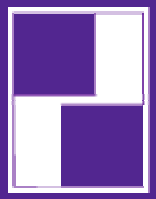

Changes in
HEALTH CARE
FINANCING &
ORGANIZATION

Defining "Defined Contribution" 2002: Research and Practice

May 15, 2002
Washington, DC

AcademyHealth

These materials were commissioned by the Robert Wood Johnson Foundation for use at the invitational meeting *When Public Payment Declines Does Cost-Shifting Occur? Hospital and Physician Responses* and to stimulate discussion and understanding of the hospital and physician responses to reductions in public payment. In the event that the Foundation and the authors intend to submit these commissioned materials or revisions thereto for publication, we request that the materials not be cited or circulated without the permission of AcademyHealth.

Cost Shifting: An Integral Aspect of U.S. Health Care Finance

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The LEWIN GROUP

Overview

- Cost Shifting Defined
- Criteria for Evaluating Public Payer Administered Payment Systems
- Cost Shifting in the Hospital Industry
  - Cost shifting "hydraulic"
  - Relationship between the need to cost shift and private payer payment-to-cost by state
  - Three case studies
- Evidence of Physician Cost Shifting
- Cost Shifting in the Nursing Facility Industry
- Policy Implications and Questions

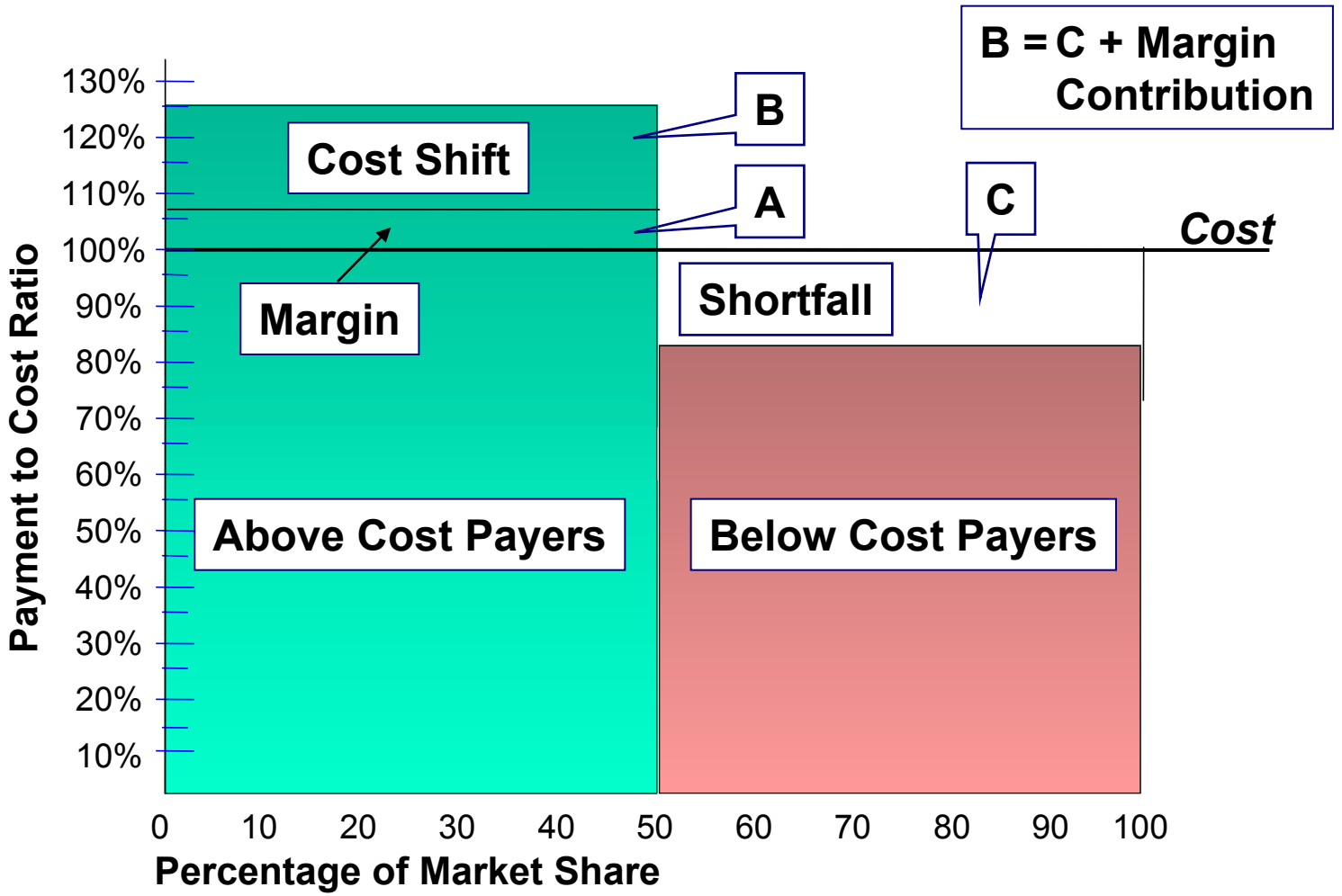
What is Cost Shifting?

- The allocation of unpaid costs of care delivered to one patient population through above-cost revenue collected from other patient populations.
- For hospitals, nursing facilities and physicians, the historical cause of cost shifting has been attributed to below-cost reimbursement rates paid by public programs and uncompensated care losses due to charity care or bad debt.

What is Cost Shifting? (continued)

- Privately insured patients have generally financed losses from other payers
  - below-cost (marginal cost) reimbursement rates
  - uncompensated care
- In some states, Medicare and/or Medicaid (plus DSH) payments exceed costs.
- Given the need to cost shift, hospitals may reduce their costs which can increase efficiency or impact quality.
- The ability to cost shift to compensate for one payer's reduction in revenue is limited if hospitals have already maximized revenues on remaining payers.

Hospital Cost Shifting "Hydraulic"



Cost Shifting: An Integral Aspect of U.S. Health Care Finance

- Cost shifting is an implicit social compact between public payers and providers.
- Cost shifting supplements public funding of safety net providers.
- Cost shifting in nursing home industry shifts costs from Medicaid to both Medicare and private payers.
- Cost shifting varies geographically based on market power of the providers, public payer (Medicaid) payment levels, and the levels of uncompensated care.
- Without cost shifting, providers might not be able to modernize and replenish physical plants and equipment.

