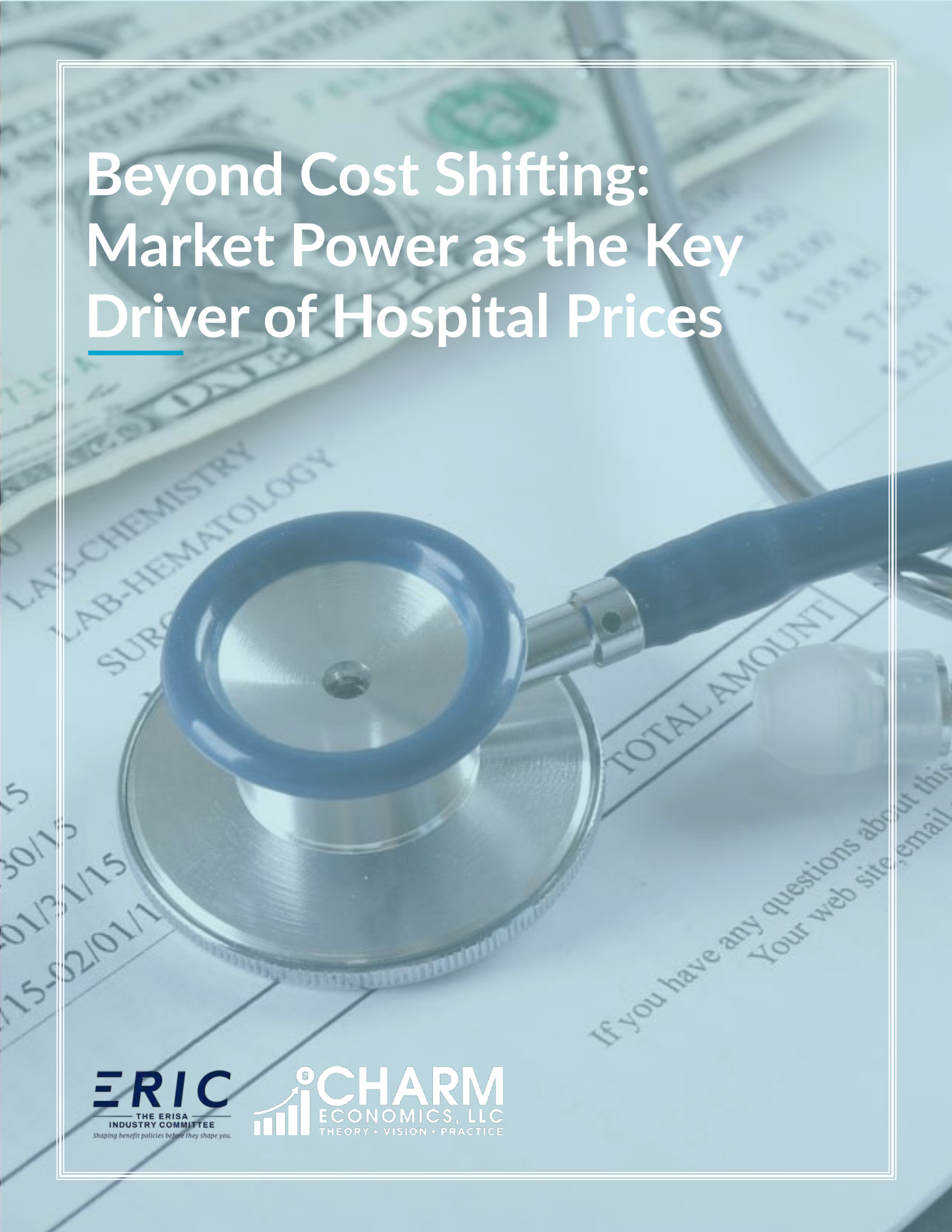
Beyond Cost Shifting: Market Power as the Key Driver of Hospital Prices



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Executive Summary

Objective

Employer-sponsored health benefits are a critical component of employee compensation in the U.S. labor market. Employers negotiate with health care providers to secure favorable rates, which directly impact premium costs, out-of-pocket expenses, and the affordability of health care for employees. However, provider rate negotiations occur in a complex health care environment where hospitals treat patients covered by both private insurance and government programs like Medicare and Medicaid. A prevailing concern is whether hospitals shift costs from lower-paying public programs onto private insurers, thereby increasing health care costs for employers and employees.

