

# 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

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- 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?

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- **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

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## Cost shift



## Revenue shift



# The inverse relationship between commercial margins and Medicare margins fits both stories

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- 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

	Conflicting implications of the two hypotheses	
Questions to test	Cost-shift hypothesis	Revenue-shift hypothesis
Are costs exogenous or do they vary with hospitals' revenue?	Exogenous (outside of hospitals' control)	Wealthy hospitals will have higher costs
Which hospitals will be under the most financial strain?	Hospitals with the highest cost and <u>lower Medicare margins</u> will have lowest all-payer margins	Hospitals under financial pressure have lower cost. So low-cost hospitals with <u>higher Medicare margins</u> will have low all-payer margins

# 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

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Hospitals' standardized 2011 inpatient costs  
as a share of the national average

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	Low-pressure hospitals (Non-Medicare margin over 5%)	High-pressure hospitals (non-Medicare margin under 1%)
Non-profit	105%	92%
For-profit	100%	92%

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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

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

# Academic testing of cost shifting

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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?

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## 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

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Measure	Relatively efficient hospitals	Other hospitals
Number of hospitals	297	1,864
30-day mortality	13% lower	3% above
Readmission rates (3M)	5% lower	1% above
Standardized costs	10% lower	2% above
Overall Medicare margin	2%	-6%
Share of patients rating the hospital highly	69%	67%

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Note: medians for each group are compared to the national median

Source: Medicare cost reports and claims data

# Conclusions

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- 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?

