COST SHIFTING

A LOOK AT PROVIDER BEHAVIOR
WHEN PUBLIC PAYER RATES AREN'T ENOUGH

Presentation to the Public Payer Commission
Thursday, June 26, 2014

http://quoteinvestigator.com/2013/04/11/better-light/

CHIA.
center for health information and analysis

Cost shifting is the idea that providers can make up for shortfalls in Medicare or Medicaid revenues by increasing the prices charged to private payers.

Source: Frakt, Austin, “A cost shifting update,” AcademyHealth Blog. Dec. 12, 2013.
http://blog.academyhealth.org/a-cost-shifting-update/

Different payers pay different prices. That observation doesn't tell us why.

Nationwide, commercial payments are approximately 135% of total expenses.

100% of Average Costs

Medicaid … 95% of total expenses.
Medicare … 91% of total expenses.

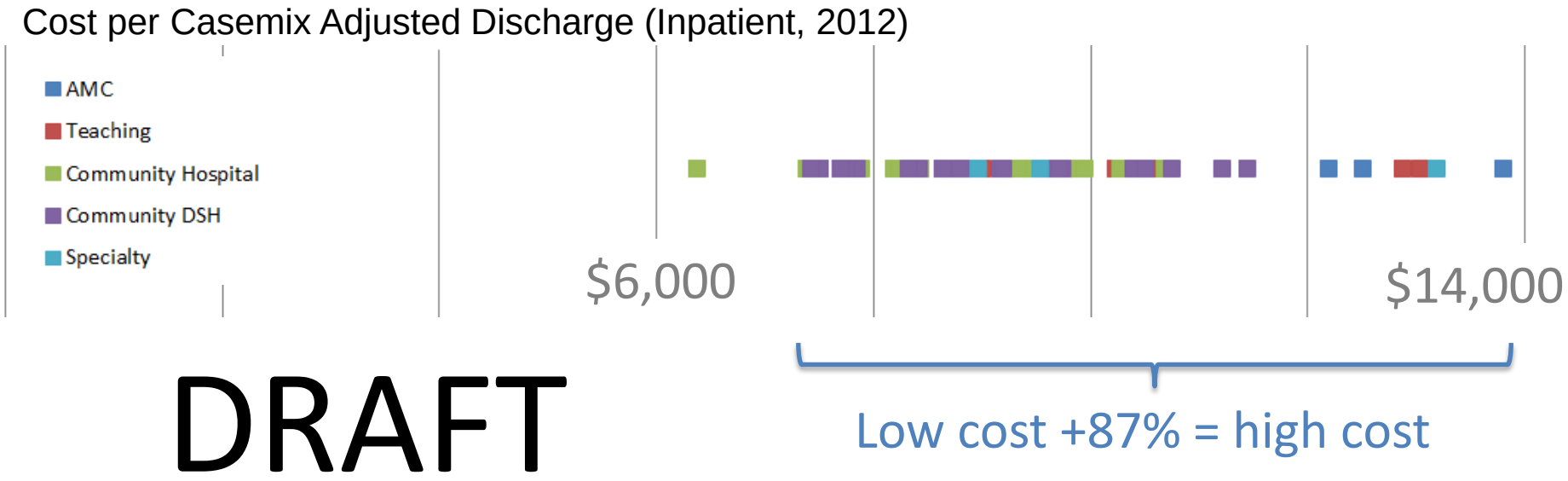
0%

Source: 2011 Aggregate U.S. hospital payment-to-cost ratios. Health Policy Commission, *2013 Cost Trends Report*. http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-full-report.pdf based on data from Avalere Health analysis of AHA Survey data.