This paper examines the validity of the cost shifting theory and evaluates the primary drivers of hospital prices in employer-sponsored health plans. While conventional wisdom suggests that hospitals compensate for lower Medicare and Medicaid reimbursements by increasing prices for private insurers, economic theory and recent research challenge this assumption. Studies from the RAND Corporation, the National Bureau of Economic Research (NBER), Kaiser Family Foundation, One Percent Steps for Health Care Reform, and the Congressional Budget Office (CBO) suggest that market power and provider consolidation, not payor mix, are the primary determinants of employer-negotiated rates.

Policy Recommendations

To address rising employer health care costs and mitigate the effects of hospital market concentration, this paper recommends two key policy actions:

Enhance Price Transparency

Expanding price transparency is essential to foster competition and empower employers and consumers. The proposed *Lower Costs, More Transparency Act* (H.R. 5378 – 118th Congress) would require hospitals, ambulatory surgical centers, and diagnostic facilities to publicly disclose negotiated rates and cash prices, enabling better-informed decision-making.

Align Payment Rates to More Accurately Match Services

Congress could establish and expand site-neutral payment programs in Medicare to establish benchmarks commercial payers can use to prevent excessive hospital pricing. A phased-in approach would allow for a smooth transition while ensuring fairness in reimbursement. Congress could also enact the *Healthy Competition for Better Care Act* (H.R. 3120 – 118th Congress) that would ban anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care.

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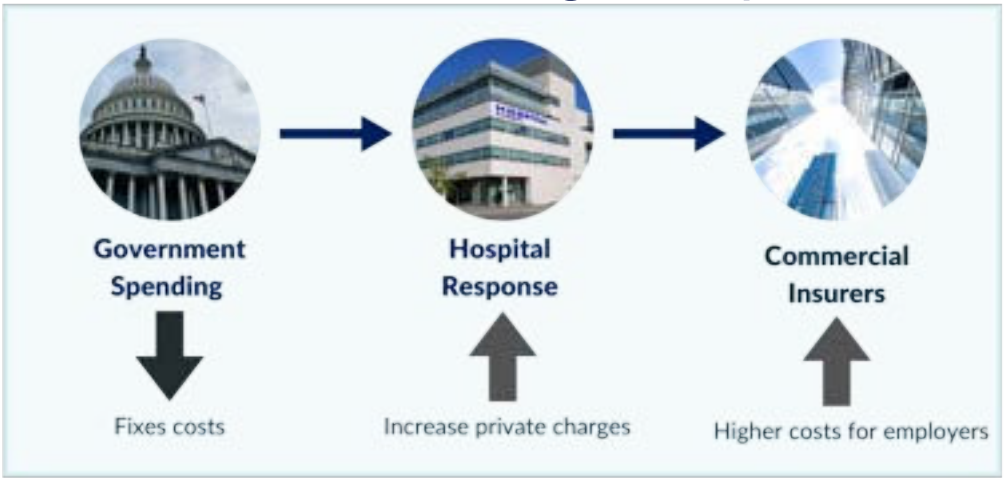
Introduction

Employer-sponsored health benefits are a central component of the compensation package offered to employees in a competitive labor market. Part of the value of health benefits is that employers can negotiate discounts with health care providers, often based on volume. These negotiations play a crucial role in determining health care costs for both employers and employees, influencing premium rates, out-of-pocket expenses, and overall affordability of care. The ability of employers and health plans to secure favorable rates helps manage health care spending and ensures employees have access to quality care. However, health care markets are complex, as providers treat both patients with employer-sponsored benefits and those covered by government programs like Medicare and Medicaid, which are less influenced by market-based negotiations.

Some have asked if provider rate negotiations may be influenced by payor mix, which is the proportion of patients covered by Medicare, Medicaid, and private insurance at a given hospital or health care system.[1] This concept is referred to as "cost shifting," which suggests that hospitals compensate for lower public program reimbursements by charging private insurers more.[2] However, this is inconsistent with economic theory and recent analyses, including one from the Congressional Budget Office, which indicate that this perspective oversimplifies the complexities of employer-provider negotiations.[3] Payor mix and cost shifting are not primary determinants of commercial rates. Instead, a range of market forces, including provider consolidation, employer bargaining power, and regional pricing dynamics, play a more influential role in shaping the rates employers ultimately pay for health care services.

