Based on Lewin Methodology, $60 billion of the $300 billion in Medicare and Medicaid Cuts Would Be Shifted to Private Patients

December 15, 1995

If the Republican plan imposes reductions of $200 billion in Medicare and $100 billion in Medicaid spending (both over seven years), about $60 billion in costs would be shifted to private patients, based on the methodology used in the Lewin-VHI cost shifting study. Workers with private health insurance would lose an average of $654 in the form of reduced wages and increased premium contributions over the period.

Methodology:

This estimate assumes that the $200 billion in Medicare cuts would be distributed among hospitals, physicians, other providers and beneficiaries in the same manner as the previous $270 billion in reductions. As assumed in the Lewin study, the $100 billion in Medicaid cuts would take the form of reductions in payments to providers to the extent possible, with the remainder taking the form of reduced enrollment. The estimate also assumes that the Medicare and Medicaid cuts would be distributed across the seven-year period in the same manner as the earlier reductions. Finally, the percentage of the cost shift passed on to workers is the same as in the Lewin study.

N E W S R E L E A S E

THE NATIONAL LEADERSHIP COALITION ON HEALTH CARE

555 13TH STREET, N.W.
WASHINGTON, D.C. 20004
PHONE (202) 637-6830
FAX (202) 637-6861

Contact: Peggy Rhoades
(202) 637-6830

CUTBACKS IN MEDICARE AND MEDICAID FUNDING UNDER THE BUDGET RECONCILIATION ACT OF 1995 COULD ADD ALMOST 8 MILLION PEOPLE TO THE ALREADY LARGE RANKS OF THE UNINSURED AND SHIFT $85 BILLION IN COSTS TO THE PRIVATE SECTOR, PREDOMINANTLY TO MIDDLE CLASS FAMILIES

Washington, D.C. -- The National Leadership Coalition on Health Care today released a study showing that almost 7.8 million people could be added to the already large ranks of the uninsured by 2002 because of the $434 billion in Medicare and Medicaid spending cutbacks proposed in the Budget Reconciliation Act of 1995. The spending cutbacks are achieved through a combination of reductions in government payments to hospitals and other providers, increased beneficiary cost sharing, reduced coverage, and expanded managed care enrollment. The study was prepared for the Coalition by Lewin-VHI.

The study also shows that under the Act, at least $84.7 billion in additional health care costs could be shifted to and paid for by the nation's families -- predominantly middle class families -- and employers, as providers shift costs to private payers over the seven years of the cutbacks.

According to the Lewin study, under the provisions of this Act about 7.8 million people could lose insurance coverage in the year 2002 alone. This includes those who could lose coverage due to reductions in enrollment in states that decide to reduce Medicaid eligibility (7.2 million) and workers who could lose employer coverage due to premium increases resulting from the cost shift. Under current policy, Lewin estimates there will be approximately 45.9 million persons uninsured in 2002. Under the Budget Reconciliation Act of 1995, their estimates indicate that the number of uninsured could increase to 53.7 million persons in 2002.

Cost shifting is the process whereby providers recover uncompensated care costs for the uninsured and the payment shortfalls for public program enrollees in the form of higher charges to private payers. The Lewin study points out that most of the cost shift that could occur under this Act, about $66.9 billion of the $84.7 billion, would be passed on to workers by employers in the form of foregone wages and in the form of higher cost sharing for health care premiums.

-- more --

THE NATIONAL LEADERSHIP COALITION ON HEALTH CARE

555 13TH STREET, N.W.
WASHINGTON, D.C. 20004
PHONE (202) 637-6830
FAX (202) 637-6861

December 1, 1995

Dear Correspondent:

Enclosed is a study conducted by Lewin-VHI for the National Leadership Coalition on Health Care showing that the proposed changes in Medicare and Medicaid under the Budget Reconciliation Act of 1995 could add almost 8 million people to the ranks of the uninsured and shift $85 million in costs to the private sector.

This study is meant to raise a warning flag. There are large, complex issues involved, and the Coalition believes they should be addressed as a whole. It is clearly beneficial for all Americans -- and certainly for American business -- that the deficit be reduced and the budget be brought into balance.

At the same time, we must be concerned that, as we make major changes in Medicare and Medicaid, we do no harm. Health care is an area where costs are so large -- and growing so rapidly -- that they tempt policy makers to make significant changes and cutbacks. Some may work out well; others may not. The better thought out the changes, the better able we will be to fine-tune the changes in these huge systems as we go.

The Coalition believes that significant increases in the numbers of the uninsured and a large cost shift to the private sector resulting from cutbacks in public programs should be part of the national dialogue on these major program changes. Health care is not a partisan issue; it is an American issue. We urge our political leaders to work together the effect changes with care, remembering always the dictum: Above all, do no harm.

Sincerely,

Robert D. Ray
Co-Chair

Paul G. Rogers
Co-Chair

Enclosures

POTENTIAL COST SHIFTING UNDER PROPOSED FUNDING REDUCTIONS FOR MEDICARE AND MEDICAID: THE BUDGET RECONCILIATION ACT OF 1995

FINAL REPORT

PREPARED FOR:

THE NATIONAL LEADERSHIP COALITION ON HEALTH CARE

By:

JOHN F. SHEILS
GARY J. CLAXTON

LEWIN-VHI, INC.

NOVEMBER 21, 1995

95TK0239

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Budget Reconciliation Act of 1995 would reduce funding for Medicare and Medicaid by about $434 billion over the next seven years. These spending reductions would be achieved through expanded enrollment in managed care, increased premiums for Medicare beneficiaries, reduced coverage, and reduced payments to hospitals, nursing homes and other providers. However, some portion of the reductions in provider payments under these programs is likely to be passed on to privately-insured persons in the form of higher charges through cost shifting.

In this study we estimate the potential effects of this cost shifting on private insurance premiums and costs for employers and families. We also estimated the number of persons who would lose coverage under the bill due to reductions in eligibility under the Medicaid program or increases in private plan premiums. In addition, we estimate the increase in charity care expenses due to increases in the uninsured population.

We begin by summarizing the Medicare and Medicaid spending reductions and reviewing the evidence on cost shifting. We also estimate the cost shift under these budget cuts and the impact that this would have on employers and families. In addition, we estimate the change in insurance coverage likely to result from this increase in insurance premiums.

Medicare Spending Reductions

The Reconciliation Act would reduce Medicare program funding by $270 billion over the next seven years. The act establishes the "MedicarePlus" program which would permit Medicare beneficiaries to enroll in a broader variety of private health plans. The act would also increase beneficiary Part-B premium payments and would improve fraud detection and coordination of benefits for persons with employer-based coverage. The plan also specifies specific cuts in provider payments and creates a "fail-safe" mechanism which would further reduce provider payments if budget spending targets under the bill are exceeded in future years.

The Congressional Budget Office (CBO) estimates that Medicare would save $57.3 billion due to the Part-B premium increase and another $9.1 billion through fraud detection and coordination of benefits provisions. Another $26.7 billion would be saved through increased enrollment in private plans. The reductions in provider payments for services (including "fail-safe" amounts) would be $105.3 billion for hospitals, $27.0 billion for long-term care and $44.5 billion for physicians and other providers.

payers in the form of higher charges. However, we assume that the percent of payment shortfalls that are shifted declines in future years to reflect continued growth in selective contracting. We also estimated cost shifting for physician payment shortfalls based upon the Rice analysis.

Under the assumptions used in this analysis, payments to providers would be reduced by about $218.9 billion over the 1996 through 2002 period. Uncompensated care expenses for those who become uninsured would also increase by about $65.5 billion over this period. The total increase in provider payment shortfalls would be about $284.4 billion. We estimate that in response to this, providers would shift about $84.7 billion (29.7 percent) of the $284.4 billion in payment shortfalls to private payers (***Figure ES- 1***). About 52.7 percent of the increase in cost shifting would be attributed to the Medicare cuts while 47.3 percent would be attributed to Medicaid cuts.

FIGURE ES- 1

ESTIMATED COST SHIFT UNDER MEDICARE AND MEDICAID BUDGET CUTS

	Hospital Cost Shift [a/]	Other Provider Cost Shift [b/]	Total Cost Shift
1996	$1.6	$0.4	**$ 2.0**
1997	3.0	0.9	**3.9**
1998	6.8	2.4	**9.2**
1999	10.3	3.5	**13.8**
2000	11.7	3.9	**15.6**
2001	14.4	4.4	**18.8**
2002	16.5	4.9	**21.4**
Total 1996 - 2002	**$ 64.3**	**$ 20.4**	**$ 84.7**

a/ Includes a percentage of hospital budget cuts under Medicare and Medicaid. The percentage of hospital budget cuts that we assume to be cost shifted is 40 percent in 1994 phasing down to 30 percent by 2002.

b/ Assumes that each 1.0 percent reduction in other provider payments under the bill results in a 0.2 percent increase in private sector rates.

Source: Lewin-VHI estimates.

Cost Shift by Payer

The increase in provider charges to private payers resulting from the cost shift ($84.7 billion) would be reflected in higher private insurance premiums. Employer health spending would increase by $69.3 billion over the 1996 through 2002 period, while employee contributions for employer health coverage would increase by $5.9 billion. Expenditures for individually purchased non-group insurance would increase by $10.2 billion over this period due to the cost shift. As a result of this cost shift, by 2002, private insurance costs would be about $21.4 billion (four percent) higher than under current trends (***Figure ES- 2***).

FIGURE ES- 3

DISTRIBUTION OF COST SHIFT PASS-THROUGH TO COVERED WORKERS BY INDUSTRY (1996 THROUGH 2002)

	Pass-through to Covered Workers (billions) [a/]	Pass-through per Worker	Percent of Total
Industry			
Construction	$3.1	$968	4.6%
Manufacturing	$15.1	$936	22.6%
Transportation	$6.4	$1,229	9.6%
Wholesale Trade	$2.8	$973	4.2%
Retail Trade	$5.2	$653	7.8%
Services	$15.3	$908	22.9%
Finance	$4.3	$914	6.4%
Other	$2.8	$973	4.2%
Government [b/]	$11.9	$950	17.8%
Total	**$66.9**	**$925**	**100.0%**

a/ Includes the increase in employee share of premium and the amount of the employer share of the cost increase that is passed on to workers in the form of lost wages.

b/ Includes federal, state and local employees.

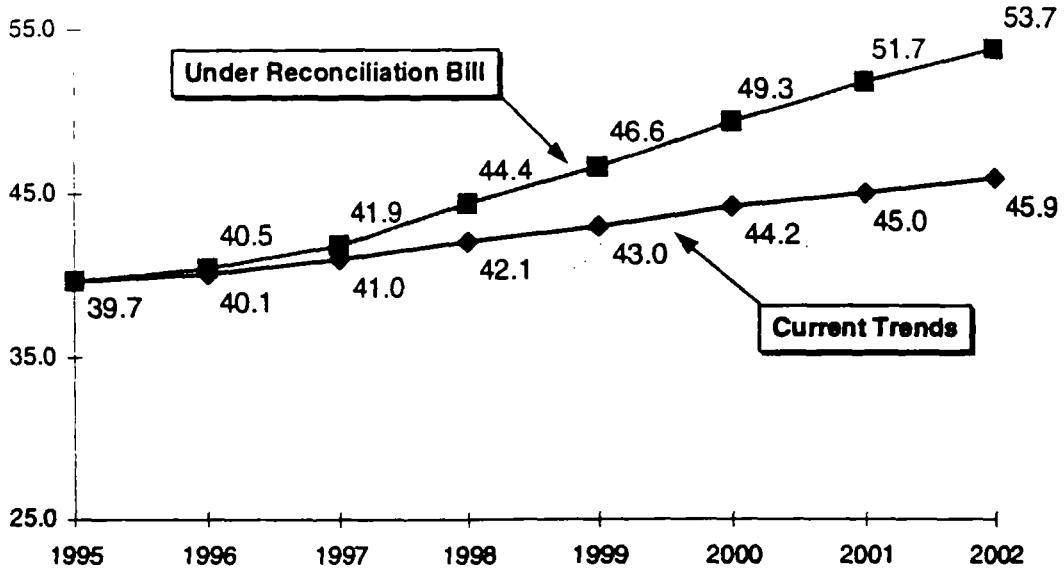
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The pass-through of the cost shift will have a disproportionate impact on insured workers in lower wage groups. The lost wage increases resulting from these budget cuts would on average equal about 2.5 percent of the wage increase that workers would have received in the absence of these budget cuts over the 1996 through 2002 period (***Figure ES- 4***). However, the wage growth lost due to cost shifting would vary from about 9.3 percent for covered workers earning $6.00 or less per hour to only 1.6 percent for persons earning $25 or more per hour. This reflects the fact that health benefits represent a much greater share of total compensation expenses for lower-wage covered workers than for higher-wage covered workers.

The cost shifting resulting from the proposed Medicare and Medicaid cuts would be distributed across families in all income brackets. Much of the increase in family expenditures would be concentrated among middle and upper income households where private insurance coverage is most prevalent. About 60 percent of the pass-through would fall on families with annual incomes between $20,000 and $75,000. About 10 percent would fall on families with incomes below $20,000 while 30 percent would fall on families with incomes in excess of $75,000 per year.