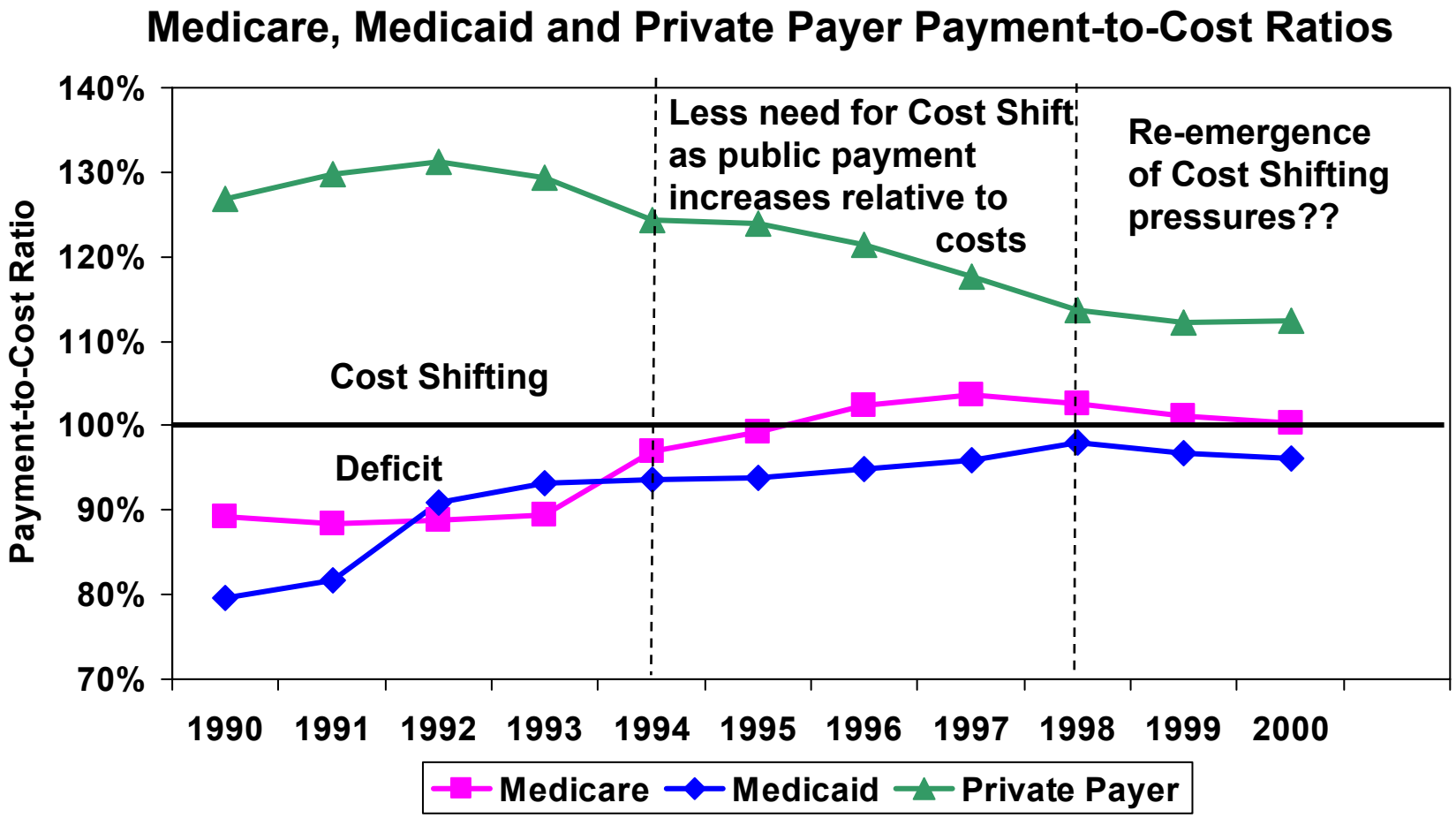
Public Payer Administered Provider Payment Rates Should Be……..

- **Adequate enough to encourage program participation and ensure provider financial stability**
- Low enough to minimize taxpayer burden
- Easy to explain and understand
- Easy to administer
- Appropriate to encourage the provision of care in the most appropriate clinical setting
- Predictable for providers

But in practice, many of these criteria are not met and cost shifting, especially at the state level, is a widespread phenomenon as public payers often do not pay full costs.

