The Relationship Between Medicare and Private Insurance Provider Payment Rates

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Cost shifting or revenue shifting?

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Common concerns

- Price of private insurance continues to rise
- Part of the reason is increasing hospital prices
  - Health Care Cost Institute reports consistent price growth
  - Prices charged by hospitals rising faster than input prices
- General agreement that hospitals with more market power have higher prices
  - Academic studies of market power
    - Horizontal integration leads to higher prices
    - Limited success slowing integration
    - No efforts to roll back integration
- Massachusetts releases payment rates by provider
- When will hospitals use their market power?
Why do hospital losses on Medicare patients and private-payer prices go up in tandem?

- **Cost shift hypothesis**: Hospitals only use their market power when forced to meet rising costs
  - Hospital’s input costs are outside of the hospital’s control
  - Medicare/Medicaid rates are below costs and force up private prices
  - Conclusion: Medicare losses cause high private prices

- **Revenue shift hypothesis**: Hospitals will use market power to increase revenue beyond minimum needed for operations
  - Costs are not fixed
  - Higher revenue leads to higher input costs per unit of output
  - High private profits cause higher hospital spending per case
  - Conclusion: Higher private prices cause losses on Medicare patients

- A middle path is also possible
Graphic of two hypotheses

Cost shift

- Medicare prices below hospital costs (costs are exogenous)
- Financial stress (losses on Medicare patients)
- Forced to have high commercial prices

Revenue shift

- Market power, choose high commercial prices
- High hospital costs per case
- Losses on Medicare patients
The inverse relationship between commercial margins and Medicare margins fits both stories

- Medicare pays about 94% of hospitals’ costs on average
  - Some hospitals make money on Medicare
  - Most hospitals lose money on Medicare
- Private insurers pay prices that are over 135 percent of hospitals’ costs per case on average
- On average, some private-payer revenue pays for Medicare patients
Two tests of the conflicting hypotheses

<table>
<thead>
<tr>
<th>Questions to test</th>
<th>Cost-shift hypothesis</th>
<th>Revenue-shift hypothesis</th>
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</thead>
<tbody>
<tr>
<td>Are costs exogenous or do they vary with hospitals’ revenue?</td>
<td>Exogenous (outside of hospitals’ control)</td>
<td>Wealthy hospitals will have higher costs</td>
</tr>
<tr>
<td>Which hospitals will be under the most financial strain?</td>
<td>Hospitals with the highest cost and lower Medicare margins will have lowest all-payer margins</td>
<td>Hospitals under financial pressure have lower cost. So low-cost hospitals with higher Medicare margins will have low all-payer margins</td>
</tr>
</tbody>
</table>
Hospitals’ Standardized input costs per discharge vary widely

Note: Costs are standardized for case mix, local wages, interest costs, outliers, teaching costs and disproportionate share costs. The sample is limited to hospitals with over 500 discharges.

Source: Medicare cost reports
**Conclusion 1: costs vary with pressure**

<table>
<thead>
<tr>
<th></th>
<th>Low-pressure hospitals (Non-Medicare margin over 5%)</th>
<th>High-pressure hospitals (non-Medicare margin under 1%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-profit</td>
<td>105%</td>
<td>92%</td>
</tr>
<tr>
<td>For-profit</td>
<td>100%</td>
<td>92%</td>
</tr>
</tbody>
</table>

High-pressure hospitals had a median non-Medicare margin of less than 1% from 2006 through 2010. In addition high pressure hospitals would have had equity growth of less than 1% if Medicare profits were zero. Low-pressure hospitals had non-Medicare margins were above 5% suggesting high profits on commercial payers.
Conclusion 2: High-cost hospitals tend to be in better overall financial shape

<table>
<thead>
<tr>
<th>2011 Median values</th>
<th>Low-pressure hospitals (n=1,567)</th>
<th>High-pressure hospitals (n=684)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medicare Margin</td>
<td>12%</td>
<td>-3%</td>
</tr>
<tr>
<td>standardized costs as a share of the national median</td>
<td>104%</td>
<td>92%</td>
</tr>
<tr>
<td>Medicare profit margin</td>
<td>-10%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total (all payer) margin</strong></td>
<td><strong>7%</strong></td>
<td><strong>0%</strong></td>
</tr>
<tr>
<td>Medicare and Medicaid share</td>
<td><strong>52%</strong></td>
<td><strong>55%</strong></td>
</tr>
</tbody>
</table>
Academic testing of cost shifting

When Medicare policy changes, do hospitals in markets with low Medicare payment rate growth have below average or above average commercial rate growth?

- Vivian Wu, 2009: 21% of the BBA cuts could be transferred to private payers through higher prices (1996 to 2000 data)
- Austin Frakt, 2011 literature review: A $1 cut in Medicare prices leads to at most a $0.21 increase in private prices
- Chapin White, 2012: Lower Medicare prices lead to lower private prices—opposite of a cost shift (1995 to 2009 data)
- General agreement: Lower Medicare rates primarily result in lower hospital costs. Effect on commercial rates is small.
Can hospitals still provide high quality care while keeping costs down to Medicare rates?

MedPAC looks for relatively efficient providers

- Must be in the best third on either risk-adjusted mortality or inpatient costs per case every year (2008, 2009, 2010), and
- Cannot be in the worst third in any year for risk-adjusted mortality, readmission rates, or costs per case
Comparing 2011 performance of relatively efficient hospitals to others

<table>
<thead>
<tr>
<th>Measure</th>
<th>Relatively efficient hospitals</th>
<th>Other hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospitals</td>
<td>297</td>
<td>1,864</td>
</tr>
<tr>
<td>30-day mortality</td>
<td>13% lower</td>
<td>3% above</td>
</tr>
<tr>
<td>Readmission rates (3M)</td>
<td>5% lower</td>
<td>1% above</td>
</tr>
<tr>
<td>Standardized costs</td>
<td>10% lower</td>
<td>2% above</td>
</tr>
<tr>
<td>Overall Medicare margin</td>
<td>2%</td>
<td>-6%</td>
</tr>
<tr>
<td>Share of patients rating the hospital highly</td>
<td>69%</td>
<td>67%</td>
</tr>
</tbody>
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Note: medians for each group are compared to the national median
Source: Medicare cost reports and claims data
Conclusions

- Hospitals under financial pressure constrain their input costs
- In contrast, hospitals with strong market power may be under less pressure, have higher non-Medicare profits, and have higher costs
- Higher costs can lead to losses on Medicare patients
Questions?