FIGURE ES- 5

NUMBER OF UNINSURED WITH AND WITHOUT THE RECONCILIATION BILL
(IN MILLIONS)



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Summary and Caveats

Ultimately, families will pay for the cost shift. Private insurers pass the burden of higher prices on to their customers in the form of higher premiums. Employers then pass on much of these increased premium costs to workers in the form of reduced wage growth and increased employee contributions. We estimate that the proposed Medicare and Medicaid budget cuts are expected to increase real health expenditures for workers by $66.9 billion over the 1996 through 2002 period. The cost shift could be substantially different than we have estimated here depending upon the effectiveness of managed care and the way in which providers respond to the budget cuts.

This analysis is limited to the financial effects on employers and employees by industry, firm size and income. It does not describe the effects of increased public-program shortfalls on the availability and quality of care for program beneficiaries and the uninsured. It also does not describe the impact of cost shifting on health care providers beyond the loss of revenues. Moreover, this study examined only the impact of those provisions of recent budgetary legislation affecting Medicare and Medicaid. The study does not examine the impact of various other budgetary changes affecting families such as tax reductions or cutbacks in public assistance benefits.

II. Medicare and Medicaid Budget Cuts

The Balanced Budget Act would cut Medicare and Medicaid spending about $434 billion over the 1996 through 2002 period. The bill specifies the cuts that will be made to Medicaid and various components of the Medicare program. In this analysis, we rely upon estimates of the changes in spending resulting from these provisions developed by the Congressional Budget Office (CBO). These estimates were used as the basis for estimating the potential cost shifting. These budget cuts are described below.

A. Medicare Budget Cuts

The act would reduce Medicare program funding by $270 billion over the next seven years. The bill creates the MedicarePlus program which expands upon the current Medicare HMO risk contract program by permitting beneficiaries to enroll in other types of private health plans such as Preferred Provider Organizations (PPOs) and traditional fee-for-service (FFS) plans. The bill also specifies increases in Part-B premiums for program beneficiaries and requires additional fraud detection and secondary payer recovery initiatives. It also specifies cuts in reimbursement for various categories of providers. In addition, the program establishes a "fail-safe" mechanism which would automatically reduce provider payment levels if the overall spending levels specified in the bill are exceeded.

The CBO indicates that of the $270 billion in savings, about 10 percent ($26.9 billion) would occur under the MedicarePlus program (***Figure 1***). These savings would result from reductions in the rate of growth in payments to health plans under the Medicare risk contract program for beneficiaries who enroll. The bill also raises about $57.3 billion through increased Part-B premiums and would save about $9.0 billion through improved fraud detection and increased Medicare secondary payer recoveries (i.e., coordination of benefits with private health plans).

The act also specifies $79.4 billion in reduced payments to hospitals for inpatient and outpatient services. These cuts include reductions in payments for services as well as reductions in medical education payments. The bill also specifies $27.0 billion in reduced payments for long-term care services including home health and skilled nursing facilities. In addition, the bill specifies $33.8 billion in reduced payments to physicians and other providers.

The CBO analysis indicates that these program changes will fall short of the $270 billion in savings called for under the bill by $36.6 billion. This will trigger additional reductions in provider payment levels under the fail-safe provisions to meet the savings targets. We assume that these fail-safe payment reductions are distributed across hospital and other services in proportion to the payment reductions by category of service specified in the bill. Under this assumption, $25.9 billion of the $36.6 billion in reductions under the fail-safe mechanism would be for hospitals while the remaining $10.7 billion in savings would take the form of reduced payments to physicians and other types of providers.

B. Medicaid Budget Cuts

The act would also reduce federal Medicaid funding by about $163.4 billion over the 1996 through 2002 period. The bill would convert the Medicaid program to a block grant program to states. In general, the amount of each state's grant would be based upon spending levels prior to implementing these reforms and would be indexed based upon an overall budget ceiling calibrated to produce $163.4 billion in federal budget savings over the 1996 through 2002 period. States would be allowed to set program eligibility and benefit levels under their state programs and would be given greater flexibility in enrolling beneficiaries in managed care plans. However, the states must match the federal contribution under current Medicaid matching rates to qualify for the federal grant amount.

A key assumption in this analysis is the amount of state funding that would go to the Medicaid program. Under the bill, states are permitted to put more into the Medicaid program than is required to qualify for the maximum amount of the federal grant for that state. States are also permitted to put less into the program than the matching amount required to qualify for the maximum federal grant provided that state funding remains above a minimum threshold amount specified in the bill. However, in these cases, the federal grant amount would be proportionally reduced. In this analysis, we assume that states will put into the Medicaid program only the amount required for the maximum federal grant amount. Under this assumption, the total net reduction in Medicaid spending under the program would be $286.7 billion (***Figure 2***) which is equal to the reduction in federal payments ($163.4 billion) plus the associated reduction in state Medicaid payments ($123.3 billion).

amount and the 5 percent growth rate to calculate per-capita spending amounts for each year 1996 through 2002.

- We next calculated total Medicaid spending under the proposal. To do so, we took the state allotments in the proposal (including the amounts in the supplemental pool and divided the amount for each year by the 1996 weighted average federal matching percentage. This is a conservative assumption because, under the proposal, states are permitted to reduce their matching payment rate.

- To calculate enrollment under the proposal, we divided the total Medicaid spending amount for each year by the per-capita spending amount for the year. The difference between baseline enrollment for each year and the enrollment level calculated for the proposal for the year is the estimated loss of Medicaid coverage under the proposal.

- To calculate the net reduction in payments to providers for those enrolled in Medicaid under the proposal, we subtracted the per-capita spending amount for each year under the proposal from the baseline per-capita spending amount for the year. This difference produces a reduction in the amount per person enrolled. We multiplied this per person reduction amount for each year by the number of enrollees under the proposal for the year to calculate the total reduction in provider payments for enrollees.

- To allocate the total reduction in provider payments between acute care and long-term care providers, we used the baseline ratios of acute care and long-term care to total expenses from the CBO baseline.

Under these assumptions, about $109.3 billion of the $163.4 billion in Medicaid spending reductions would come in the form of reduced provider payments for services while about $177.4 billion would take the form of reduced enrollment (***Figure 2***). The $109.3 billion in provider payment reductions are assumed to be distributed across provider groups in proportion to current program spending by type of service. Thus, about 36 percent of program spending cuts ($39.9 billion) would go to nursing home services. Hospitals would account for about 35 percent of spending cuts ($38.1 billion), while about 29 percent ($31.3 billion) would go to physicians and other providers (***Figure 2***).[3]

There is likely to be a substantial reduction in enrollment in the Medicaid program under the Budget Reconciliation Act. Under current policy, Medicaid enrollment would grow from 36.8 million persons in 1995 to 45.9 million in 2002. Under the Budget Reconciliation Act, states will find it hard to fund this increase in enrollment. Under the assumptions used in this analysis, Medicaid enrollment in 2002 would drop from 45.9 million persons under current policy to 37.4 million persons under the Act (***Figure 3***). This is a reduction in Medicaid enrollment of 8.5 million persons in 2002. We estimate

[3] Estimates derived from national health spending estimates provided by the Health Care Financing Administration, Office of the Actuary: data from the Office of National Health Statistics.

III. Estimated Cost Shift

Cost shifting is the process whereby providers recover uncompensated care costs and payment shortfalls for public program enrollees in the form of higher charges to private payers. In this section we review the available evidence on cost shifting. We also present the assumptions used in our analysis and estimate the amount of the increase in cost shifting that could result under these budget proposals.

A. Evidence on Cost Shifting

Payment levels under public programs are typically less than payments for comparable services under private insurance plans. In 1993, Medicare hospital payments were equal to about 89 percent of hospital costs for Medicare patients. In addition, payments under the Medicaid program were equal to about 93 percent of costs and hospitals incurred about $12.3 billion in bad debt and charity care expenses in that year for uninsured and underinsured patients.[5] In theory, these payment shortfalls are recovered by hospitals in the form of higher charges to private payers. For example, private payer payments were equal to about 129 percent of costs for private sector patients in 1993.[6]

In recent years, some debate has arisen over the existence of the cost shift. While public payers do pay less than average costs, even after adjusting for case mix, this does not necessarily mean that there is cost shifting. In fact, differential pricing across purchasers is often found in many industries. Arguably, the hospitals are engaged in marginal cost pricing and there is no actual cost shift unless services are sold for less than the marginal cost of providing these services. The fact that hospitals have not closed their doors to Medicare patients suggests that the marginal revenues for serving this population exceed their marginal costs. Moreover, with the advent of selective contracting, it has become increasingly difficult for hospitals to shift costs to private payers.[7]

Regardless of whether it is marginal cost pricing or cost shifting, the key question in this analysis is whether prices paid by private payers increase as provider payment shortfalls rise. The literature is mixed on this question. Two studies show that about half of hospital payment shortfalls are passed on to private payers in the form of higher charges.[8] However, two other studies showed considerably less evidence of hospital cost

---

[5] Uncompensated care is estimated on a cost basis.

[6] "Medicare and the American Health Care System: report to the Congress," Prospective Payment Assessment Commission (ProPAC), June 1995.

[7] Morrisey, M., Cost Shifting in Health Care: Separating Evidence from Rhetoric, American Enterprise Institute, September 1993.

[8] Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost Shifting," Journal of Health Economics, Vol. 7, No. 1 (March 1988); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," Journal of Health Politics, Policy and Law, Vol. 8., No. 4 (Winter 1984).

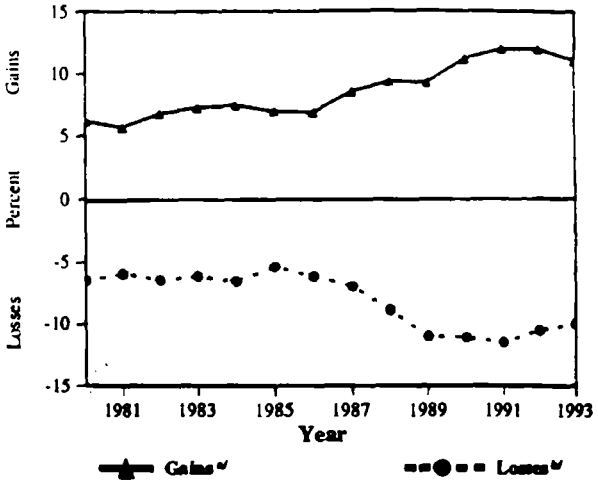
FIGURE 5

HOSPITAL GAINS AND LOSSES FOR HOSPITALS 1980 - 1993

	Hospital Payment to Cost Ratios		
Year	Medicare	Medicaid	Private
1980	0.96	0.91	1.12
1981	0.97	0.93	1.12
1982	0.96	0.91	1.14
1983	0.97	0.92	1.16
1984	0.98	0.88	1.16
1985	1.01	0.90	1.16
1986	1.01	0.88	1.16
1987	0.98	0.83	1.20
1988	0.94	0.80	1.22
1989	0.91	0.76	1.22
1990	0.89	0.80	1.27
1991	0.88	0.82	1.30
1992	0.89	0.91	1.31
1993	0.89	0.93	1.29

Note: Payments and costs include both inpatient and outpatient services. These ratios cannot be used to compare payment levels, because both the mix of services and the cost per unit of service vary across payers. They do, however, indicate the relative degree to which payments from each payer cover the costs of treating its patients. Due to reporting inconsistencies related to Medicaid disproportionate share payment and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992 and 1993.

Source: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals



a/ From private payers and operating subsidies above uncompensated care costs.

b/ From Medicare, Medicaid, and other government payers, and uncompensated care.

Note: Gains and losses are the difference between the cost of providing care and the payment received. Operating subsidies from state and local governments are considered payments for uncompensated care, up to the level of each hospital's uncompensated care costs. Excludes non-patient care income. Due to inconsistencies related to Medicaid disproportionate share hospital payments and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992 and 1993.

Source: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals

FIGURE 6

ESTIMATION OF PERCENT OF PAYMENT SHORTFALLS SHIFTED TO PRIVATE PAYERS

	1990 - 1991 Change	1991 - 1992 Change
Change in Payment Shortfall		
Change in Payment Shortfall (in billions)	$1.5	$1.0
Calculation of Private Mark-up Used for Payment Shortfall		
Dollar Change in Private Mark-up (in billions)	$1.9	$1.2
Dollar Change in Hospital Margin Financed with Change in Private Mark-up (in billions)	$1.2	$0.8
Change in Private Mark-up Shifted to Cover Payment Shortfall (in billions)	$0.7	$0.4
Percent Cost Shifted		
Percent of Payment Shortfall Shifted to Private Sector	47%	40%

a/ Includes uncompensated care (on a cost basis) and the total shortfall for public payers including Medicare and Medicaid less state subsidies and net revenues from non-patient income.

b/ Increase in private sector payments in excess of what would have been paid under the prior year's private sector mark-up percentage.

c/ Increase in hospital net revenues in excess of what they would have been under the prior year's hospital total margin (i.e., profits as a percent of revenues).

d/ The difference between the dollar change in the private sector mark-up and the dollar change in the hospital margin is the amount that was used to offset payment shortfalls for other payers.