Cost Shifting in the Hospital Industry

Cost Shifting as an Evolving Phenomenon In The Hospital Industry

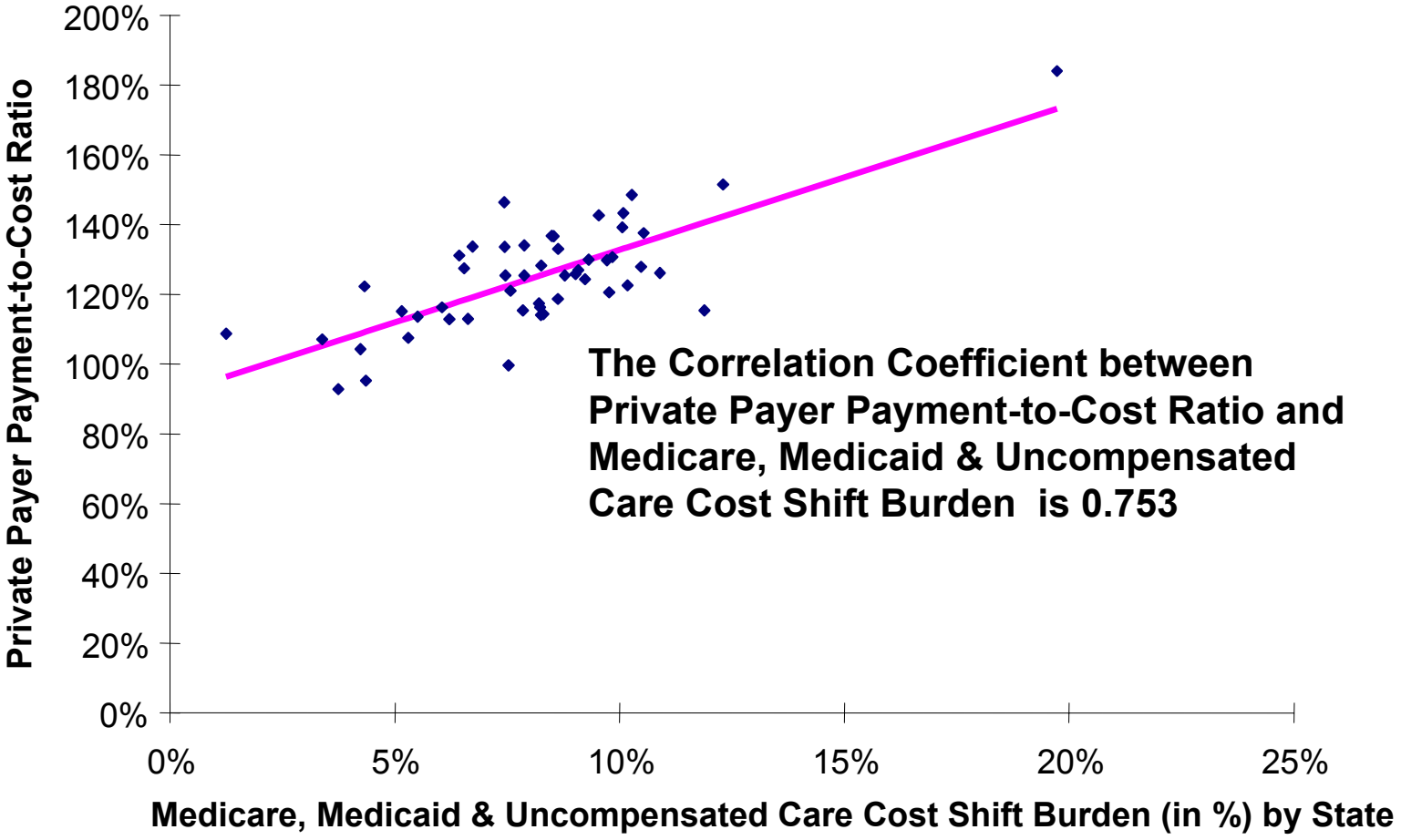


Source: MedPAC report to Congress, March 2002, Figure 5-9 as modified by The Lewin Group.

Dynamics of Cost Shifting in the Hospital Industry

- Cost shifting promotes the stability of hospital financial margins.
- As hospitals were affected by the BBA and intense pressure from managed care during the late 1990s, cost shifting abated and margins fell. This may have reversed in 2000.

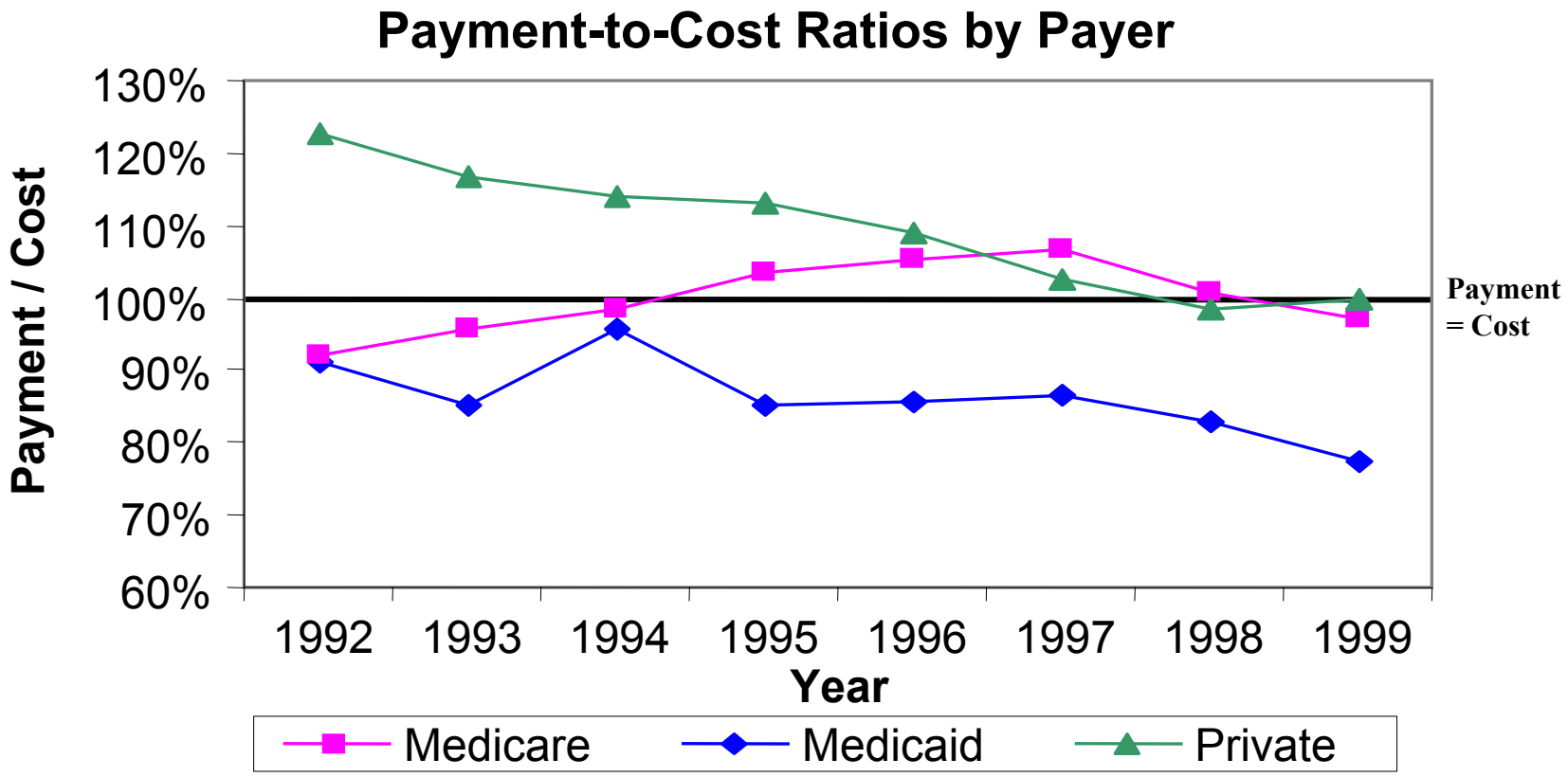
For Community Hospitals, as the Cost Shift Burden Increases the Private Payment-to-Cost Ratio Increases



Source: The Lewin Group analysis of data contained in AHA TrendWatch Chartbook: Trends Affecting Hospitals and Health Systems, 2001.Includes data for hospitals that reported data in the AHA Annual Hospital Survey.