Cost Shifting Theory



Payor mix varies widely based on geographic location, patient demographics, and state Medicaid expansion policies. Traditionally, hospitals with a higher proportion of Medicare and Medicaid patients have been thought to shift costs that are underpaid by government programs onto private payers to compensate for lower reimbursement rates from public insurance programs.[4] However, recent research challenges this assumption, showing that commercial price variation is driven more by market concentration and provider leverage than by any systematic cost shifting strategy.[5] For example, hospitals with a high share of Medicare and Medicaid patients may still maintain competitive commercial rates due to factors such as market power, geographic location, and the presence of competing facilities. Conversely, hospitals with a more balanced payor mix might ask for higher payments from employers if they have significant market leverage due to a competitive health plan environment, or if they are in areas with limited hospital competition.[6] In the commercial health care market, rates between employers and health care providers are established through negotiations, and as economic theory predicts, the other payers in the market and the rates they receive do not impact the rates received by each employer.

For example, a study found that a one percentage point increase in a hospital system's market share is associated with an $88 to $118 higher negotiated rate per admission, indicating that it is market share and concentration that is a critical component driving health care prices.[7] This indicates that market dynamics and provider leverage play more critical roles in rate determination than the composition of a provider's payor mix.

The Evidence on Cost Shifting

Key Economic Studies on Cost Shifting

To evaluate the validity of cost shifting, we examine several economic studies, some of which support cost shifting, while most refute it.

1. In ***Cost Shifting or Cost Cutting? The Incidence of Reductions in Medicare Payments***, David Cutler analyzed two periods of Medicare payment reductions (1985-1990 and 1990-1995). In the 1980s, hospitals fully cost shifted, increasing private prices dollar-for-dollar with Medicare cuts. However, by the 1990s, cost shifting had disappeared as managed care increased price sensitivity, forcing hospitals to cut costs rather than raise prices.[8]

2. Vivian Wu's study, ***Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997***, used the 1997 Act as a natural experiment. She found that some urban hospitals with a smaller reliance on Medicare were able to shift up to 37% of lost Medicare revenue onto private insurers. However, hospitals with a high share of Medicare patients could not cost shift at all and faced financial distress, suggesting that cost shifting is limited to hospitals with significant market power over private insurers.[9]

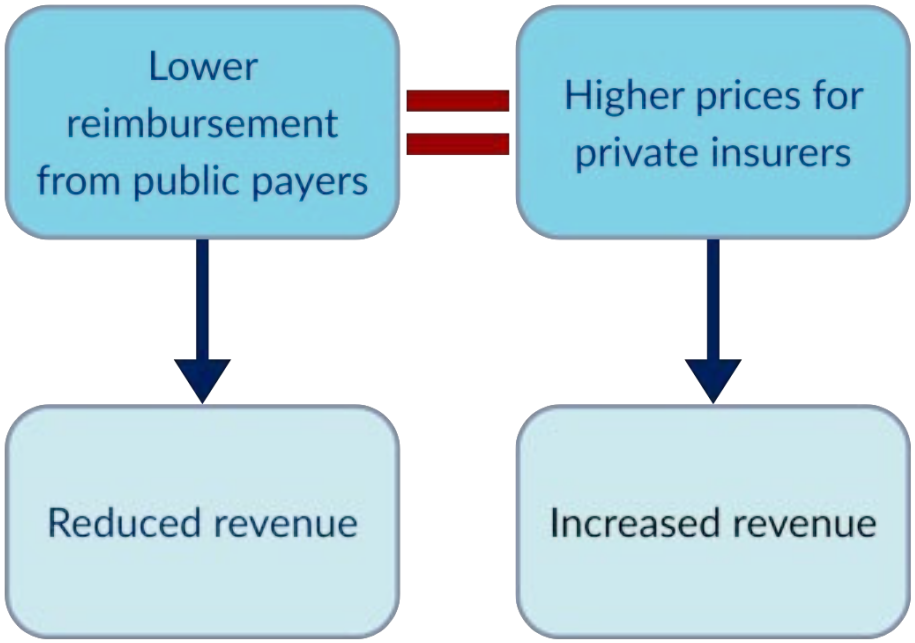
3. In ***Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates***, Chapin White analyzed a dataset combining MarketScan private claims data with Medicare hospital cost reports from 1995 to 2009. He found that

lower Medicare rates were associated with lower private insurance rates, contradicting the cost shifting hypothesis. His regression analysis suggested that a 10% reduction in Medicare rates correlated with a 3%–8% reduction in private rates, implying that hospitals adjust operating costs rather than shifting costs onto private payers to become more efficient.[10]