When hospitals face lower public payer rates, they have one of three options:

1. Reduce costs
2. Reduce profit expectations
3. Increase revenue

1. Reduce Costs
Costs vary widely between hospitals



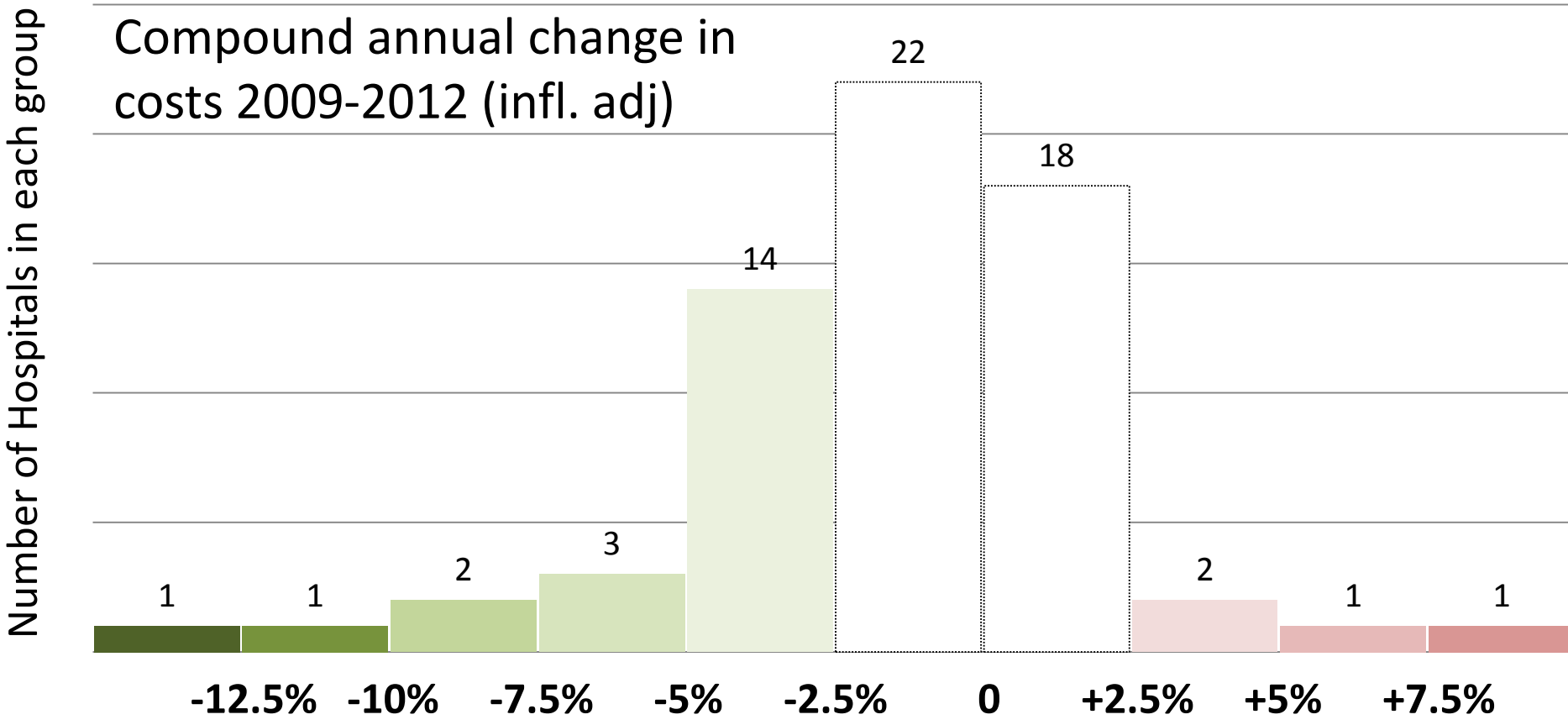
DRAFT

Source: Cost per casemix adjusted discharge, 2012 all hospitals. CHIA Acute Hospital data book: http://www.mass.gov/chia/researcher/hcf-data-resources/massachusetts-hospital-profiles/overiew-and-current-reports.html

Chart excludes three small geographically isolated hospitals with high per discharge costs.

