Vermont Legislative Joint Fiscal Office

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ISSUE BRIEF

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The Medicaid Cost Shift: Background and Considerations

1. Vermont's regulatory environment may lead to a different outcome; but nationwide, economic studies question the idea that increasing Medicaid payments necessarily will reduce the rate of growth in commercial insurance premiums.

- Increasing Medicaid payments might lead to slower growth in private insurance premiums in Vermont if the funds are targeted carefully to areas where the Green Mountain Care Board (GMCB) has regulatory authority
- Some leakage will likely occur because of the nature of Vermont's health care system and the limitations of GMCB regulation

2. There are reasons to increase payments to Medicaid providers other than to slow growth in private insurance premiums. Those other reasons include:

- Improving access to health care services for Medicaid patients; the Vermont Household Health Insurance Survey suggests areas of concern
- Possibly facilitating a move toward an all-payer waiver and payment reform

3. The "cost shift" can be measured in different ways. The key differences are related to different prices paid by Medicaid, Medicare, and commercial insurers relative to "actual cost" that includes fixed costs (see Chart on back).

- The Medicaid cost shift: raise Medicaid prices to "actual cost"
  - One piece would raise Medicaid prices to the Medicare levels (see Figure 1)
- The Medicare cost shift: raise Medicare prices to "actual cost"
- The total cost shift (sum of Medicaid, Medicare, and free care/bad debt cost shifts; estimated by GMCB as directed in VT law)

4. Not all price variation is bad. As is the case in other sectors, firms often charge different prices to different types of consumers for the same good/service based on ability to pay, intensity of demand, regional price differences, and availability of the good/service.

5. Empirical studies using nationwide data show that commercial insurance rates often rise when Medicaid payments increase

- Not-for-profit hospitals seek to improve the health of their patients as they also seek to improve their financial viability
- Increased payments from one payer can lead to more spending overall and higher payments for everyone

6. Vermont has a strong regulatory structure that has the tools to put downward pressure on commercial insurance rates

- The GMCB must approve hospital budgets and review insurance rates for a sizable share of the commercial insurance market; together, that authority covers a large share of health care spending outside of government programs
- Additional Medicaid payments targeted at health care spending that is regulated by the GMCB makes slower growth in private insurance premiums more likely

Introduction

It is widely believed that when Medicaid or Medicare constrains its payments for various types of care, private insurers end up paying more as a result. Price differentials for the same services can arise because prices for the Medicaid and Medicare programs are generally lower than prices paid by commercial insurers. The term "cost shift" is commonly used to reflect the idea that hospitals and other health care providers need to obtain additional revenue from patients who have private insurance or no insurance to make up for lower payments from Medicare, Medicaid, charity care, or bad debt. When policy makers talk about addressing the cost shift, they often expect that raising prices paid by Medicaid will lead to lower prices paid by private insurance. Other reasons to address the cost shift include providing better access to health care for Medicaid patients and facilitating a move toward an all-payer waiver and payment reform.

This Issue Brief contains background information and considerations regarding the cost shift under current law. It does not specifically analyze the proposal put forth by the Governor of Vermont in the 2015 session.

What is Meant by the Cost Shift: The Chest X-Ray Example

The term "cost shift" can be confusing because it means different things to different people. In the context of hospital budgets, calculating the cost shift involves overall revenues, expenses, and operating margins for different payers. To simplify understanding the cost shift, we look at illustrative prices and price differentials for one particular type of service: a chest x-ray.

Each year, the Annual Report of the Green Mountain Care Board (GMCB) to the Legislature must describe the cost shift and quantify its impact.[1] To estimate the cost shift, the GMCB looks at revenues received by different payers. Those revenues are the result of the various prices paid to hospitals and hospital-affiliated providers by different payers and the volume of services provided. To give an example of differences in prices paid and how they affect the estimate of the cost shift, we refer to illustrative prices paid for a chest x-ray as listed in a GMCB presentation (2013) (see Chart below). According to the data collected by sampling hospitals in Vermont, Medicaid paid $187.50 for a chest x-ray, Medicare paid $216.75, and commercial insurers paid $357.15. In this example, the "actual cost" of providing the chest x-ray, including a portion of any overhead or fixed costs, is hypothetically set at $250.00, as it is very difficult to know the actual cost.[2] Four components of the total "cost shift," labeled a, b, c, and d in the Chart, are explained below.

a) The Medicaid-to-Medicare cost shift that is the focus of many policymakers is based on the price differential between the price paid by Medicaid and the price paid by Medicare (see box a in the Chart). In the example above, the Medicaid price is 87 percent of the Medicare price, or in our example, $29.25 lower than the Medicare price. If 100 Medicaid patients received chest x-rays, the Medicaid-to-Medicare cost shift for chest x-rays would be 100 times the Medicare-Medicaid price differential of $29.25, or $2,925.