4. The Dranove et al. NBER paper, ***How Do Hospitals Respond to Negative Financial Shocks? The Impact of the 2008 Stock Market Crash***, examined how hospitals reacted to endowment losses. They found no evidence of cost shifting at the average hospital. Instead, hospitals responded by delaying health IT investments and reducing unprofitable services, indicating that financial distress leads to cost reductions rather than price increases for private payers.[11]

While some studies find limited instances of cost shifting, particularly in hospitals with high market power, most economic research demonstrates that cost shifting is neither widespread nor a primary determinant of commercial pricing. Instead, hospital pricing is primarily driven by other market factors.

How Cost Shifting Works



Limited Correlation Between Payor Mix and Negotiated Rates

Key Findings from RAND

The RAND corporation is a leading research organization studying the most relevant policy-related questions and was responsible for the RAND Health Insurance Experiment in the 1970s, one of the most important social science studies in the health field in U.S. history. More recently, RAND has done substantial research into health care prices and cost shifting. To explore this, RAND used a data-driven approach that takes advantage of differences in how hospital prices change across regions due to shifts in market structure, particularly hospital mergers. These mergers create natural differences in price growth that allow for meaningful comparisons. To analyze the relationship between hospital mergers, health care costs, and wages, RAND integrated two primary data sources: the American Community Survey (ACS), which provides detailed wage and worker demographic information, and the Health Care Cost Institute (HCCI) medical claims database, which tracks health care spending among the privately insured. The study uses a difference-in-differences framework, a research technique that compares two groups over time, one that experiences a change (such as a hospital merger) and one that does not. By looking at trends before and after the merger, this method helps isolate the effect of price increases on wages and benefit design while accounting for other factors that could influence the results. RAND controlled for factors such as local economic conditions, industry composition, and baseline differences in health care costs. Additionally, the study examines how employers adjust benefit structures, specifically the adoption of high-deductible health plans, following health care price increases. Through this approach, RAND provides evidence on the

extent to which rising health care costs are passed on to employees via wage adjustments and benefit design changes. Hospital pricing and private plan payments have been a growing concern in health care economics, particularly in relation to employer-sponsored insurance.

Findings from recent RAND studies show that payor mix is not a significant determinant in the outcomes of employer-provider rate negotiations. Instead, RAND found that market consolidation and hospital mergers play a dominant role in driving price variations.[12]

- **Hospital Mergers Drive Price Increases**

  Hospital mergers within the same market result in a 2.6% increase in hospital prices ($521 per admission).[13] These mergers lead to an increase of $579 per-enrollee in hospital spending for the privately insured population, and a similar $638 reduction in wages to all workers across the affected market.[14] Cross-market mergers, however, were not found to lead to significant price increases, further reinforcing that local market concentration is a primary factor.

- **Limited Influence of Payor Mix in Rate Negotiations**

  The study found no substantial correlation between payor mix and the negotiated rates between employers and providers. Instead, provider market power and consolidation were the most influential factors in determining price variations in employer-sponsored insurance.[15] A 1% increase in health care prices, often resulting from hospital mergers, leads to a 0.4% decrease in employers' total payroll, suggesting that increased health care costs are passed on to employers and employees, potentially through higher premiums or reduced wages.[16] Hospitals with higher commercial insurance revenue did not necessarily negotiate lower rates, countering the assumption that payor mix influences pricing.

- **Wage Implications of Rising Hospital Prices**

  Higher hospital prices are passed on to workers through lower wages. On average, hospital mergers resulted in a $638 reduction in wages for employees receiving employer-sponsored insurance.[17] These wage reductions were more pronounced in markets with higher provider consolidation. The RAND study challenges the assumption that payor mix is a major determinant in employer-provider rate negotiations.

Additional Evidence Showing a Limited Correlation Between Payor Mix and Negotiated Rates

In addition to RAND, a number of recent studies have investigated the relationship between payor mix and the rates negotiated between providers and insurers. These findings also indicate that payor mix is not a significant determinant in these negotiations.