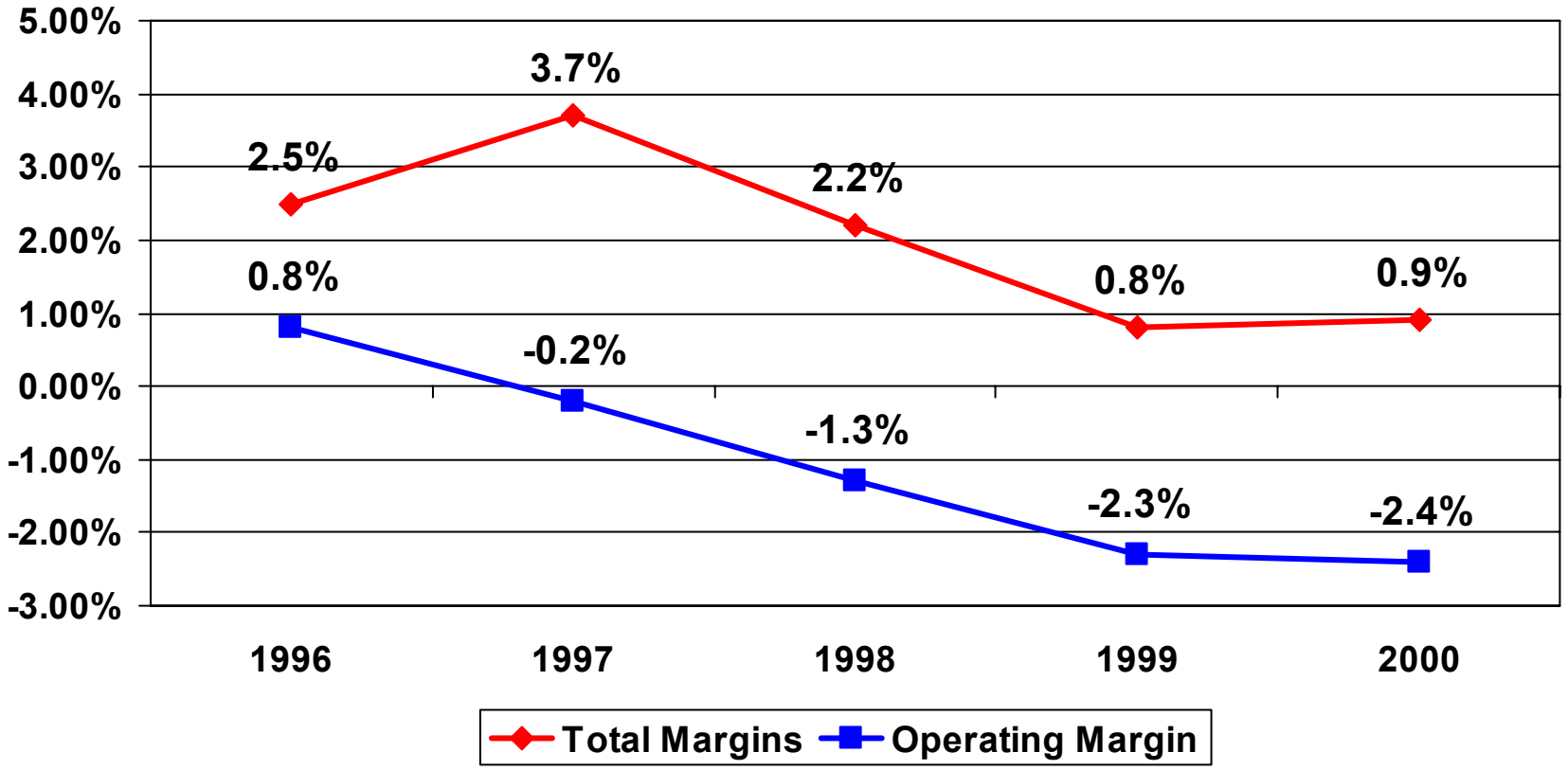
Three Case Studies

Hospitals in Massachusetts Have Lost Market Power and the Ability to Shift Costs



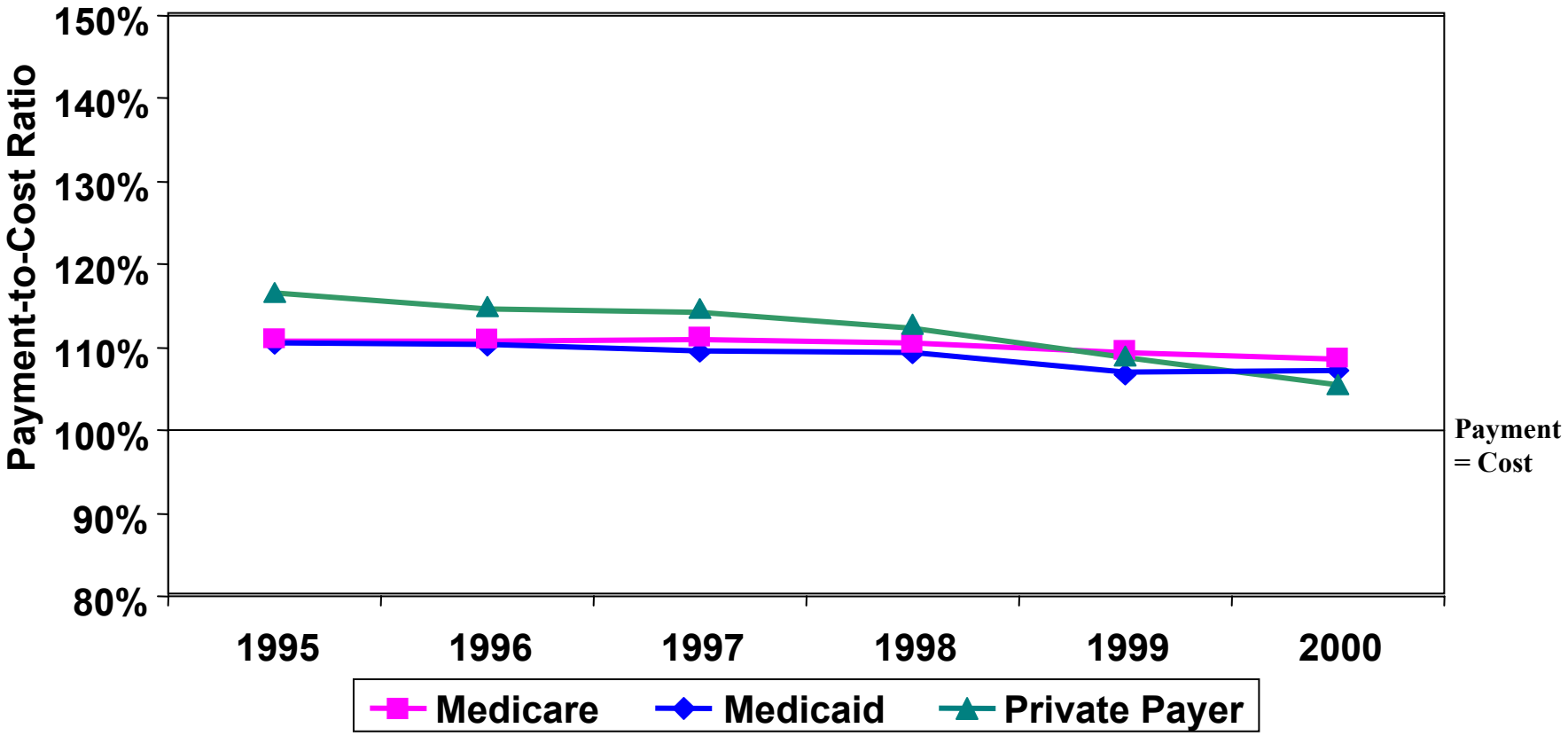
Source: The Lewin Group, "Analysis of Medicaid Reimbursement Rates for Acute Hospitals, Nonacute Hospitals, and Community Health Centers in Massachusetts," prepared for Massachusetts Division of Medical Assistance, June 25, 2001.