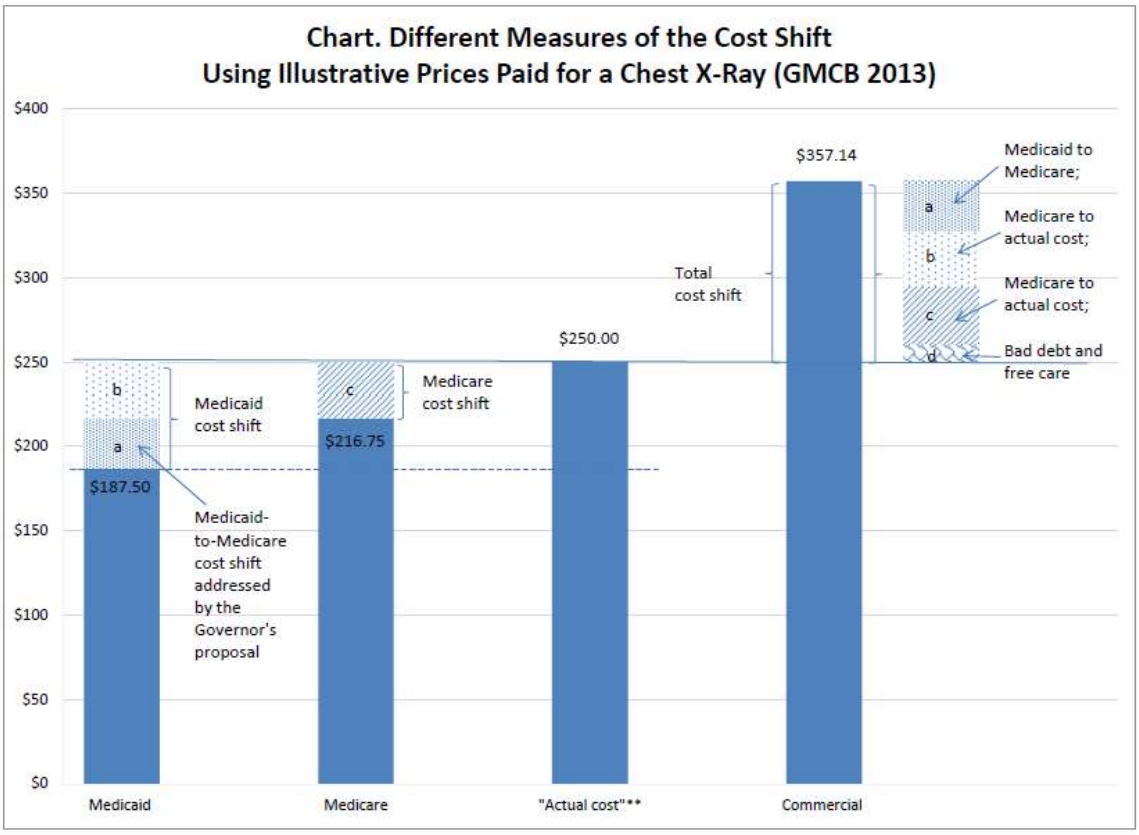
b) The Medicaid cost shift consists of two pieces: the Medicaid-to-Medicare cost shift (box a) and the distance from the Medicare price to the "actual cost" (box b). Estimating the Medicaid

[1] In 2006, the Legislature in Act 191 created the Cost Shift Task Force; its 2006 Report laid out methodology for estimating the hospital cost shift largely followed by the GMCB today. See Appendix C, State of Vermont (2006).
[2] The Vermont Association of Hospitals and Health Systems was unable to provide an estimate of the "actual cost" of a chest x-ray.

