Medicaid and the Hospital "Cost Shift"

VERMONT GENERAL ASSEMBLY
HEALTH REFORM OVERSIGHT COMMITTEE

NOVEMBER 4, 2019

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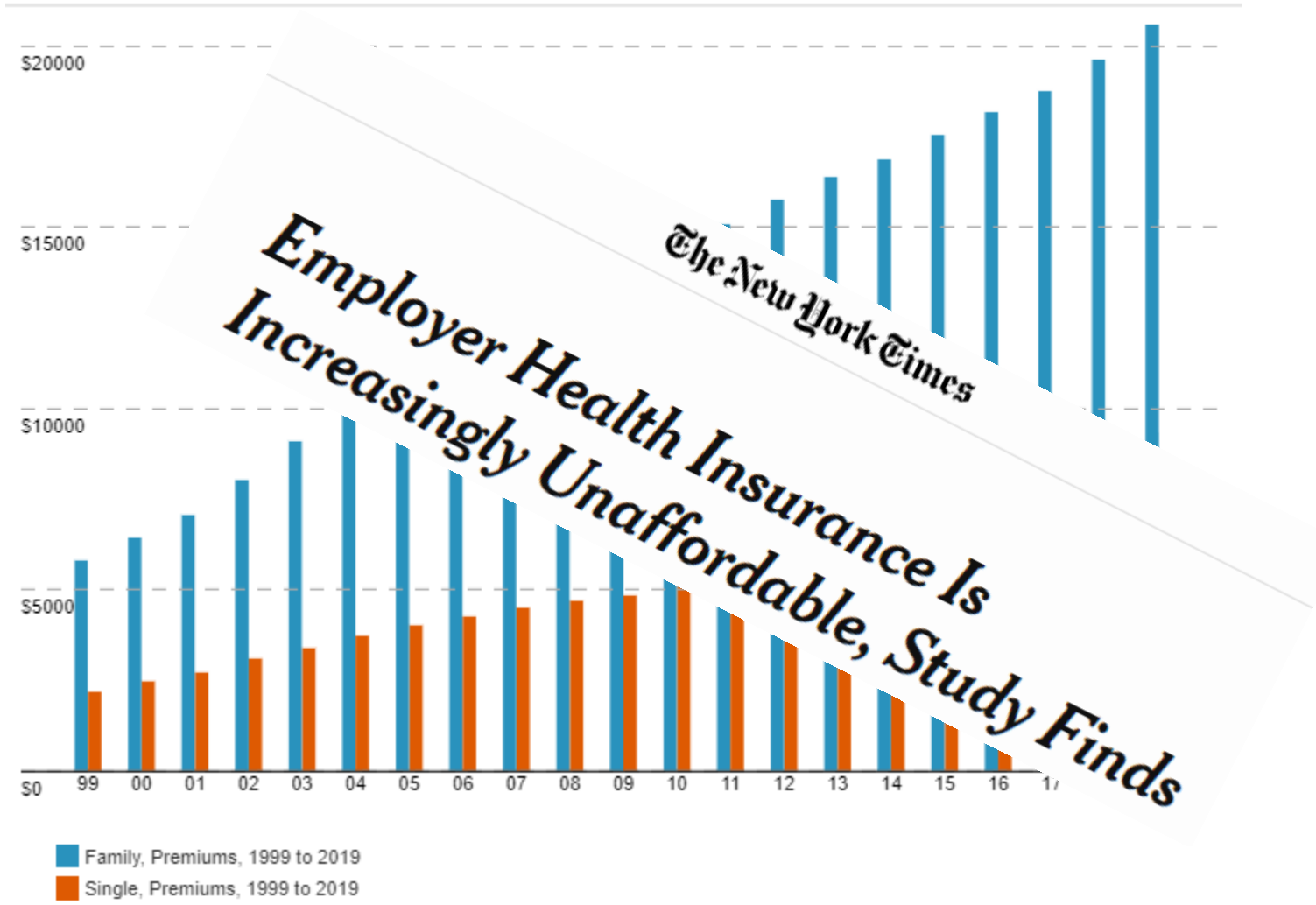
The Context:
Unsustainable Growth in Employer-Sponsored Premiums

