
VERMONT HOSPITAL COST SHIFT REPORT

April, 2013

Green Mountain Care Board

Purpose of this report

- Develop an understanding of the cost shift
- Present information about the magnitude and effect of the cost shift
- Identify the problems with calculating the cost shift
- Examine options for addressing cost shifting as part of health care reform

What is the cost shift? Two views...

1. Commercial insurers (and uninsured individuals) are charged higher prices to compensate for bad debt, free care, and underpayments by Medicare and Medicaid.
2. Cost shifting is evidence of a market failure, showing that commercial insurers are not able to negotiate effectively with providers.

A more balanced view of cost shifting

- It is real – private payers pay more because public payers underpay
- But there should be a limit to this effect – at some point private payers will refuse to pay for additional cost shift
- Degree to which private payers exert control relates to provider market power
- Lack of transparency also makes it difficult for private payers to exert control
- The regulatory system can counter-balance provider power or reinforce it

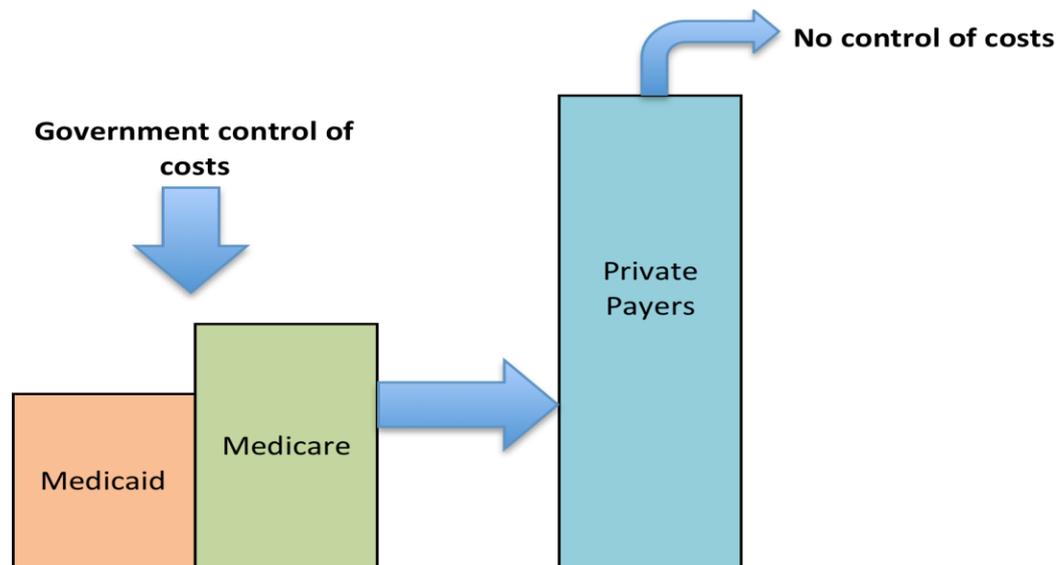
Evidence of the provider market power effect?

“A common assumption is that hospitals have little control over their costs and must charge high rates to private health insurers when Medicare rates are lower than hospital costs. We present evidence that contradicts that assumption. Hospitals with strong market power and higher private-payer and other revenues appear to have less pressure to constrain their costs.”

Stensland, Gaumer and Miller, “Private Payer Profits Can Induce Negative Medicare Margins,” Health Affairs, May 2010 volume 29 number 5.