cost shift is based on the price differential $250 less $187.50, or $62.50. Again, if 100 Medicaid patients received chest x-rays, the Medicaid cost shift would be $6,250. When the GMCB calculates the Medicaid cost shift, they look at revenues from Medicaid based on the current Medicaid price relative to what revenues would be if Medicaid were paying at "actual cost." A big obstacle here is that the actual cost for a particular service is extremely difficult to discern. In the illustrative example here, the actual cost of performing a chest x-ray is purely hypothetical at $250. In the hospital context, overall hospital costs are known and are used in the cost shift calculation.

c) The Medicare cost shift reflects the difference between the Medicare price and the "actual cost" (see box c). In the example, the price differential is the gap between $216.75 and $250, or $33.25. If 200 Medicare patients had chest x-rays, the Medicare cost shift would be $6,650.

d) The total cost shift consists not only of the Medicaid cost shift and the Medicare cost shift but also the piece that arises from free care and bad debt (box d in the Chart). The total cost shift is based on the price differential between the commercial insurer's price and "actual cost," or $357.14 less $250, which is $107.14. If the hospitals and affiliated providers performed 1000 chest x-rays, of which 100 were at the Medicaid price and 200 were at the Medicare price, and the value of bad debt and free care for chest x-rays was $600, the total cost shift for chest x-rays would be $13,500 in this illustrative example.



**"Actual cost" is a hypothetical number that is intended to represent a portion of provider fixed costs as well as the cost of the x-ray itself.

How Big is the Cost Shift?

As required by law, the GMCB (2015) estimates that the total cost shift in Vermont for hospitals and affiliated primary care and professional services in calendar year 2015 is $393 million, of which an estimated $150 million comes from the Medicaid cost shift and $175 million comes from the Medicare cost shift.[3] Bad debt and free care are the other components of the total cost shift for hospitals and affiliated services as estimated by the GMCB. Those estimates rely on price differentials between prices for various payers and "actual cost." The GMCB estimate for the Medicaid cost shift dropped in 2013 in response to provisions in the Affordable Care Act aimed at boosting physician participation in the Medicaid program, but it has risen since then.

Green Mountain Care Board's Estimated Cost Shift for Hospitals and Affiliated Primary Care and Professional Services

Fiscal Year	Medicare	Medicaid	Free Care	Bad Debt	* Commerical Insurance & Other
Actual 2012	$ 68,334,861	$ 151,931,648	$ 24,347,367	$ 39,264,676	$ 283,878,552
Actual 2013	$ 128,033,776	$ 105,998,937	$ 24,685,204	$ 37,386,222	$ 296,104,139
Budgeted 2014	$ 166,065,165	$ 134,778,449	$ 25,982,503	$ 40,263,981	$ 367,090,098
Budgeted 2015	$ 175,171,362	$ 150,394,735	$ 26,137,170	$ 41,464,624	$ 393,167,891

Notes: Payer values include all hospital and employed physician practices.

Medicaid values include non-Vermont Medicaid of approximately 5% *Data Source: Green Mountain Care Board, 2015*

How Do Medicaid Fees Compare to Medicare Fees?

Policymakers often look at reducing the Medicaid-to-Medicare cost shift as a way to reduce pressures on insurance rates in the private market or as a way to increase access to health care for people on Medicaid. Comparing Medicaid prices for all services to those paid by Medicare is difficult in part because the two public programs do not provide exactly the same services and each offers managed care options that pay on a per capita basis rather than on a fee-for-service basis. A recent study of fee-for-service Medicaid and Medicare prices paid to physicians offers one view of price differentials between the two programs (Zuckerman and Goin, 2012).[4] It measures Medicaid physician fees relative to Medicare physician fees in each state. The fees represent only those payments made under the fee-for-service component of each program, and Medicare fees are adjusted for geographic and other location-specific factors.[5]

On average across the United States in 2012, Medicaid physician fees were 66 percent of Medicare fees. Considerable variation across states underlies that national statistic, however (see Figure 1 below). The Medicaid-to-Medicare fee ratio ranged from just 37 percent in Rhode Island to 134 percent in North Dakota, California, Florida, Michigan, Missouri, New Hampshire, New Jersey, New York, and Rhode Island, where almost 40 percent of Medicaid beneficiaries live, paid the least relative to Medicare–less than 60 percent. Almost half the states paid no more than 75 percent of Medicare fee levels.