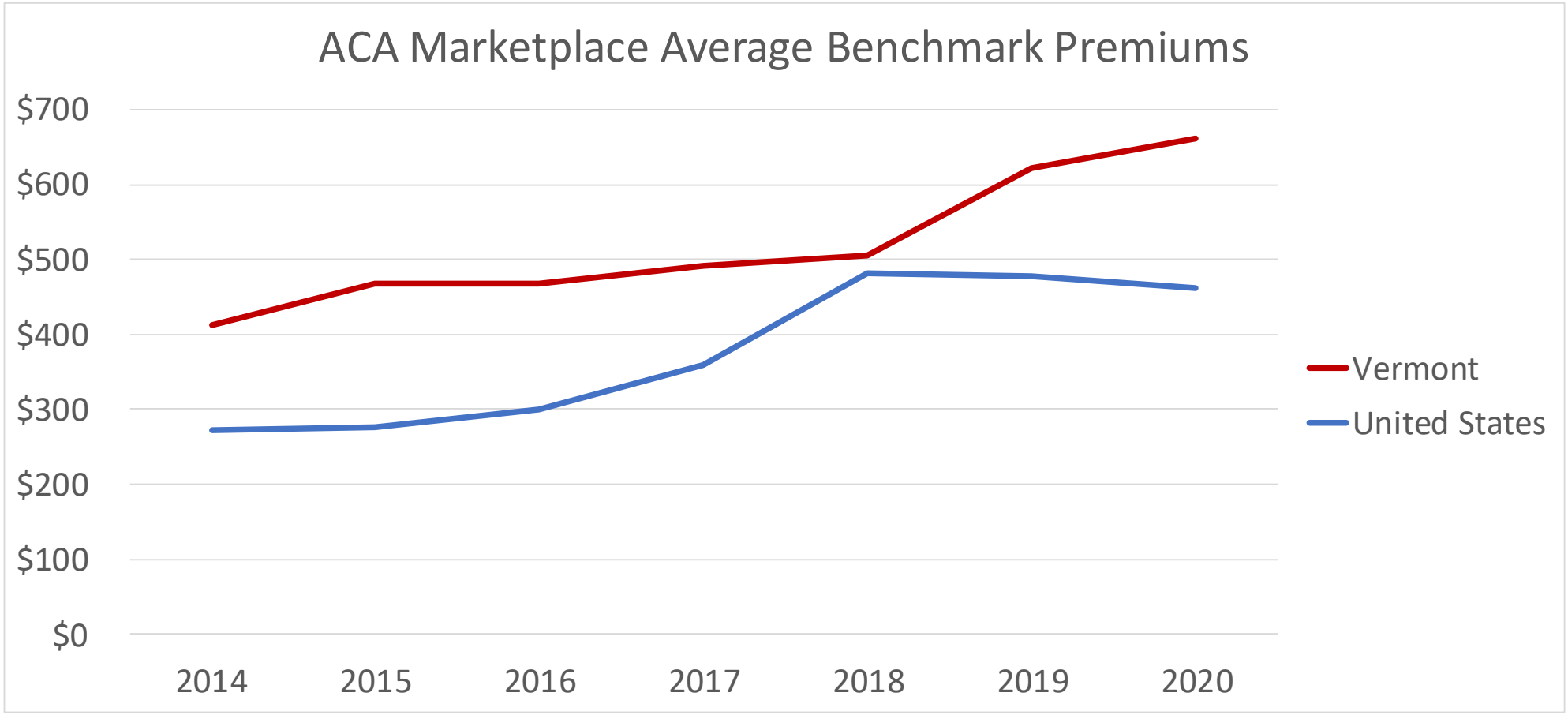


The New York Times

Employer Health Insurance Is Increasingly Unaffordable, Study Finds

SOURCE: KFF Employer Health Benefits Survey, 2019 (http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019)

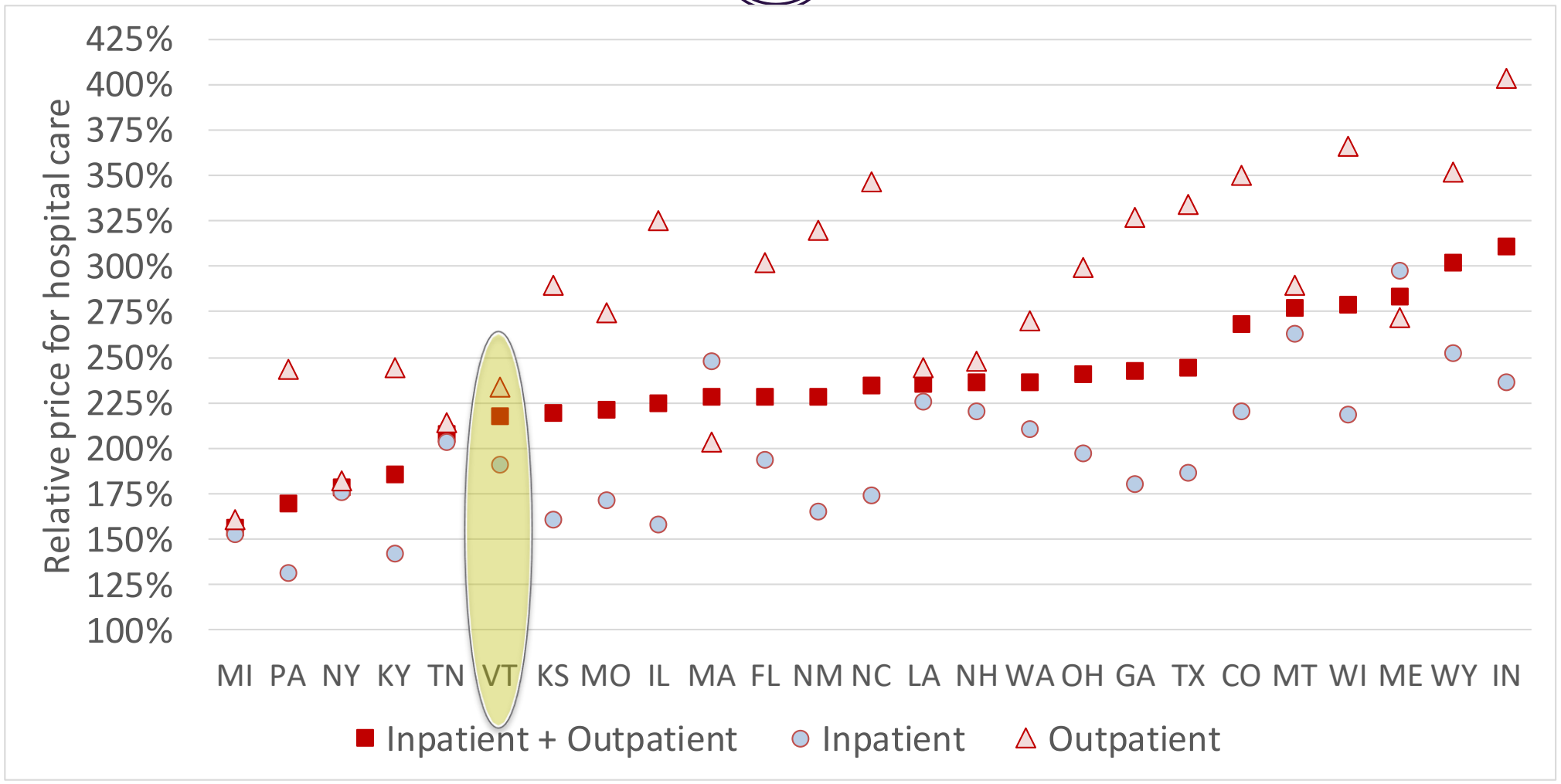
The Context:
Unsustainable Growth in ACA Exchange Premiums