Effect of cost shift on costs

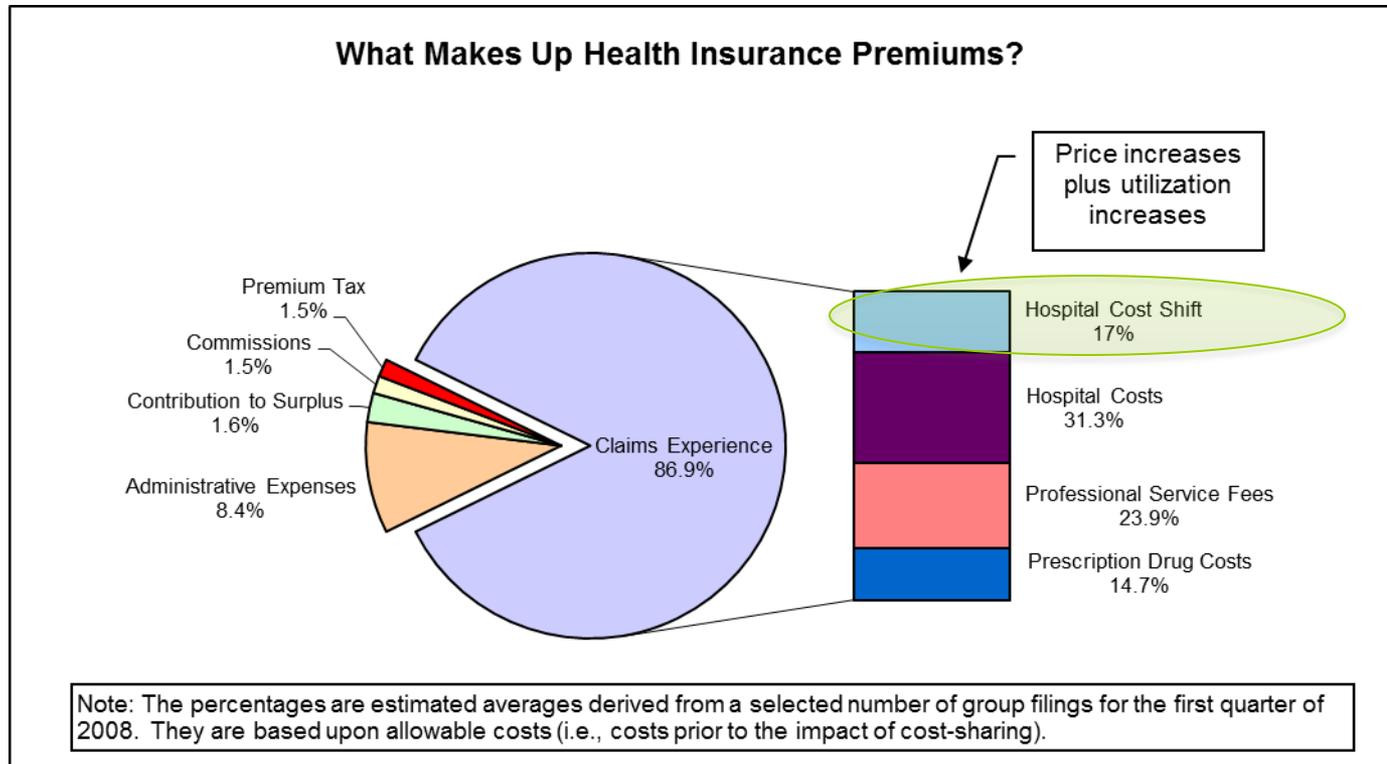
- Cost shifting does not affect overall costs, only the distribution of costs across payers and across providers
- On the other hand, the complexity brought to the system by cost shifting undermines cost control



What is the magnitude of the cost shift in dollars?

COMMUNITY HOSPITAL SYSTEM						
(in 000's)	Medicare (in 000's)	Medicaid	Free Care	Bad debt	Commercial & Other	
ACT 05	(\$55,848)	(\$57,652)	(\$40,836)		----->	\$154,335
ACT 06	(\$53,748)	(\$81,612)	(\$41,375)		----->	\$176,735
ACT 07	(\$59,774)	(\$88,256)	(\$48,247)		----->	\$196,277
ACT 08	(\$69,004)	(\$103,569)	(\$23,624)	(\$30,253)	----->	\$226,450
ACT 09	(\$73,627)	(\$119,979)	(\$24,292)	(\$32,391)	----->	\$250,290
ACT 10	(\$73,516)	(\$138,017)	(\$24,806)	(\$33,077)	----->	\$269,416
ACT 11	(\$88,400)	(\$152,257)	(\$25,784)	(\$34,331)	----->	\$300,772
Bud 12	(\$100,411)	(\$170,216)	(\$25,285)	(\$40,176)	----->	\$336,087
Act 12	(\$68,625)	(\$151,847)	(\$27,273)	(\$39,243)	----->	\$286,988
Bud 13	(\$142,359)	(\$183,340)	(\$26,759)	(\$39,929)	----->	\$392,387

What is the impact of the cost shift on commercial insurance premiums?*



* 2011 estimates extrapolated from 2008 data

What percentage of provider costs does Medicare pay?