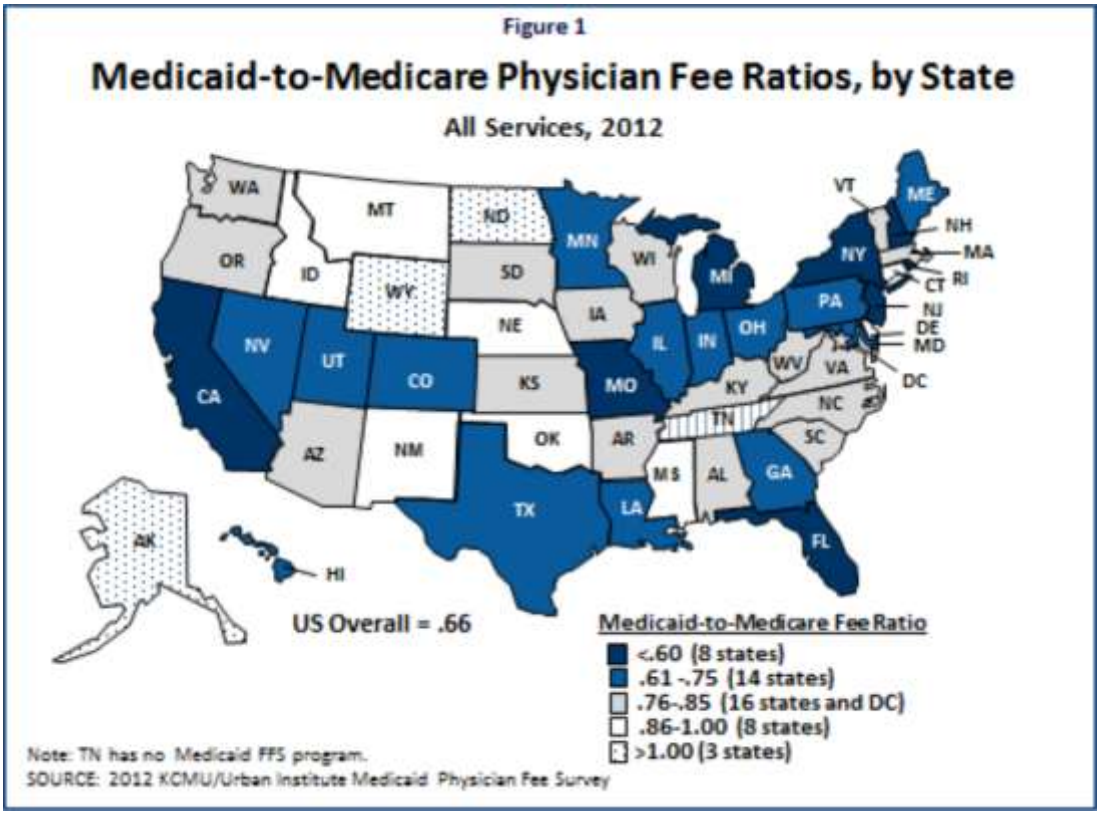
Vermont's Medicaid fees for physicians were 80 percent of its Medicare fees for physicians for all services in 2012, placing it at #17 when the states are ranked from highest to lowest (see

[3] The estimate does not include independent professional services because the data are not available. For further information on the methodology used by the GMCB, see GMCB 2013.

[4] The study looked at fee-for-service office visits as well as services. It included office visits for primary care physicians and obstetricians, for example, as well as services such as electrocardiograms, Cesarean deliveries, and upper gastrointestinal endoscopy.

[5] In the last few years, a rising share of doctors received a salary through a hospital affiliation or per capita payments through managed care. Those doctors would be less affected by the Medicare-Medicaid price difference.

Kaiser Family Foundation). For primary care physicians, the ratio was 81 percent, and Vermont ranked #12. Vermont's ratio for physicians in obstetric care was 82 percent, and its rank was #27. For physicians in all other services, the ratio was 77 percent, and the rank was #24.



Why Address the Cost Shift?

Putting downward pressure on commercial insurance rates is commonly cited as the reason to raise Medicaid payments, but improving access to provider services and enhancing the state's efforts to move toward an all-payer waiver and payment reform are important reasons as well.