Source: Lewin-VHI analysis of ProPAC data.

C. Cost Shift Estimates

We estimate that the shortfall in payments to hospitals under the reconciliation bill would be $202.3 billion over the 1996 through 2002 period (***Figure 10***). This includes reduced payments to hospitals for services provided to Medicaid and Medicare enrollees and increased charity care expenses for those who become uninsured. In addition, we estimate that payment shortfalls for physicians would be $82.4 billion.

Under the assumptions used in this analysis, we estimate a total cost shift of about $84.7 billion resulting from these budget cuts over the 1996 through 2002 period (***Figure 9***). This includes $64.3 billion in hospital cost shifting and about $20.4 billion in cost shifting among other providers. Overall, about 52.7 percent of the cost shift would be attributed to the Medicare cuts while 47.3 percent would be due to the Medicaid cuts.

FIGURE 9

ESTIMATED COST SHIFT UNDER MEDICARE AND MEDICAID BUDGET CUTS (IN BILLIONS)

	Hospital Cost Shift a/	Other Provider Cost Shift b/	Total Cost Shift
1996	$1.6	$0.4	**$ 2.0**
1997	3.0	0.9	**3.9**
1998	6.8	2.4	**9.2**
1999	10.3	3.5	**13.8**
2000	11.7	3.9	**15.6**
2001	14.4	4.4	**18.8**
2002	16.5	4.9	**21.4**
Total 1996 - 2002	**$ 64.3**	**$ 20.4**	**$ 84.7**

a/ Includes a percentage of hospital budget cuts under Medicare and Medicaid. The percentage of hospital budget cuts that we assume to be cost shifted is 40 percent in 1994 phasing down to 30 percent by 2002.

b/ Assumes that each 1.0 percent reduction in other provider payments under the bill results in a 0.2 percent increase in private sector rates.

Source: Lewin-VHI estimates.

IV. Effects of Cost Shifting

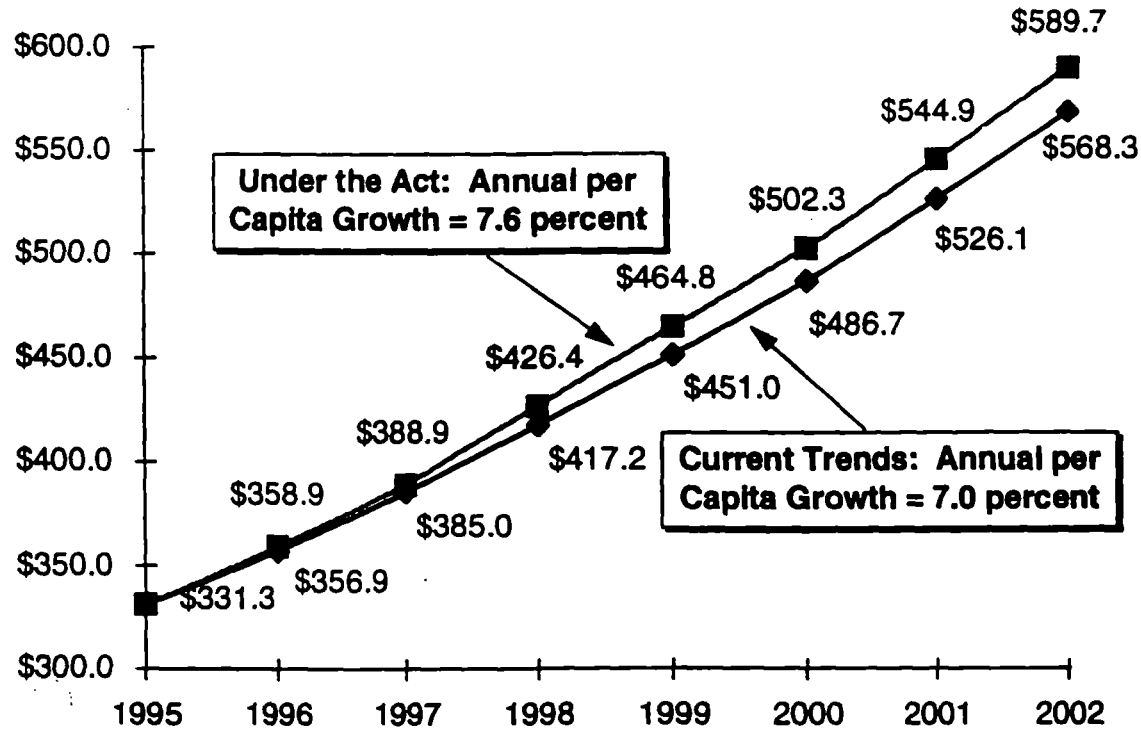
The $84.7 billion in cost shifting would result in substantial increases in health insurance premiums over the 1996 through 2002 period, affecting all purchasers of private insurance including employers and individuals. The growth in employer costs is also likely to result in slower wage growth for workers in firms with insurance. In addition, some covered individuals and employers would be unable to afford the increase in premiums, resulting in a loss of coverage. These effects are discussed below.

A. Cost Shift by Type of Payer

The increase in provider charges to private payers resulting from the cost shift ($84.7 billion) would be reflected in higher private insurance premiums. Premiums would increase for both employer health plans and individually purchased non-group insurance. The annual rate of growth in per-capita private insurance costs would increase from 7.0 percent under current trends to 7.6 percent with the Medicare and Medicaid budget cuts. By 2002, private insurance premiums would be about $21.4 billion (four percent) higher than under current trends due to this cost shift (***Figure 11***).

FIGURE 11

PRIVATE INSURANCE COSTS RESULTING FROM MEDICARE AND MEDICAID BUDGET CUTS IN THE BUDGET RECONCILIATION ACT OF 1995
(IN BILLIONS)



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

FIGURE 13

COST SHIFT TO EMPLOYERS UNDER ILLUSTRATIVE MEDICARE AND MEDICAID CUTS

	Amount Shifted to Employers (In billions)	Percent Increase In Employer Costs	Cost Increase per Covered Worker
1995	$0.0	- - -	- - -
1996	$1.6	0.5%	$22
1997	$3.2	1.0%	$44
1998	$7.5	2.1%	$104
1999	$11.3	3.1%	$157
2000	$12.8	3.2%	$175
2001	$15.4	3.6%	$210
2002	$17.5	3.7%	$238
Total 1996 - 2002	**$69.3**	**2.7%**	**$950**

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

B. Impact on Workers by Industry Type and Firm Size

Empirical evidence indicates that employers are likely to pass on much of the increase in employer costs to employees in the form of reduced wages.[12, 13] Employers are typically limited in what they can charge in the market place, necessitating changes in other compensation costs as employer premiums increase. Based upon a review of the literature, we assume that, on average, 88 percent of the change in employer costs under these reforms would be passed on to workers in the form of lost wage growth.[14]

Under these assumptions, about $61.0 billion of the $69.3 billion increase in employer costs due to cost shifting would be passed on to workers in the form of lost wage growth. This wage loss is in addition to the $5.9 billion increase in employee premium contributions resulting from higher private insurance premiums. Overall, the amount of the cost shift passed through to workers would be $66.9 billion including lost wage growth and higher employee premium contributions (***Figure 14***). Lost wages and

[12] See, for example, Jonathan Gruber and Alan B. Kreuger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in Tax Policy and the Economy (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," American Economic Review, (forthcoming); and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," American Economic Review (May 1989).

[13] See, for example, James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty years?" American Economic Review, (May 1993).

[14] This estimate is consistent with estimates presented in the literature. For example, Gruber and Kreuger, *op. cit.*, find that about 85 percent of the costs of mandated worker's compensation benefits are shifted to employees in the form of reduced wages, while Gruber, *op. cit.*, found that virtually all of the employer's cost of mandated maternity benefits are shifted to the employee.

in these industries. For example, about 23 percent of the pass-through would fall on the services industry due to the large number of persons employed in that industry, even though fewer than half of all workers in this industry have coverage on their job. Thus, even though the cost impact per worker would be greatest in high coverage industries, much of the cost shift will fall on lower coverage industries.

C. *Effects By Family Income And Wage Level*

As discussed above, employers will pass through to workers about $66.9 billion of the cost shift resulting under the proposed Medicare and Medicaid cuts. This includes increased employee premium contributions and lost wage growth. About 25 percent of this pass-through will be borne by workers earning less than $10.00 per hour ($20,800 per year). The amount of the pass-through to workers over the 1996 through 2002 period would range from $685 for the lowest-wage workers to $1,233 for workers making $25.00 or more per hour (***Figure 15***).

FIGURE 15

DISTRIBUTION OF COST SHIFT PASS-THROUGH PER WORKER BY FAMILY INCOME AND WAGE LEVEL (1996 THROUGH 2000) [a/, b/]

	Pass-through to Covered Workers (billions)	Pass-through per Covered Worker	Percent of Total
Family Income			
Under $10,000	$2.2	$863	3.3%
$10,000 - $14,999	$1.7	$772	2.5%
$15,000 - $19,999	$3.0	$962	4.5%
$20,000 - $29,999	$7.6	$711	11.4%
$30,000 - $39,999	$9.2	$913	13.8%
$40,000 - $49,999	$8.1	$881	12.1%
$50,000 - $74,999	$15.0	$923	22.4%
$75,000 - $99,999	$10.3	$1,015	15.4%
$100,000 and over	$9.8	$1,084	14.6%
Wage Level			
Under $4.25 per hour	$3.4	$685	5.1%
$4.25 - $6.00 per hour	$2.3	$726	3.4%
$6.00 - $10.00 per hour	$11.0	$828	16.4%
$10.00 - $15.00 per hour	$13.9	$784	20.8%
$15.00 - $25.00 per hour	$21.1	$1,011	31.5%
$25.00 or more per hour	$15.2	$1,233	22.7%
Total	$66.9	$925	100.0%

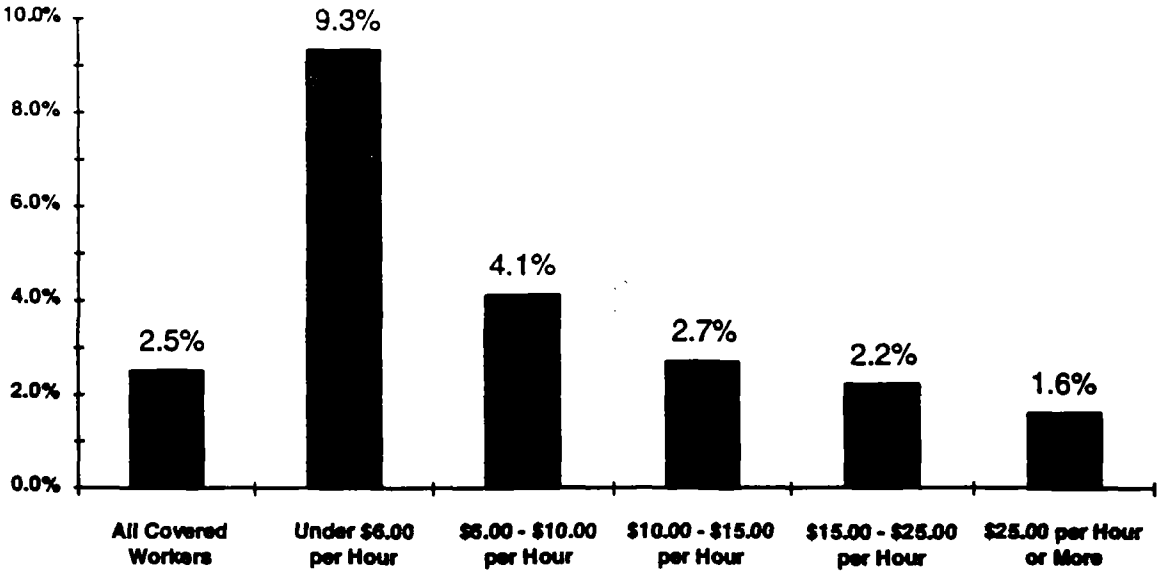
a/ Includes the increase in employee share of premium and the amount of the employer share of the cost increase that is passed on to workers in the form of lost wages.

b/ Family income and wage level are based on 1994 dollars.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

FIGURE 17

PERCENT OF WAGE INCREASE FOR COVERED WORKERS OFFSET BY COST SHIFT FROM MEDICARE AND MEDICAID CUTS: 1996 THROUGH 2002 a/



a/ This figure shows the cost shift pass-through (i.e., lost wages and increased payroll deductions) as a percentage of the total amount of wage increases that would have occurred over the 1996 through 2002 period for covered workers if the Medicare and Medicaid cuts had not been enacted.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

2002. Many employers also may respond by increasing employee cost sharing in these plans.[17]

B. Medicaid Coverage

As discussed above, Medicaid enrollment is assumed to decline due to the reductions in Medicaid funding. Under the assumptions used in this analysis, we estimate that the number of persons covered under Medicaid in 2002 would decline from 45.9 million to 37.4 million. This represents a reduction in Medicaid coverage of 8.5 million persons in that year.

