

# The Foundation, History and Implications of the Cost-Shift Hydraulic

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# Purpose

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- ◆ To define the cost-shift hydraulic
- ◆ To track the history of cost-shifting from 1980 to 2001
- ◆ To emphasize the importance of the cost-shift to healthcare finance system stability

# Defining the Cost-Shift

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- ◆ The cost-shift is not simply a set of differential prices as seen in the airline industry, but rather higher prices (above cost) systematically paid by one payer group to offset lower prices (below cost) paid by another payer group.
- ◆ In particular, the cost-shift is the allocation of unpaid costs of care delivered to one patient population through above-cost payments collected from other patient populations.
- ◆ The cost-shift also covers activities associated with hospital missions such as teaching, standby capacity and charity care.
- ◆ The cost-shift can be thought of as a “sick tax” levied on the insured to cover the costs of the under- and uninsured “sick.”

# Defining the Cost-Shift (continued)

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According to the Congressional Budget Office:

*“These results suggest that, in the current multiple-payer health care system, actions taken by one payer to control health spending can have a significant impact on spending by other payers—and therefore a more limited effect on total spending. As a consequence, in the absence of other changes, further attempts to control public-sector spending would probably produce additional cost shifting to the private sector, although it is not known whether past rates of cost shifting could continue.”*

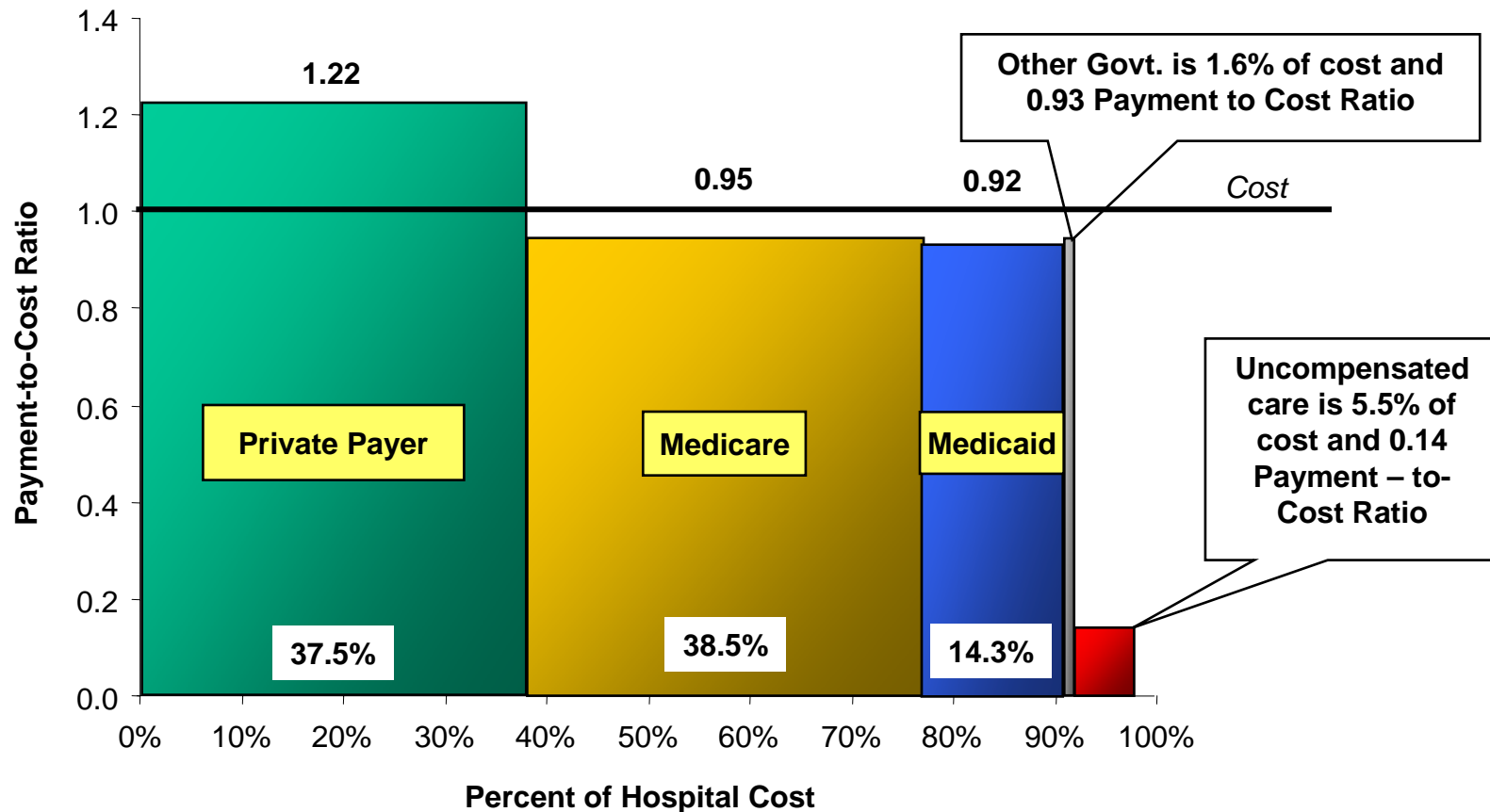
Source: Congressional Budget Office (CBO) Papers “Response to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals “Cost-Shift?” May 1993

