Who Will Pay Future Hospital Bills?

BY JANE H. WHITE

"Change" is the rallying cry of the 1992 presidential candidates. In the healthcare sphere, change is the one agreed-on goal in an arena strewn with competing reform proposals and ideas. Change has recently been rapid and far reaching to ensure hospitals' survival. Hospitals have jumped to adapt to each new policy change coming out of Washington and to heightened competition in the marketplace. The Medicare prospective payment system (PPS) of 1983 and adjustments each year thereafter, the growth of managed care, and changes in the way healthcare is delivered add to the picture of enormous evolution for hospitals.

After so much change in financing, structure, and organization in the past decade, what picture emerges for hospitals facing more reforms in the twenty-first century? Hospital services have always made up the largest portion of personal healthcare spending, yet this percentage is now on the decline. In 1980 hospital spending represented 47 percent of personal healthcare spending; this fell to just under 44 percent in 1990.[1]

If one subtracts the outpatient side of hospital care from this figure, the decline is much more dramatic. Outpatient services accounted for 13 percent of community hospital revenue in 1980; this burgeoned to 24 percent by 1990, according to the Prospective Payment Assessment Commission (ProPAC).

ProPAC Chairperson Stuart Altman commented on this decline at a June 17, 1992, hearing: "The decline in relative importance of the hospital in our medical system and the potential for further decline in the years ahead is only one indication of the confusing picture facing today's hospital. The most serious is the complicated situation with respect to who pays the bill for the care provided and who will pay in the future." Rep. Fortney H. "Pete" Stark, D-CA, chaired this hearing before the House Joint Economic Subcommittee on Investment, Jobs, and Prices. It was the first of two hearings held this summer on the structure of the hospital industry in the United States in the twenty-first century.

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This column looks at some of the significant policy changes that have altered the financial base of hospital payment. These include cost shifting among payers; the effect of Medicare payment policies on hospitals—who wins and who loses; the shift from inpatient to outpatient care; and the potential effect of future cost containment and healthcare reforms. Next month's column will examine issues surrounding tax-exemption and not-for-profit hospitals in a reformed healthcare system.

The Source of Cost Shifting

In his testimony at the June hearing, ProPAC's Altman said:

> There are those who suggest that the hospital should become the center of the healthcare delivery system of the future. Others question, however, whether the hospital as we know it today will even be needed in the future. They point to the revolution taking place in the biomedical-biotechnical fields, which will permit more patients to be treated in an outpatient setting or even at home. While this debate is centered on the technical aspects of patient care, my concern is with the financing of hospitals. Can we be sure that the series of cross-subsidies that currently underpin our hospital system will continue in the future?

This cross-subsidization, or cost shifting by charging private payers higher prices to cover the shortfall created by uncompensated care and underpayment by public payers, leaves many hospitals vulnerable. According to ProPAC analyses, in 1989, 10 percent of hospitals were unable to cover their shortfall by shifting costs to private payers. An additional 40 percent of hospitals had limited ability to recover their costs; many of these hospitals, however, managed to show positive total margins with the help of nonpatient revenues.[2]

In 1989 the amount of unsponsored care (bad debt and charity care minus government subsidies for indigent care) for hospitals totaled $8.9 billion. Undercompensated care resulting from underpayment by Medicare, Medicaid, and other government payers reached $11.2 billion. By 1992, according to estimates by Lewin-ICF, these figures will rise dramatically to $11.9 billion for unsponsored care and $22.7 billion for undercompensated care, vastly increasing the pressure on the hospital cost-shifting process.[3]

The Lewin-ICF report, prepared for the Healthcare Financial Management Association, examined the cost-shifting process and its impact on providers, payers, and the public. The report calls into question the wisdom of relying on cost shifting to cover the rapid increases in unreimbursed care to hospitals. Some of the main findings include:

- The magnitude of the cost shift is large and growing—rising from 11.0% of hospital costs in 1989 to 14% by 1992;
- The source of the cost shift has changed markedly over the 1989 to 1992 time period from uncompensated care associated with individuals to underpayment by public payers;
- Medicare beneficiary outpatient care represents a significant source of Medicare related cost shift;
- There is a wide range of the cost shift around these averages;
- As the magnitude of cost-shifting increases, employer support could erode. If the cost-shift mechanism loses employer support, the current system of hospital finance will need to be rethought.

ProPAC's analysis of American Hospital Association (AHA) data shows the extent to which government payers "underpay" and private payers "overpay."[4] In 1990 the hospital payment-to-cost ratio was 89.6 percent for Medicare and even lower for Medicaid at 80.1 percent. For private payers, this ratio was 127.6 percent. Without the income from non-patient care revenue, the pressure to shift costs to private payers would have been even higher. Such nonpatient income covered 3 percent of hospital costs in 1990 and had a payment-to-cost ratio of 143.0 percent.

ProPAC also analyzed data from MEDSTAT Systems, Inc., Ann Arbor, MI, and found a large variation in the amount of subsidies private payers cover. Payments for inpatient hospital care by specific employer groups covered 89 percent to 168 percent of costs for the employer's patients.