Not all of those who lose Medicaid coverage under the act would become uninsured. For example, many of those who are receiving Medicaid benefits are also covered under Medicare (15 percent). Dual eligible Medicaid beneficiaries who lose their supplemental Medicaid coverage under the act would not be counted as uninsured because they would retain their Medicare coverage. After adjusting for dual eligibility, we estimate that of the 8.5 million persons who lose Medicaid coverage under the act, about 7.2 million would be added to the ranks of the uninsured.[18]

C. Combined Loss of Coverage

Under current policy, we estimate that the number of uninsured persons in the U.S. would increase from 39.7 million in 1995 to 45.9 million by 2002 (***Figure 18***). Under the reconciliation act, the number of uninsured in 2002 would increase from 45.9 million to 53.7 million; an increase of 7.8 million persons. This includes the 7.2 million persons who would lose coverage due to coverage terminations under Medicaid and a reduction in employer coverage of 647,000 persons resulting from the premium increases caused by the cost shift.

[17] The Methodology used to develop these estimates is presented in: John F. Sheils, et al., "The Health Insurance Premium Model (HIPM): Technical Documentation," Lewin-VHI, Report to the Healthcare Leadership Council, March 27, 1995. These estimates are a net figure reflecting the fact that some of the workers who lose employer coverage will purchase individual non-group coverage.

[18] We estimate that 15 percent (1.3 million) of the 8.5 million persons who lose Medicaid coverage under the act would be dually eligible for Medicare.

VI. Summary and Caveats

Our analysis indicates that cost shifting does occur among both hospital and physician services. However, we find that only a portion of increases in payment shortfalls are passed on to private payers in the form of higher prices. The remainder is covered through either increased efficiencies or reductions in services provided. The growing trend toward selective contracting suggests that the provider's ability to shift costs would diminish as selective contracting increases over time.

Ultimately, families will pay for the cost shift. For example, private payers pass the burden of higher prices on to their customers in the form of higher premiums. Employers then pass on the cost of the increased premiums to workers in the form of reduced wage growth and increased employee contributions. We estimate that the proposed Medicare and Medicaid budget cuts are expected to increase real health expenditures for workers by $72.4 billion over the 1996 through 2002 period. The cost shift could be substantially greater than we have estimated here depending upon the effectiveness of managed care and the way in which providers respond to the budget cuts.

This analysis is limited to the financial effects on employers and employees by industry, firm size and income. It does not describe the effects of increased public-program shortfalls on the availability and quality of care for program beneficiaries and the uninsured. It also does not describe the impact of cost-shifting on health care providers beyond the loss of revenues.

COST SHIFTING

Medicare Savings Without Reform Will Lead to Cost Shifting

- If deep reductions in Medicare spending are taken in the absence of health care reform, the burden of these cuts will be shifted to those who buy private insurance. This "cost shifting" occurs when doctors and hospitals provide services below cost to Medicare patients and then overcharge people with private health insurance to make up the difference. The experts agree:

  - Henry Aaron, an economist and an expert on health care issues, recently said that "[l]arge reductions in Medicare spending within the current program framework will impose . . . taxes on private businesses and individuals."

  - The Congressional Budget Office (CBO) has estimated that about one-quarter of spending cuts will simply be shifted -- in the form of price increases -- to private purchasers of health care services. (Analysis of Congressman Gephardt's Health Care Proposal, December 27, 1994) In an earlier report (where CBO found even more cost shifting), CBO stated that, during the 1980s, "[h]ospitals offset most of the rise in unreimbursed costs by generating higher revenues from private payers, a practice commonly known as 'cost shifting.' The revenues from private payers that were used to cover unreimbursed costs increased over the period -- from a 6 percent average markup over the costs of treating private patients in 1980 to a 15 percent markup in 1989. . . . These results suggest that, in the current multiple-payer health care system, actions taken by one payer to control health spending can have a significant impact on spending by other payers. . . . As a consequence, in the absence of other changes, further attempts to control public sector spending would probably produce additional cost shifting to the private sector . . . . (*Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals Cost Shift?*, Congressional Budget Office, May 1993)(emphasis added)

  - The Prospective Payment Assessment Commission (ProPAC) says that "every percentage point of Medicare cost increase not reimbursed by the Medicare payment increase will, all else equal, translate into a percentage point of additional revenue needed from the private sector." And these numbers are not small change. In 1992, "hospitals spent $26 billion more than they received for furnishing services to Medicare, Medicaid and uninsured patients" -- and $11 billion of this total was from Medicare alone. "In the same year, [hospitals] took in $29 billion in revenue above their costs of providing care to privately insured patients." (*Report and Recommendations to Congress*, Prospective Payment Assessment Commission, March 1, 1995)(emphasis added)

- And an editorial in the May 13, 1995 issue of *The Economist* raises the same concerns about "tackling Medicare on its own." "Although the federal budget would benefit, these savings could be offset by higher costs in private health care . . . Thus the best way to cut Medicare . . . would be to subsume them within broader health reforms."

- It's a basic rule of physics. And it's common sense. For any action there is an equal and opposite reaction. If you squeeze a balloon on one side, it forces the air to the other. Likewise, cutting Medicare costs without reforming the health care system merely forces privately insured middle class Americans to pay more. And the purchasers with less power in the health care marketplace, like small businesses, are most likely to pay higher prices to offset the losses.

Health Care Reform Will Protect Against Cost Shifting

- Health care reform, including insurance reforms targeted to the small group market, will cushion the effects of this cost shift by improving the efficiency and fairness of the health care system.

  - Expanding coverage, ensuring that people can keep the coverage they have, and making affordable insurance more available will reduce uncompensated care, which in turn will reduce the unrecovered costs that providers pass on to people with private insurance to make up the difference.

  - In addition, purchasing pools -- which allow small businesses to pool their bargaining power -- will give them the clout they need to protect themselves against cost shifting.

- That's why the President has consistently said that we must control the growth of federal health care spending, but we must do it as we reform our health care system as a whole -- not by arbitrarily cutting these programs to pay for tax cuts or other priorities.

If we did some type of rate controls that limit variation and guaranteed issue:

- Forcing insurers to compete on price and quality, rather than by choosing only younger, healthier individuals as they can today, will make the market more efficient. This should reduce premiums over time and offset the effects of cost shifting.

6-2-95

To: Jennifer Klein +
Gene Sperling

From: Kim

Let me know how this is going ☺

Hope this is helpful. I know it's rough.

If deep Republican Medicare cuts take place in the absence of health care reform, the burden of the cuts will be shifted onto the backs of those who pay for private health insurance, especially small employers, while the money will be used for a whole range of other Republican priorities, such as tax cuts for the wealthy. Cost shifting Medicare losses takes place when health care providers agree to provide services below cost to Medicare patients and then overcharge people with private health insurance to make up the difference. The weakest payers, such as small businesses and individuals purchasing health insurance on their own, are the most likely to have to pay inflated health premiums that are increased to offset the cost of Republican cuts.

Independent health care experts at the Prospective Payment Commission confirm that "every percentage point of Medicare cost increase not reimbursed by Medicare payment will, all else equal, translate into a percentage point of additional revenue needed from the private sector." And these numbers are not small change. In fact, in 1992, "hospitals spent $26 billion more than they received for furnishing services to Medicare, Medicaid, and uninsured patients" -- and $11 billion of this total was from Medicare alone [ProPAC 1995, page 5]. "In the same year, [the hospitals] took in $29 billion in revenue above their costs of providing care to privately insured patients" [ProPAC 1995, page 5]. If this trend continues, deep Republican Medicare cuts will continue to come right out of the back pockets of the privately insured.

We believe that the Medicare system needs reform and that we have to get Federal health spending under control. But to really make this work and not just cost-shift ~~to~~ spending from tax dollars to insurance premiums, we need to improve our health care system as a whole. If we get Medicare savings while taking the first steps toward health care reform, we can minimize cost shifting by strengthening the private marketplace and giving more purchasing power to our small businesses and individuals.

NOTES ON MEDICARE/MEDICAID CUTS AND COST-SHIFTING

mjm 6/2/95

• In general, the burden of cuts in spending on Medicare and Medicaid will not stay with the party immediately affected as these parties try to escape the burden of the cut or to shift the burden somewhere else. This is especially true for cuts that initially affect providers.

• The burden of spending cuts will usually wind up resting with the party least able to shift the burden elsewhere. In this sense, the process of burden-shifting resembles a game of musical chairs. All participants in the health care market try to ensure that they are not the party winding up bearing the brunt of the spending cuts.

• For example, a reduction in Medicare payments to hospitals may not actually reduce the total resources available to hospitals. Possible responses include:

Hospitals increase the quantity of services provided to Medicare beneficiaries keeping net revenues approximately constant. In this case, the burden is shifted back to Medicare.

Hospitals become more reluctant to treat Medicare beneficiaries or reduce the quality of services provided. In this case, the burden is shifted to beneficiaries.

Hospitals, seeing revenues from Medicare falling, increase the charges for care provided to other, non-Medicare, patients. In this case, the burden is shifted to individual patients and insurers.

To the extent insurers are charged more for health care, the cost is borne either by shareholders of the insurer or passed on to customers (e.g., employers who purchase insurance coverage for their employees). If employers' costs of purchasing health insurance increase, they may respond by charging employees more for health care benefits provided or dropping health insurance coverage altogether. In these cases, workers bear the burden of the Medicare cuts in the form of lower take-home pay or dropped coverage.

Hospitals unable to shift the cost of lower Medicare reimbursements to other paying patients may view the uncovered cost of treating Medicare beneficiaries as uncompensated "charity care". In this case, the burden of Medicare spending cuts is borne by society as a whole, through either tax revenues used to support public hospitals or through collective charitable contributions.

• Similar examples apply to Medicare cuts placed on other health care providers (e.g., physicians, laboratories, and outpatient

facilities).

• In recent years, employers and insurers and especially health maintenance organizations (HMOs) have become more sophisticated and more successful at avoiding the efforts of health care providers to shift costs in their direction. This makes it very difficult to predict who ultimately will bear the burden of expenditures cuts in the major public health programs (Medicaid and Medicare).

PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION

REPORT AND RECOMMENDATIONS TO THE CONGRESS

MARCH 1, 1995

risk contracting program, and in fact may increase Medicare spending as a recent evaluation indicated. In addition, Medicare's policy of allowing beneficiaries to disenroll on a monthly, rather than annual, basis may contribute to biased selection. It could also disrupt the continuity of care.

- Determining the AAPCC annually on a county basis results in substantial payment variation among neighboring counties and from year to year. As a result, many HMOs are discouraged from participating in the risk contracting progam because of low payments in their service areas and payment variability from one year to the next. In addition, the AAPCC methodology does not account for the costs of services provided to Medicare beneficiaries by Department of Veterans Affairs and other military facilities. Consequently, Medicare capitated payments in some areas may be inappropriately low, further discouraging HMO participation.

- The Medicare program needs to provide beneficiaries with more information regarding available plans and how they compare. This information should include findings regarding the quality of care delivered to beneficiaries by HMOs in their area and data on enrollee satisfaction with alternative plans.

Alert 3: Changing Patterns of Subsidies Across Payers and Providers

A price competitive health care system will alter past patterns of subsidies across payers and providers. The ability of providers to cover losses from Medicare and Medicaid patients with excess revenues from private payers will diminish as competition intensifies.

- Hospitals have always used gains from some payers to cover losses from others. They have also relied on direct and indirect subsidies to help finance the care they furnish to the uninsured. These practices have spread rapidly in recent years. But as competition accelerates, payers will become less willing to finance these extra costs.

- Over the past decade, Medicare and Medicaid have curtailed the rise in their per case payments to hospitals. Instead of reducing cost growth as public payers constrained payments, however, hospitals responded by increasing revenue from private payers. In 1992, hospitals spent $26 billion more than they received for furnishing services to Medicare, Medicaid, and uninsured patients. In the same year, they took in $29 billion in revenue above their costs of providing care to privately insured patients. Because hospitals could get additional revenue from private payers, Medicare was able to slow payment growth without a commensurate decrease in the cost of furnishing care to its beneficiaries.

- Many hospitals will have difficulty securing extra revenues from private payers to subsidize losses from public programs because of accelerating price competition. To remain financially viable, therefore, they will have to constrain the growth in the costs of furnishing care to all patients.

- This deceleration in hospital costs per case began in late 1992. Contributing to this trend were improved labor productivity, smaller wage and salary increases, and a more gradual rise in the cost of supplies and services that hospitals purchase. In addition, hospital length of stay has declined for elderly and nonelderly populations alike. Consequently, growth in the average cost per case is moderating for Medicare and other payers.

- Medicare's payments relative to the costs of services provided to beneficiaries continue to be below those of most private payers. Because of the recent slowdown in cost growth, however, subsidies from private payers that offset these losses will not need to increase. Indeed, though still substantial, these subsidies appear to have dropped in 1994.

- Surplus revenue from private payers also has been used to subsidize losses from Medicaid and uninsured patients. If hospitals are unable to continue to obtain these additional revenues, they may avoid providing care to some public program beneficiaries and to the uninsured. Moreover, the pressure to do so is likely to rest most heavily on certain hospitals.