A working paper from the National Bureau of Economic Research (NBER)[18] analyzed inpatient reimbursement rates across various payers, including traditional Medicare, Medicare Advantage (MA), Medicaid, and private insurers. After adjusting for enrollee and hospital characteristics, the study found that private insurers pay approximately 37% more than traditional Medicare, while MA pays about 10% more than traditional Medicare, for the five most common inpatient diagnoses.[19] Further, another study observed significant variation in negotiated prices within and across private payers.

Among the five largest U.S. insurers, the most expensive insurer negotiated prices that were 5-26% higher than the mean price for the 20 most common inpatient diagnoses.[20] This variation indicates that factors other than payor mix, such as insurer market share and bargaining power, play a more substantial role in determining negotiated rates.

Other Cost-Drivers: Hospital Market Consolidation, Provider Power, and Geographic Variations

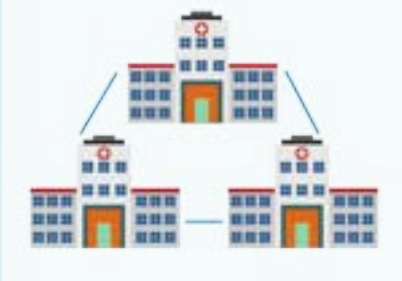
While payor mix has a limited impact on negotiated rates, other factors significantly influence these negotiations, including hospital market consolidation, provider power, and geographic variations.

Hospital market consolidation refers to the merging of hospitals or the acquisition of smaller medical practices by larger health systems, leading to increased market share and reduced competition. A 2017 study found that as hospital systems increase their market share, they gain greater bargaining power, enabling them to negotiate higher prices with insurers.[21] The One Percent Steps Initiative highlights that the U.S. hospital sector

is increasingly defined by highlevels of consolidation, with more than 80% of hospital markets now classified as “highly concentrated” under DOJ and FTC standards.[22] This consolidation has profound implications for both price and quality. Over the past two decades, nearly 1,600 hospital mergers have occurred, many between direct competitors, resulting in price increases of 20% to 50% in affected markets.[23] The report also underscores the risks of vertical integration,[24] as hospitals increasingly acquire physician practices, reducing competition, limiting patient choice, and further driving up prices for services such as imaging and specialist visits.

Additionally, provider power, defined by the ability of health care providers to influence prices and terms during negotiations, significantly affects negotiated rates. Supporting this conclusion, research from the Kaiser Family Foundation[25] demonstrates that provider consolidation is a primary driver of rising negotiated prices in the commercial market. For example, in an analysis of 25 areas with the highest levels of hospital consolidation between 2010 and 2013, the average price paid by private insurers for a hospital stay increased between 11% and 54% in the years following consolidation.

Geographic variation further contributes to disparities in employer-provider negotiated rates. Hospitals in highly consolidated or rural areas often face limited competition, enabling them to command higher prices regardless of payer mix. By contrast, hospitals in competitive urban markets or states with stronger regulatory oversight tend to have more moderate pricing. For instance, an NBER working paper[26] noted that among the five largest U.S. insurers, the least expensive negotiated rates were, on average, 16.5% lower than the mean price, while the most expensive were 15.5% higher, illustrating how local provider leverage and geography affect pricing outcomes.



Hospital Consolidation

Provider Power

Geographic Variation

Case Studies

RAND Study: Hospital Pricing in Michigan

The RAND analysis of hospital prices paid by private health plans across various states revealed that Michigan's hospitals, despite having diverse payor mixes, maintained relatively consistent employer-negotiated rates. In 2022, Michigan's commercial prices averaged below 200% of Medicare prices, placing it among the states with the lowest relative hospital prices. This uniformity suggests that factors such as hospital competition and market dynamics play more significant roles in determining negotiated rates than payor mix.[27]

Contrasting Markets: Beyond Payor Mix in Pricing Differences

Further analysis by RAND highlighted substantial variations in hospital prices among states, with some states exhibiting relative prices above 300% of Medicare rates.[28] For instance, states like California and New York, despite having diverse patient demographics and payor compositions, show higher relative prices. These discrepancies cannot be solely attributed to differences in payor mix, indicating that other dynamics, such as hospital consolidation, market power, and regional economic factors, are more influential in driving pricing differences.