Access to care may be a problem for some Vermonters on Medicaid. The 2014 Vermont Household Insurance Survey found that 7 percent of adults on Medicaid "delayed or missed receiving health care because they could not find or did not know a doctor or other health care provider who accepts Medicaid" (see State of Vermont 2014). Among people in the survey with other sources of insurance, that statistic was between 1 percent and 3 percent. On the provider side, preliminary data for 2014 showed that about 83 percent of primary care physicians in Vermont were accepting new Medicaid patients, whereas about 90 percent were accepting new patients in general (see Vermont Department of Health 2015). Among Vermont dentists in 2011, only 29 percent accepted five or more new Medicaid patients per month (Stevens and Hofmann, 2013). A recent nationwide study provides early evidence that increased Medicaid payments to primary care providers were associated with improved appointment availability for Medicaid enrollees without generating longer waiting times (Polsky, et al. 2015).

In addition, a smaller price differential for Medicaid and Medicare might facilitate Vermont's request for an all-payer waiver from the federal government to change the payment system for

health care providers and encourage greater continuity of care. Increasing payments to Medicaid providers would be one way to shrink the Medicaid-Medicare price gap.

What Could Happen if Medicaid Payments Increased?

If the state were to increase Medicaid payments by a specified amount, to what extent would Vermonters see lower commercial premium rates? Or to what extent would the increase in Medicaid spending result in an increase in overall spending? The short answer is that Vermont's regulatory structure would likely ensure some but not all of the increased Medicaid payments could be offset in private insurance premiums. It seems likely that if Medicaid payments were increased in Vermont, private insurance premiums would grow at a slower rate than would otherwise be the case.

The GMCB has two distinct ways to regulate health care prices and payments in Vermont. The GMCB can exercise regulatory authority through the hospital budget process and put pressure on hospitals to reflect offsets on the commercial side in their annual budget submissions. The GMCB also has regulatory authority to approve or disapprove commercial insurance rates in the part of the commercial insurance market that it regulates. Through the process of hospital budget review and health insurance rate review, the GMCB has authority over a large share of spending for health care outside of government programs such as Medicare and Medicaid.[6] However, only the additional Medicaid payments that fall under the regulatory scope of the GMCB would likely be offset in private insurance rates.

Of those payments that fall under GMCB's regulatory purview, not all would lead to offsets in commercial premiums on a dollar-for-dollar basis because of various "leakages." In other words, increasing Medicaid payments by $50 million is unlikely to result in a $50 million offset in commercial insurance. In addition to the limited regulatory reach already mentioned, further sources of leakage follow.

- Cross-border care. Approximately 15 percent of in-patient discharges in Vermont are for patients who live in other states and likely have coverage through out-of-state insurance carriers. In addition, approximately 22 percent of health care spending for Vermonters is provided by out-of-state providers—such as Dartmouth-Hitchcock Medical Center–that are not directly within the GMCB's purview ("2012 Vermont Health Care Expenditure Analysis"). The GMCB has had informal talks with Dartmouth-Hitchcock that have been successful to some degree in influencing prices. Beyond that, negotiations between insurance carriers and out-of-state providers would determine the impact on prices paid to those providers.

[6] The GMCB regulates about 40 percent of the provider side of health care in Vermont through the hospital budget process (community hospitals and hospital-owned physician practices). It does not regulate independent physician practices, nursing homes, or pharmaceutical services, for example. The GMCB also regulates about 25 percent of the payer side through the insurance rate review process, with the balance being Medicare, Medicaid, the self-insured, other government spending such as the Veterans Administration, and out-of-pocket spending. Some overlap between those regulated portions exists because a sizeable portion of private insurance dollars pays for hospital care. Hence we estimate that the GMCB regulates about 40 percent to 45 percent of provider services in Vermont. Government health care programs such as Medicare and Medicaid pay for about half of health spending in Vermont, suggesting that the GMCB regulates between 80 and 90 percent spending for health care outside of government programs. See GMCB, 2014.

- Rate setting and negotiations. Commercial insurance carriers, not the GMCB, are responsible for negotiating commercial payment rates with the hospitals, adding to the uncertainty of obtaining a dollar-for-dollar offset.