Alert 4: Assessing Further Reductions in Medicare Hospital Updates

While the growth in Medicare hospital per case payments can be reduced further, it is important

Chapter 1

Medicare and the Evolving Health Care System

America's health care system is undergoing a transformation, resulting from spending that consistently has risen much faster than can be explained by population growth and general inflation for the past three decades. A major restructuring in the financing and delivery of care is under way that will have lasting effects on how care is provided to the entire population, including Medicare beneficiaries. Before looking at the changes, however, it is important to understand the context in which they are taking place.

Among the factors contributing to higher health care spending are greater demand for services and the development, diffusion, and use of medical and technological advances. Not only are people receiving more services, but these are of higher intensity. The utilization spiral historically has been fueled further by the nature of health care financing, characterized by third-party insurance coverage and fee-for-service payment. Providers traditionally have been paid on a per service basis, linking their revenues with the quantity of services they furnish. Health insurance has shielded consumers from the direct cost of service use.

The dynamics of the medical marketplace also differ from those in the markets for most other goods and services—and may help explain why costs have grown. In most markets, consumers choose the lowest-priced product of acceptable quality, but price has been less important in the health care sector, partly because of insurance. Additionally, physicians generally select the services provided; rarely—until recently—have they been held accountable for patient care costs. Further, hospitals and other providers have competed for patients based on the perceived quality of their products, rather than on price. Frequently, competition has entailed acquiring costly technologies, expanding capacity, and offering services and amenities with little attention to cost.

All this is changing. Recent trends indicate that the growth in health care spending is moderating. Competition among insurers and providers is increasing, with price becoming a more important consideration in health care purchasing decisions. Employers and other buyers of insurance are demanding lower premiums. Third-party payers are using capitation and other managed care techniques to constrain their costs by negotiating price reductions, sharing financial risk with providers, and controlling service use.

For a decade, Medicare has attempted to curb its expenditures by limiting the rise in payment for each service that is furnished. For example, Medicare policies control the payment for each hospital discharge as well as for each unit of service delivered by physicians and other providers. Nevertheless, program spending has continued to grow rapidly because there are more beneficiaries, and because the number of services each Medicare patient receives is rising.

The major restructuring of the financing of health care services will affect how health care is provided. Increased price competition, together with continued payment constraints by government payers, has the potential to slow the rise in health care spending by reducing excess capacity, eliminating services of little or no value, and enhancing overall system efficiency. Greater competition, however, can have adverse effects if insurance plans or providers attempt to control their costs by accepting only the healthiest individuals or by failing to provide appropriate services. People who are uninsured or at high risk for illness, those who cannot afford to travel to selected providers, and those living in underserved areas may be at a disadvantage in a highly competitive health care system. The providers that care for these vulnerable populations and those that furnish other socially valuable services, such as medical education, also may be disadvantaged.

In this chapter, the Prospective Payment Assessment Commission (ProPAC) examines the evolving health care marketplace and Medicare's role within that marketplace. Changes in health care financing and service delivery are described. Recent health care spending trends are presented, along with the relationship between Medicare's payment policies and those of other payers. The increased competition and restructuring occurring in the financing and delivery of medical care are likely to affect the rate of growth and the distribution of spending by the private sector and by government programs. These changes could, therefore, have important consequences for access, service use, and quality of care.

THE CHANGING HEALTH CARE MARKETPLACE

Between 1980 and 1993, national health care spending grew more than 250 percent, largely because of the financial environment in which health care services are delivered.[1] Insurers traditionally played a passive role in managing spending because they were able to increase insurance premiums. Employers—the predominant payers of health insurance premiums—either raised product and service prices or delayed wage increases or other benefits to pay for higher premiums.

As a result of this financial environment, hospitals and other providers have attempted to improve the quality of their services with little regard to the cost. Capital improvements and expansions, along with technological advances, have enhanced the quality of and access to health care. At the same time, however, they have contributed to the tremendous growth in health care spending—from 9 percent of the nation's domestic output in 1980 to nearly 14 percent in 1993.[2]

Payment methodologies also have played a significant role in the rise of health care expenditures. Providers historically have been paid based on their costs or charges for each unit of service. These cost-based and fee-for-service payment methods give providers incentives to increase the frequency, duration, intensity, and specialization of services, leading to growth in overall spending.

In the early 1980s, Medicare expenditures were outpacing those in the private sector. To contain spending, Medicare implemented several payment policy changes, most notably the prospective payment system (PPS) for inpatient hospital care. Under this system, hospitals generally receive a fixed payment for each patient discharge, regardless of the amount or duration of services provided. PPS helped contain the growth in inpatient expenditures, thereby reducing the increase in total program spending.

Medicare's PPS, together with a decline in hospital admissions, resulted in an initial slowdown in overall hospital expenditures. This phenomenon was temporary, however, due to the relative lack of spending controls by other payers. While PPS constrained Medicare inpatient hospital payments, hospital costs continued to grow at historical rates. As their costs increasingly exceeded Medicare payments, many hospitals generated larger revenue surpluses from private insurers, a practice commonly referred to as cost shifting. Because they were able to cost shift, many health care providers did not have to confront financial pressures imposed by Medicare and some other payers. Cost shifting also meant that the constrained growth in Medicare payment rates generally did not impede access to or quality of care for Medicare beneficiaries.

Medicare's inpatient hospital payment policies hastened the decline in hospital admissions and length of stay; technological advances also contributed to this trend. An increasing number of services are provided in other sites, such as hospital outpatient and ambulatory settings, post-acute facilities, and the home. These factors have contributed to an overall excess in hospital inpatient capacity.

Recent trends indicate that price is becoming a more important consideration in health care purchasing decisions. Many of these changes began during the 1980s, but they have accelerated recently. This may be attributable to various factors, including a growing share of employers' dollars being spent for health care benefits, as well as a greater awareness of spiraling health care spending, highlighted during the 1994 debate on national health care reform.

Financial Constraints

The growth in health care expenditures is causing many buyers (primarily employers) to seek

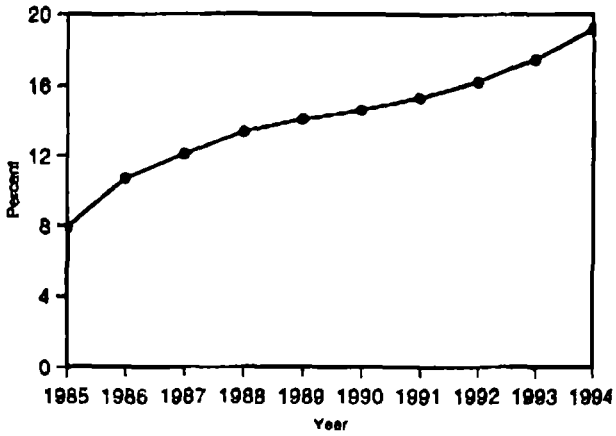
insurers or benefits managers that offer health benefit packages at lower premiums. Insurers are implementing new strategies to contain spending by controlling the payment per unit of service, as well as the total number of services furnished. These approaches include converting provider payment methodologies from fee for service to more comprehensive payment units—such as per day and per case or per capita—and implementing utilization review programs. Consequently, providers face different financial incentives, as they bear more of the risk associated with health care cost increases.

Many health care purchasers are turning to managed care plans, which often have lower premiums than conventional indemnity plans. The term managed care encompasses a variety of arrangements, but all rely on restricting the choice of health care providers and limiting clinicians' options to prescribe treatments. Common plan types include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service plans.

Managed care plans use various techniques to control their costs. Subscribers are limited in their choice of providers or given strong financial incentives to choose particular providers. By specifying doctors and hospitals, managed care plans can negotiate favorable payment rates and select providers that demonstrate lower-cost practice patterns. Further, plans may share financial risk with providers by using capitated payment arrangements or, in the case of hospitals, a per diem or per case payment. Other techniques include utilization review mechanisms and requirements that all specialized services be preauthorized by a primary care practitioner. Many managed care plans encourage preventive services to detect or avoid future costly conditions. Some control costs by acquiring hospitals and employing physicians so that they can provide services directly to subscribers.

The number of people enrolled in some form of managed care is growing rapidly. Enrollment in HMOs—the most tightly controlled managed care arrangement—more than doubled between 1985 and 1994, from 8 percent of the population to about 19 percent (see Figure 1-1). While HMO membership is expanding at the national level,

Figure 1-1. U.S. Population Enrolled in Health Maintenance Organizations, 1985-1994 (In Percent)



Note: Data for 1985-1988 are reported as of June 30; data for 1989-1993 reported as of December 31; 1994 data are estimated as of December 31, 1994.

SOURCE: Group Health Association of America, *Patterns in HMO Enrollment*, June 1994, and the Department of Commerce, Bureau of the Census.

HMO market penetration varies widely at the state level. In California and Massachusetts, for example, almost 35 percent of residents belonged to an HMO in 1993, compared with Alaska, West Virginia, and Wyoming, where there was virtually no HMO activity.[3]

Enrollment in PPOs and other types of managed care also is accelerating. PPO subscribers generally have more choice of providers, although they are encouraged to use particular ones through financial incentives. In firms with 100 or more employees, PPO enrollment rose from 16 percent of all insured workers in 1991 to 26 percent in 1993.[4] Similarly, PPO enrollment for workers in smaller firms went up from 13 percent to 18 percent between 1990 and 1992.[5] Data on other forms of managed care are limited; however, anecdotal evidence suggests they are experiencing similar trends.

Managed care methods increasingly are affecting people who remain in fee-for-service indemnity insurance arrangements. Many indemnity insurance plans are incorporating utilization management features. In 1993, 90 percent of workers in firms with 100 or more employees were enrolled in fee-for-service plans that required certain services to be preauthorized by the insurer.[6]

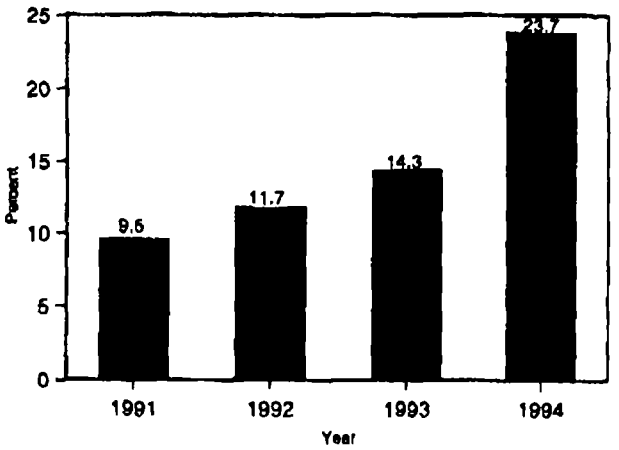
A growing number of states are attempting to control rising Medicaid expenditures by establishing managed care programs for Medicaid recipients. States generally need a waiver from the Federal government to implement such programs. Currently, 44 states and the District of Columbia have some type of managed care program in place, ranging from primary care case management to mandatory HMO enrollment.[7] These programs usually encompass specific geographic areas or populations, but several states have implemented statewide programs. The number of Medicaid recipients enrolled in managed care plans increased 66 percent between 1993 and 1994, from 4.8 million to nearly 8 million.[8] Managed care enrollment grew from almost 10 percent of the Medicaid-eligible population in 1991 to nearly 24 percent in 1994 (see Figure 1-2).

Provider Responses

Changes in the financing of health care are causing providers to reconsider how they do business. Confronted with intensified pressures to compete on the basis of price, they have three choices: control costs, increase volume in order to raise revenues, or both. Given changing financial incentives, the challenge for health care providers is to manage care delivery—and the resources used to provide that care—more effectively.

For hospitals, this is especially important. The combined growth in risk sharing arrangements, utilization review, and technological innovations has exacerbated the problem of excess capacity. Many services that previously were furnished on an inpatient basis are now being delivered in ambulatory settings. In addition, patients with conditions that require an inpatient stay are recovering in post-acute facilities and at home. The heightened demand for nonacute services has stimulated growth in the number and type of providers that compete for patients. Among these are hospital outpatient departments; free-standing ambulatory, surgical, and diagnostic imaging centers; rehabilitation facilities; and home health agencies. Insurers and managed care plans are capitalizing on the excess inpatient capacity to negotiate favorable prices for hospital services. Competition also is rising in other sectors, as private payers use managed care techniques to channel patients to selected physicians and other providers.

Figure 1-2. Medicaid Managed Care Enrollment, 1991-1994 (In Percent)



SOURCE: Health Care Financing Administration, Office of Managed Care.

To succeed in the increasingly competitive environment, hospitals and other providers are seeking ways to strengthen their market position. These methods range from developing outpatient and post-acute components to forming joint ventures with other providers and, in some cases, merging hospitals and entire hospital systems. The amount of collaboration between providers is widespread and unprecedented. The extent of this activity varies and often is directly related to the private sector market forces within an area. Each market differs, and these differences influence how providers respond to growing price competition. Areas heavily penetrated by managed care arrangements, for instance, are seeing more and more provider collaboration.

One of the more significant structural changes in the health care industry is the formation of integrated service delivery networks. These networks jointly market a comprehensive set of services to health benefit plans, insurers, or purchasers. They try to achieve savings through economies of scale and scope and the coordination of patient care.

