

THE HIDDEN HEALTH CARE TAX
*How **NOT** Reforming Medicaid
Could Lead To Cost Shifting*

KEY FINDINGS

- Cost shifting imposes a significant “hidden health care tax” on privately insured Missourians. Medical care provided with reduced or no compensation is a significant driver of cost shifting.
- Cost shifting occurs when health care providers are reimbursed at a higher rate for privately insured patients in order to cover the losses incurred by treating Medicare and Medicaid patients and uninsured or underinsured patients who default on payments for services previously rendered in good faith.
- Missouri hospitals provided \$10.5 billion in uncompensated care throughout the past decade. Growth in uncompensated care exceeded 90 percent between 2002 and 2011. Per capita growth in uncompensated care exceeded 80 percent.
- During the same period in Missouri, net earnings per capita increased nearly \$400 per month. Adjusting for inflation brought the real gain in net earnings for Missourians to just \$23 per month. After accounting for cost shifting attributable to uncompensated care, annual net earnings for the average privately insured Missourian was \$370 lower in 2011 compared to 2002.
- Hospital uncompensated care in Missouri was \$1.3 billion in 2011. It is projected to grow to more than \$3.5 billion per year by 2019. Medicaid reform would offset \$11.1 billion in uncompensated care in Missouri between 2014 and 2019. The decision to expand Medicaid carries the potential to substantially reduce the “hidden health care tax” burden for privately insured Missourians and their employers.

ACKNOWLEDGEMENT

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INTRODUCTION

On Feb. 10, 2013, *The Wall Street Journal* chronicled the tough choices facing states in the Medicaid reform debate. A headline on one graphic in the article called out, “If states spurn Medicaid, employers could foot the bill.”

As the *Journal* noted, there are “... tough choices for states. If states don’t expand the Medicaid programs, the cost of covering millions of uninsured full-time workers will fall to employers.” As described in the article, the director of New Mexico’s Human Services Department called it a “de facto tax increase.” Missourians call this the “hidden health care tax.” Amanda Austin, director of federal public policy for the National Federation of Independent Business, told the *Journal* “Business owners may be exposed [to higher costs] if the expansion does not go through.”

So, why are Missourians facing a “hidden health care tax” in excess of \$1 billion if the state fails to reform Medicaid? The logic is simple, but the calculations are complicated. In a nutshell, hospitals are reimbursed below their cost of delivering care when they treat Medicare and Medicaid patients, and they are frequently uncompensated altogether for treating uninsured and underinsured patients. Some of the burden of uncompensated care is typically passed on to privately insured individuals, a practice known as cost shifting, or the “hidden health care tax.” This report reviews the concept of cost shifting and takes a closer look at one of its major drivers — hospital uncompensated care. **Because of shifts in the health**

insurance market, state Medicaid policy and the more recent economic downturn, the trend line for uncompensated care in Missouri has grown at a staggering pace during the past decade. The continuation of this trend and resulting cost shift is a major factor in lawmakers’ consideration to expand Medicaid coverage to individuals earning less than 138 percent of the federal poverty level (\$26,951 for a family of three) beginning in 2014.

Cost shifting could increase in the near future. Missouri hospital payment cuts from Medicare and Medicaid totaling \$4.2 billion between 2013 and 2020 were intended to create savings that would be used to cover more of the uninsured through Medicaid expansion and health insurance exchanges. However, in June 2012, the U.S. Supreme Court ruled that the mandate to expand Medicaid was optional for states. Although these cuts will increase pressures to pass uncompensated health care costs on to the privately insured, expanded Medicaid coverage will actually mitigate much of the effect by reducing hospitals’ burden of caring for uninsured and underinsured Missourians. Although the uninsured account for a relatively small share of hospital utilization, they account for a disproportionate share of the uncompensated costs that hospitals must make up through a variety of means. Hospitals treating Medicaid patients in Missouri are reimbursed at approximately 65 percent of costs. For uninsured patients and patients with high deductible health insurance plans who can’t afford to pay them, hospitals often receive little or no compensation.

HOW DOES COST SHIFTING WORK?



Assume that one out of every five customers who bring their cars to an automobile dealership for repair are unable to pay. By law, the auto dealer must repair their cars and because the dealership cannot collect from the customers, their services are written off as either “uncompensated” or “bad debt.” Also assume that two out of the five receive significant discounts for their care, and again, the auto dealer is required to repair their cars for this discounted rate. Now, nearly half of the repair business is either heavily discounted, or those services are provided for free. How does the dealership stay in business? The costs are shifted to those who pay for their car repairs.