Note: "Benchmark premium" is the second-lowest silver premium for a 40-year-old nonsmoker.

Source: Kaiser Family Foundation, Marketplace Average Benchmark Premiums, 2014-2020, State Health Facts, 2019. https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/

The Context:
Large Divergence in Public vs Private Hospital Prices



Source: White, Chapin, and Christopher Whaley, Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative, 2019. https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3033/RAND_RR3033.pdf.

Overview

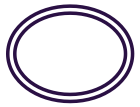
- Would boosting Medicaid payments to hospitals lower private premiums?

1. Do costs determine revenues, or revenues determine costs?
2. Do public insurers underpay, or do private insurers overpay?
3. Do hospitals in Vermont operate efficiently?
4. Would increasing Medicaid prices lower private premiums?

- Wrapup

1. Do hospitals' costs determine revenues, or revenues determine costs?

Definitions

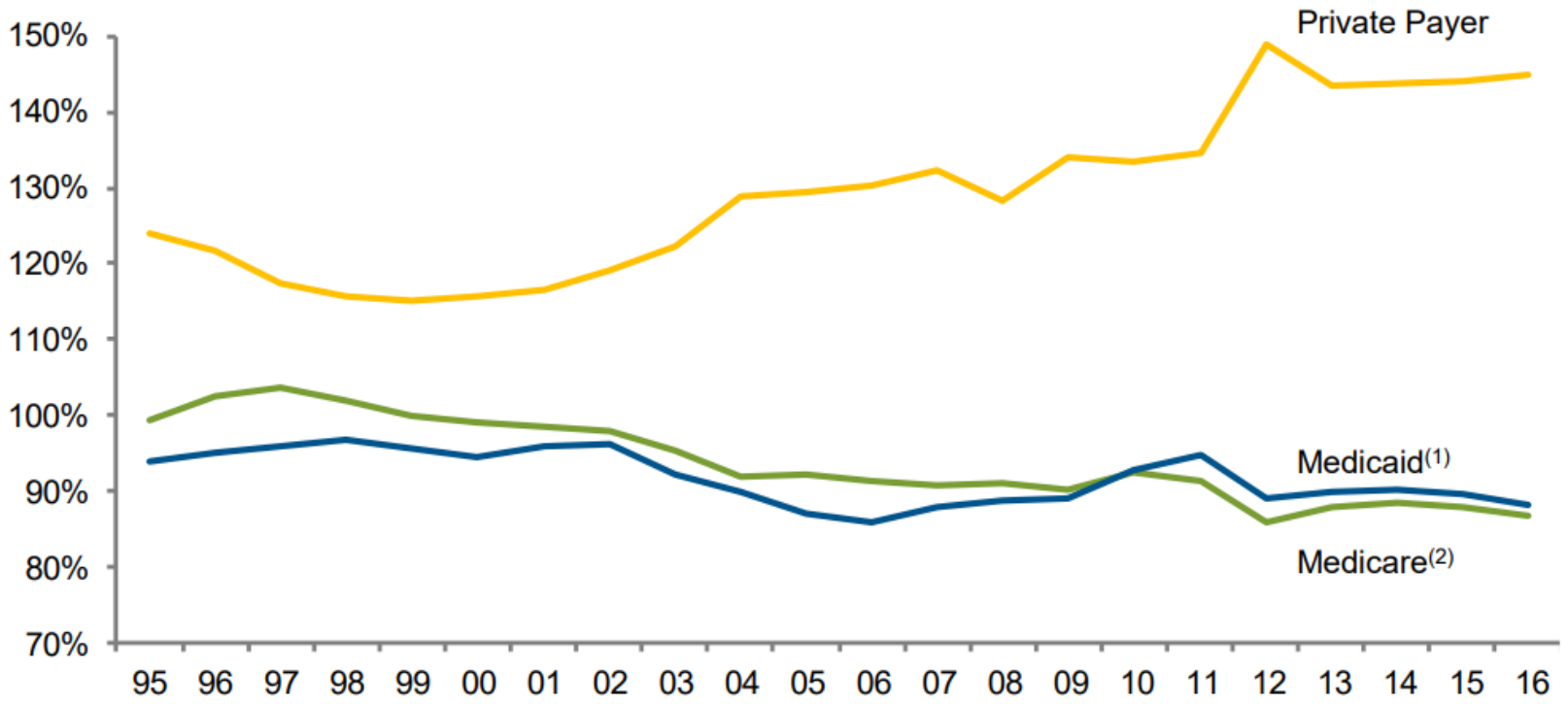


- "Costs": Expenses hospitals incur providing patient care
- "Revenues": Payments to hospitals for providing patient care
- "Payment-to-cost ratio": Ratio of revenues over cost
- "Price": Revenue per service, casemix-adjusted
- "Casemix": Complexity and intensity of services provided

- "Public insurance": Medicare and Medicaid
- "Private insurance": employer-sponsored and ACA exchange

Trends in Payment-to-Cost Ratios

Chart 4.6: Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1995 – 2016

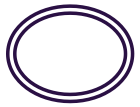


Source: Analysis of American Hospital Association Annual Survey data, 2016, for community hospitals.
(1) Includes Medicaid Disproportionate Share Hospital payments.
(2) Includes Medicare Disproportionate Share Hospital payments.

