

## **Cost Shifting: The Cyclical Inflation And Subsequent Erosion Of The Health Care System**

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The increasing cost of health care has become a bipartisan theme for local, state, and national politicians, and will inevitably culminate in systemic health care reform. It is unsettling that the focus is on the effect (cost) and not the multitude of causes (cost-shifting due to fixed, less than cost, remuneration, unaffordable malpractice premiums, the defensive practice of medicine due to litigation, the shortage of qualified healthcare professionals, the price of matching and pacing technological advances, soaring fees for pharmaceuticals, etc.).

Additionally, when Medicare and Medicaid were signed into law in 1965, there were six working individuals for every retiree; within the next 10 to 20 years that number will contract to less than three working individuals for every retiree; thus, our current health care system will not survive this looming demographic alteration in its current form.

Unfortunately, the complexities of funding health care are understood by few, yet discussed by many. Before our national health care delivery system is repaired, modified, altered, and/or reconstructed, it is imperative that our collective universal comprehension of the aforementioned causes is enhanced.

To bridge the knowledge chasm, Franklin Pierce College established a Master of Business Administration (MBA) in Leadership in Health Practice Management using an action based learning model which converts the traditional classroom environment into one which encourages students to focus discussions on current problems in the institutions in which they are employed and within their communities by developing models and solutions for local and regional problems, which may then have national relevance and to use the classroom as a “think tank” that will facilitate the expansion of the collective health care knowledge-base.

The purpose of this whitepaper is to highlight the complicated intricacies of health care payment methodologies, cost shifting, and the innumerable consequences of unprecedented healthcare inflation. To reiterate, systemic health care reform is inevitable and our opportunity to ensure the “new” system is sustainable and equitable will be to collectively participate in its design and to make sure that all of us can comfortably articulate and comprehend the current state of affairs.

## **Payment methodologies overview**

In today's evolving health care environment, health care providers (hospitals, physicians, clinicians, nursing homes, etc.) are faced with the challenge of providing safe, technologically advanced, high quality care as payment methodologies continue to change and as payment sources contract. Consequently, providers are challenged to match and pace these changes as costs continue to escalate and as insurance carriers uniformly demand rate relief. Providers are finding it increasingly difficult to satisfy consumer demand for the three things they require from a health care delivery system: quality, access, and affordability.

In order to comprehend the complexity of the innumerable array of payment methodologies, it is necessary to first examine the three payers on the national health care landscape: self, public, and private.

Individuals who do not have health insurance comprise the self-pay sector: people who are required to pay the total charges after they receive care. Medicare and Medicaid (public sector) are the nation's largest health insurance programs. Medicare (administered on the federal level) covers recipients 65 years and older, and Medicaid (administered on the state level) covers the disabled and/or the indigent. Medicare and Medicaid recipients may be required to pay a co-insurance or a deductible; however, they rarely pay the total charges. The last insurance sector is comprised of private insurances that generally negotiate payment rates for their premium-paying constituency. Therefore, depending on the plan, commercially insured patients (other than plans with high deductibles that must be met) pay less than the full charges.

The Centers for Medicare and Medicaid Services (administer the Medicare and Medicaid programs) reimburse on a prospective payment system (PPS) for inpatient care. The Prospective Payment System is a payment method that is based on predetermined rates for each unit of service. Payments are made prospectively and are intended to pay a provider a set amount for a group of services regardless of the actual cost associated with provision of services. Other payment methods vary. However, the most common are per diem, fee for service, and capitation.

Under the per diem method, a health care organization is provided a "lump-sum" payment for each day. However, a fee for service model is generally based-on an insurance carrier's interpretation of "reasonable and customary" charges. Capitation, generally administered by managed care organizations, pay a fixed monthly rate for the patients who subscribe to the plan. This method regulates services and provides an incentive to keep the collective cost minimized.

Public payment policies and potential modifications to these policies continuously draw the attention of health care providers. Due to the fact that Medicare and Medicaid

generally pay less than cost for a preponderance of the services rendered, providers attempt to offset the loss by inflating their charges. These inflated charges target the private insurers/third party payers who generally reimburse at a percentage of the charges; thus, the various insurance sectors and payment methods (specifically the ones that reimburse less than cost) result in cost shifting.

## **Cost shifting**

President Ronald Reagan introduced the prospective payment system (PPS) to control the ever-increasing Medicare inpatient costs. Under this system, Medicare shifted to payment by diagnostic groups (Diagnostic Related Grouping or DRG) instead of by the actual cost of treatment. This resulted in reimbursement for a fixed amount based on the patient's discharge diagnosis and procedures performed. The goal was to give hospitals a financial incentive that encouraged cost-efficient management of resources. Private plans followed suit; however, there were major problems with the DRG-based system.