BACKGROUND

Cost shifting occurs when health care providers are reimbursed at a higher rate for privately insured patients in order to cover the losses incurred by treating uninsured or underinsured patients who default on payments for services previously rendered in good faith. The concept of cost shifting is presented graphically in Figure 1. Some arguments that dispute the existence of cost shifting are based on the premise that health care providers are motivated primarily by profits, so they will set prices as high as possible regardless of reimbursement rates from public payers and the number

Cost Shift: When health care providers are reimbursed at a higher rate for privately insured patients to cover the losses incurred by treating patients who default on payments for services previously rendered in good faith.

of patients unable to pay for services. To the contrary, many health care providers, particularly hospitals, have missions to improve the health of their patients and communities by providing patients access to medical care, regardless of their ability to pay. As such, hospitals shift costs when doing so allows them to provide care to the maximum number of patients, regardless of their insurance status. Hospitals' mission statements are significant drivers of their business practices, which affects the payments they receive from different insurers.¹ Further, such arguments disregard the Emergency Medical Treatment and Active Labor Act federal law that hospitals provide care to anyone in need of emergency health care treatment regardless of their citizenship, legal status or ability to pay.

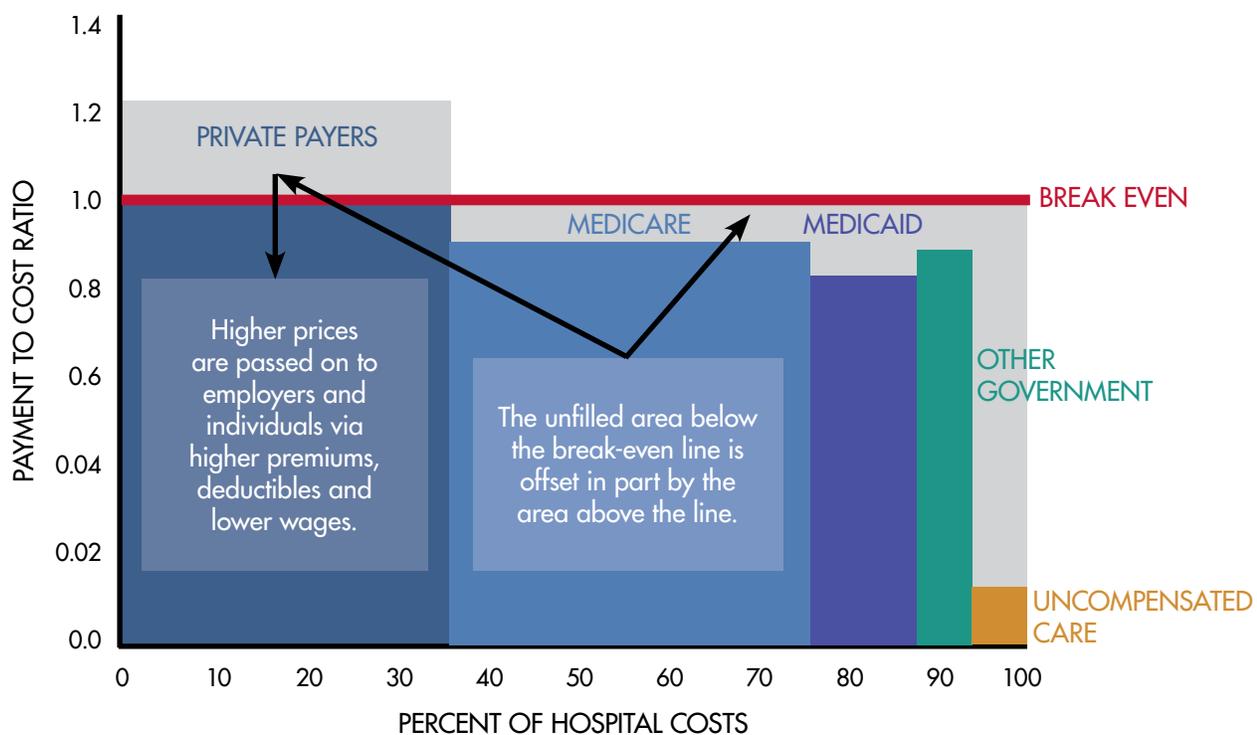
Although cost shifting is not a new phenomenon, the current reimbursement of hospitals by the Centers for