Networks may include otherwise competing providers as well as those offering complementary or unrelated services. Besides physicians, they also may incorporate acute and post-acute facilities, other ambulatory-based providers, and, in some cases, an insurance component. By participating in networks, hospitals and other providers can compete more

effectively for managed care contracts, thereby increasing their market share and improving their financial condition.

Quality and Access

Changes in the financing and delivery of health care services are likely to affect the type, amount, and quality of services people receive. Access to care for certain individuals, particularly those without insurance, may also be compromised in a price-competitive environment. An estimated 39.7 million Americans (15.3 percent of the population) lacked health insurance coverage during the 1993 calendar year, an increase of 1.1 million over 1992.[9] The amount and quality of services used by uninsured patients are lower than for the rest of the population. Uninsured persons visit a physician less often and have fewer hospitalizations despite their poorer health status.[10] Those who are hospitalized are sicker on admission; use fewer costly, discretionary services; and appear to have a higher risk of death, both in the hospital and after discharge.[11]

With rising price competition in the marketplace, these disparities could be exacerbated. As payers negotiate larger discounts from providers, those that serve a population made up predominantly of Medicaid enrollees and the uninsured will be increasingly disadvantaged. Fewer payers may be willing to finance care to the uninsured through cost shifting, and fewer providers may be willing to take on this financial burden.

Changes in the health care market are also likely to affect the care received by the insured population. Many studies have shown that HMO enrollees have different utilization patterns, compared with members of traditional indemnity fee-for-service health insurance plans. HMO enrollees have lower hospital admission rates and more physician office visits than non-enrollees.[12] It appears that managed care physicians substitute ambulatory care for at least a portion of inpatient care. In addition, these physicians provide less intensive care in both inpatient and ambulatory settings compared with their fee-for-service counterparts.[13] Despite differences in the patterns of care furnished, the quality of care and health outcomes do not appear to differ between HMOs and fee-for-service plans. Moreover, HMO consumer surveys indicate a high degree of satisfaction.

Some have argued that the lower utilization rates in HMOs and other managed care plans are due to favorable enrollee selection. Another explanation is the reliance on physician "gatekeepers" to authorize the use of specialty services and otherwise coordinate care. It is clear, however, that providers paid a predetermined amount for furnishing comprehensive services have incentives to minimize the quantity and intensity of those services. How this will affect the quality of health care in the future is not known.

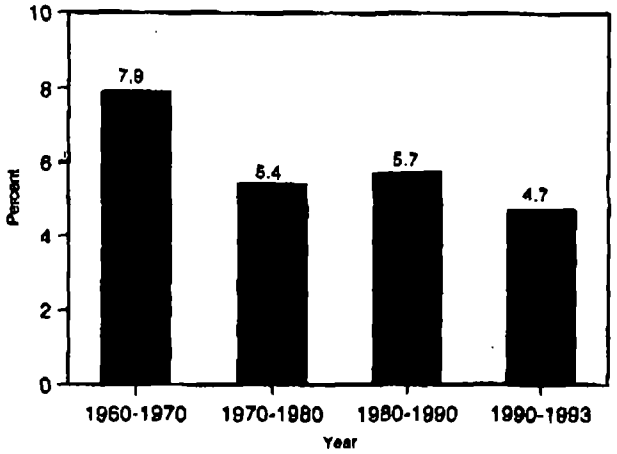
Research has documented wide variation in the use of health care services by various population groups.[14] While some of this variation may be appropriate—reflecting, for example, differences in patients' health status—much may be inappropriate and undesirable. To the extent that providers constrain needless use and control the intensity of services that do not improve patient outcomes or are furnished inefficiently, quality of care can be maintained or even improved. Providers can also improve quality and possibly avoid future use of expensive services through prevention and health promotion activities. The ability to identify inappropriate or inefficient service use, however, is limited. Most diagnostic and therapeutic interventions have not undergone rigorous evaluations of long-term outcomes that would allow targeted elimination or expansion of use.

HEALTH CARE SPENDING AND COSTS

Data on overall health care spending provide some indication of the impact of the changes in the health care marketplace. Recent trends suggest a slowdown in national health care spending over the past few years (see Figure 1-3). After accounting for inflation, between 1990 and 1993 national expenditures grew at an average annual rate of 4.7 percent, compared with 5.7 percent between 1980 and 1990 and 5.4 percent between 1970 and 1980.

Marketplace changes may also help explain why private sector spending per person has, in recent years, grown more slowly than Medicare's spending per enrollee (see Figure 1-4). Medicare expenditures grew faster than private sector spending in the early 1980s. This pattern reversed in 1984—following PPS implementation—and continued through 1991. In 1992 and 1993, however, Medicare expenditures again were growing faster than those in the private sector.

Figure 1-3. Real Average Annual Change in National Health Expenditures, 1960-1993 (In Percent)



SOURCE: ProPAC analysis of national health expenditure data from the Health Care Financing Administration, Office of the Actuary.

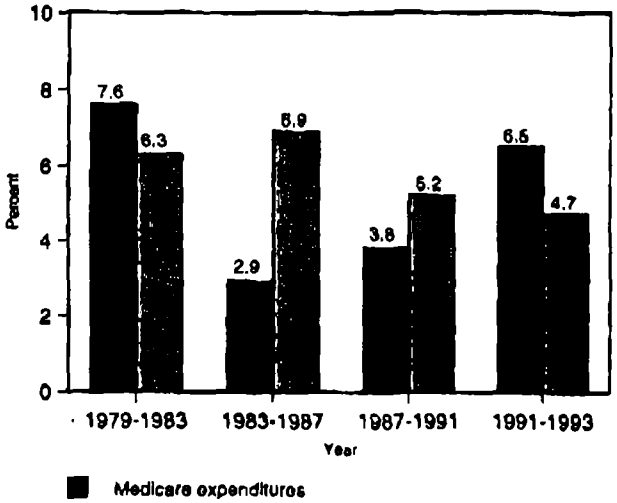
Spending growth rates for the different health care sectors have varied substantially in recent years. For example, overall hospital spending experienced the third lowest real increase since the beginning of the Medicare program, decelerating from an annual growth rate of 5.2 percent in 1992 to 3.6 percent in 1993.[15] Real spending for home health care continued growing the fastest—20.2 percent in 1993—although even this was lower than the 23.6 percent in 1992. Spending for physician services grew 2.8 percent after adjusting for inflation, compared with 4.5 percent in 1992.

Hospitals

Inpatient hospital care represents the largest share of health care spending. Payment policy changes and technological advances, however, have shifted many procedures to ambulatory settings, resulting in lower hospital occupancy rates and excess capacity. Insurers and managed care plans are taking advantage of these factors to pursue price discounts. Consequently, many hospitals are being pressured to lower their prices to more competitive levels, necessitating lower cost growth as well.

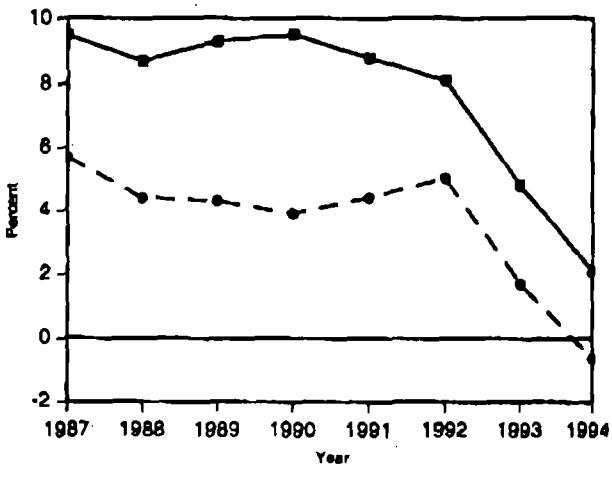
The dramatic decline in the growth of hospital costs over the past two years suggests that hospitals are adjusting to their changing financial environment (see Figure 1-5). From 1987 until 1992, hospital costs per case grew about 9 percent annually. In 1993, the rate dropped to 4.8 percent. This trend appears to have continued into 1994, with costs

Figure 1-4. Real Average Annual Change in Medicare Expenditures Per Enrollee and Private Health Insurance Expenditures Per Person, 1979-1993 (In Percent)



SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

Figure 1-5. Annual Change in Hospital Costs Per Adjusted Admission, 1987-1994 (In Percent)



* Value for January - September 1994 compared with same months in 1993.

SOURCE: American Hospital Association National Hospital Panel Survey.

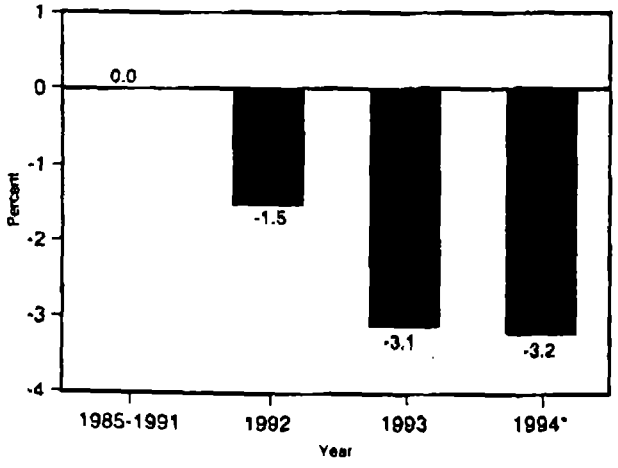
growing at a rate equivalent to 2.1 percent annually for the first nine months. The slowdown is even more striking when the effects of inflation are removed. Real cost growth fell from an annual rate of 5.0 percent in 1992 to 1.7 percent in 1993. In the first nine months of 1994, inflation-adjusted costs per case actually declined by 0.6 percent, compared with the same period in 1993.

Declines in average lengths of stay and slower employee wage growth appear to be key factors in the recent downward trend. After fluctuating slightly with no net change between 1985 and 1991, average length of stay fell 1.5 percent in 1992 (see Figure 1-6). This trend continued in 1993 and 1994, with additional stay reductions of slightly more than 3 percent in each year.

For many years, hospital wages grew faster than those for all civilian workers. This gap began to narrow in early 1993 (see Figure 1-7). By the end of that year, hospital wage increases fell below those in the rest of the economy. Since then, hospital wage growth has continued to slow. In the third quarter of 1994, average wages for hospital employees grew no faster than general inflation.

The recent downward trend in hospital cost growth is not unprecedented. Rates have slowed

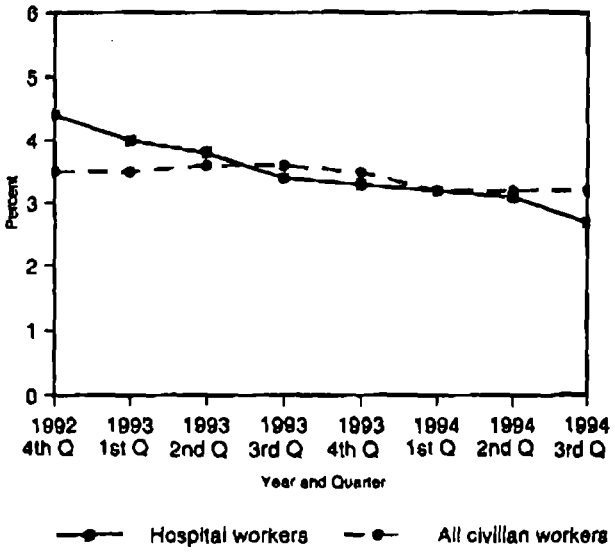
Figure 1-6. Average Annual Change in Length of Stay: 1985-1991 and 1992-1994 (In Percent)



* Value for January - September 1994 compared with same months in 1993.

SOURCE: American Hospital Association National Hospital Panel Survey.

Figure 1-7. Change in Hospital Workers' and All Civilian Workers' Compensation, 1992-1994 (In Percent)



Note: Each period compared with the same period in the previous year.

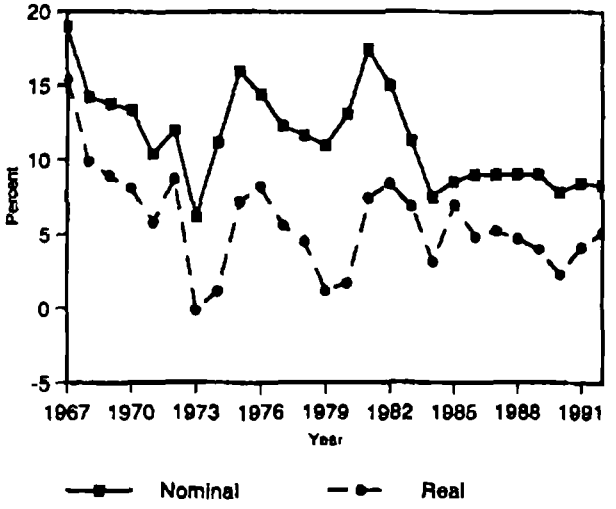
SOURCE: Department of Labor, Bureau of Labor Statistics.

dramatically several other times during the past 25 years, each time in response to an explicit government policy or cost-containment initiative (see Figure 1-8). For example, the steep decline in 1973 coincided with the Nixon Administration's economic stabilization program. Decreases in the late 1970s and early 1980s corresponded with implementation of the Carter Administration's voluntary hospital cost controls and Medicare's prospective payment system for hospitals, respectively. In each of these periods, however, when the explicit pressure was withdrawn or lessened, the slowdown did not continue. Similarly, because comprehensive Federal health care reform seems unlikely in the immediate future, the pressure to slow cost growth could diminish. Nonetheless, many believe that today's trend differs from earlier ones because of changes in the private insurance market that appear to be accelerating, rather than subsiding. Moreover, because the impetus is based on the marketplace, there is a greater likelihood that the pressure will be sustained.