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The Lewin-ICF report uses AHA data to project the hospital cost shift from public to private payers for 1992. The report estimates that private payers will pay about 38 percent more than their "actual" hospital costs in 1992, up from 25 percent more in 1989.

How Stable Is Cost Shifting?

As long as private payers are willing to foot this "hidden tax," cost shifting will continue. The Lewin-ICF report notes that "hospitals are in effect serving as quasi-governmental bodies, imposing taxes on one set of patients to cover the unreimbursed costs of another. . . . If and when the cost-shift tax burden is perceived as unreasonable, however, the existing method of financing hospitals in this country will become unstable."

At present, private payers, as represented by the business community, seem willing to pay the cost shift rather than fight with Congress and the administration to pay their fair share. Catholic Health Association (CHA) Vice President for Government Services William J. Cox explained that the current Washington motto regarding lower Medicare and Medicaid payments—that is, "the system will absorb it"—is really "a code for cost shifting." To win the fight with Washington policymakers for higher public payments to hospitals, "we need the business community to insist on it," said Cox. "However, it has been easier for business to raise costs, rather than to fight the political process," he added.

Business, in turn, shifts its higher costs to employees and the public via increased insurance costs, decreased benefits, smaller real increases in salary, and increases in the price of goods and services for consumers. So perhaps it is the individual, fearful of losing insurance or being unable to pay the rising costs, who will ultimately fight the political battle with Congress for a more equitable payment system. The prominence of healthcare in this year's presidential campaign—in word, if not in action—is a testament to the growing unrest.

At an August 10, 1992, meeting of the National Academy for State Health Policy in Minneapolis, healthcare advisers for President George Bush and Democratic candidate Gov. Bill Clinton squared off on their candidate's healthcare position, each trying to convince the audience that healthcare reform was a priority issue. Clinton spokesperson John McGrath said, "Clinton is committed to comprehensive health system reform in the first year of his administration. He made this commitment in the first

month of his campaign." Bush administration representative Kevin Moley countered that "the president has four pieces of [healthcare reform] legislation before Congress . . . and the Congress has done nothing. I urge Clinton to push Congress to action now if he's sincere" about healthcare reform.

Redistribution of Costs within Medicare

Beyond the shift of hospital costs between public and private payers, a significant amount of shifting is occurring within Medicare. As CHA's Cox describes it, "The Medicare program has been converted to a pool of dollars that are redistributed on the basis of social need and political clout, while the rest of the hospitals are left to fend for themselves."

ProPAC's Altman explained some of the internal Medicare shifts: "Within the annual Medicare PPS budget of $54.9 billion in fiscal year 1992, about $5.3 billion, or almost 10 percent, is redistributed from the overall payment total to two classes of hospitals: teaching hospitals and disproportionate-share hospitals. In addition, significant extra sums are reallocated to rural sole community hospitals."

ProPAC estimates underscore the variation in payments among hospital groups. Urban hospitals accounted for 53 percent of PPS hospitals, but 85 percent of payments in fiscal year 1992. Rural hospitals, on the other hand, accounted for 47 percent of all PPS hospitals and 15 percent of payments. Factors behind the variation in payments include differences in Medicare discharge volume, the number of outlier cases, local wage rate, case mix, operation of a graduate medical education program, and treatment of a large proportion of poor patients (thus qualifying the hospital for the "disproportionate-share" PPS subsidy).

Profit Margins The disparity in Medicare payments can also be viewed through the measure of hospital profit margins. If one looks at PPS operating margins for all hospitals combined, one sees a picture of steep decline. Aggregate PPS margins averaged 14.5 percent in the first year of PPS (1983-84). This fell to −3.6 percent in 1989-90 (PPS year seven) and to −10.2 percent in 1991-92, according to ProPAC estimates.[5] However, a different picture emerges as hospital groups are separated. For instance, in 1989-90 nonteaching hospitals had a −7.8 percent PPS margin, while major teaching hospitals posted a +7.8 percent PPS margin. Urban and rural hospitals were both in the negative category, but urban hospitals fared slightly better with a −2.8 percent PPS margin versus −6.4 percent for rural hospitals.

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ProPAC also found that the gap between hospitals faring well under PPS and those doing poorly had widened. By the seventh year of PPS, the margin spread for the middle half of all hospitals ranged from −16.5 percent PPS operating margin for hospitals in the 25th percentile to a 5.9 percent margin for those in the top 75th percentile. This 22.4 percentage-point spread compares with a first-year differential of only 14.3 percentage points. For hospitals at the very top and bottom end of the scale, the margin differentials are even greater, ranging from −30.4 percent to 15 percent in the seventh year of PPS.