Medicare & Medicaid Services below the cost of care is different from the program's original design. When Medicare and Medicaid began, reimbursements were designed to cover costs plus a 2 percent profit margin on care provided by for-profit hospitals and a 1.5 percent margin for nonprofit hospitals. The positive returns were eliminated in 1969, when hospitals were reimbursed at their reported cost.² This approach was criticized because it did not place pressure on hospitals to reduce health care costs, which were already increasing much faster than wages and inflation during the 1970s. Beginning in 1983, Medicare transitioned to a prospective payment system in which hospitals were paid based on costs incurred in prior years. Justification for the lower reimbursement was based on the notion that it more closely aligned incentives to control costs and encourage efforts within the health

care sector to slow the pace of rising costs. As intended, lower reimbursement rates forced health care providers to cut costs and increase efficiency. The drawback is that efficiency gains are subject to the law of diminishing marginal returns — each dollar saved becomes increasingly difficult to capture. Experts hypothesize one adverse outcome of underreimbursement in the face of diminishing marginal efficiency gains may be reductions in the quality and intensity of care that health care providers are able to extend to patients, particularly under a fee-for-service payment structure.^{3,4,5}

Estimates on the scope of cost shifting vary. In 2005, Families USA estimated that private insurance premiums were about 10 percent higher to cover the uncompensated cost of services provided to the uninsured alone. Others have estimated that the effect is less than 2 percent of annual

Figure 1. Cost Shift Payment Hydraulic



Adapted from Dobson, DaVanzo & Sen (2006)

health insurance premiums.^{6,7} A thorough review of the literature from 1996 to 2011 found that empirically-valid estimates of cost shifting resulted in a 10 to 20 percent increase in premiums for holders of private health insurance policies.² In 2010, the Congressional Budget Office reported that cost shifting from the uninsured to the privately insured costs the average family an additional \$1,000 per year in health insurance premiums.⁸

THE DRIVERS OF COST SHIFTING

Cost shifting is mainly driven by underreimbursement for services covered by Medicare and Medicaid and uncompensated care provided to uninsured and underinsured patients. The term underinsured refers to individuals with health care coverage but with high exposure to the risk of exorbitant out-of-pocket medical spending. The risk exposure may occur as a result of the deductible structure of the individual's health insurance policy, the individual or a family member experiencing a catastrophic medical event or a combination of the two. A growing number of Missourians are exposed to this risk because of the significant growth in the number of employers shifting their coverage to high deductible health plans.

In an attempt to rein in costs, many employers and insurance providers are moving toward consumer directed, high deductible health plans. High deductible plans are a major factor driving the growth of uncompensated care. Many of these plans

leave individuals liable for out-of-pocket expenses in excess of \$10,000 per year.⁹ High deductible plans have been touted as a mechanism to reduce health care spending because they force patients to assume a large share of the costs upfront, requiring them to weigh the benefits of care against the out-of-pocket expense of obtaining it. Unfortunately, these plans also provide strong disincentives for individuals to obtain primary and preventive health care services. The unintended consequences of high deductible plans can lead to increased disparities in health and income between the working poor and wealthy families because low-income families are more sensitive to co-payments and deductibles.^{10,11} Patients often fail to see the value of preventive care and management of chronic diseases because they lack adequate information, or they overestimate the cost of such services. The result is that growth in short-term health care expenditures slows slightly, but population health worsens over time, especially for low-income and working poor families. The indirect effects and incentive structure underlying high deductible plans suggest they could actually increase health care spending in the long run.

A recent study found that in 2012, about 13 percent of individuals covered by employer-sponsored health plans were in a high deductible version. For 2013, 70 percent of firms surveyed said they would offer a high deductible plan, and nearly one-fifth will offer only high deductible plans. The study found that by 2022, half of all privately insured individuals will be covered by a high deductible

plan.¹² A major concern with these plans is that individuals who are likely to select them based on their low premiums are unlikely to have sufficient resources to pay their deductible should they become ill.¹³ The popularity of high deductible plans also places an indirect burden on consumers of traditional health insurance plans because they draw younger and healthier individuals from the larger risk pool, leaving the remaining beneficiaries with higher premiums as a result of being in a higher-risk pool.