With The Inability To Shift Costs, Margins Have Fallen For Massachusetts Hospitals



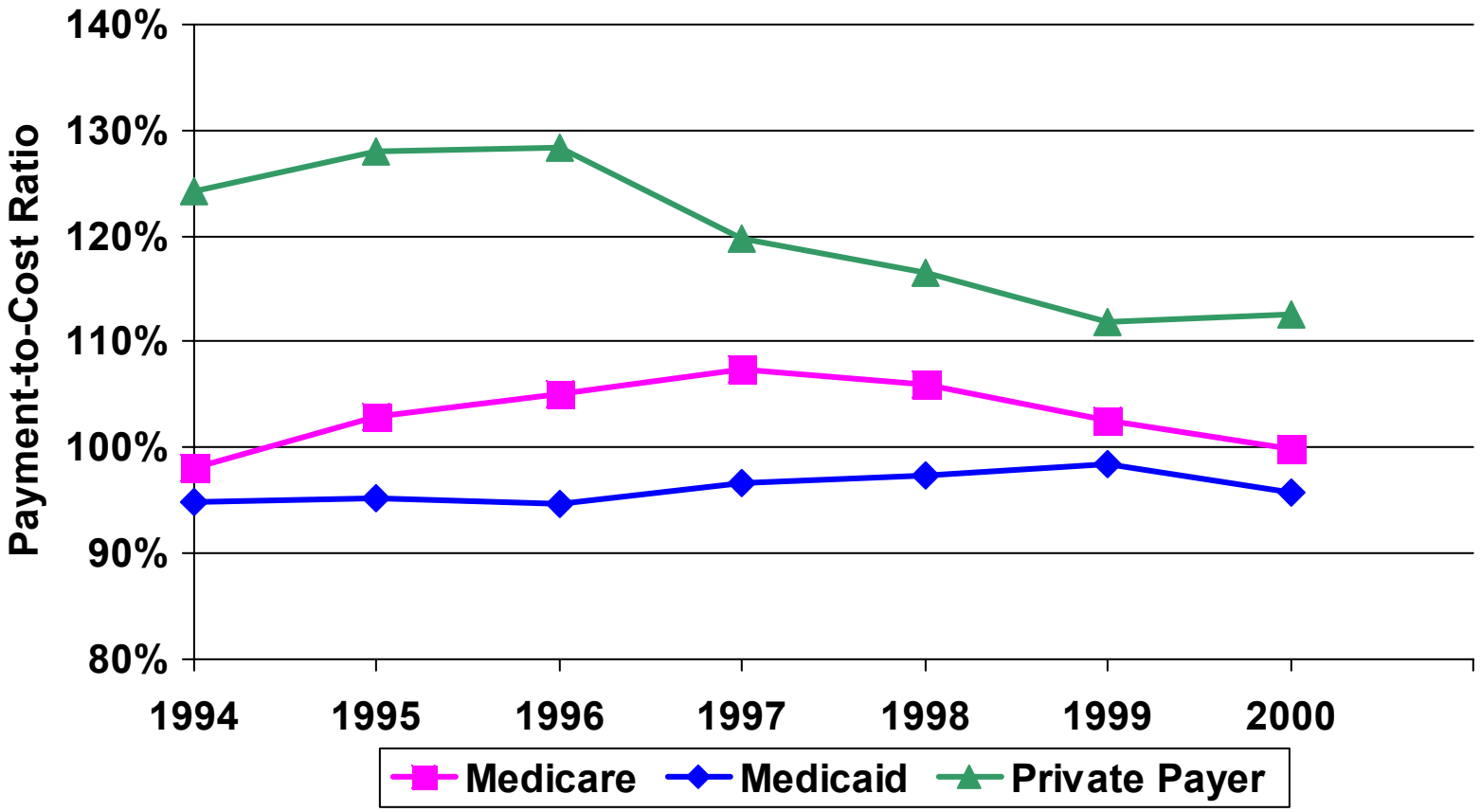
Source: The Lewin Group, "Analysis of Medicaid Reimbursement Rates for Acute Hospitals, Nonacute Hospitals, and Community Health Centers in Massachusetts," prepared for Massachusetts Division of Medical Assistance, June 25, 2001.

