed, have not charged private insurers "what the traffic will bear," then cost shifting can exist—even as a matter of theory.

Old Confusions

■ **The behavior of nonprofits.** Throughout much of the casual discussion of cost shifting, there is still a strong sense that if a nonprofit provider has market power, it can successfully shift costs. This argument typically takes one of two strains. One argues that nonprofits don't have to provide a return to stockholders, so they don't have to charge as high of prices to private insurers. The other is that the community-service nature of hospital boards keeps them from maximizing much of anything.

Some elements of each story are consistent with cost shifting, but one wants to be careful. If a nonprofit provider has a goal to provide as much charity care as possible, for example, it will not shift costs. Instead, it is better served by charging private insurers "what the traffic will bear" and using any surpluses above costs to fund its charitable mission. If it wishes to provide specific services that the community will not pay for, it will not shift costs. Again, it will charge private insurers as much as it "profitably" can and use the surpluses to subsidize the burn care unit or the neonatal intensive care unit. Cost shifting can be a successful strategy only if the provider with market power sees its goal as providing care to insured folks at prices less than their insurance companies would have paid.

The argument that nonprofit organizations are unable to maximize anything is disturbing. The least worrisome interpretation is that nonprofits have a broad, complex set of objectives. This is undoubtedly true, but unless one of those objectives is to charge private insurers less than they are willing to pay, cost shifting is a strategy that is dominated by other approaches. If, instead, the argument is that nonprofits are so inefficient that they are unable to identify a direction, much less a means of moving in that direction, then society should probably reconsider what role, if any, nonprofit providers should play in health care. As a former American Hospital Association (AHA) employee and as an instructor of health administration students for nearly twenty years, I do not see "directionless" and "inefficient" as characteristics of the industry.

■ **Knowing cost shifting when you see it.** A second confusion entails knowing cost shifting when it exists. Perhaps this confusion is at the root of the attention that cost shifting gets in the public eye. Yes, health care providers charge different prices to different payers. No, this is not cost shifting. Airlines, hotels, movie theaters, even my local Lowe's Home Improvement Center charge different prices to different buyers. These actions are artifacts of having some degree of market power, but they would constitute cost shifting only if the hotel, for example, raised its price to me because it lowered its price to the convention group. Both Ginsburg and Lee and colleagues do a service in focusing on this point. Just as the hotel almost certainly didn't lose money on the convention, there is no reason to necessarily believe that the health care provider loses money that had to be made up when it accepted a lower price from one group of buyers.

Enduring Reality

Lost in the discussion of whether cost shifting exists is the enduring reality that a lack of

competition in the health care sector permits cost shifting in the first place. If one accepts the conventional wisdom that cost shifting was the norm in the mid- to late 1980s, one would see the prices paid by private insurers rising as Medicare cut its payment levels. Rates of increase began to decline precipitously in the first half of the 1990s as managed care became the dominant form of payment. Good research has demonstrated that managed care plans got lower prices when there was more competition in the local hospital market.[1] In the context of cost shifting, hospitals that tried to raise prices in response to Medicare or Medicaid cutbacks found that local managed care plans were unwilling to accept those prices. Idle capacity and multiple competing providers in the hospital industry meant that some hospitals were willing to offer lower prices to attract managed care contracts. Attempts to charge higher prices meant that some hospitals undoubtedly lost the private-pay patients they needed to "offset" governmental payment declines.

There is a sense that hospital competition has declined since the mid-1990s. There have been mergers, and many hospital networks have been formed to negotiate with managed care plans. The Blue Cross and Blue Shield Association has argued that the increase in insurance premiums stems, in part, from the reduction in hospital competition.[2] The Federal Trade Commission (FTC) has hearings under way to identify the extent to which hospital consolidations have affected competition.[3] The robust economy of those days also led employees to demand more choice of providers and a backlash against narrow provider panels in managed care. Whatever else one might say about closed panels, they did provide health plans with the sort of patient volume that could take advantage of the local provider competition to negotiate lower prices. These are the conditions that can permit cost shifting.

As a matter of public policy, what should be done? Remarkably little is said about potential solutions. The one exception is that cost shifting is used to garner support for higher provider payments from Medicare and Medicaid. The straightforward assertion is that if these payment levels aren't raised, private insurers—and by extension employers and employees—will face higher prices. The irony is that if economists' skepticism about cost shifting is correct and the more conventional models of firm behavior are better predictors of providers' actions, then higher Medicare and Medicaid prices will lead to higher, not lower, prices to private insurers.

A better solution is to deal with the causes and not the symptoms. To prevent the threat of cost shifting, make health care markets more competitive. Enforce antitrust laws where appropriate. Remove barriers to entry and exit, such as the certificate-of-need laws. Repeal limitations on contracting such as any-willing-provider and freedom-of-choice laws that limit managed care plans' ability to effectively negotiate on price. Cost shifting is a symptom of market power. Reduce the market power and thereby reduce the fear of cost shifting.

NOTES

1. M.A. Morrisey, "Competition in Hospital and Health Insurance Markets: A Review and Research Agenda," *Health Services Research* (April 2001): 191–221.
2. Blue Cross and Blue Shield Association, "New Blue Cross and Blue Shield Association Research Points to Technology Explosion, Hospital Consolidation as Leading Causes of Soaring Healthcare Costs," Press Release (Chicago: BCBSA, 23 October 2002).
3. T.J. Muris, "Everything Old Is New Again: Health Care and Competition in the Twenty-first Century" (Speech before the Seventh Annual Competition in Health Care Forum, Northwestern University, Evanston, Illinois, 7 November 2002).