Other Facilities

While inpatient hospital care continues to represent the largest share of total health care spending,

Figure 1-8. Annual Change in Hospital Costs Per Case, 1967-1992 (In Percent)



SOURCE: American Hospital Association Annual Survey of Hospitals.

Table 1-1. Medicare Home Health Care Utilization, 1980-1994

Year	Persons Served		Visits	
	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1980	726	26	16,322	22.5
1981	948	34	22,688	23.9
1982	1,154	40	30,628	26.5
1983	1,318	45	36,898	28.0
1984	1,498	50	40,422	27.0
1985	1,549	51	39,449	25.5
1986	1,571	51	38,000	24.2
1987	1,544	49	35,591	23.1
1988	1,582	49	37,132	23.6
1989	1,685	51	46,199	27.4
1990	1,940	58	69,565	35.9
1991	2,223	65	100,044	45.0
1992	2,523	72	134,844	53.4
1993	2,900	81	173,953	60.0
1994*	3,220	88	209,149	65.0

* Estimated

SOURCE: Health Care Financing Administration, Office of the Actuary.

payment policies and technological advances have shifted the site of care for a growing number of services to ambulatory settings, driving up spending in this area. In 1984, for example, 15 percent of hospital care was provided on an outpatient basis. By 1993, this share had increased to 23 percent.[16] Hospital outpatient spending grew 290 percent between 1984 and 1993, while hospital inpatient expenditures went up 82 percent.[17]

Spending for post-acute services also has grown rapidly, as patients increasingly are transferred to skilled nursing facilities, rehabilitation and long-term hospitals, and the home to recuperate from inpatient services or to be treated for chronic conditions. The rising use of these settings may result from several factors, including private sector incentives to treat patients in less costly sites as well as changes in Medicare payment and coverage policies.

Volume continues to play a major role in the growth of spending by these other health care providers. This is best exhibited by examining Medicare spending for home health services (see Table 1-1). Increases in the number of people receiving home health care and the number of visits for each person are primarily responsible for the rising spending for this service. In 1980, for every 1,000 Medicare enrollees, 26 received home health services. This figure nearly tripled by 1993, while the number of visits received by each person nearly doubled. Much of this growth was associated with changes in coverage policies. Increases in the numbers of users and services provided per user also have driven much of Medicare's higher spending for skilled nursing facility care (see Table 1-2). Dialysis for end-stage renal disease and certain outpatient procedures demonstrate a similar—though less pronounced—pattern.

MEDICARE IN THE CHANGING MARKETPLACE

The changes in the health care marketplace will undoubtedly affect the Medicare program. Medicare is a major player in the health care arena, responsible in 1994 for the health care services of some 36 million people at an annual cost of about $150 billion.[18] Although the program's payment policies are distinct from those of private payers, the cost of providing care to Medicare beneficiaries—particularly for hospital services—has been linked to private sector payments through cost shifting. Financial constraints in the private sector may affect this relationship. In addition, there is an increasing divergence between Medicare's payment

Table 1-2. Medicare Skilled Nursing Facility Utilization, 1980-1994

Year	Persons Served		Days	
	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1980	257	9	8,645	33.6
1981	251	9	8,518	33.9
1982	252	9	8,814	35.0
1983	265	9	9,314	35.1
1984	299	10	9,640	32.2
1985	314	10	8,927	28.4
1986	304	10	8,160	26.8
1987	293	9	7,445	25.4
1988	384	12	10,667	27.8
1989	636	19	27,780	43.7
1990	638	19	25,200	39.5
1991	671	20	23,700	35.3
1992	785	22	28,960	36.9
1993	870	24	34,437	39.6
1994*	925	25	36,865	39.9

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

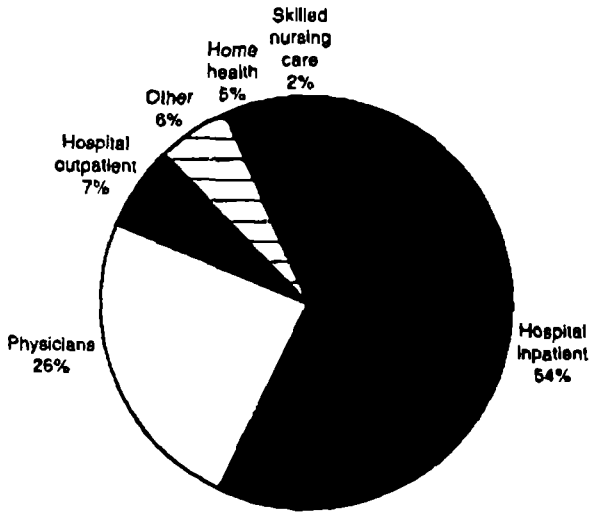
structure and those of a growing number of private payers. While Medicare offers its enrollees a managed care option, its primary payment method continues to be fee for service. The style of care provided to Medicare beneficiaries may change as providers alter their practice patterns to meet the incentives of a health care environment dominated by managed care.

Medicare Spending

The Medicare program is experiencing shifts in spending across provider types similar to those seen in the overall health care system. Although hospital inpatient payments continue to be Medicare's largest outlay, skilled nursing care and home health services account for disproportionate shares of overall Medicare spending growth (see Figures 1-9 and 1-10). In 1991, expenditures for skilled nursing care and home health services constituted 2 percent and 5 percent of total Medicare spending, respectively, yet they represented 11 percent and 17 percent of the increase in total Medicare expenditures between 1991 and 1993.

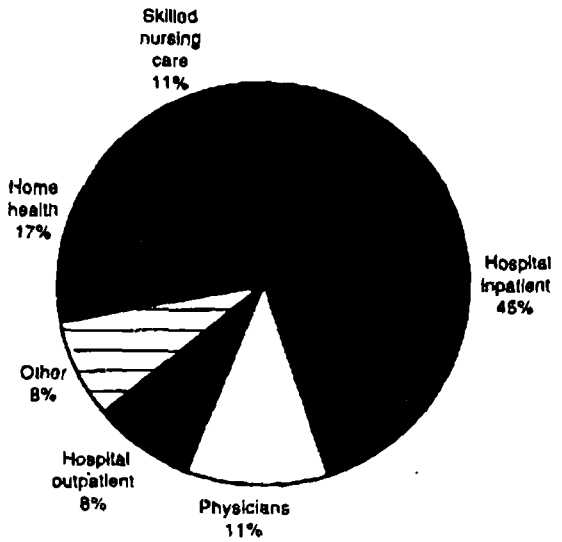
This significant shift in Medicare spending shares results from sustained spending increases for post-acute services. Between 1991 and 1993, real expenditures per enrollee for skilled nursing care rose almost 40 percent per year; those for home health care services grew just over 30 percent annually (see Figure 1-11). These growth rates reflect a combination of technological advances, modifications

Figure 1-9. Share of Total Medicare Spending, by Sector, 1991 (In Percent)



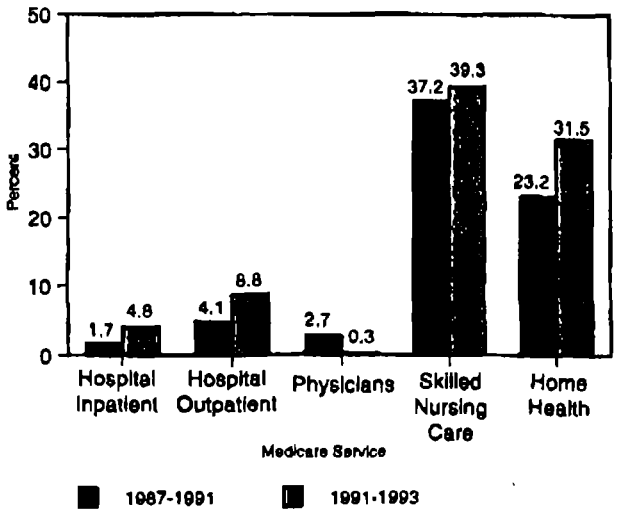
SOURCE: Health Care Financing Administration, Office of National Health Statistics.

Figure 1-10. Contributors to Increase in Medicare Spending, by Sector, 1991-1993 (In Percent)



Note: Increase in total Medicare expenditures = 25.4 percent.
SOURCE: Health Care Financing Administration, Office of National Health Statistics.

Figure 1-11. Real Average Annual Growth Rates Per Enrollee for Selected Medicare Services, 1987-1993 (In Percent)



SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

in physicians' practice patterns, and changes in Medicare's coverage policies. Further, even though Medicare's cost-based payment methodologies incorporate payment limits, they do not provide strong enough incentives to control costs.

Medicare's hospital payment policies are having an increasing impact on the financial condition of hospitals. Medicare represents a rising share of hospitals' total patient care. The number of Medicare enrollees is growing faster than the general population, and Medicare admissions per enrollee have not been decreasing as have those for the under-65 population. In 1980, Medicare revenues represented about 40 percent of hospitals' patient care costs; in 1992, this proportion rose to 43 percent.[19]

Future Medicare Hospital Payments and Costs

The slowdown in hospital cost growth, along with continued Federal budgetary pressures, has focused attention on further reducing the growth in Medicare payments for hospitals and other providers. As discussed earlier, for a number of years hospitals have offset increases in Medicare costs per case that exceeded Medicare payments by obtaining extra revenues from private insurers. In 1992, for example, Medicare payments were $11 billion less than the costs of treating program beneficiaries.[20] All of this deficit was offset by higher payments from private payers. Whether additional Medicare payment constraints can be imposed without exacerbating the pressure to cost shift depends on the rate of increase in both payments and costs.

PPS updates through fiscal year 1997 were set by the Omnibus Budget Reconciliation Act of 1993.[21] The actual payment increases received by hospitals, however, depend not only on these updates, but also on the growth in the Medicare case-mix index. ProPAC has estimated this increase to be 1.0 percent in fiscal year 1994 and 1.1 percent in fiscal year 1995. The Commission believes a level of 1.0 percent likely will be maintained through 1997 in the absence of major changes in the payment system.

Because it is impossible to predict whether the current cost slowdown will continue, ProPAC projected cost growth under three scenarios that it believes represent the range of likely increases in Medicare cost per case (see Table 1-3). A reasonable estimate of the upper end of the range after 1994 is 4.9 percent annually (equal to the projected increase in the PPS hospital market basket index plus 1.8 percentage points)—the level experienced in fiscal year 1992. This upper limit reflects the assumption that the combination of cost-containment pressure from the private sector and public concern about rising costs will prevent cost growth from escalating to the 8 percent to 9 percent level of the late 1980s.

The lower boundary on the future rate of cost increase is best represented by the cost growth through the first nine months of 1994, which was 2.1 percent.[22] In ProPAC's view, the hospital industry's response to these pressures is not likely to be any more intense in the future than it is today. Further, the current growth rate is actually less than inflation in the general economy. The intermediate range cost growth estimate for 1995 and beyond is based on the forecasted market basket increase plus an allowance for changes in the mix and complexity of hospital admissions. The Commission's best estimates of these variables through 1997 are 1.0 percent per year for real case-mix growth and 2.9 percent per year for the market basket increase.[23]

Table 1-3. Medicare PPS Per Case Payments Relative to Costs, Under Three Cost Growth Scenarios, Fiscal Years 1994-1997 (In Percent)

Variable	1994	1995	1996	1997	Average 1994-1997
Payment increase[a]	3.0%	3.1%	2.6%	4.2%	3.2%
Range of likely cost increase:					
High[b]	2.1	4.9	4.9	4.9	4.2
Intermediate[c]	2.1	3.8	4.0	4.1	3.5
Low[d]	2.1	2.1	2.1	2.1	2.1
Difference between payment and three alternative cost increases:					
High	-0.9	1.8	2.3	0.7	1.0
Intermediate	-0.9	0.7	1.4	-0.1	0.3
Low	-0.9	-1.0	-0.5	-2.1	-1.1

[a] Derived from the legislated update (which is the forecasted market basket increase less a prescribed number of percentage points) and ProPAC's estimate of case-mix index change.

[b] For 1994, based on the American Hospital Association National Hospital Panel Survey increase for the first nine months of 1994. For 1995 through 1997, assumes return to the per case increase in Medicare inpatient hospital costs experienced in fiscal year 1992.

[c] After 1994, based on the market basket increase (as forecasted by the Health Care Financing Administration in September 1994), plus increments for expected market basket forecast error correction and real case-mix growth (both as estimated by ProPAC).

[d] Assumes continuation of the 1994 experience.

SOURCE: ProPAC analysis.

The additional pressure to cost shift can be estimated by subtracting the Medicare payment increase from the cost increase each year. Medicare and the private sector account for approximately equal shares of hospital spending, 40 percent and 39 percent in 1992. Consequently, every percentage point of Medicare cost increase not reimbursed by the Medicare payment increase will, all else equal, translate into a percentage point of additional revenue needed from the private sector.