American Hospital Association

Source: American Hospital Association, TrendWatch Chartbook 2018, 2018. https://www.aha.org/system/files/2018-07/2018-aha-chartbook.pdf.

Interpretions of Divergence in Payment-to-cost Ratios



- "Price discrimination"
  - hospitals are able to negotiate high and growing prices with private insurers because of market leverage
  - high and growing private prices allow hospitals' costs to rise
  - rising costs drive public payment-to-cost ratios lower and lower
- "Cost shifting"
  - hospitals costs' are what they are, and must be reimbursed by insurers
  - because of underpayments by public insurers, hospitals are forced to negotiate high and growing prices with private insurers

Evidence on Price Discrimination vs. Cost Shifting

1. Hospitals' costs are not fixed
   - Hospitals are a not-for-profit industry, hospitals are not cost-minimizers
   - Hospitals facing constrained Medicare prices reduce their costs (White and Wu, 2014)
   - Market power leads to high private prices, high costs, and losses on Medicare (Stensland et al., 2010)

2. Prices paid by private insurers influenced by market leverage on hospital and insurer sides (Cooper et al., 2019)

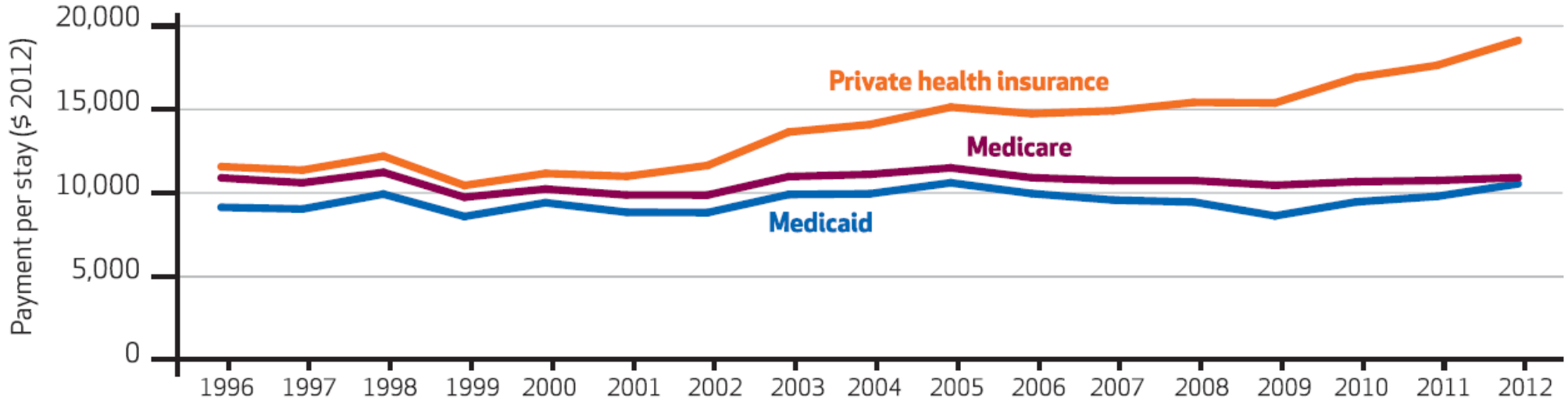
3. Reducing prices paid by public insurers does not increase private prices (White, 2013)

2. Do public insurers underpay, or do private insurers overpay?

Public Prices for Hospital Inpatient Care Growing In Line With Inflation, Private Prices Rising More Rapidly

EXHIBIT 1

Average Standardized Payment Rates Per Inpatient Hospital Stay, By Primary Payer, 1996–2012



SOURCE Authors' analysis of data for 1996–2012 from the Medical Expenditure Panel Survey. **NOTES** The average payment rates were computed as if each primary payer paid for all nonmaternity adult stays in a given year. Payments were adjusted for inflation and standardized across payers in terms of patient's age, sex, race/ethnicity, geography, household income as a percentage of the federal poverty level, conditions, charges, length-of-stay, and whether or not a surgical procedure was performed. They were not standardized for changes over time in the bundles of treatments and services provided during inpatient stays. Estimates and standard errors can be found in online Appendix F and Appendix Table F.1 (see Note 9 in text).

Source: Selden, Thomas M., Zeynal Karaca, Patricia Keenan, Chapin White, and Richard Kronick, "The Growing Difference Between Public And Private Payment Rates For Inpatient Hospital Care," Health Affairs, Vol. 34, No. 12, 2015, pp. 2147-2150.