# Health Sector Economy: Cost-Shifting Takes Many Forms

- ◆ Cost-shifting is endemic to the U.S. healthcare system
  - Old to young
  - Sick to well
  - Uninsured to insured
  - Teaching programs to others
  - Low technology to high technology
  - Medicaid to Medicare to everybody else
  - Payers/providers to shareholders

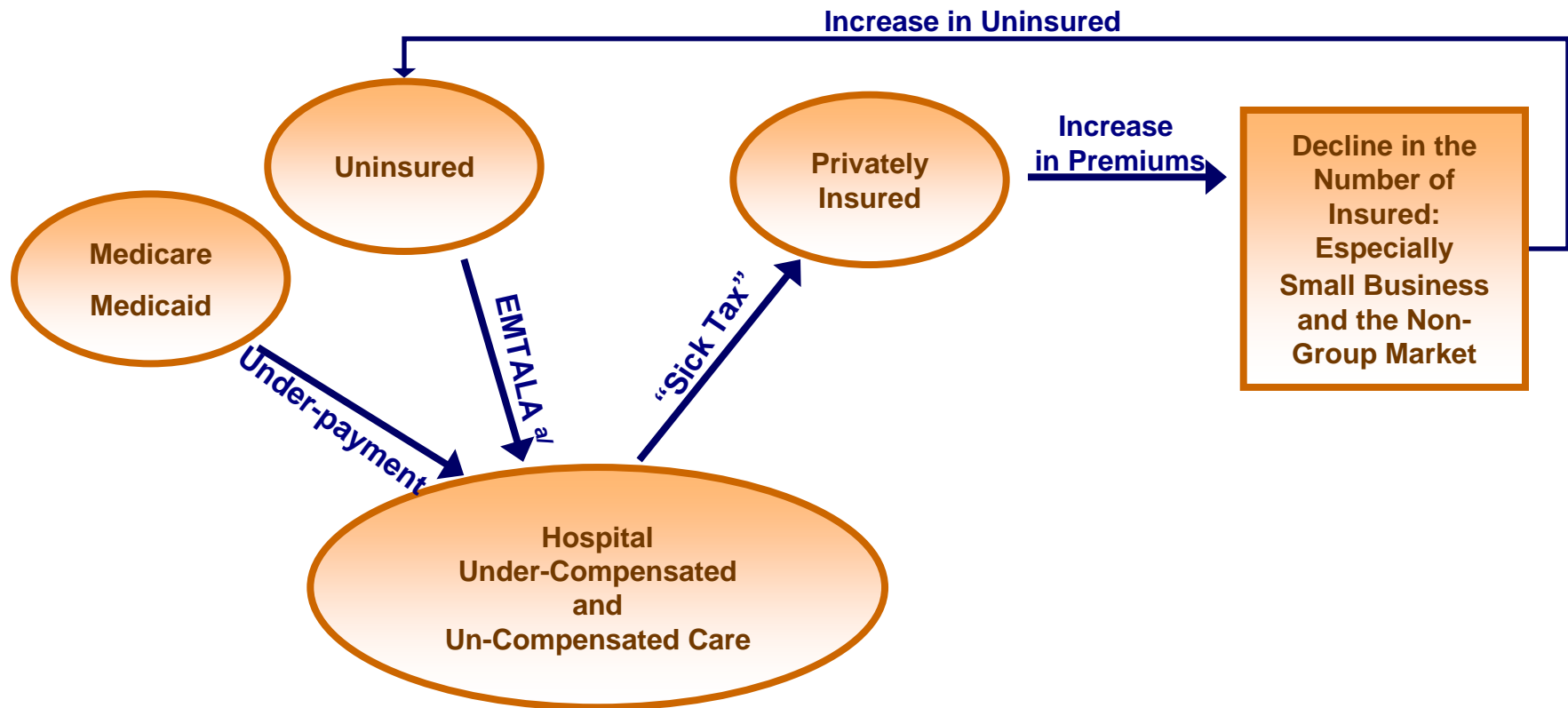


# Cost-Shift as a Payment “Hydraulic”



Source: The Lewin Group analysis of data presented in the American Hospital Association/ Lewin Group Trendwatch Chartbook 2005.

