Why hospital cost shifting is no longer a viable strategy

Many providers have chosen to shift cost rather than become more efficient, a stopgap strategy that will not work in tomorrow's healthcare environment

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American hospitals face two major reimbursement challenges in coming years. First, healthcare reform will lead to a flood of new Medicaid patients starting in 2014 as the law's universal healthcare provisions kick in and subsidized plans are available to low-income individuals through state exchanges. Second, in coming years the Baby Boom generation will complete its move from high-margin commercial business (age 50-65) to become Medicare eligible. Since both Medicare and Medicaid pay lower reimbursement rates than commercial insurance, providers must contend with the prospect of reduced reimbursement for many new and more expensive patients. In the face of this change, there may only be one choice: increased efficiency. The old strategy of shifting costs onto commercial insurers simply won't sustain itself much longer.

A BRIEF HISTORY OF THE STATUS QUO

The rate at which Medicare and Medicaid reimburse for a service varies significantly by area, type of service, and place of service (hospital, clinic, skilled nursing facility, etc.). But generally Medicare- and Medicaid-eligible members, and the uninsured, pay less per service than commercial insured.

A 2008 Milliman analysis quantified the cost of this differential revenue and verified the existence of a provider cost shift.[1] The analysis concluded that, in the face of these lower Medicare and Medicaid reimbursements, many providers have been operating on negative margins on this business. To offset the negative margin on Medicare and Medicaid, these providers have added margin to commercial insurers, with an estimated impact of around $1,800 in shifted cost per American family, or about 10.7% more than the total cost in an environment without cost shifting.

Research conducted for the National Business Group on Health verifies that cost shifting is indeed happening. The analysis looks at 65 cities, selected from high and low hospital utilizing regions, and in many instances confirms the practice of cost shifting. But the analysis also identifies 16 cities where there is little or no sign of cost shifting for inpatient care. Hospitals in these cities have confronted the problem of revenue shortfalls in Medicare and Medicaid business not by passing on costs to other payors, but rather by becoming more efficient.

This analysis was important in order to identify hidden cost currents in the ever-fluid world of healthcare financing, but it was not the final word. An analysis conducted for the National Business Group on Health (NBGH) in March 2010 has advanced

FIGURE 1: PROJECTED COMMERCIAL REIMBURSEMENT RELATIVE TO MEDICARE AVERAGE (NATIONAL AVERAGES)*
AFTER COST SHIFT TO NET SIMILAR PROFIT MARGINS

		ESTIMATED POPULATION IN EACH CATEGORY			
YEAR	COMMERCIAL/MEDICARE (FACILITY + PROFESSIONAL)	COMMERCIAL	MEDICARE	MEDICAID	UNINSURED
CURRENT	140%	56.1%	11.9%	16.7%	15.3%
2015	155%	57.7%	14.3%	18.7%	9.3%
2020	166%	58.7%	15.9%	20.9%	4.5%

* Current data point is based on national averages. Medicaid average reimbursement is assumed to stay unchanged relative to Medicare over time (approximately 70% of Medicare). Uninsured members who leave the uninsured group are split between the Medicaid and commercial markets (individual/small-group exchanges).

1 Fox, W. & Pickering, J. (December 2008). Hospital & physician cost shift: Payment level comparison of Medicare, Medicaid, and commercial payers. Milliman Client Report. Retrieved April 20, 2010, from http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf.

2 Pyenson, B., Iwasaki, K., Goldberg, S. & Fitch, K. (March 18, 2010). High value for hospital care: High value for all? Milliman Client Report. Retrieved April 20, 2010, from http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/high-value-hospital-care.pdf.

the thinking around cost shifting.[2] The NBGH research conducted for the National Business Group on Health verifies that cost shifting is indeed happening. The analysis looks at 65 cities, selected from high and low hospital utilizing regions, and in many instances confirms the practice of cost shifting. But the analysis also identifies 16 cities where there is little or no sign of cost shifting for inpatient care. Hospitals in these cities have confronted the problem of revenue shortfalls in Medicare and Medicaid business not by passing on costs to other payors, but rather by becoming more efficient. To put it another way, the latter research proves that cost shifting is not destiny but rather a convenient choice (vs. the harder choice to become more efficient).

If action is not taken to minimize status quo cost drivers, the yield on current equivalent billed charges is projected to fall by 2020 in our most likely scenario. Specific localized areas could see a shift significantly more detrimental based on current payor mix, an aging population, and/or a heavy percent of low-income newly Medicaid-eligible members. Our projection in Figure 2 shows a 12% decrease in average yield over the next 10 years before the influence of trend by payer. With governments limiting increases and little or no room left for cost shifting, this mix issue will go straight to providers' bottom lines over time.

THE STATUS QUO GLIDE PATH

The NBGH research is important in qualifying the opportunity, but it is Medicaid expansion and a larger population of Medicare-eligibles that will force providers to follow the lead of inpatient facilities in the 16 efficient cities. To understand this, consider this illustration of how much cost shifting would be required to offset these two major changes to payor-provider mix.

For this exercise, we assumed Medicaid enrollment increases of roughly 18% over current levels in 2015 and another 17% by 2020. We can model entire systems, fully adjust for reform initiatives, anticipate provider fee movement for commercial business, etc., based on our healthcare reform modeling capabilities, but in order to calculate the status quo we have only modeled the demographic changes expected in the population as the Boomers enter Medicare and as Medicaid expands. We have not figured in differences by region, type of service provider, or other sources of variation, nor have we tried to anticipate changes to the status quo and how those changes would be reflected in various cost relativities. By their very nature, those changes are dynamic and highly variable, and will depend on a number of factors, including the eventual success of provider efforts to pursue efficiency instead of cost shifting.