Maryland's All Payer Rate Setting System Equalizes Payment-to-Cost Ratios Across Payers



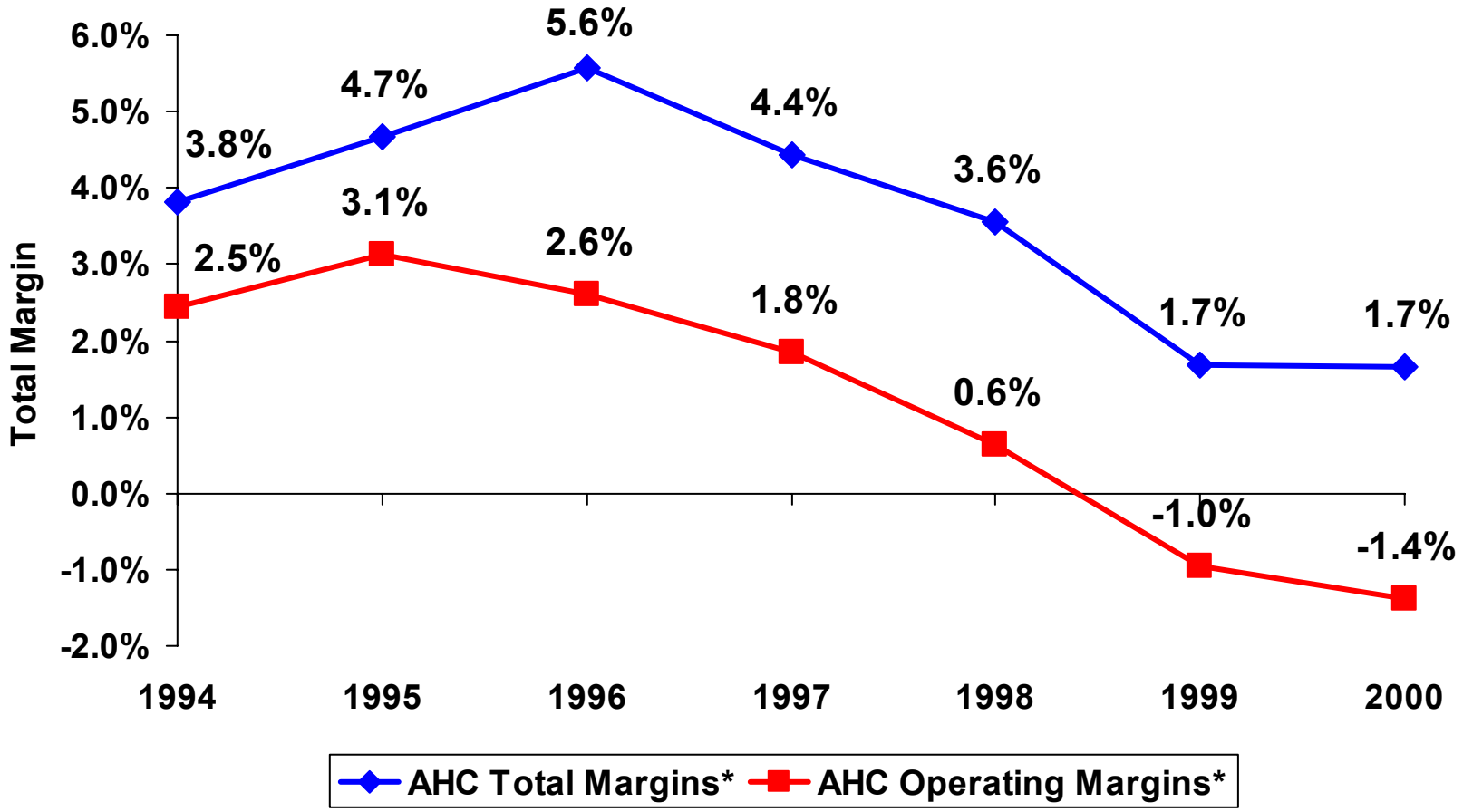
Source: The Lewin Group analysis of AHA Annual Survey data.