# The Cost-Shift Hydraulic is the Glue that Binds our Healthcare Finance System: But is it Sustainable?



*a/ The Emergency Medical Treatment and Active Labor Act .*

*Source: Dobson, A. and Clarke, R., "Shifting no Solution to Problem of Increasing Costs," Healthcare Financial Management, July 1992.*

# Hospital Responses to Underpayment Pressures

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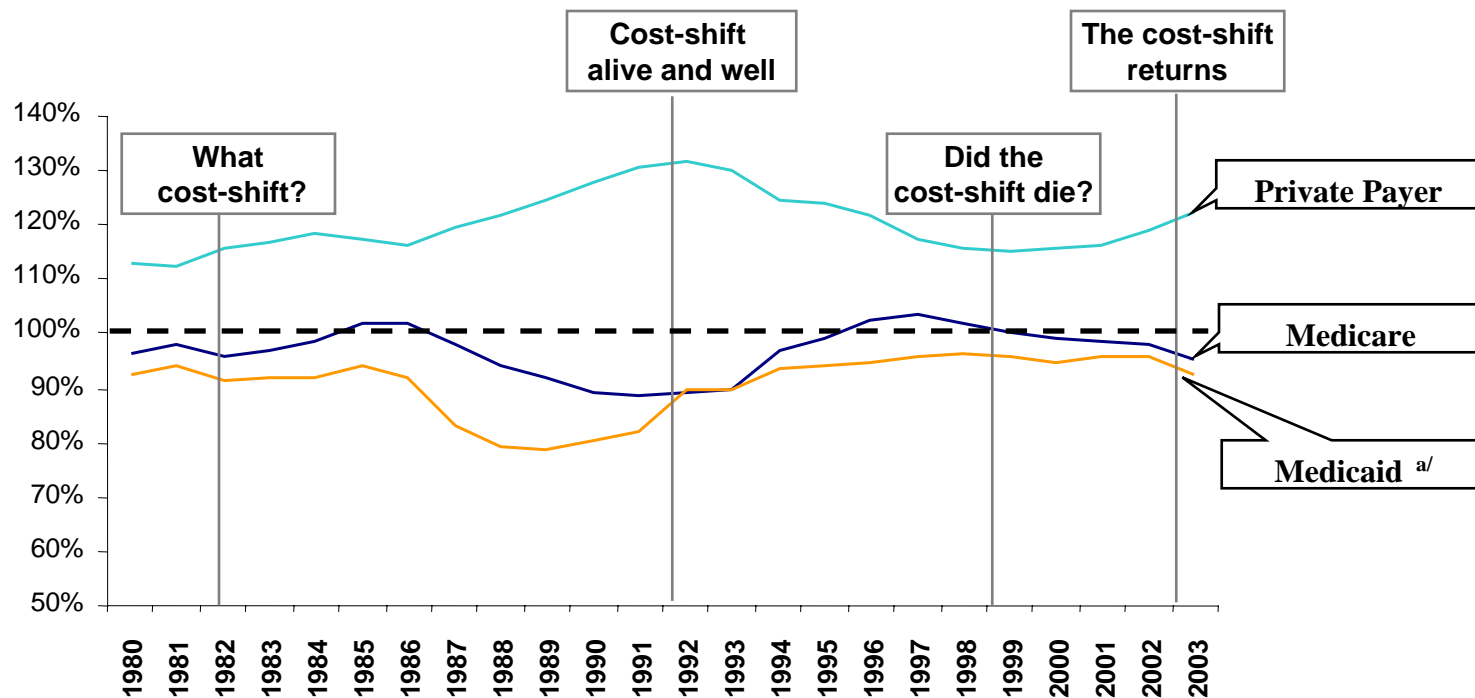
- ◆ Cross payer cost-shift
- ◆ Cut costs/increase efficiencies
- ◆ Cut programs/missions
- ◆ Cut quality
- ◆ Lobby for payment
- ◆ Go out of business (when all else fails)