The financial burden of health care costs facing families is increasing dramatically. In 2003, 35 percent of the population age 19 to 65 had health care costs at or above 10 percent of their annual income or deductibles larger than 5 percent of their annual income. In 2007, the number had risen to 42 percent of adults.¹⁴ From 1999 to 2009, the median income for U.S. families with health insurance through their employer increased from \$76,000 to \$99,000. This was a nominal increase of more than \$1,900 a month for the average family. A recent study found that after adjusting for growth in health insurance premiums, out-of-pocket costs, taxes for public health insurance and inflation, the average family had a 10-year gain of only \$95 per month.^{10,11} If health care costs had increased at the same rate as inflation, the median family would have had an additional \$545 of disposable income per month. Health expenditures for Missourians increased an average of 5.8 percent per year between 1991 and 2009. The national average was 5.3 percent. In the United States, the average cost of a family's health insurance premium in 2010 was \$13,871. By 2020, this cost is projected to increase by 72 percent to nearly \$24,000 per family in the United States. At an average cost of \$12,754 per family in

Despite the evidence that high deductible plans are not good for overall health, they continue to grow more popular because of the increasingly cost-prohibitive practice of employer-sponsored health insurance.

2010, Missourians enjoyed some of the lowest health insurance premium costs in the country.

Missourians paid 23 percent of their health insurance premiums out of pocket in 2011, 2 percentage points above the nationwide average. At the same time, the average annual household income in Missouri from 2009 to 2011 was \$2,385 lower than the national average.¹⁵ These data imply much is at risk. Although Missouri families currently enjoy relatively low premiums, they also are more sensitive to higher premium costs because they pay for a larger share out-of-pocket expenses. At the same time, every out-of-pocket dollar means more to the average Missouri family because out-of-pocket spending accounts for a larger percentage of total household income.

As demonstrated in the next section, continued trends in hospital uncompensated care have the potential to further exacerbate the cost of premiums for Missouri families by increasing out-of-pocket spending or decreasing net earnings, if employers respond to cost shifting with wage reductions. Compounding the issue is that despite the state's favorable standing in terms of the cost of premiums, Missouri families pay for a larger share of those premiums while earning less. Much of the risks facing Missouri families with private insurance can be mitigated through Medicaid reform.

THE ECONOMIC BURDEN OF COST SHIFTING IN MISSOURI

The cost of uncompensated care provided by Missouri hospitals increased 93 percent during the last 10 years. Figure 2 shows uncompensated care costs between 2002 and 2011. In 2002, \$699 million in care was provided to patients at free or reduced charge or absorbed by hospitals through defaults on loans to uninsured patients or patients who could not meet their deductible. By 2011, uncompensated care costs nearly doubled to \$1.35 billion.¹⁶ In per capita terms, uncompensated care in Missouri grew from \$123 in 2002 to \$224 in 2011 (an increase of 82 percent). Less than 6 percent of the increase can be explained by actual population growth during the period.

The current economic conditions, along with the state's Medicaid policies, contributed significantly to the rapid growth of uncompensated care in Missouri during the last decade. In 2005, a state budget crisis resulted in drastic cuts to the Medicaid program. The cuts imposed some of the

country's most stringent eligibility standards for program participation, eliminating coverage for 100,000 Missourians and drastically reducing coverage for another 300,000.¹⁷ These cuts and eligibility standards remain in effect today.

The economic downturn and recession also played a significant role in the growth of uncompensated care in Missouri by reducing the number of individuals with employer-sponsored health insurance. The unemployment rate in Missouri increased from 5 percent in 2007 to 9.4 percent in 2009, a relative increase of 88 percent. Employment has rebounded slightly during the recovery — unemployment was 6.5 percent in December 2012. However, the measure does not account for discouraged workers or individuals who have dropped out of the labor market completely.¹⁸ Coupled with the growth in the overall cost of health care, firms with tighter bottom lines resulting from a recessionary business climate also contributed to the increased popularity of high deductible insurance plans during the period.