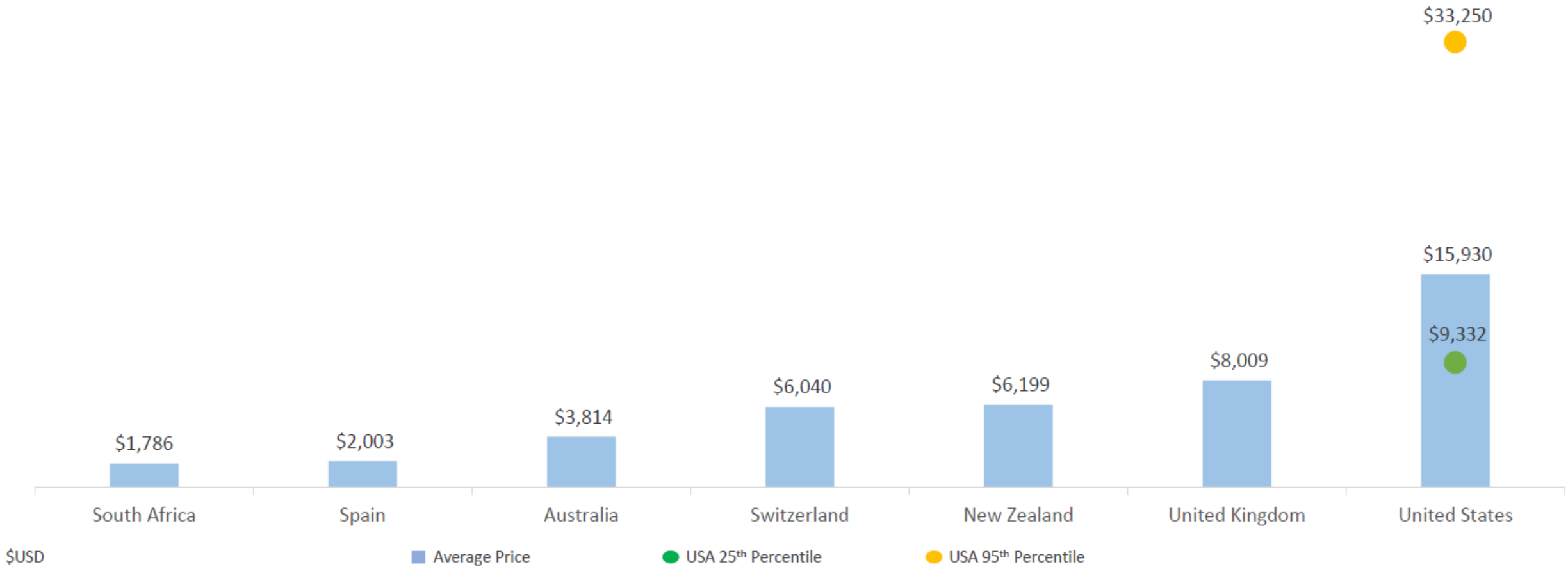
International rate differences after adjusting rates for input prices

Hip replacement rate	International range*	Medicare Average	Commercial insurer 25th to 75th percentile
Rate including physician fees	$9,000 to $12,000	$17,000	$25,000 to $88,000
Rate as a share of the average person's wage	20 to 26%	31%	46% to 161%
Rate as a share of the average RN wage (a proxy for input prices)	20 to 26%	24%	36% to 126%

Note: * Range is for the 2nd and 5th highest rates out of six countries: Australia, France, Netherlands, New Zealand, Switzerland, and the United Kingdom. Rates include the amount paid for physician fees.
Source: CMS data on average Medicare hospital payments for joint replacement and data on physician payments. Data on rates in other countries are from the International Federation of Health Plans. All rates are adjusted for purchasing power parity using data from the Organization for Economic Cooperation and Development (OECD). Wage data is from the OECD.

Source: Stensland, Jeff, International Comparison of Rates Paid to Hospitals, Medicare Payment Advisory Commission, October 9, 2014. http://www.medpac.gov/documents/october-2014-meeting-presentation-international-comparison-of-rates-paid-to-hospitals.pdf.

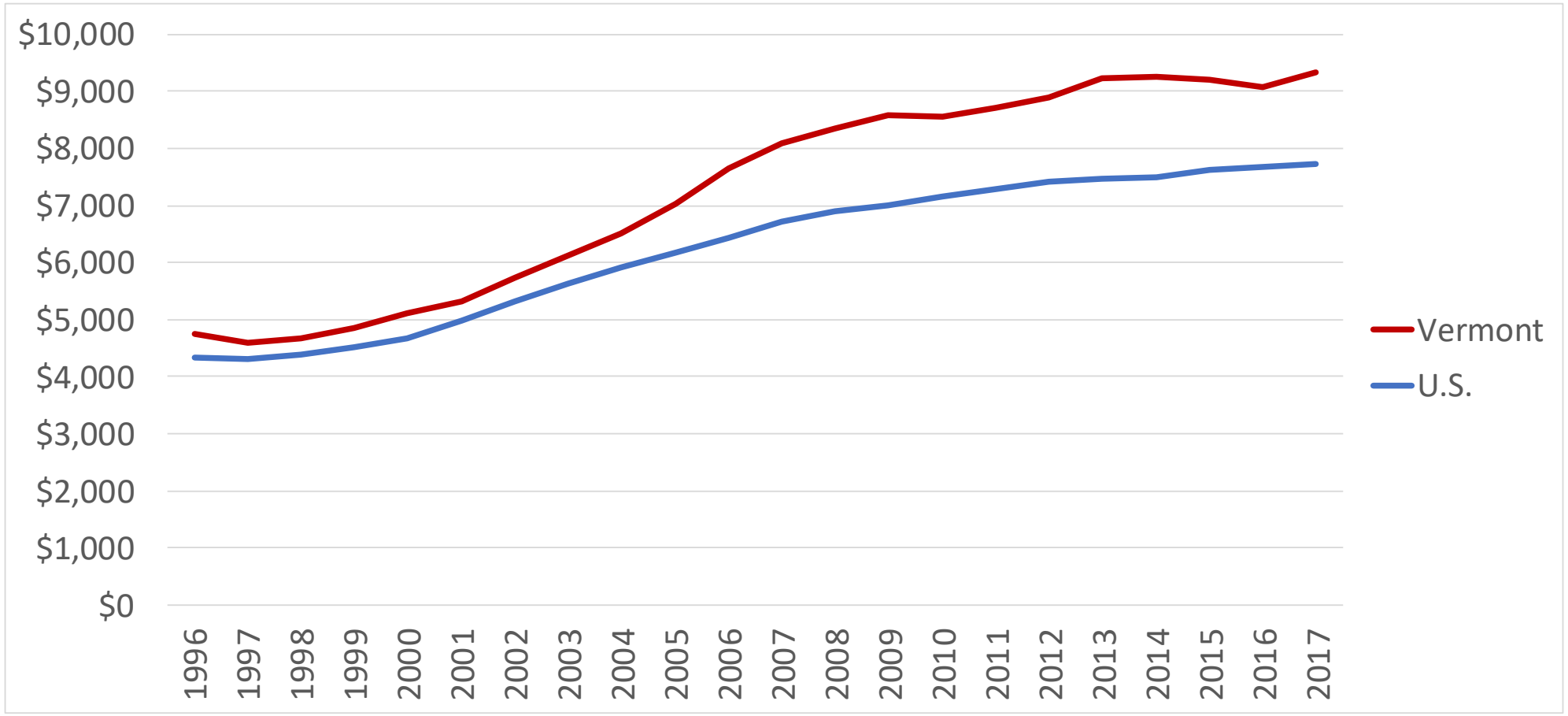
Total Hospital and Physician: Appendectomy