1. Reduce Costs

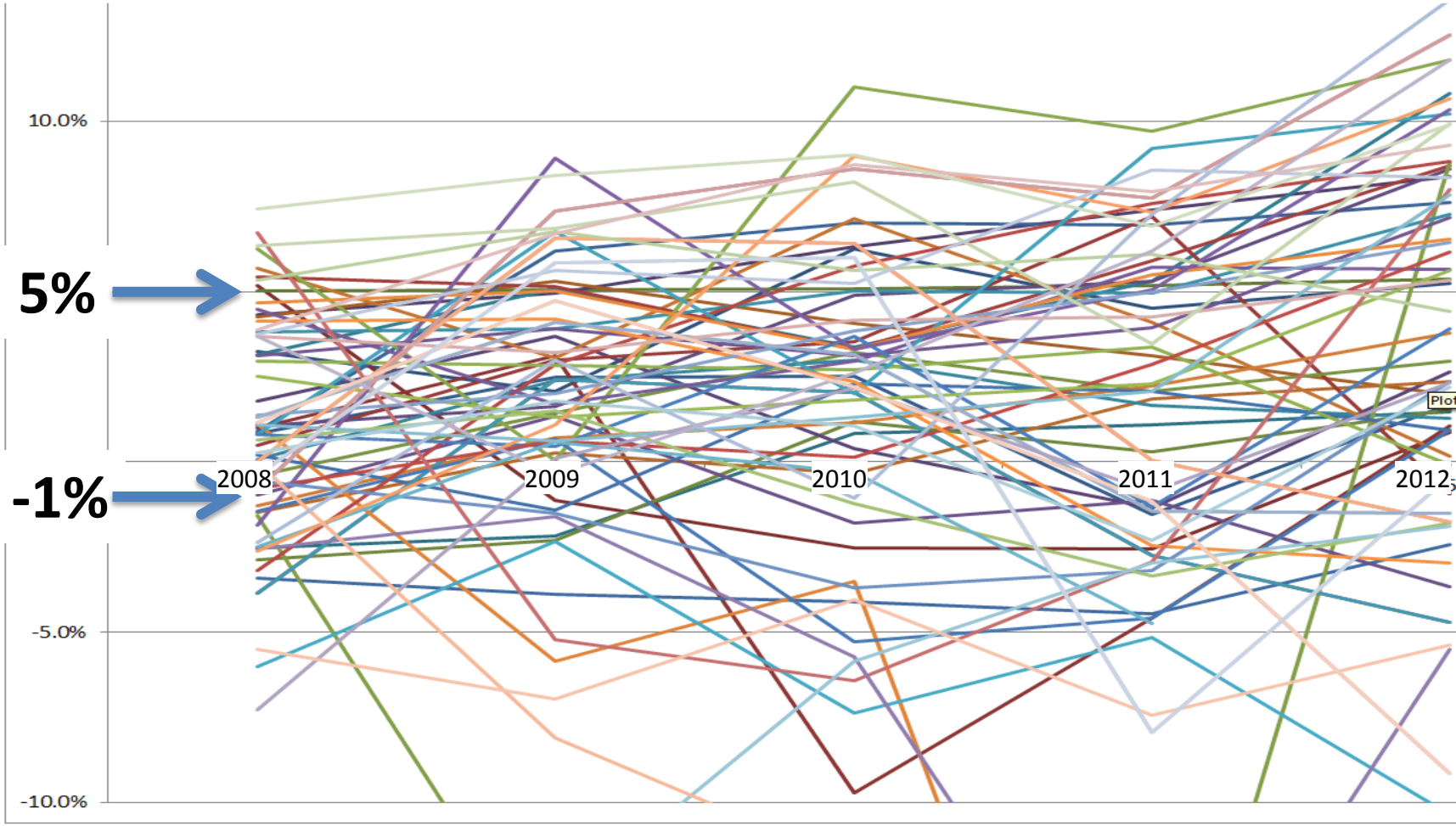
Many hospitals have been successful in reducing costs year-over-year.