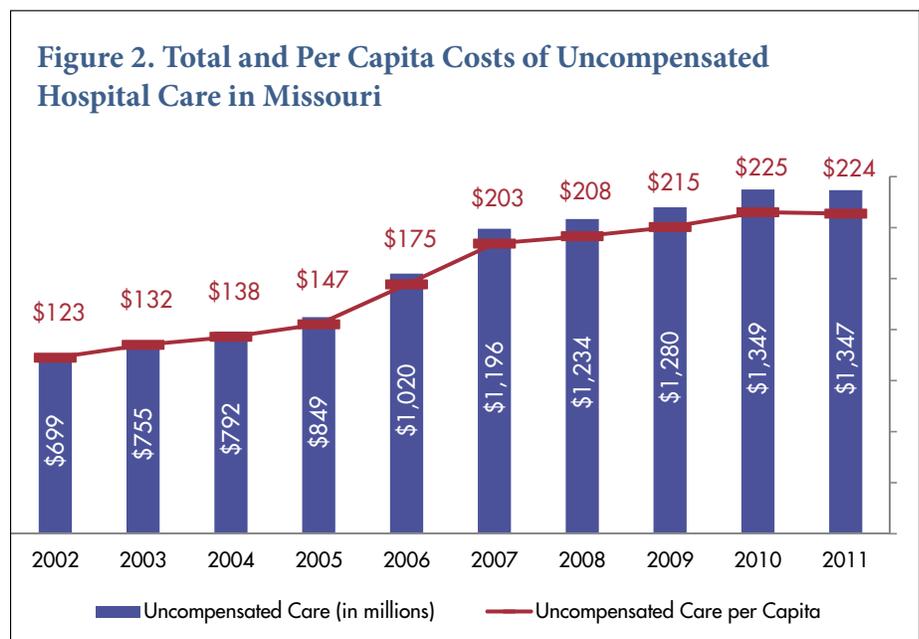
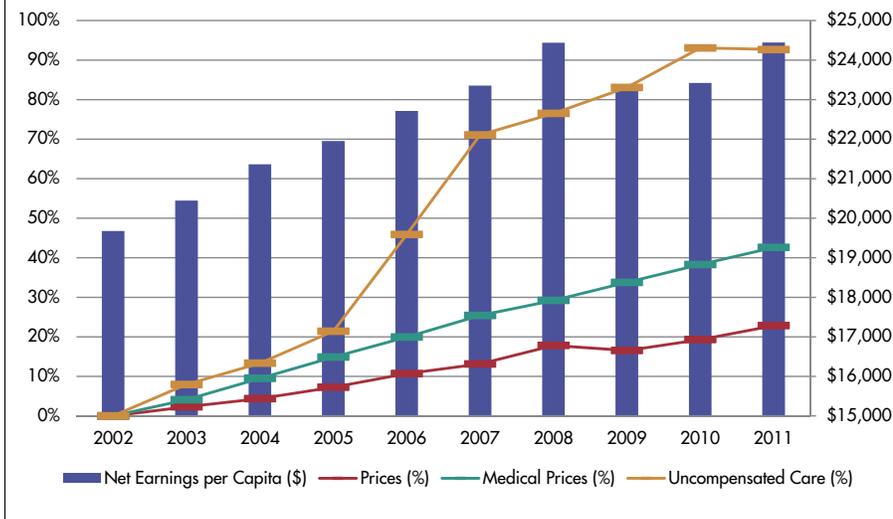


Figure 3. Net Earnings, Prices and Uncompensated Care Growth in Missouri



Net earnings per capita reflect the average yearly personal income for workers after taxes for government social insurance programs. Net earnings for Missourians increased \$4,800 per year between 2002 and 2011, an increase of 24 percent or nearly \$400 more per month for every resident of the state on average.¹⁹ Figure 3 shows that during the same period, prices for all goods and services in the Midwest increased 23 percent. Overall price growth was nearly doubled by prices for medical care at 43 percent and quadrupled by growth in uncompensated care costs at 93 percent growth. After accounting for inflation, net earnings per capita were only \$277 higher in 2011 compared to 2002. **This was a real increase of only \$23 per month for Missourians on average.**