Source: International Federation of Health Plans, 2015 Comparative Price Report: Variation in Medical and Hospital Prices by Country, 2018. https://fortunedotcom.files.wordpress.com/2018/04/66c7d-2015comparativepricereport09-09-16.pdf.

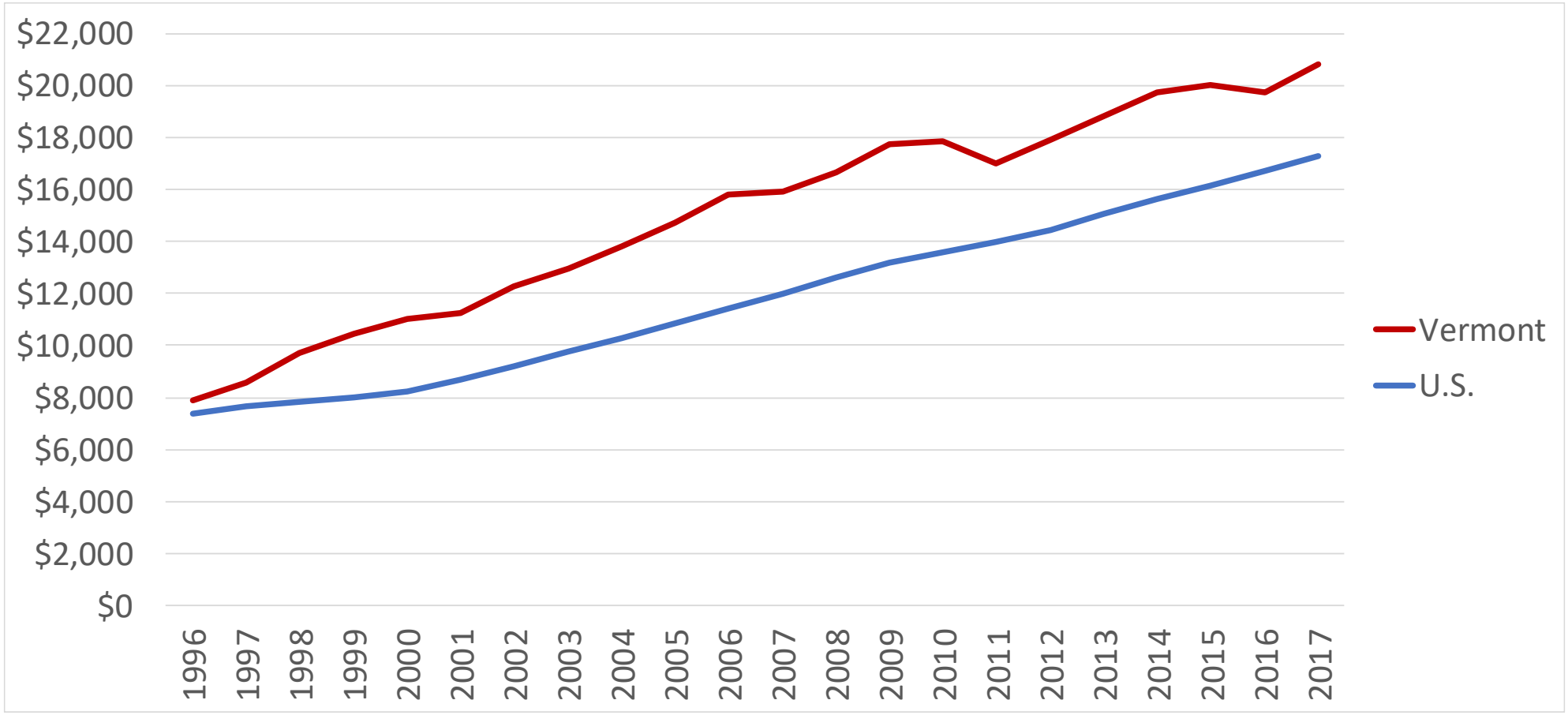
3. Do hospitals in Vermont operate efficiently?