Employer Influence: The 32BJ Health Fund Initiative

The 32BJ Health Fund provides a compelling example of an employer actively managing hospital pricing and network negotiations. Upon analyzing claims data, the Fund discovered significant price variations for identical procedures across different hospitals. In response, the Fund

decided to remove New York-Presbyterian Hospital from its network due to its high charges, which averaged 200 to 300% more than Medicare rates for the same services.[29] Government entities spend significant taxpayer dollars on high hospital prices. In New York City, paying hospital rates above Medicare's benchmarks may result in overpayments of up to $2.0 billion.[30] This strategic move underscores the potential for employers to influence hospital pricing through informed decision-making and network management.

These case studies collectively illustrate that employer-provider negotiated rates are influenced more by market dynamics, hospital competition, and employer interventions than by payor mix. Employers that proactively analyze pricing and engage in strategic negotiations can play a pivotal role in managing health care costs.

Broader Implications

Policy Recommendation: Price Transparency

To address the structural dynamics of provider market concentration, policymakers can implement reforms that enhance competition and transparency in the health care market. One approach involves increasing price transparency, allowing employers and consumers to access pricing information and make more informed decisions. For instance, the implementation of hospital price transparency rules by the Centers for Medicare and Medicaid Services (CMS) requires hospitals to provide clear, accessible pricing information online, aiding consumers in understanding the cost of services before receiving them.[31] Therefore, empowering consumers with clear pricing information is crucial for fostering competition and informed decision-making. Building upon existing initiatives, Congress can enact legislation that requires all health care providers, including hospitals, ambulatory surgical centers, and diagnostic laboratories, to publicly disclose their negotiated rates and cash prices, and to do so at the facility level.

The proposed *Lower Costs, More Transparency Act* (H.R.5378 – 118th Congress)[32] aimed to promote price transparency in the health care sector by mandating such disclosures. It was intended to ensure that patients and employers have access to pricing information, enabling them to make cost-effective health care choices. Employers should then consider removing outliers from provider networks, forcing the most expensive hospitals to compete on price in order to access the volume of patients available through employer plans.

Policy Recommendation: Align Payment Rates to More Accurately Match Services

Congress could also consider setting site-neutral (reference-based) payment rates for certain services in Medicare. This policy would help set an example that could be followed by commercial payers, which could in turn curb excessive pricing without disrupting hospital operations. Evidence from Medicare's site-neutral payment policy for certain outpatient services and from commercial reference pricing programs, such as the California Public Employees' Retirement System (CalPERS) initiative, shows that such reforms can reduce spending without harming patient outcomes.[33] Implementing these limited reforms would directly address the issue of rising health insurance costs by limiting the extent to which hospitals can charge private insurers excessively high rates. Based on findings from several of the studies above, site-neutral payment reforms may motivate hospitals to operate more efficiently, resulting in cost savings not just to the Medicare program but also to commercial payers.

Furthermore, providing more equilibrium in the contracting process between employer health benefit plans and providers would restore fairness and push back on the use of consolidation, driving high prices for care provided to employers and their beneficiaries. Congress should enact the *Healthy Competition for Better Care Act* this Congress to further mitigate anti-competitive behavior, such as anti-tiering, anti-steering, and all-or-nothing contracts used by large hospital systems to reduce competition.

Conclusion

A comprehensive analysis of hospital pricing and employer market negotiations challenges the long-held belief that payor mix is the primary determinant of employer-negotiated rates. Evidence from multiple studies, including the RAND Corporation's analysis of hospital prices across states, demonstrates that hospital market power plays a more significant role in determining prices. Even in states with diverse payor mixes, such as Michigan, employer-negotiated rates have remained relatively stable, reinforcing the conclusion that market concentration and bargaining power exert greater influence over pricing than payer composition. Additionally, hospital consolidation has further diminished the ability of self-insured employers to negotiate lower rates. Research indicates that highly concentrated hospital markets, particularly in rural areas, allow hospitals to leverage their market power to demand higher prices from insurers, making cost-shifting arguments less relevant in explaining price variation.

To achieve sustainable health care pricing, policymakers and employers must shift their focus toward addressing the true cost drivers in the system. Increasing price transparency and limiting payment for hospital services can serve as crucial mechanisms for controlling excessive costs and mitigating the financial burden on employers and employees. Strengthening competition and reducing provider market concentration are also essential strategies to counteract the pricing power of dominant hospitals. These policy measures, if effectively implemented, offer a viable path toward a more sustainable and equitable health care system.

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