# Cost-Shift and Market Power

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- ◆ If revenues are already maximized, no market power remains to drive the cost-shift.
  - Investor owned hospitals are presumably attempting to maximize their market power so less cost-shifting is expected.
  - Not-for-profit hospitals' focus on accounting profits is more diffuse.
    - Community pressures for numerous competing missions
  - Need to cost-shift may vary over time as public payers pay more or less relative to costs and the number of uninsured fluctuates.
  - Market setting may affect the need and ability to cost-shift.
    - Suburban versus urban/inner city
    - Rust Belt versus Southwest
    - Extent of public payer market penetration and public payer generosity
    - Number of uninsured
    - Local market economy
    - Market power of hospitals relative to private payers

# Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare and Medicaid 1980-2003



a/ Includes Medicaid Disproportionate Share payments.

Source: Lewin Group analysis of data presented in the American Hospital Association/Lewin Group Trendwatch Chartbook 2005.

# As Public Payers Pay Less, the Balance of Power Between Hospitals and Private Payers Seems to Shift Over Time

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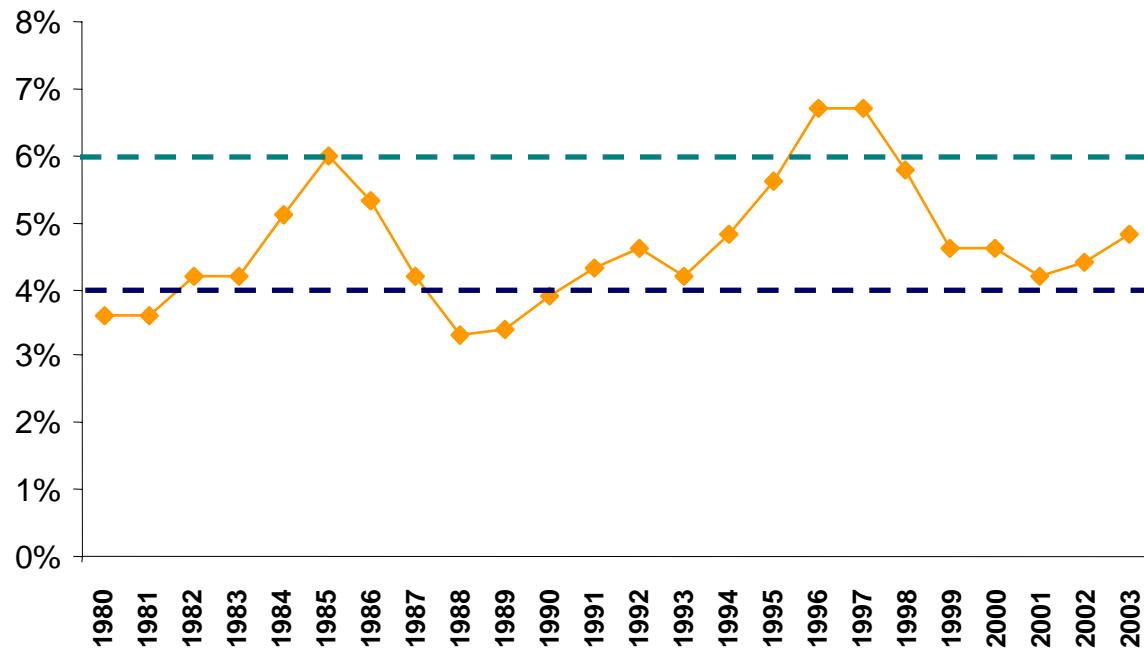
- ◆ During the early to mid 1980s, public payers essentially covered costs and private payer payments to costs were in the 113 to 119 percent range.
- ◆ During the late 1980s to the early 1990s, public payers paid relatively less and private payer payments to costs rose to 132 percent.
- ◆ During the mid to late 1990s, public payers paid more, relative to their costs, and private payer payments to costs fell to 115 percent.
- ◆ During the early 2000s, Medicare payments, relative to costs, fell and private payments to costs rose to 119 percent by 2002.

Could the “herd mentality,” where hospitals tend to move together, explain micro studies not reflecting the cost-shift?

Did the cost-shift die in the 1990s only to resurrect itself in the 2000s?

