

Future Hospital Care: How Will We Pay the Bill?

Abstracts of Papers Submitted by Speakers to Health Affairs

Stuart Altman, David Shactman, and Efrat Eilat. The market for hospital services, like global markets, in general, is becoming more competitive. Increased price transparency and focused competition can squeeze out inefficiencies, restraining prices and making some consumers better off. But competition can have a dark side. U.S. hospitals are able to treat Medicare and Medicaid patients at less than cost, care for the uninsured, and provide other money-losing services because they can cross-subsidize by charging higher prices to the privately insured. We estimate that between now and 2025, the need for general hospitals to cross-subsidize will increase significantly, but their ability to do so will be diminished. If market competition evolves without explicit and adequate payments for services, U.S. hospitals could begin to resemble U.S. airlines--severely cutting costs, eliminating services, and suffering financial instability.

Al Dobson, Joan DaVanzo, and Namrata Sen. The cost-shift hydraulic is sometimes considered to be the glue that binds our fragmented U.S. healthcare finance system. Our healthcare economy depends upon various forms of cost shift for its very survival. If private payers' acceptance of the cost-shift burden were to erode, our system of healthcare finance could be rendered unsustainable. This could be especially true for the hospital industry. We provide a series of examples of cost shifting and a historical profile of the cost shift in the hospital industry since 1980, noting that cost shift pressures seem to fluctuate over time and across market. The presentation concludes with the implications of the demise of the cost shift "sick tax."

Chip Kahn, Tom Ault, Howard Isenstein, Lisa Potetz, and Susan Van Gelder. In recent years, Medicare, employers, insurers, and consumers have increased their emphasis on bolstering quality, improving safety, and getting greater value for healthcare spending. Hospitals have responded with initiatives, including public reporting of quality performance to enhance accountability, while purchasers are seeking ways to link payment to performance. This paper seeks to examine the impact that Medicare pay-for-performance might have on hospital payment. It uses a national quality database and data about Medicare payments to hospitals to model financial gains or losses using the Premier quality demonstration rules, as well as a key element of the pay-for-performance approach recommended by the Medicare Payment Advisory Commission. The analysis provides a snapshot of how hospitals are performing at a relatively early stage of documenting quality reporting, and reveals considerable variation and room for improvement among all types of hospitals and across all measures within each of the three conditions studied: heart attack, heart failure and pneumonia. It also shows, initially, that hospitals' financial gains and losses likely would be marginal using Premier payment rules and somewhat larger under the Medicare Payment Advisory Commission (MedPAC) recommendations as modeled.

David Nexon. This paper analyzes how the current hospital reimbursement system affects technology and how it would be affected by the most prominent alternative

reimbursement paradigms. Central to the analysis is how each system balances both cost and value. The paper concludes that the current system does a reasonably good job of recognizing the cost of technology, but that despite recent reforms, it still is slow to recognize new technology, and judges the value of technology only indirectly. The alternative reimbursement paradigm—"pay-for-performance" or "value-based purchasing"—offers the possibility of combining more rapid reimbursement for valuable new technologies and improved recognition of value. However, for the foreseeable future, technical limitations will require most reimbursement to be based on the old system. Moreover, unless the new paradigm is implemented carefully, it could have the effect of creating rather than reducing additional barriers for valuable new technology. Finally, certain variations of the "value-based purchasing" approach could have a perverse effect on adoption and utilization of technology and on quality.

Len Nichols and Ann O'Malley. Unsustainable health care cost growth is forcing payers to re-examine goals for hospital payment systems. Employers want simplicity and transparency, with comparative performance data available in the public domain. Insurers favor simplicity but would prefer to keep comparative performance data privately held. Thirty-five pay-for-performance experiments have been devised in the private sector to reward higher quality hospitals and point the way to more effective payment systems. No definitive results are known and caveats remain, but some early signs are promising. This paper features three scenarios for future hospital pricing systems and identifies policy actions that would improve outcomes.

Uwe Reinhardt. High-deductible health insurance policies, supported by tax-favored Health Savings Accounts (HSAs), commonly are referred to as "Consumer Directed Health Care" (CDHC) on the mistaken belief that prospective patients have available to them reliable data about the prices charged by competing health care providers for their products and services and the quality of these services, and that patients thus are "empowered" to act as savvy consumers who can effectively shop around for cost effective health care. By describing current pricing practices in the American hospital sector, this paper exposes the fictional nature of the CDHC story. The paper then explores the major changes that would have to be made to current hospital pricing practices to convert mere high-deductible health insurance into genuine consumer-driven health care.