Cost Shifting among Academic Health Center Hospitals has Declined



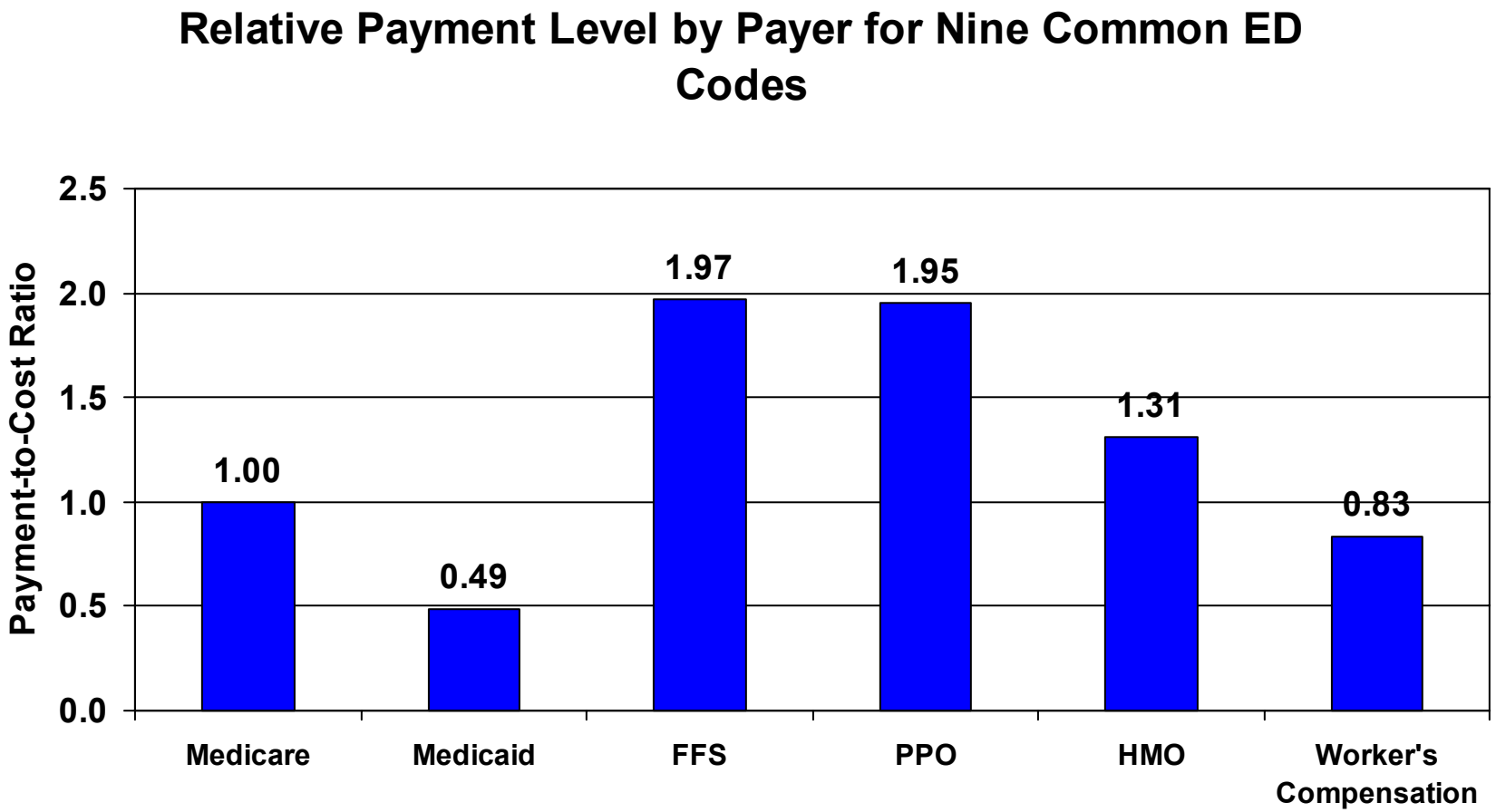
Source: The Lewin Group, "Financial Performance of Academic Health Center Hospitals, 1994 – 2000," prepared for The Commonwealth Fund, September 2002.

As have Academic Health Center Hospital Margins



Source: The Lewin Group, "Financial Performance of Academic Health Center Hospitals, 1994 – 2000," prepared for The Commonwealth Fund, September 2002.

Evidence of Physician Cost Shifting



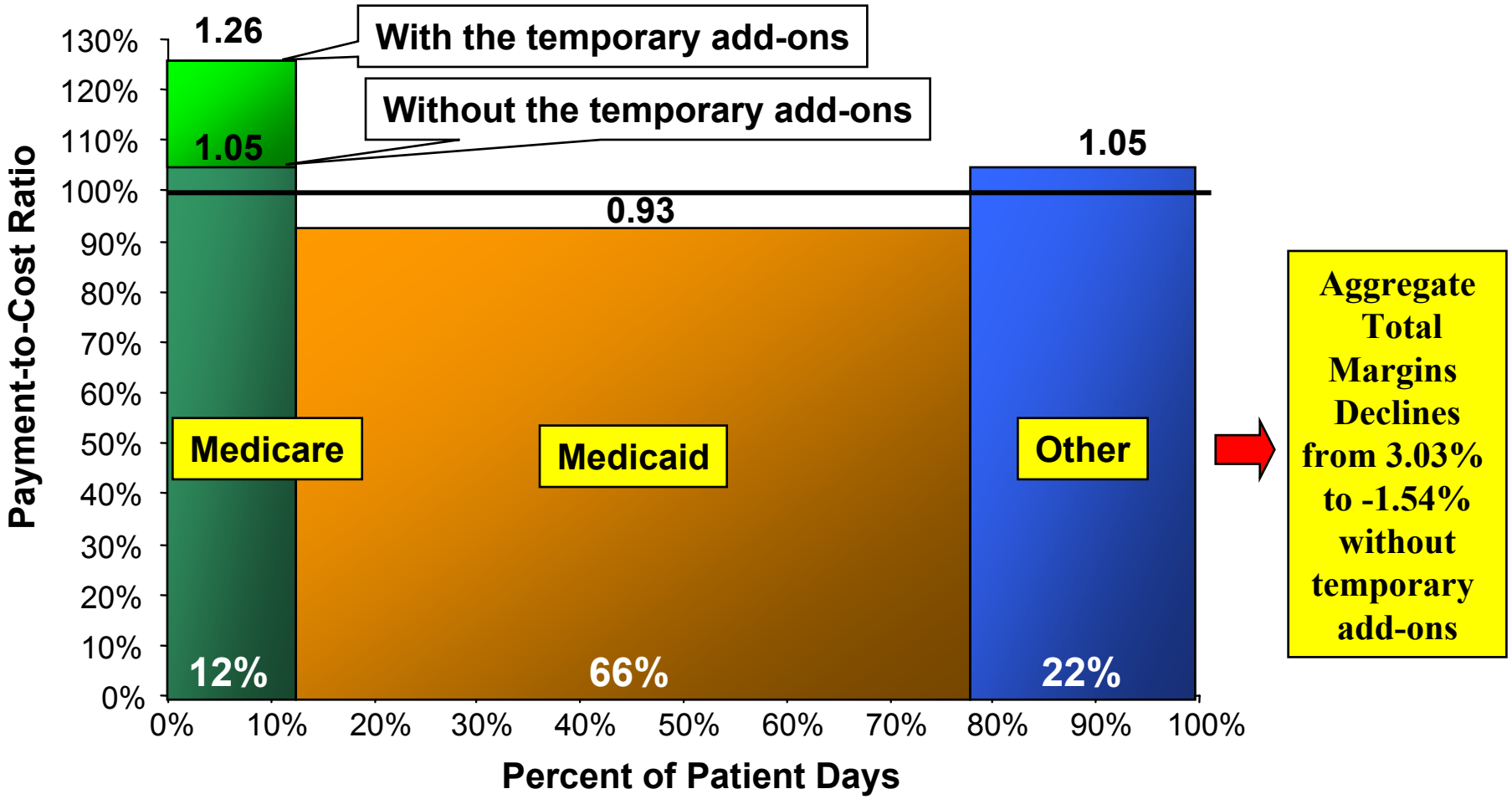
Source: The Lewin Group, "The American College of Emergency Physicians (ACEP) Practice Expense Study", for the American College of Emergency Physicians, September 15, 1998.