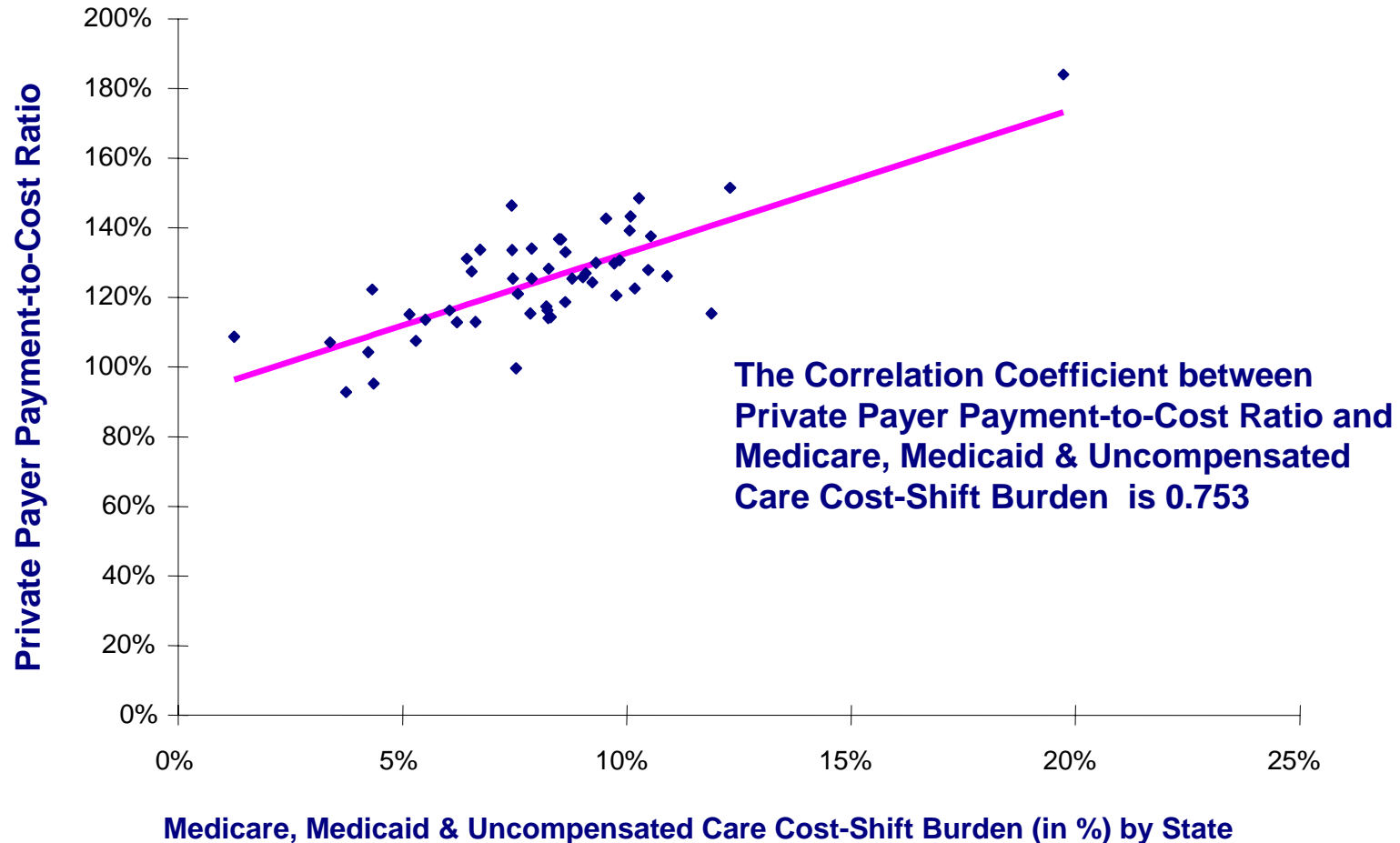
# Despite Changing Markets, Hospitals Have Shown Relatively Consistent Total Margins (between 4 and 6 percentage points) from 1980 to 2003