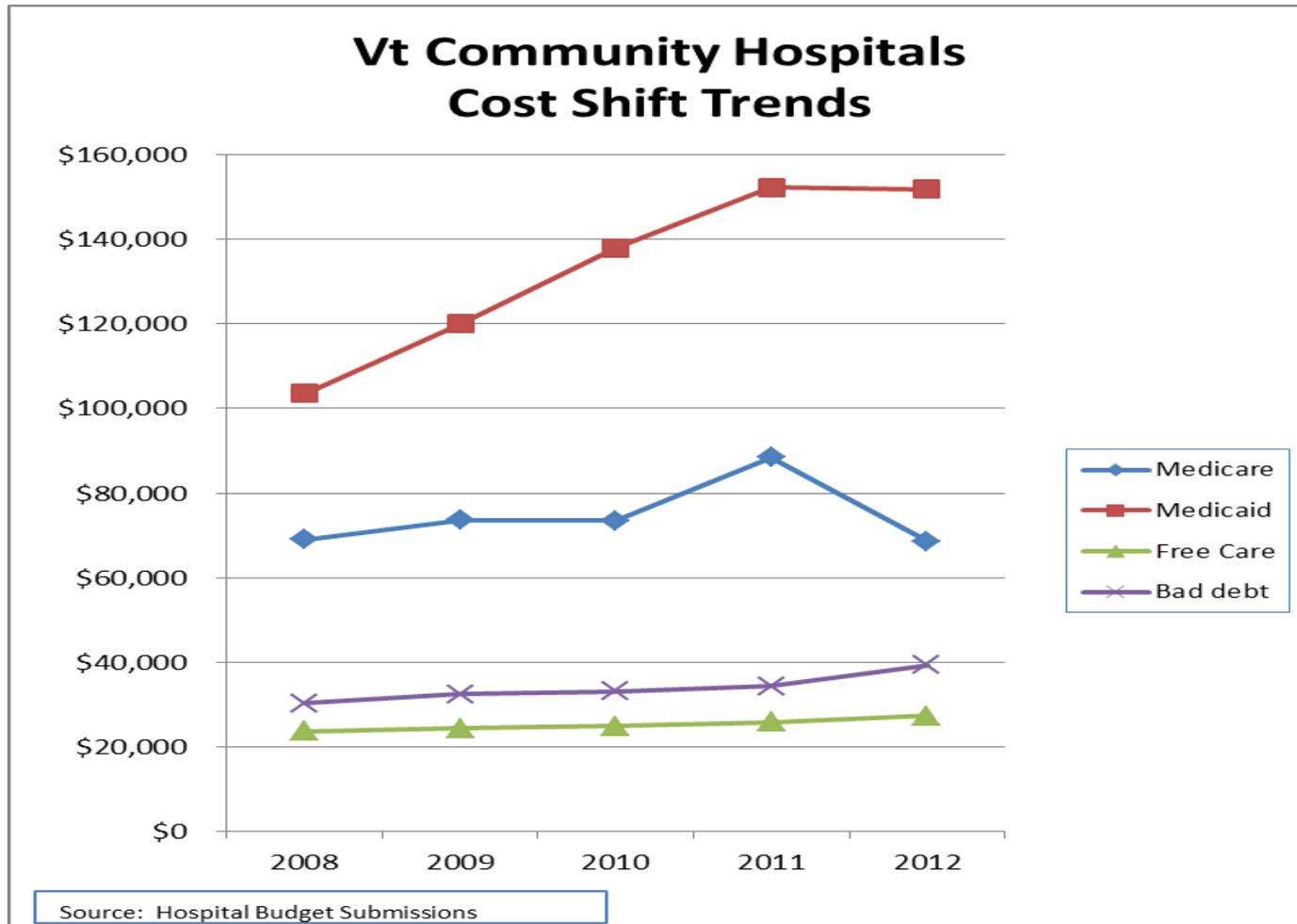
- Some controversy about the answer to this question
- Calculations run from 79% of hospital costs to more than 100%, with median at 92%
- Medicare covers “costs” as defined by the federal government
- Medicare does not cover certain categories of expenditures