Cost Shifting in the Skilled Nursing Facility Industry

Background

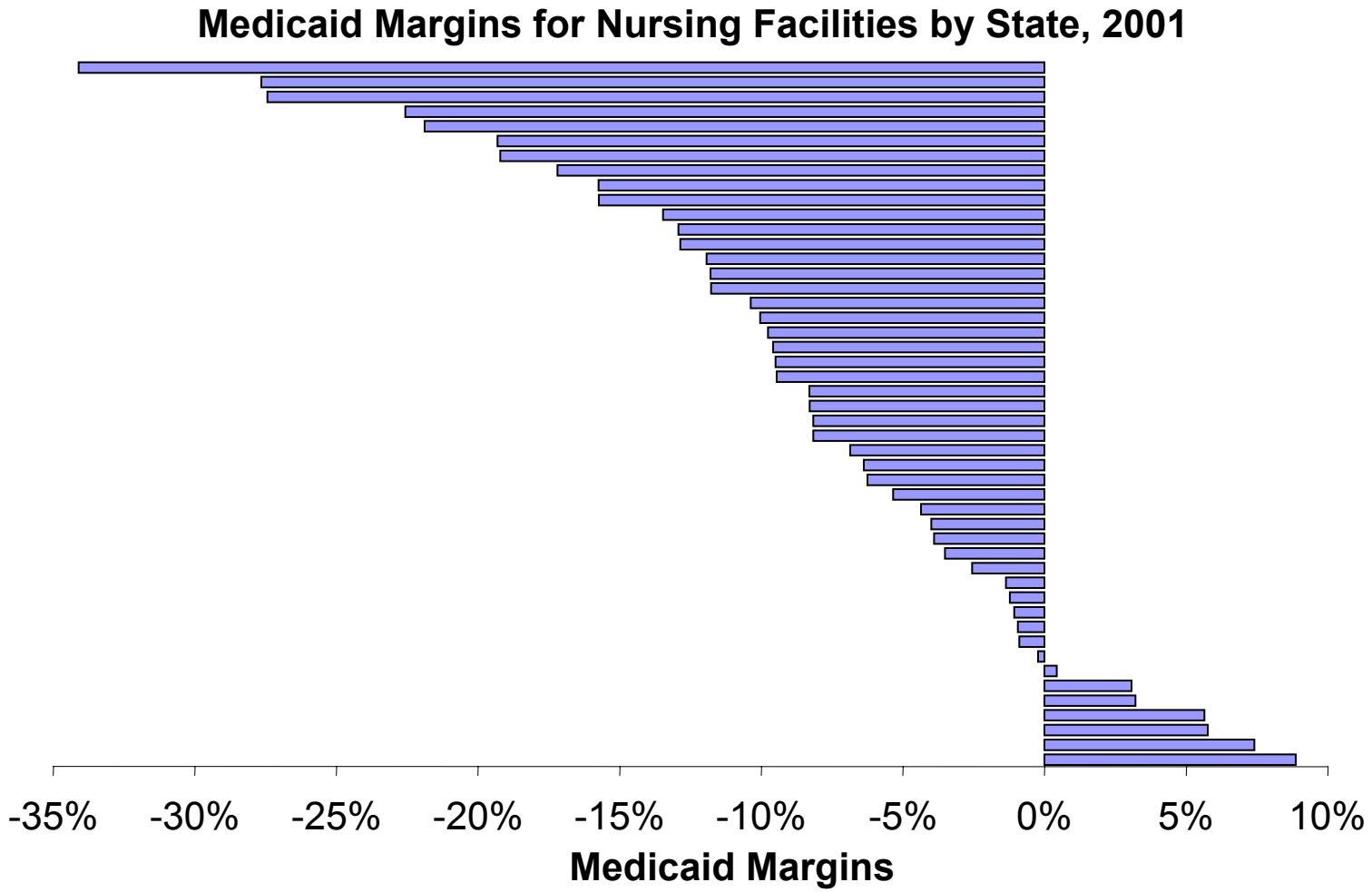
- Historically, Medicare generally subsidized Medicaid underpayment for the nursing facility industry.
- The Balanced Budget Act of 1997 required the implementation of a skilled nursing facility (SNF) prospective payment system which presented significant challenges to the SNF industry.
- With the extension of the "RUGs refinement" and other payment add-ons, Medicare continues to support Medicaid underpayments in the nursing facility industry.

With Medicaid Underpayments, Medicare Plays a Significant Role in Financing the Nursing Facility Industry



Source: The Lewin Group, "Payer-Specific Financial Analysis of Nursing Facilities," prepared for American Health Care Association / Alliance for Quality Nursing Home Care, March 1, 2002

Medicaid Margins for Nursing Facilities Varies by State



Source: Unpublished results from The Lewin Group survey of nursing facilities conducted for American Health Care Association / Alliance for Quality Nursing Home Care.

Policy Implications and Questions

Policy Implications

- Cost shifting enables many uninsured individuals to receive medical care.
- Cost shifting implicitly "taxes" the premium rates of insured individuals. This "tax" may price some small business purchasers out of the insurance market altogether.
- This cost shifting "tax" varies dramatically state by state.

Key Policy Questions

- Does cost shifting exist between public payers (e.g. Medicare cross subsidizes Medicaid) ?
- How does the variability in the combined Medicare and Medicaid payments relative to costs for hospitals and nursing facilities across states affect providers groups and other stakeholders?
- Should the federal government study the joint effect of Medicare and Medicaid payment upon providers?
  - Analysis of state by state differences
  - Coordination of Medicaid/Medicare payments to ensure horizontal equity across states