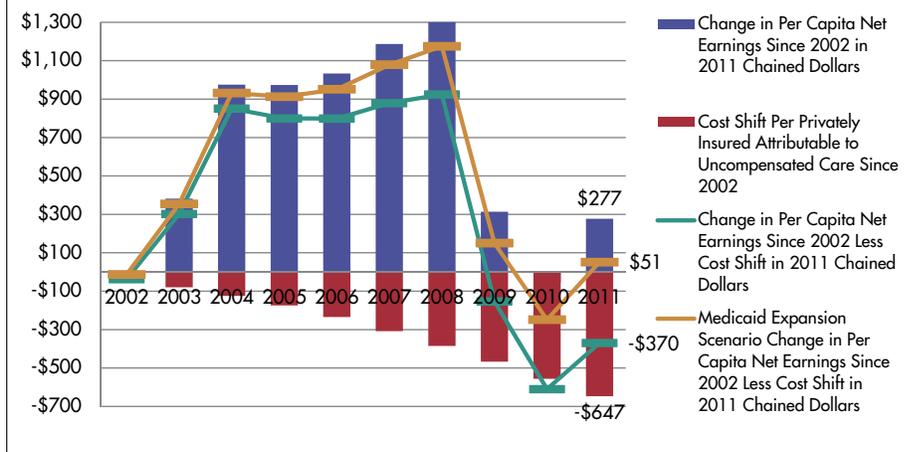
A recent University of Missouri study estimated an annual cost shift of \$74 per privately insured individual coincides with every \$1 billion reduction in hospital revenues.²⁰ Using this estimate, Figure 4 shows that **after adjusting for inflation, the average privately insured Missourian paid**

an additional \$647 between 2002 and 2011 as a result of cost shifting for uncompensated care alone. This implies that after accounting for all factors — inflation, higher insurance premiums, out-of-pocket medical spending and lower wages accrued as a result of shifted uncompensated costs — **real net earnings for Missourians were actually \$370 lower in 2011 than in 2002.**

Consider the following scenario. Patients who receive uncompensated care have Medicaid coverage, and hospitals are reimbursed 65 percent of the \$10.5 billion in costs incurred, with no compensation during the last decade. This suggests that real net earnings for individuals with private insurance would have been \$206 higher in 2011 compared to 2002. **Compared to what was actually observed between 2002 and 2011, the Medicaid expansion scenario implies a net gain of \$421 in annual earnings per privately insured Missourian during the 10-year period.**

A recent estimate places cost shifting in Missouri in excess of \$1.1 billion by 2021 as a result of sequestration and CMS cuts in the Affordable Care Act.²¹ Uncompensated care in Missouri is projected to grow to \$3.5 billion per year by 2019.²² Figure 5 shows that between 2014 and 2019, Medicaid expansion could offset \$11.1 billion in uncompensated costs. Left unchecked, the cost of uncompensated care has the potential to exacerbate the amount of cost shifting that

Figure 4. Inflation-Adjusted Net Earnings Per Capita and Costs Shifted Per Privately Insured Individual Attributable to Uncompensated Care in Missouri



will occur in response to policies in health care reform and significantly limit the earnings of Missourians with private insurance.

DISCUSSION

The pressure on hospitals to cost shift is expected to continue. However, the extent of cost shifting in Missouri is heavily dependent on the state's elected officials and their decision to reform Medicaid. Although Medicaid reimburses

health care providers below the cost of care, it is much preferred to the steady growth of unpaid care that Missouri providers have experienced during the last 10 years. This preference is particularly evident considering disproportionate care payment reductions that drastically cut reimbursement for hospitals that treat a large share of low-income and uninsured patients. Furthermore, as it becomes increasingly difficult for hospitals to cut costs — their ability to become more efficient is subject to the law of diminishing marginal returns — they must increasingly reduce costs at the same time to remain fiscally solvent. This ultimately leads to higher levels of cost shifting. If uncompensated care increases to the point that providers can no longer shift costs enough to remain financially viable, they may be forced to cut costs in ways that result in a reduction of the quality or intensity of care they are able to provide, or they may be forced to simply close their doors.

Figure 5. Projected Uncompensated Care in Missouri With and Without Medicaid Expansion