- Insurance carrier filings. Commercial insurance carriers would likely recognize increases in Medicaid payments in their rate filings with the GMCB. The GMCB has rate review authority over the individual and small group markets and some remnants of the association market. It also has limited review authority over the large group market but does not directly regulate those premium rates or rates for the self-insured. For that reason, a decrease in commercial rates across the entire commercial insurance market equivalent to the increased Medicaid payments seems unlikely.

- Timing. Hospital budgets as well as most private insurance products span a calendar year. But some prices are set well before the start of a new calendar year. In 2015, for example, the commercial carriers will have to file rates in April before they know whether or not the legislature will approve increases in Medicaid payments. The carriers and hospitals will need to know how much Medicaid payments will increase and when they take effect to fully reflect them in their filings.

To the extent that those leakages turn out to be significant and not all of the total additional Medicaid payments are offset in commercial premiums, total health care spending in Vermont will increase.

The Economics Literature—A Different Perspective

Recent research in the economics literature suggests that the relationship between Medicaid prices and private insurance rates is complex. In some cases, the cost shift may go the other way: higher payments in Medicaid could lead to higher costs reflected in private insurance rates. No recent evidence supports more than a small offset in private insurance rates following changes in Medicaid payments (see Frakt 2011).

Lower prices paid for Medicaid services than for private insurance services are not necessarily unexpected and do not automatically imply that private insurance customers are charged higher prices because Medicaid payments are too low. Instead, the behavior may result from price variation or price discrimination. Providers may be willing to sell identical or largely similar goods or services at different prices to different customers to maximize profits.

We see price variation in many different sectors, such as gasoline or airline tickets. Gas stations just off the interstate with a "captive audience" charge a higher price than gas stations in an area where there are many because the market of interstate drivers is willing to bear a higher price. People pay vastly different prices for seats on the same plane flying the same route depending on when and how the ticket was purchased and the day of travel. We wouldn't necessarily think that the same price is the right solution for the gas stations or the airline tickets. If different prices for different customers cause other problems, such as insufficient access to services, some kind of government intervention might be warranted to help to correct the situation.

If all hospitals were profit maximizers in competitive markets, higher payments in one market segment would lead to higher spending for that segment and spillover in higher spending for all segments. But hospitals in Vermont and most hospitals across the country do not operate in

competitive markets but instead are not-for-profit hospitals. Not-for-profit hospitals are utility maximizers that often seek to improve the health of their patients as they also seek to improve their financial viability just as profit maximizers would. Any profits generated often are used to fund hospital operations or projects such as capital improvement or charity care. Low payments for Medicaid could imply cost shifting by such hospitals if it helps increase the volume of services provided, but it is not guaranteed.

One recent empirical study using nationwide data from both for-profit and not-for-profit hospitals found that the cost shift goes in the opposite direction. A paper by Wagner (2014) showed that falling hospital revenues in response to Medicaid expansions for individuals with disabilities who previously had private insurance resulted in lower revenue for the same services. As a result, hospitals learned to be more efficient in providing care. All hospital costs declined and private insurance premiums fell as well. Higher Medicaid payments seem likely to be accompanied by higher private sector premiums whether hospitals are profit maximizers or not. Again, it could be that the different payment rates reflect price variation, as providers are willing to accept different prices from different customers for the same services to achieve their overall objectives.

In an analysis of the cost shift regarding Medicare payment rates, White (2013) found that hospital markets with relatively slow growth in Medicare inpatient hospital payment rates also had relatively slow growth in private hospital rates. His study used U.S. private claims data together with Medicare hospital cost reports during the period 1995 to 2009. White's findings indicate that repealing cuts in Medicare payment rates nationwide would not slow the growth in spending on hospital care by private insurers and would in fact be likely to accelerate the growth in private insurers' costs and premiums.

Again, it is critical to note that Vermont's hospital sector operates under different rules than in most of the country because the GMCB has regulatory authority that extends over hospital budgets and much of the commercial insurance market. It is possible that the GMCB will be able to exert pressure on hospital budgets even as the Medicaid payments increase. But that offset most likely will be the result of the regulatory authority of the GMCB, not a result of internal business decisions in the hospital sector.

In short, a dollar-for-dollar offset is unlikely, in part because the system has leakages. The GMCB has the authority to put pressure on hospital budgets and will likely achieve some offsets in insurance premiums. How significant those offsets will be depends in large part on whether the additional Medicaid payments can be targeted to segments of the health care market that are regulated by the GMCB.

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