William Scanlon. The combination of health care cost growth exceeding general inflation and the swelling of beneficiary rolls with baby boomers will create considerable future fiscal pressure for Medicare. Despite dramatic declines in the growth of hospital costs following the introduction of the Prospective Payment System (PPS), Medicare's current methods of paying hospitals, the growth in Medicare hospital spending per beneficiary since 2000 was close to three times overall inflation. Adopting payment policies creating stronger incentives for containing cost growth will very likely be a necessary step. This paper will examine issues related to Medicare using its pricing policies to more aggressively pursue cost containment for hospital care. The need to simultaneously attempt to calibrate payments to avoid interference with treatment decisions and to more precisely align payments to reflect variation in the costs of services

due to factors beyond hospitals' control to reduce potential impacts on beneficiary access, care quality, or technological improvements are discussed.

Christopher Tompkins, Stuart Altman, and Efrat Eilat. Over the past 20 years, the average ratio of hospital charges for services (gross revenues) to payments received (net revenues) has grown from 1.1 to 2.6. This reflects a transition from predominantly cost-based and charge-based payment systems to regulated and negotiated fixed payments. Hospitals have been able to squeeze additional revenues from remaining charge-based payers and services by sharply increasing charges, negatively affecting the uninsured. Though protection of the uninsured seems warranted, it might be difficult to regulate hospital pricing systems in isolation from other controversial issues such as the acceptability of cross-subsidies and the role of market forces.

Bruce Vladeck. American hospitals incur costs of between \$25 billion and 50 billion annually providing "community services," primarily in the form of health professions education and standby costs. They also provide approximately \$30 billion in uncompensated care. Historically, such "community service costs" have been subsidized explicitly by Medicare, and implicitly in the prices paid by at least some private payers. The sustainability of this system is highly uncertain. With a growing number of uninsured patients, allocating non-reimbursable costs to paying customers can create a death spiral, in which fewer and fewer paying customers bear a larger and larger proportion of such costs. The obvious solutions to this problem all have serious limitations.

Gail R. Wilensky. With the introduction of Health Savings Accounts, in addition to the adoption by selected employers of Health Reimbursement Accounts, there is a greater potential for interaction between individual patients and hospitals regarding hospital pricing and payment than has existed under traditional insurance plans. At the moment, much of this remains hypothetical. Only relatively small numbers of employers are offering HRAs or HSAs. As a result, most individuals who deal directly with hospitals regarding payment issues do so because they are uninsured. The future growth of HSAs and HRAs clearly is uncertain at this point. 2006 may provide a better indication of HSA/HRA near-term future than current levels of enrollment since many firms already have decided their insurance offerings for 2005 by the time the IRS had issued its guidelines. In addition, high deductible plans may be an idea that needs more time to germinate. When or if there is a big push for expanding access to insurance coverage for those without employer-sponsored insurance through the use of refundable tax credits or other financial instruments, the interest in high-deductible/major medical type plans may grow substantially. It currently appears that this is unlikely to occur before the end of the decade. Thus, the numerical growth in high deductible plans may not have a significant impact on hospitals and hospital pricing issues, at least not in the near term; i.e. within the current decade, although it is too early to make this statement definitively. Furthermore, most patients are likely to exceed any deductible, including those associated with HSAs and HRAs, whenever they have an encounter with the hospital although this may not be true for emergency rooms encounters. Along with the uncertainty about the numerical impact of the growth in high deductible plans is uncertainty about the effect that their growth will have on hospital pricing. In part, any effect may depend on

whether the insurance plan providing the high deductible plan is a national plan or a boutique, specialized HSA company. National plans appear to believe that they will be able to access their PPO networks at PPO pricing levels. Whether or not this assumption is true should become known in the near-term. Boutique plans are likely to have more problems. If they are unable to claim similar discounts from retail charges, any reductions in premiums reflecting altered utilization could be offset by increased charges. Even with modest growth in HRAs and HSAs, their presence may feed on the increased interest in hospital pricing and pricing transparency that has arisen within the past year. While initially focusing on the increased charges faced by many of the uninsured, attention has now turned to pressuring hospitals to increase their disclosure of pricing across different payers. Interest in increased disclosure raises a whole host of questions that need to be explored. These include but are not limited to the following: disclosure of “what” and “to whom,” what are the likely effects of pressuring toward uniform pricing, what will happen to traditional targets of cross-subsidization under uniform pricing, whether differential pricing would be permitted under strict disclosure rules, who would determine “appropriate” differentials, whether pressure toward uniform pricing would increase the lowest price and if so by how much, and how much of the experience in the pharmaceutical world regarding differential pricing is likely to be replayed in the hospital sector.