Medicare Costs per Inpatient Stay, Casemix-adjusted



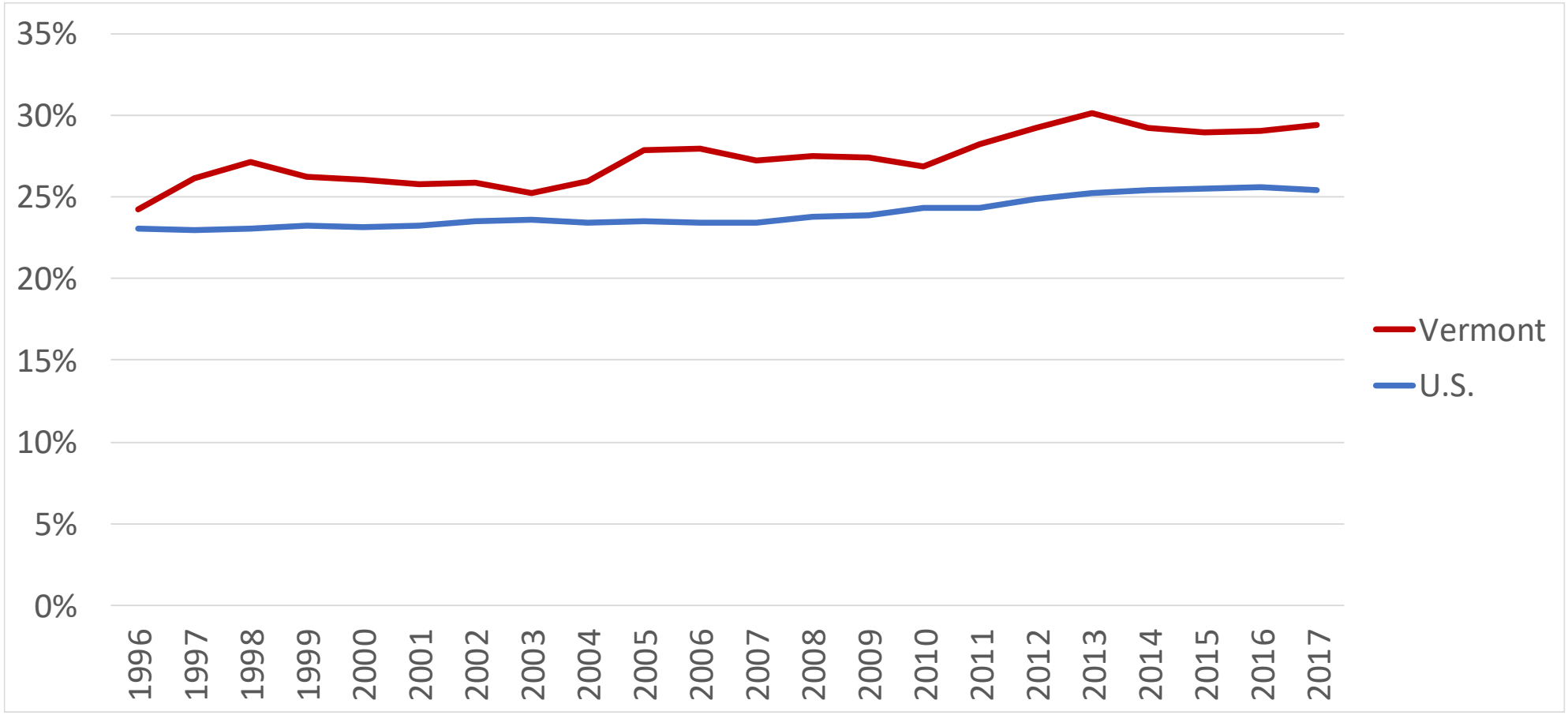
Sources: RAND Hospital Data, rand_hcris_cy_st_a_2019_08_01.csv.zip (level of aggregation=State, time period=Calendar year, outliers corrected=Yes, vintage=2019_08_01) and rand_hcris_cy_natl_a_2019_08_01.csv.zip (level of aggregation=National, time period=Calendar year, outliers corrected=Yes, vintage=2019_08_01), https://www.hospitaldatasets.org, 2019.