What percentage of provider costs does Medicaid pay? Two methods of calculating

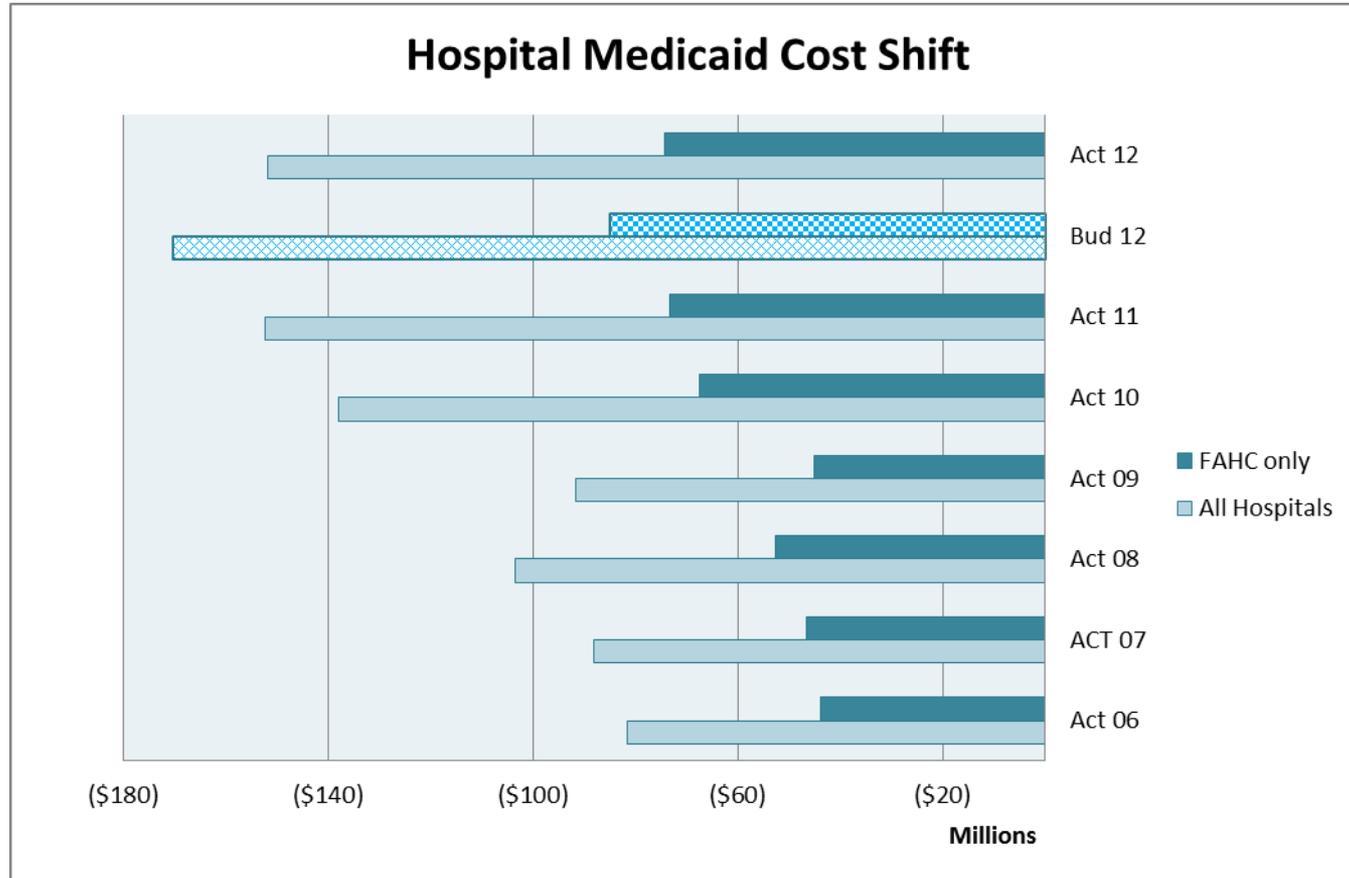
	Provider Tax as Revenue deduction		Provider Tax as Expense	
	"State"		"State"	
	FY 2013	Budget	FY 2013	Budget
Medicaid VT				
Gross Patient Service Revenue		680.2	680.2	
Deductions				
Contractual Allowances		(467.2)	(467.2)	
DSH		37.3	37.3	
Provider Tax		(116.1)		
Total Deductions		(546.0)	(429.9)	
Net Patient Revenue		134.2	250.3	
Allocated: Other Revenue		15.2	15.2	
Total Revenue		149.4	265.5	
Expenses:				
Allocation on RCC		307.9	307.9	
Provider Tax			116.1	
Total Expenses		307.9	424.0	
Cost Shift Prior to Net Income/Loss		(158.5)	(158.5)	
Cost Coverage (Total Rev / Total Exp)		48.5%	62.6%	

Accounting for the provider tax affects cost coverage ratio

How has the cost shift changed over time?



Growth in Medicaid cost shift over time: more than doubled over six years



How could we address the cost shift as part of health care reform?

- Increase Medicaid payments
- Track those increases through the hospital budget process so they reduce cost-shifting to commercial payers
- Participate in Medicare demonstration projects that provide for reasonable rates of increase
- Use rate-setting authority to reduce rate variation and strengthen the market – more transparent and fair pricing provides payers leverage to negotiate on real costs and quality

An economist's perspective: if costs are getting shifted, then the market is failing

“If the cost-shift theory is generally valid, it implies that in many local markets, private health insurers bring relatively weak market power to the bargaining table with major hospitals or groups of physicians. This would explain why they cannot resist price increases triggered by the alleged cost shift and pass these on to their clients. But if they cannot resist price increases triggered by low Medicare and Medicaid payments, they are unlikely to be able to resist price hikes triggered by other cost drivers—for example, the so-called medical arms race, the instrument for nonprice competition through which hospitals seek to attract both patients and physicians with ever more expensive technologies and treatments.