Source: Change (CAGR) in Cost per casemix adjusted discharge, 2009-2012 all hospitals. Adjusted for inflation using CPI-U Northeast
CHIA Acute Hospital data book:
http://www.mass.gov/chia/researcher/hcf-data-resources/massachusetts-hospital-profiles/overiew-and-current-reports.html

2. Reduce Profits

Total Margins tend to be modest, but some hospitals are consistently successful.



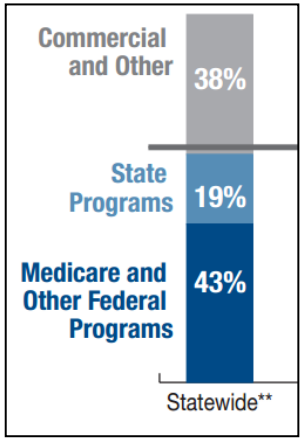
Source: Acute hospital Total Margins 2008-2012. CHIA Acute Hospital data book:
http://www.mass.gov/chia/researcher/hcf-data-resources/massachusetts-hospital-profiles/overiew-and-current-reports.html

3. Increase Revenue

Increasing revenue is a complex and multifaceted challenge.

Improve Medical Coding to Maximize Payment

Change Payer Mix or Service Mix



Increase Volume

Seek Other Revenue

3. Increase Revenue
How would cost shifting work?

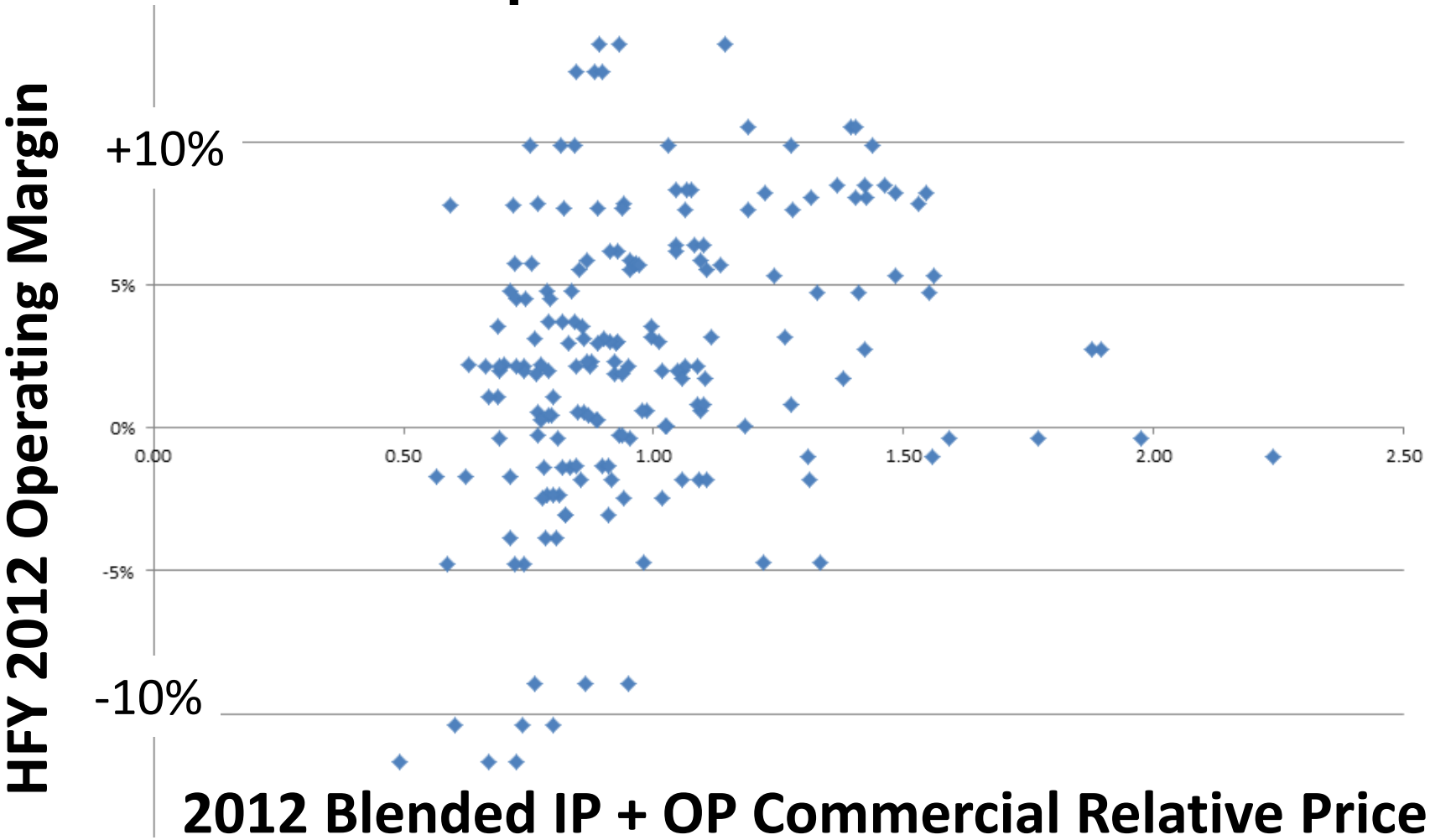
For Cost Shifting to be a viable option, providers must have sufficient power to set rates well above [marginal or average] costs of providing the services.