Expenses per Discharge Equilvalent



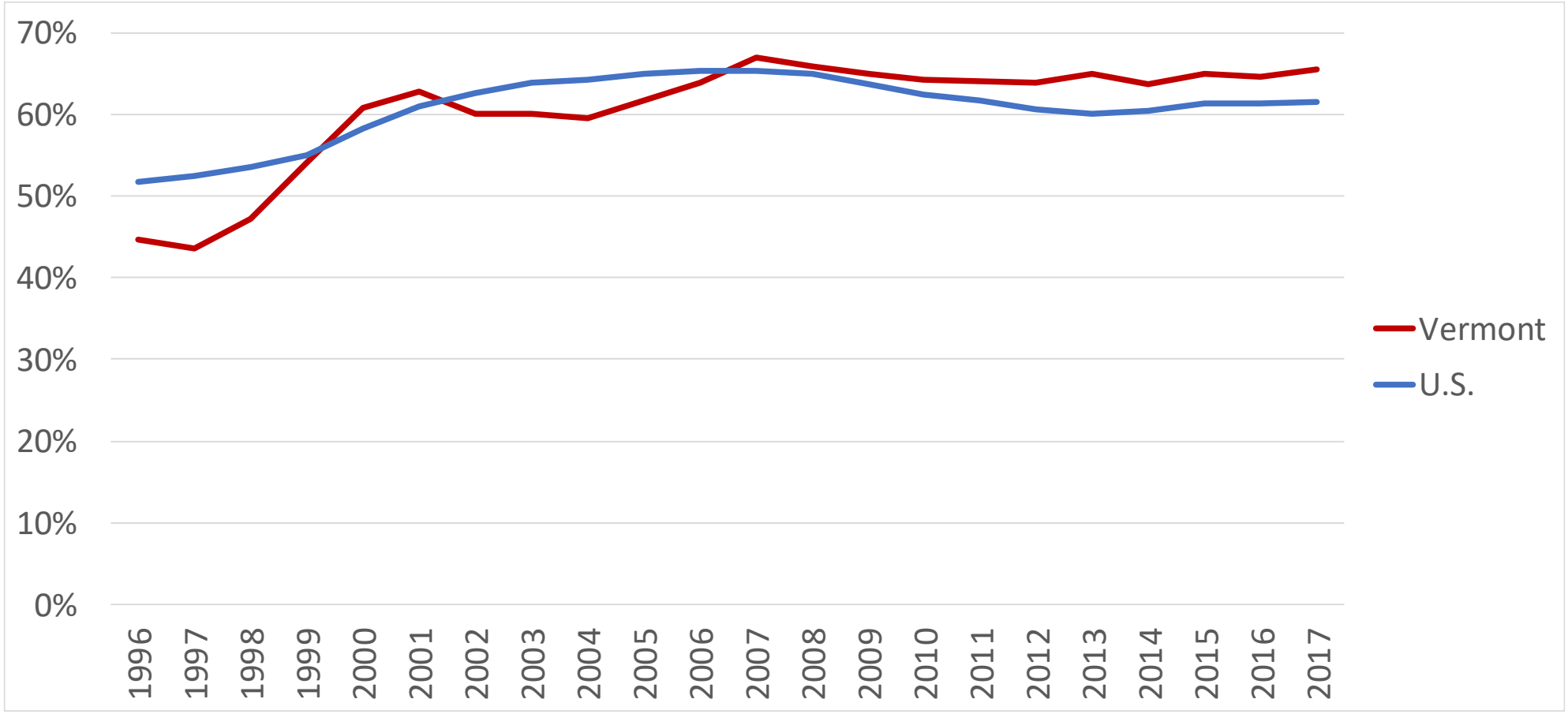
Sources: RAND Hospital Data, rand_hcris_cy_st_a_2019_08_01.csv.zip (level of aggregation=State, time period=Calendar year, outliers corrected=Yes, vintage=2019_08_01) and rand_hcris_cy_natl_a_2019_08_01.csv.zip (level of aggregation=National, time period=Calendar year, outliers corrected=Yes, vintage=2019_08_01), https://www.hospitaldatasets.org, 2019.

Administrative Cost Shares



Sources: RAND Hospital Data, rand_hcris_cy_st_a_2019_08_01.csv.zip (level of aggregation=State, time period=Calendar year, outliers corrected=Yes, vintage=2019_08_01) and rand_hcris_cy_natl_a_2019_08_01.csv.zip (level of aggregation=National, time period=Calendar year, outliers corrected=Yes, vintage=2019_08_01), https://www.hospitaldatasets.org, 2019.

Occupancy



Sources: RAND Hospital Data, rand_hcris_cy_st_a_2019_08_01.csv.zip (level of aggregation=State, time period=Calendar year, outliers corrected=Yes, vintage=2019_08_01) and rand_hcris_cy_natl_a_2019_08_01.csv.zip (level of aggregation=National, time period=Calendar year, outliers corrected=Yes, vintage=2019_08_01), https://www.hospitaldatasets.org, 2019.

4. Would increasing Medicaid prices lower private premiums?

Two Questions

1. Would reducing private hospital prices reduce premiums?
   - Yes
     - Hospitals account for 44% of private insurers' paid benefits (NHE, 2019, Table 20)
     - Reduced prices ⇒ reduced paid benefits ⇒ reduced premiums

2. Is there an enforcement mechanism to lead to lower prices?
   - No
     - Does GMCB regulate private hospital prices or total revenues from private insurers?
     - If so, are regulated limits on private hospital prices/revenues based directly on Medicaid shortfall?

Source: Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, Historical NHE Tables, 2019. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip, Table 20, row 7 divided by row 6.

Wrapup

Wrapup

1. Revenues determine costs
2. Private insurers overpay
3. Efficiency metrics for hospitals in Vermont are mixed
   - high costs per service, but in a state with above-average cost of living
4. Without enforcement mechanism, adding Medicaid $ should not be expected to lower private premiums

Sources

- Cooper, Zack, Stuart V. Craig, Martin Gaynor, and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*," The Quarterly Journal of Economics, Vol. 134, No. 1, 2019, pp. 51-107. https://academic.oup.com/qje/article-abstract/134/1/51/5090426.
- Stensland, Jeffrey, Zachary R. Gaumer, and Mark E. Miller, "Private-Payer Profits Can Induce Negative Medicare Margins," Health Affairs, Vol. 29, No. 5, 2010, pp. 1045-1051. http://content.healthaffairs.org/cgi/content/abstract/29/5/1045.
- White, Chapin, "Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates," Health Affairs, Vol. 32, No. 5, May, 2013, pp. 935-943. http://content.healthaffairs.org/content/32/5/935.abstract.
- White, Chapin, and Vivian Yaling Wu, "How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices?," Health Services Research, Vol. 49, No. 1, February, 2014, pp. 11-31. http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12101/abstract.