The chief problem hinged upon reimbursement rates not keeping pace with health care inflation. This led to patient inconveniences, early (premature) discharges that sometimes resulted in readmission, and a lower quality of care and other negative outcomes. The result was the birth of cost-shifting. From a hospital perspective, cost-shifting occurs when a payer reimburses less than cost and another payer will remunerate more to make up the difference (by law all payers are "charged" the same amount).

When one payment source is down another must rise to compensate. Medicare, Medicaid, uninsured patients (self-payers), bad debt, and charity all contribute to the unpaid costs. Medicare and Medicaid have federally set reimbursement rates that are below actual costs. Hospitals must accept these rates or they may face the possibility of exclusion from the federal programs. ***Hospitals attempt to recoup their losses by setting rates based on their payer-mix (higher percentage of commercial insurances) anticipating higher reimbursements from private and commercial insurance payers.***

Private commercial insurance companies traditionally assume the largest portion of cost-shifting because they, in-turn, pass the costs back to the consumers through higher premiums, larger deductibles, and, possibly, less coverage. Additionally, uninsured patients (self-pay) who cannot/do not pay their charges force the hospital to write off the remaining charges as bad debt or charitable care. Hospitals need to make charges high enough to reflect a positive balance to maintain fiscal viability and increase the likelihood of retained earnings.

Retained earnings are necessary for hospitals to match and pace advances in technology, the high cost of pharmaceuticals, and the shortage of available health care professionals (nurses, pharmacists, radiology technologists etc.). The result is hospitals are faced with a financial/quality of care dichotomy. Although there are no easy answers or quick fixes, it

is abundantly clear the national health care system cannot continue down the same path; quite simply, it is not sustainable or reasonable.

## **The results of cost shifting**

The New Hampshire Center for Public Policy Studies estimated that cost shifting added 17 percent to the charges that New Hampshire employers and individuals with private health insurance paid for hospital care in 2001. During that year, this cost shift totaled \$197 million. (Business and Industry Association of NH.)

As of June 2005, the New Hampshire Senate passed a two-year state budget that proposed \$26 million in additional Medicaid cuts. These cuts will most likely be shifted to privately insured individuals.

Over the last five years, inflation has seen an average annual increase of 2.88 percent, while health insurance premiums have increased by an annual average of 11.62 percent. (Kaiser, 2005 exec summary.)

The average annual premium for a worker with single coverage rose to \$4,024 in 2005. The average annual premium for family coverage rose to \$10,880. During the same period, the percentage of small firms (defined as having less than 200 employees) offering health insurance declined from 68 percent to 59 percent (ibid), while large firms (employing 200 or more employees) have been more consistent: 98 to 99 percent have offered some sort of coverage to their employees. (ibid.) In part, this is because the smaller firms have seen premium increases that outpace the national average. Additionally, although the percentage of larger firms that offer insurance has remained steady, there is speculation that larger firms are using more temporary and part-time employees who are not insured.

Ratios for premium cost increases have been largely unchanged during this period. For single coverage, workers have paid 16 percent of premium costs for the last four years and 14 percent in 2001. For family coverage, workers have paid between 26 and 28 percent during the same period. (ibid.)

Although ratios have remained constant, employee spending for health insurance coverage has increased 126 percent between 2000 and 2004. (National Coalition for Healthcare.)

In an attempt to mitigate their costs for premium increases, employers are increasing employee copays and reducing overall benefits. This has been especially true over the last two years and the trend is predicted to increase in 2006. (USA Today, 9-13-2005.) In effect, employers have instituted their own cost shift.

Literally, many Americans cannot afford to get sick. Roughly one-half of Americans who filed for bankruptcy in 2001 cited medical causes as the source of their financial difficulties. Additionally, almost 76 percent of those who filed bankruptcy had at least some form of health insurance at the onset of illness. Also, the average bankrupt person with private insurance spent \$13,460 on deductibles, co-pays, and out-of-pocket expenses. People with no insurance filing for bankruptcy spent an average of \$10,893 for the same such expenses. (Health Affairs, Feb. 2, 2005.)

## **Conclusion**

This whitepaper does not purport to offer any specific suggestions to diminish the financial liability of illness and/or mitigate the problem of cost-shifting. Health care in the United States, as we know it, is unsustainable. However, change can occur and there is no reason to think that the system cannot be corrected. Nevertheless, profound philosophical and cultural shifts need to occur in order to reverse health care's current course. To salvage the system, the health care crisis will need to be captained by leaders with health care industry knowledge. These leaders need to view saving of the system as their primary task rather than engaging in the perpetual political posturing that results in nothing more than innumerable rhetorical statements.

The bipartisan political posturing of both parties must be put aside to establish a functional healthcare industry that provides coverage for all citizens. The steps that need to be taken will impact all individuals within the decision-making/political arena in a multitude of ways. Labor issues, administrative issues, quality of care, private insurance, entitlement program, and patient affordability will all play an important role in the resolution of the health care funding crisis. For success, the change must be apolitical, open, and understood; or, quite simply, we are destined to repeat our failures.

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