For it to be the dominant strategy, you need cost shifting to be the most available (least painful) option:

- Operating costs hard to decrease
- No room to decrease profits
- No other sources of revenue available
- High bargaining leverage with payers

Take a deep breath

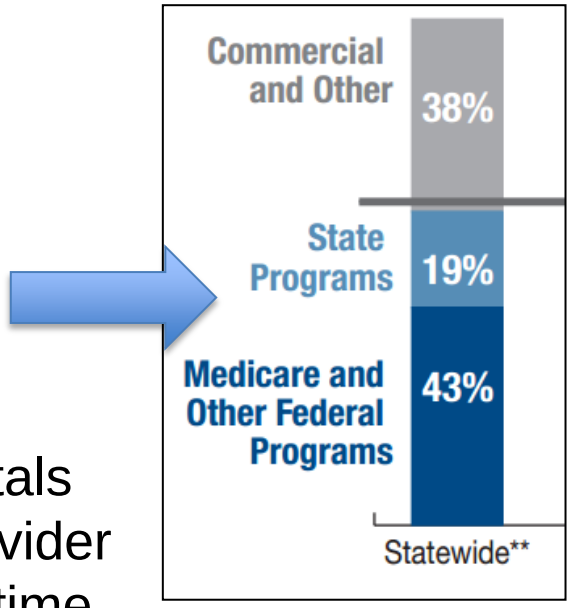
Commercial price seems to be (weakly) correlated with profits.



Source: CHIA Acute Hospital data book:
http://www.mass.gov/chia/researcher/hcf-data-resources/massachusetts-hospital-profiles/overiew-and-current-reports.html

Cost Shifting: the Evidence

- Cost shifting is small or maybe even negative.
- Medicare cost shifting is bigger than Medicaid (Medicare is a bigger deal for hospitals).
- Studies have focused predominantly on hospitals and may be difficult to extrapolate to other provider types. Findings are specific to certain point in time and market conditions.
- Experiences at individual providers may be vary from the effect across the market.



Conclusions

Prices Vary. We can’t say precisely why.

Providers may respond to public payer payment reductions in a variety of ways.

Evidence for cost-shifting is modest and mixed at best and magnitudes seem to be small.

Circumstances matter and are specific to market position and other factors.

Payment systems that pay for value will simplify the incentives faced by hospitals.