Figure 1 includes the illustrative results of the cost shift status quo after reflecting the population shift into Medicare eligibility and an expansion to Medicaid at today's rates. We also reflect a significant decrease in the uninsured per projections related to reform proposals.

The payor mix and subsidy occurring within the commercial/Medicare/Medicaid provider market is already at a point where it can't sustain itself. There is very little cushion left for the kinds of cost shifting that will ensue if the status quo endures.

Using the nationwide average numbers to create a few examples, Figure 2 projects the changes in yield on billed charges (calculated as allowed charges divided by billed charges) today with existing payor mix and projected forward to 2015 and 2020 under our best estimate scenario.

FIGURE 2: CHANGES IN YIELD ON BILLED CHARGES*

YEAR	BEST ESTIMATE SCENARIO PER FIGURE 1 DEMOGRAPHICS
CURRENT	44.1%
2015	41.2%
2020	38.8%

* Yield indicates the percent of billed charges a provider collects (also known as allowed charges)

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PROVIDERS MUST PREPARE FOR FUTURE CASH FLOW CHANGES NOW

The impending strain on provider margins comes at a time when healthcare financing is undergoing unprecedented scrutiny. Insurers are facing pressure to keep rates down, while large providers face an incentive to be profitable and to increase their rates and further shift costs to the commercial population, the only business sector that they still can control to some degree.

Providers can ready themselves by:

- **Becoming as efficient as possible, particularly in facilities where demand for beds will likely begin to exceed capacity.** Tight length-of-stay management will open beds for more patients and optimize reimbursement under diagnosis-related group (DRG) types of contracts common to Medicare. Providers need to redesign the way they approach Medicare admissions as well to reach a break-even point in this market.

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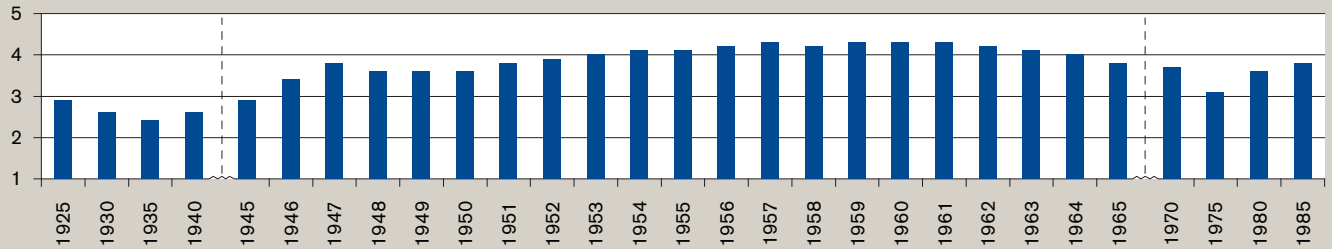
HOW BABY BOOMERS AFFECT PAYOR/PATIENT MIX

The Baby Boom occurred after a generation of Americans returned home from World War II. The beginning of the boom is recognized as 1946 when births increased from 2.8 to 3.4 million in one year. The end of the boom is generally considered to be the early 1960s when the birth rate dropped below 4 million after topping out around 4.5 million a few years prior. This puts the early boomers at 64 years old (one year from Medicare eligibility). The following exhibit shows the birth rates from that era.

NATIONAL BIRTH RATES BEFORE, DURING, AND AFTER THE BABY BOOM (IN MILLIONS)



Decades later, the Baby Boom has created one of the most profitable cohorts of customers in the history of healthcare. Patients between the ages of 50 and 64 have three key virtues for providers:

1. They are usually covered by commercial group or individual insurance, which tends on average to pay about 1.4 to 2.3 times the Medicare payment rates for similar services, depending on location.
2. They are in a high-income phase of their lives and have significant discretionary income to spend on elective procedures and more robust insurance coverage.
3. They are starting to require significantly more care than younger adults.

These three intersecting attributes will likely drive provider profits up in the very near term. Longer-term, payor mix issues will strain the industry as this cohort becomes Medicare-eligible and looks to receive a similar to increased volume of care at reduced reimbursement rates.

- **Understanding the demographic mix expected in their service area**. Some counties will be affected more severely than others. Providers should simulate the population mix impact in their respective service areas to better appreciate the possible change to their bottom line. Demographic projections can also help balance the supply of providers and beds with expected demand.
- **Investing in service sectors that afford consistent margins in the long term**. Care management includes resource and service efficiency management. Certain procedures that currently produce very high margins (scans, oncology drugs, etc.) may be singled out by government and commercial payers alike. If a provider is getting by on these high margin services today, they may not be able to do so tomorrow.
- **Rethinking cost structures and potentially lowering expectations for future income**. One possible solution is to lower overall administrative costs. It seems that all businesses are trying to do more with less, or paying their employees less to do the same or more; healthcare is likely not immune to this trend.

While cost shifting is problematic in a financial system where payment and service are already somewhat disengaged, it is also not a predetermined necessity. If ever there was a time for providers to find new efficiencies, that time is now. Hospitals that continue shifting costs rather than pursuing efficiency are likely to find they have run out of options to remain profitable.

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