Furthermore, if private insurers have insufficient market power with providers and therefore the cost-shift theory is valid, it raises the question to what extent the nation can rely on private health insurers as agents of cost control. As long as such imbalances in the allocation of market power persist between providers—especially hospitals—and private insurers, cost control by private insurers would be an illusion.

If the argument is that the private market sets prices for health care appropriately, and that government should adapt the prices it pays to those private-sector norms, then the question is how exactly one would determine these price norms, given the huge variation of prices for identical services within the private market, even within small areas such as cities.”

Uwe E. Reinhardt, Health Affairs November 2011 vol. 30 no. 11: 2125-2133.

VERMONT HEALTH REFORM



Most payers don't pay charges

Payment Type	Inpatient		Outpatient	
	6 Prospective Payment Hospitals (PPS)	8 Critical Access Hospitals (CAH)	6 PPS Hospitals	8 CAH Hospitals
DRG Medicare	X			
DRG Medicaid (%Medicare)	X	X		
Commercial Discount off Charges/Per Diem/DRG	X	X		
Commercial Discount off Charges/Fee Schedule			X	X
Medicare Cost		X		X
Medicare Fee Schedule			X	
Medicaid Fee Schedule			X	X

Chargemaster example: Price of Chest X-Ray – Current System

- Current system

Income				
Payer	% Total	Volume	Paid @	Tot Paid
Other	5%	50	\$396.82	\$19,840
Comm. (90% charge)	25%	250	\$357.14	\$89,285
Medicaid (75% cost)	20%	200	\$187.50	\$37,500
Medicare (85% cost)	50%	500	\$216.75	\$108,375
Tot. Inc.				\$255,000
Cost		Volume	Cost@	Tot. Cost
Chest X-Ray		1000	\$250.00	\$250,000
Profit (2%)				\$5,000

Chargemaster example: Price of Chest X-Ray – All Payer System

- All-payer example, reduces prices from from \$397 to \$255

Income				
Payer	% Total	Volume	Paid @	Tot Paid
Other	5%	50	\$255.00	\$12,750
Comm. (90% charge)	25%	250	\$255.00	\$63,750
Medicaid (75% cost)	20%	200	\$255.00	\$51,000
Medicare (85% cost)	50%	500	\$255.00	\$127,500
Tot. Inc.				\$255,000
Cost				
		Volume	Cost@	Tot. Cost
Chest X-Ray		1000	\$250.00	\$250,000
Profit (2%)				\$5,000

* Both Medicare and Maryland allow for variation in charges across hospital categories, but all payers pay the same rate within a category

Assumptions built into our calculation of cost shift

- All payers are treated equally for allocation of most costs
 - It is assumed that they all “owe” an average cost
 - They each pay their share of the operating surplus
 - Bad debt and free care are treated as a separate category of “cost-shifter” – not allocated to other payers
 - Payers’ share expenses are not adjusted for the complexity of illness in their covered populations or differences in the type of services for which they pay
- Provider tax is treated separately

Problems with calculating the cost shift

- Provider systems are not designed to capture costs by payer and/or specific services.
- Actual costs for services to patients are estimated at the payer level. Accounting systems are not designed to measure input costs by payer type.
- Actual costs for bad debt and free care have similar problems and may be understated – improvements forthcoming.
- All payers are assumed to have a “responsibility” to pay their share of the operating surplus.

Issues to be addressed: future improvements in cost shift calculations

- Better treatment of bad debt free care costs
 - Would change the impact of the cost shift by payer
- Payer allocations that could change impact of cost shift by payer
 - Provider tax
 - Operating surplus
- Reporting considerations
 - Disproportionate share
 - As a revenue or a contra deduction
 - Better disclosure
 - Provider tax
 - As an expense or revenue deduction
 - Impact on the cost coverage ratio
- How should we value Medicaid payment rates?
 - Payments alone
 - Payments plus disproportionate share less provider tax

Acknowledgements

This report would not have been possible without the work of many individuals, including Kara Suter of the Department of Vermont Health Access, Marc Stanislas and Amy Vaughan of Fletcher Allen Health Care, Spenser Weppler and Richard Slusky of the Green Mountain Care Board staff, Steve Kappel of Policy Integrity and Mike Del Trecco of the Vermont Association of Hospitals and Health Systems. If you have questions about this report, please contact Michael Davis or Lori Perry at the GMCB: (802) 828-2177. The GMCB is solely responsible for the content of this report and any opinions expressed herein.