Reference Slides

The following slides include a number of academic papers Studying cost shifting and related issues.

For ongoing reporting on the evidence, see Austin Frakt's blog: http://theincidentaleconomist.com/wordpress/tag/cost-shifting/

Morrissey 1996

Reviewed three types of studies:

1. Industry wide studies (3 major studies): Examine trends in industry wide "payment to costs" for public and private payers
   - Several methodological flaws to this approach:
     - Does not establish causality: not a dynamic analysis
     - Views cost as average cost rather than marginal cost; does not account for incentive of hospitals to cover their fixed costs
     - Does not account for potential differences in marginal costs of treating patients of different payers
2. Cross sectional studies (2 studies): Examine whether hospitals with lower Medicare and/or Medicaid payments have higher private prices
   - Results are inconsistent with cost-shifting
   - Limitation: Difficult to control for hospital specific differences

Morrissey 1996

3. Dynamic studies (2 studies): Examine change in private price as a result of a change in government payments
   - Hadley, Zuckerman and Iezzoni (1996):
     - Hospitals with low profits increased costs less and increased their efficiency, but did not increase their total revenues
   - Dranove and White (1996)
     - Examined the impact of changes in Medicaid and Medicare payments on California hospitals
     - Found negative and statistically significant effects of Medicaid and Medicare mix on the price/cost margins (i.e., hospitals with higher public payer mix had bigger decreases in price/cost margins)

Frakt 2011

- Reviewed literature from 1996-2011, including 9 relevant empirical studies
- Described historical context, notably:
  - 1987-1992: Medicare payment reductions, without significant containment pressures from private health plans
  - 1992-1997: Rise of managed care increases cost containment pressures from private health plans
  - 1997-2008: Managed care backlash and the Balanced Budget Act
- Summarized empirical studies:
- Cross sectional studies (2):
  - Stensland: Low private margins associated with lower cost and higher Medicare margins; high private margins associated with higher cost and lower Medicare margins
  - Dobson: Industry wide study shows correlation between states with higher private payment to cost ratios and states with “underpayment” from Medicare, Medicaid and uncompensated care

Frakt 2011

- Fixed effects models (2)
  - Studies of California market in 1983-1991 and 1997-2011 (Zwanziger 2000, 2006)
  - From 1983-1991, 0.17-0.59% increase in private prices in response to 1% decrease in Medicare; estimates range from a 0.04% decrease to a 0.07% increase in private prices in response to 1% decrease in Medicaid
  - From 1997-2011, 0.17% increase in private prices in response to 1% decrease Medicare; 0.04% increase in private prices in response to 1% decrease in Medicaid
- Difference models (5)
  - Three from California: Clement 1997/1998 with some evidence of cost shift (Medicare more than Medicaid); Dranove and White 1998 with no evidence of cost shift; Friesner and Rosenman 2002 did not support cost shifting but was based on charges, not payments
  - Cutler (1998) examined Medicare hospital payment reductions over two time periods (1985-1990 and 1990-1995). From 1985-1990, found dollar-for-dollar cost shifting, but none between 1990-1995.
  - Wu (2009) examined Medicare payment reductions as a result of the BBA (1996 and 2000) and found an average shift of 0.21 of each Medicare dollar lost.

Articles since 2011

- White 2013: Studied hospital payments from 1995-2009. Areas with lowest Medicare rate increases had the lowest private rate increases, and areas with the highest Medicare rate increase had the highest private rate increases
- White and Wu 2013: Examines changes in Medicare reimbursements between 1996-2009. Medicare cuts offset by cost-cutting, not cost-shifting. $1 loss in Medicare revenue associated with $1.55 in overall revenue loss ($1.40 in reduced operating expenses, $0.15 as reduced profits)
- Robinson 2011: Examined payment and costs for 7 common surgical procedures at 61 hospitals across 8 states in 2008. Hospitals with more market power get better reimbursements from private payers, and are also more likely to lose money on Medicare patients.