Aggregate Total Hospital Margins <sup>a/</sup>  
1980-2003



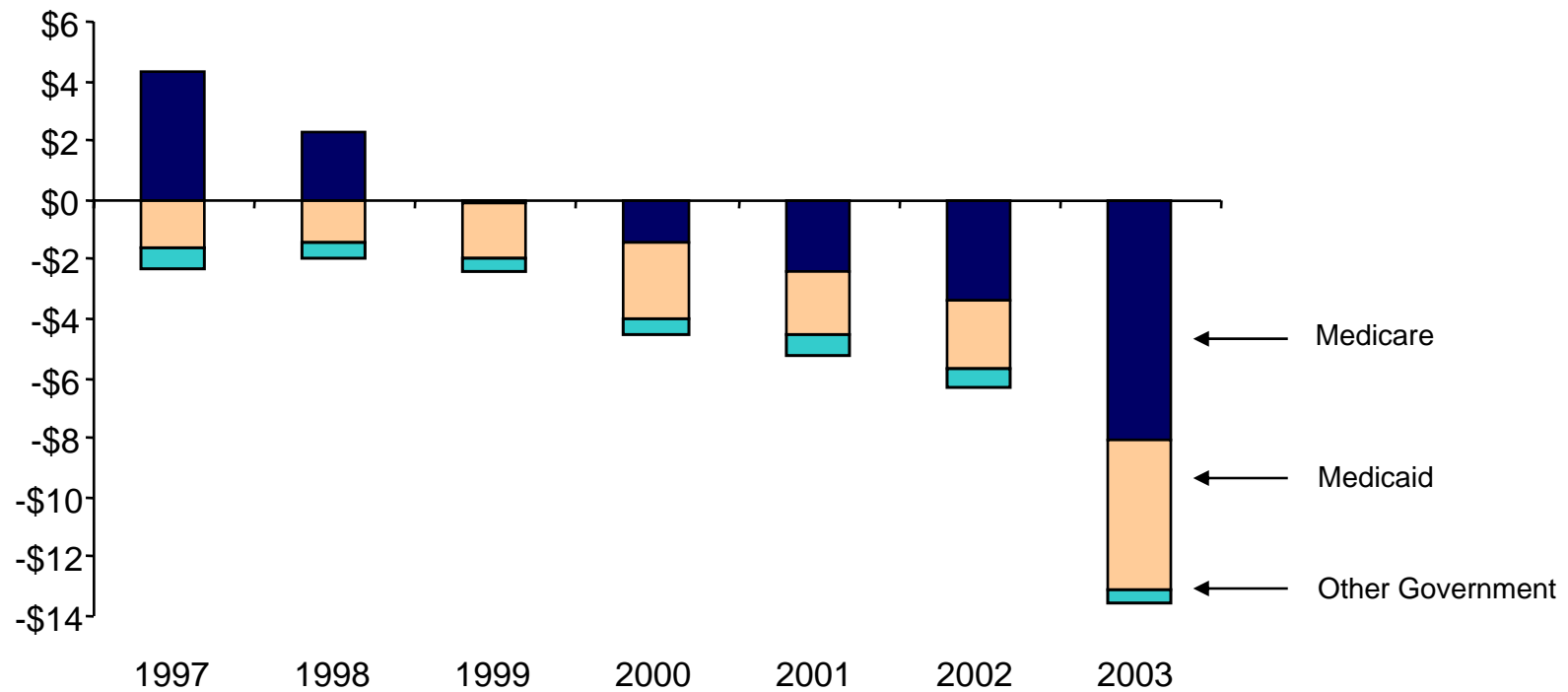
a/ Total Hospital Margin is calculated as the difference between total net revenue and total expenses divided by total net revenue.  
Source: Lewin Group analysis of data presented in the American Hospital Association/ Lewin Group Trendwatch Chartbook, 2005.

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



Source: Dobson, A., DaVanzo, J., & Sen, N., "Cost-Shifting: An Integral Part of the U.S. Health Care Finance," Presented to Academy Health and sponsored by the Robert Wood Johnson Foundation (RWJF), November 13, 2002.

## A Resurgence in the Cost-Shift Could be Related to Increasing Hospital Payment Shortfalls Relative to Costs: Medicare, Medicaid and Other Government: 1997-2003



Source: Lewin Group analysis of data presented in the American Hospital Association/Lewin Group Trendwatch Chartbook, 2005.

# Cost-Shift Implications

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- General revenue taxes and cost-shift “sick taxes” show very different tax incidence; while many uninsured pay general revenue taxes, they are beneficiaries, rather than contributors, to the cost-shift “sick tax.”
  - Lower wage growth as health insurance premiums rise in part due to cost-shift
  - Highest cost-shift with comprehensive plans
  - Low-wage workers disproportionately affected as health insurance premiums reflect a higher proportion of their wages
  - Healthcare costs associated with cost-shifting contribute to a increase in costs of doing business
- Cycle: Cost-shifting leads to premium increases, leads to more uninsured, leads to more cost-shifting.
- Ultimately, financially sick hospitals are sick for everyone, not simply the uninsured or public beneficiaries.

*Source: Sheils, John and Ricks, David, “Potential Cost Shifting Under Proposed Funding Reductions for Medicare and Medicaid”, Lewin-VHI, Inc, August 3, 1995. And, Dobson, A., Haught, R., Sen, N., and El-Gamil, A., “Evaluation of the Adequacy of Medicaid Payments to Hospitals in Pennsylvania,” Sponsored by The Hospital and Health System Association of Pennsylvania, June, 2005.*

## Key Questions

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- ◆ If the cost-shift “dies,” who pays for the uninsured and under-funded public programs?
- ◆ Would the “death” of the cost-shift represent the point at which our healthcare system becomes unsustainable?