Winners and Losers Determining which hospitals have emerged as "winners" or "losers" under Medicare's PPS is the subject of another Lewin-ICF report, this one commissioned by ProPAC.[6] Lewin-ICF conducted case studies of 10 pairs of winning and losing hospitals to assess which characteristics affected performance. An additional internal report by ProPAC staff statistically analyzed the winning and losing hospitals under PPS.[7]

The Lewin-ICF report found that a number of external environmental factors, as well as internal hospital operations, affected hospital performance under PPS. Hospital-specific characteristics among winners included strong leadership, a tradition and culture of cost containment before PPS, more productive physician-administrator relationships, greater production efficiency, use of specific objectives for improving and monitoring performance, and smaller declines in patient volume.

The report's authors wrote that "the complexities [of these factors] preclude developing any single set of solutions that can be generalized to all hospitals." Nevertheless, one conclusion reached is that "study hospitals did not achieve winning Medicare performance solely because they focussed on Medicare financial performance. Rather they focussed primarily on total performance (including non-financial measures such as patient satisfaction and quality of care) and secondarily on Medicare performance (if at all)."

Shift to Outpatient Care

Between 1979 and 1989 the number of ambulatory surgical procedures increased 261 percent. During the same decade, inpatient surgery declined 30 percent, according to ProPAC analyses. Because Medicare pays for outpatient treatment on a procedure basis, rather than on the prospectively determined case basis used for inpa-

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report a consultation or subsequent hospital care, as circumstances warrant.

Third, separate Medicare payment can be made to the physician for both hospital discharge management and a nursing facility admission when discharge and admission occur on the same day. Special rules apply, however, if the physician is a surgeon.

If the patient's admission to the nursing facility is for a condition unrelated to the surgery, the surgeon may bill separately for the admission. If the admission is for a related condition, no separate payment is made because the admission would be covered by the global surgery fee.

Fourth, separate Medicare payment may be available when a given physician transfers a patient between facilities. If the transfer is between (1) different hospitals, (2) different hospitals under common ownership and without merged records, or (3) an acute care unit and a prospective payment system–exempt unit within the same hospital that do not have merged records, the physician may bill for both hospital discharge management and initial hospital care for the admission to the other hospital or exempt unit.

In other transfer circumstances, the hospital discharge management code and the admission code may not be billed separately. The physician should bill only the appropriate level of subsequent hospital care.

Future Clarifications

The RBRVS fee schedule is evolving. Physicians, hospital medical directors, clinical department heads, and other interested parties are scrutinizing the relative values and the associated CPT codes. And additional revisions can be expected in the near future.

Hospitals and physicians should study the soon-to-be-published RBRVS rule for 1993; it may contain changes that are financially consequential. □

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This massive shift to outpatient treatment has implications for the organization and future of hospital care.

tient care, the volume and total Medicare spending for such care have skyrocketed. This massive shift has implications for the organization and future of hospital care.

As hospital outpatient care has grown, so has the competition to provide such care. ProPAC estimates that the number of freestanding ambulatory surgical centers increased from 239 in 1983 to 1,383 in 1990. Ambulatory treatment in physicians' offices and new types of diagnostic centers are also burgeoning. In his June testimony, ProPAC's Altman questioned the impact of these trends on hospitals: "If these trends accelerate, will the hospital of the future be able to use its outpatient department as a profit center to counter the losses on the inpatient side? If it cannot, how will hospitals cope with declining income?"

Future Reform

To counter the negative trends of falling profit margins, wide cost shifts, and hospital occupancy rates that had fallen to a low of 63.5 percent for 1991, Altman offered several policy recommendations to Congress.

First, he recommended that "we continue to tighten the reimbursement system for all payers of hospital care. This will force hospitals themselves to deal with their excess capacity."

Second, "to keep overall financial pressure on hospitals and the total healthcare system," Altman recommended the establishment of a national healthcare expenditure board and a system of regional healthcare expenditure boards, similar to the Federal Reserve System. All insurers, public and private, would pay hospitals the same price for the same service. The national board would set a total expenditure target related to the growth in the national income. However, the board would have the flexibility to make trade-offs regarding healthcare spending and other national priorities.

Such a plan is but one strategy for reducing the inefficiencies and inherent instability of the current system of paying hospitals. Whatever direction reform takes, some change seems necessary. As Lewin-ICF's Allen Dobson and James Roney observe, "The evidence suggests that cost-shifting's days may be numbered and that systemic healthcare reform will be required if we are to avoid a serious breakdown in the financial structure of the nation's healthcare delivery system."[8] □

NOTES

1. Prospective Payment Assessment Commission (ProPAC), *Medicare and the American Health Care System: Report to the Congress*, Washington, DC, June 1992, Table 1-2.
2. ProPAC.
3. Allen Dobson and James Roney, "Cost-Shifting: A Self Limiting Process," Lewin-ICF, Fairfax, VA, April 1992.
4. ProPAC, Table 1-7.
5. ProPAC, Figure 2-2.
6. Allen Dobson et al., "An Evaluation of Winners and Losers under Medicare's Prospective Payment System," Extramural Report E-92-02, prepared by Lewin-ICF for ProPAC, Washington, DC, May 1992.
7. Deborah Williams et al., "Winners and Losers under PPS," Intramural Report I-92-01, ProPAC, Washington, DC, June 1992.
8. Dobson and Roney.