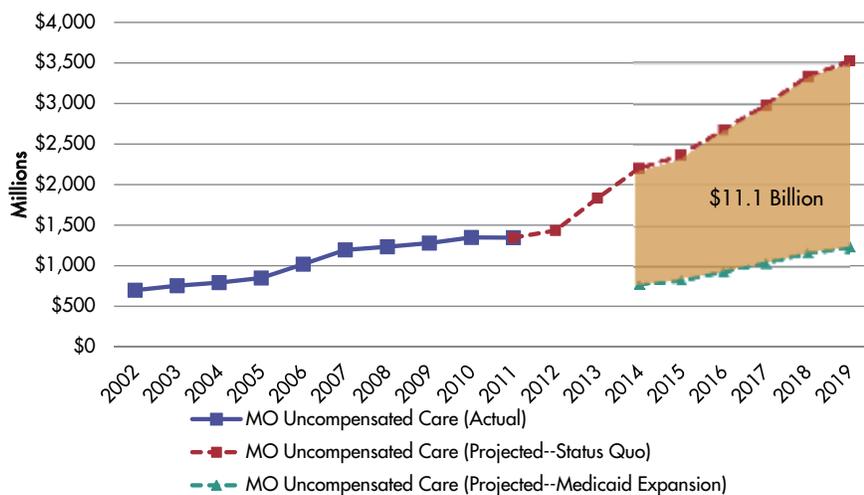


Table 1. Uncompensated Care, Earnings, Cost Shift and Prices in Missouri, 2002-2011

Missouri	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Hospital Uncompensated Care (in millions)	\$699.0	\$754.6	\$792.1	\$848.7	\$1,019.6	\$1,195.7	\$1,233.7	\$1,279.6	\$1,349.5	\$1,346.7
Personal Income: After Taxes for Government/Social Insurance										
Net Earnings per Capita	\$19,676	\$20,447	\$21,365	\$21,952	\$22,713	\$23,354	\$24,438	\$23,226	\$23,423	\$24,445
Change from 2002	\$0	\$771	\$1,689	\$2,276	\$3,037	\$3,677	\$4,762	\$3,550	\$3,747	\$4,768
Adjusted for Inflation	\$0	\$382	\$975	\$973	\$1,033	\$1,187	\$1,310	\$314	-\$54	\$277
Adjusted for Cost Shift	-\$38	-\$80	-\$125	-\$174	-\$235	-\$308	-\$385	-\$467	-\$556	-\$647
Real Change in Net Earnings (in 2011 \$)	-\$38	\$302	\$851	\$799	\$798	\$879	\$924	-\$154	-\$610	-\$370
Simulated Change Under Medicaid Expansion Scenario	-\$13	\$354	\$931	\$912	\$951	\$1,079	\$1,175	\$150	-\$248	\$51
Purchasing Power: Price Change Since 2002										
All Goods and Services	0.0%	2.3%	4.4%	7.2%	10.7%	13.1%	17.8%	16.5%	19.3%	22.8%
Medical Care	0.0%	4.1%	9.5%	14.9%	19.9%	25.4%	29.2%	33.8%	38.3%	42.6%

Sources: MHA Annual Hospital Licensing Survey; U.S. Bureau of Labor Statistics; U.S. Bureau of Economic Analysis. Hospital uncompensated care figures are cost-based. Price changes are measured with the nonseasonally adjusted CPI-U for Midwestern cities for all goods and services and for medical care.

HOW THE COST SHIFT WORKS



You have health insurance.

If Missouri expands Medicaid

The burden of uncompensated health care services is reduced and limits the financial impact on taxpayers and the cost of private health insurance premiums.

If Missouri does NOT expand Medicaid

You and your employer help defray the costs associated with uncompensated health care services through payment of higher health insurance premiums.

Cost shifting occurs when health care providers are reimbursed at a higher rate for privately insured patients in order to cover the losses incurred by treating uninsured or underinsured patients who default on payments for services previously rendered in good faith. Hospital uncompensated care in Missouri was \$1.3 billion in 2011. It is projected to grow to more than \$3.5 billion per year by 2019. Medicaid reform would offset \$11.1 billion in uncompensated care in Missouri between 2014 and 2019. The decision to expand Medicaid carries the potential to substantially reduce the “hidden health care tax” burden for privately insured Missourians.



A family of four will pay an additional **\$1,688** from 2014-2020.*



Your employer pays higher health insurance premiums.



OR

An individual will pay an additional **\$610** from 2014-2020.*



* University of Missouri School of Medicine Department of Health Management and Informatics and Dobson DaVanzo & Associates, LLC, 2012. *The Economic Impacts of Medicaid Expansion on Missouri.*

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²² Historic and projected uncompensated care amounts are cost-based. Projections hold the cost-to-charge ratio constant at the 2011 level for Missouri. The Medicaid expansion scenario assumes 65% of uncompensated care would be offset between 2014 and 2019.



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