The unusually low 2.1 percent per case cost growth in fiscal year 1994 means that, for the first time since 1985, Medicare's payment increase will probably exceed the growth in costs. Further, if hospitals maintain cost growth at the current level for three more years, this situation would continue. Even under those circumstances, however, the difference between payment and cost increases is estimated at only 1.1 percentage points per year, so at best there could be only a modest reduction in the level of cost shifting from Medicare to the private sector. Moreover, pressures from rising uncompensated care losses, lagging Medicaid payment increases, and private sector payment constraint might prevent even this modest change from materializing. It should also be pointed out that even though the amount of cost shifting might be reduced slightly each year under this scenario, the amount hospitals spend to treat Medicare beneficiaries would still substantially exceed payments.[24]

If, alternatively, hospital cost growth follows the Commission's intermediate estimate, Medicare costs would continue to grow faster than payments. The uncovered cost increase would average about 0.3 percentage points annually from 1994 to 1997. This means that, to the extent private insurers would allow it, there would be additional cost shifting from Medicare to the private sector each year, and further reductions in the updates or other forms of scaling back payments would only exacerbate the problem. At the high end of the growth range for hospital costs, the legislated Medicare updates would increase the pressure to cost shift by 1.0 percentage point per year.[25]

The ability to use cost shifting to fill the revenue gap when Medicare cost increases exceed payment increases varies across hospitals. Facilities that treat larger shares of Medicare, Medicaid, and uninsured patients have a lesser ability to cost shift to the private sector. In view of growing price competition in the marketplace, these facilities will face

a greater risk of declining margins, which eventually could threaten their financial viability and their ability to care for Medicare beneficiaries.

Medicare and Managed Care

The growth of managed care in the private sector may have implications for the Medicare program and its beneficiaries. Currently, the primary methods used by Medicare for financing and delivering care have different incentives than those inherent in managed care. Most Medicare beneficiaries have a large choice of health care providers, which are paid on a fee-for-service basis. By contrast, managed care is premised on a limited number of providers that share financial risk for patients' overall use of health care services. The private sector's increasing focus on managing patients' overall health service use, rather than on distinct service units, likely will influence providers' overall practice patterns. This, in turn, will affect the care provided to all patients, including Medicare beneficiaries.

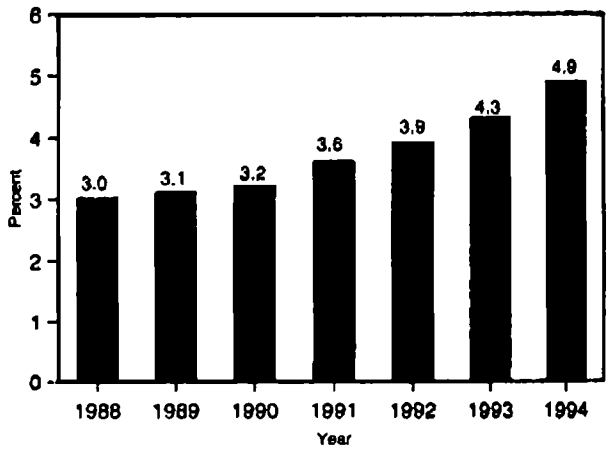
Medicare beneficiaries have the option to receive their health care through HMOs, but enrollment growth lags behind that seen in the private sector. Medicare has offered at least one managed care option since its inception. Initially, however, plans were paid on the basis of their costs. In 1982, Medicare introduced the risk contracting program, which most resembles private sector managed care. Under this program—the largest of Medicare's managed care initiatives—Medicare pays HMOs a capitated rate that is based on estimated Medicare fee-for-service spending.

Beneficiary enrollment in risk contracting plans has risen slightly since the late 1980s, from 3 percent of the total Medicare population in 1988 to almost 5 percent in 1994 (see Figure 1-12). This is a much smaller proportion, however, than the 19 percent enrollment in similar arrangements in the privately insured population. Geographically, enrollment in risk contracting plans parallels that in the private sector. States with large private sector HMO enrollments also have high Medicare HMO penetration.

CONCLUSIONS

Increased price competition is causing fundamental changes in the financing and delivery of

Figure 1-12. Medicare Beneficiaries Enrolled in Managed Care Risk Contracting Programs, 1988-1994 (In Percent)



SOURCE: Health Care Financing Administration, Office of Managed Care.

care. Insurers are negotiating larger discounts from providers and increasingly managing where their subscribers obtain services. The growth in managed care arrangements reflects a heightened interest in controlling overall expenditures. Providers are responding to these competitive pressures by reconfiguring their relationships with each other as well as with payers to try to boost their market share. Whether these changes will influence quality of care will depend on the extent of cost-containment efforts, the services that are affected, and the need for and effectiveness of those services.

The financial pressures in the health care marketplace already seem to be working. Health care spending shows signs of moderating. Further, after accounting for inflation, hospital per case costs actually declined in 1994. The distribution of expenditures across health care sectors also is shifting. The hospital inpatient setting accounts for a smaller share of total health spending, with utilization moving to less intensive sites such as ambulatory settings and post-acute care facilities. Even though services may be less expensive in these alternative sites, higher utilization is driving up spending.

Medicare has managed to control its hospital expenditures by limiting its payment updates through PPS. By relying on greater revenues from

private payers, hospitals have, in aggregate, managed to offset increases in Medicare costs per case that exceeded payment increases. Two trends—greater price consciousness and slower hospital cost growth—will affect hospitals' ability and need to cost shift. If cost growth remains at the low levels of 1994, there could be modest reductions in the need for cost shifting. On the other hand, if costs grow at an intermediate level—between current and historical rates—cost-shifting pressures may continue to increase. There are concerns, however, that private payers will not continue to support even existing levels of subsidies. Particularly as payers receive larger discounts from providers and facilities compete to enlarge their market share, certain hospitals, such as those serving large numbers of Medicare, Medicaid, and uninsured patients, will be less able to rely on cost shifting to maintain their financial position.

Profound changes are taking place in the health care marketplace. It is too early to assess the impact of these changes, but there is one certainty. Restructuring the relationships among payers and providers will have a lasting influence on the way health care is delivered and financed in this country.

Notes to Chapter 1

1. Data provided by the Health Care Financing Administration, Office of the Actuary.

2. Ibid.

3. Data provided by the Group Health Association of America and the Department of Labor, Bureau of Labor Statistics.

4. "Employee Benefits in Medium and Large Private Establishments, 1991." Bulletin 2422, Department of Labor, Bureau of Labor Statistics, May 1993; and Department of Labor News Release, USDL: 94-477, September 30, 1994.

5. "Employee Benefits in Small Private Establishments, 1992." Bulletin 2441, Department of Labor, Bureau of Labor Statistics, May 1994; and "Employee Benefits in Small Private Establishments, 1990." Bulletin 2388, Department of Labor, Bureau of Labor Statistics, September 1991.

6. Department of Labor News Release, USDL: 94-477, September 30, 1994.

7. Under case management, a fee-for-service payment system is retained, but patients must obtain prior approval for specialized services from a primary care physician, who receives an additional fee to monitor an individual's service use.

8. Data provided by the Health Care Financing Administration, Office of Managed Care.

9. Bureau of the Census, "Statistical Brief: Health Insurance Coverage—1993," October 1994.

10. Chris Haffner-Eaton, "Physician Utilization Disparities Between the Uninsured and the Insured: Comparisons of the Chronically Ill, Acutely Ill, and Well Nonelderly Populations," *Journal of the American Medical Association* 269(6):787-92, February 10, 1993; Beth Hahn and Doris Lefkowitz, *Annual Expenses and Sources of Payment for Health Care Services*, National Medical Expenditure Survey Research Findings 14, AHCPR Pub. No. 93-0007 (Rockville, MD: U.S. Public Health Service, November 1992).

11. Jack Hadley, Earl P. Steinberg, and Judith Feder, "Comparison of Uninsured and Privately Insured Hospital Patients," *Journal of the American Medical Association* 265(3):374-79, January 16, 1991; Joel S. Weissman and others, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association* 268 (17):2388-94, November 4, 1992; John Z. Ayanian and others, "The Relation Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer," *New England Journal of Medicine* 329(5):326-31, July 29, 1993.

12. Albert L. Siu and others, "Use of the Hospital in a Randomized Trial of Prepaid Care," *Journal of the American Medical Association* 259(9):1343-46, March 4, 1988; Jane McCusker, Anne M. Stoddard, and Andrew A. Sorensen, "Do HMOs Reduce Hospitalization of Terminal Cancer Patients?" *Inquiry* 25(2):263-70, Summer 1988; Sheldon Greenfield and others, "Variations in Resource Utilization Among Medical Specialties and Systems of Care," *Journal of the American Medical Association* 267(12):1624-30, March 25, 1992; and Robert H. Miller and Harold S. Luft, "Managed Care Plan Performance Since 1980: A Literature Analysis," *Journal of the American Medical Association* 271(19):1512-19, May 18, 1994.

13. Mark C. Hornbrook and Sylvester E. Berki, "Practice Mode and Payment Method: Effects on Use, Costs, Quality, and Access" *Medical Care* 23(5):485-511, May 1985; Alan N. Johnson and others, "Differences in Inpatient Resource Use by Type of Health Plan," *Inquiry* 26(3):388-98, Fall 1989; Robert H. Brook and others, "Quality of Ambulatory Care: Epidemiology and Comparison by Insurance Status and Income," *Medical Care* 28(5):392-433, May 1990; and James P. Murray and others, "Ambulatory Testing for Capitation and Fee-for-Service Patients in the Same Practice Setting: Relationship to Outcomes," *Medical Care* 30(3):252-61, March 1992.

14. Sherman Folland and Miron Stano, "Small Area Variations: A Critical Review of Propositions, Methods, and Evidence," *Medical Care Review* 47(4):419-65, Winter 1990; Jose J. Escarce and others, "Racial Differences in the Elderly's Use of Medical Procedures and Diagnostic Tests," *American Journal of Public Health* 83(7):948-54, July 1993.

15. ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary. The two lower real increases were in 1984 and 1985, the first two years of PPS.

16. Data provided by the Health Care Financing Administration, Office of the Actuary.

17. ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

18. Data provided by the Health Care Financing Administration, Office of the Actuary.

19. Ibid.

20. ProPAC analysis of data provided by the American Hospital Association.

21. The updates are 2.0 percent in both fiscal years 1994 and 1995 and, based on current forecasts, estimated at 1.6 percent in 1996 and 3.2 percent in 1997.

22. Data from the American Hospital Association National Hospital Panel Survey covering January through September 1994.

23. The latest forecast of the increase in the PPS market basket index averages 3.5 percent from 1995 through 1997. However, in recent years the forecasts have turned out to be higher than the actual increase. Even though HCFA's forecasts have recently been revised downward, ProPAC believes they may still prove to be too high and thus lowered them by 0.6 percentage points each year for purposes of estimating future cost per case growth. The unadjusted forecast was used in estimating payment updates, however, in accordance with current law.

24. In 1992, $10.8 billion of Medicare losses were cost shifted to the private sector. Under the low cost growth scenario, this amount would have been reduced by only $0.7 billion, or 6.5 percent of the total.

25. If HMO penetration in the private sector increases dramatically over the next three years, hospital inpatient service use might decline because patients with less complex conditions would most likely be treated on an outpatient basis. While this would create savings in the private sector, it also would elevate costs per case because hospitals' fixed expenses (for example, equipment and management salaries) would have to be spread over fewer cases. Additionally, the remaining patient mix would be sicker and therefore costlier. This situation would increase the probability of the highest of the three per case cost growth scenarios occurring.

Background

Between 1980 and 1993, health care spending increased from 9 percent of the nation's domestic output to nearly 14 percent. At the same time, in an effort to contain federal health costs, Medicare implemented several payment policy changes, including the prospective payment system for inpatient hospital care. While these changes slowed Medicare inpatient hospital payments, hospital costs continued to grow at higher rates. Unable to meet their costs with Medicare payments, "many hospitals generated larger revenue surpluses from private insurers, a practice commonly known as cost shifting." (Report and Recommendations to Congress, Prospective Payment Assessment Commission, March 1, 1995) According to ProPAC, in 1992, Medicare payments were $11 billion less than the costs of treating beneficiaries. This entire amount was offset by higher payments from private payers. Quite simply, in ProPAC's words, "every percentage point of Medicare cost increase will, all else equal, translate into a percentage point of additional revenue needed form the private sector.

As ProPAC noted, "[w]hether additional Medicare payment constraints can be imposed without exacerbating the pressure to cost shift depends on the rate of increase in both payments and costs.

Cost shifting from the Medicare to the private sector will be exacerbated

FAX TRANSMITTAL SHEET

TO: Jennifer Klein
456-2878

FROM: Jon Orszag

DATE: June 2, 95 TIME: 4:15 pm

PAGE NUMBER ONE OF 19 PAGES

ADDITIONAL COMMENTS:

TRANSMITTER TELECOPIER: (202) 219-4902
IF YOU HAVE QUESTIONS REGARDING THIS FAX CALL
202-219-5108.

AN ANALYSIS OF CONGRESSMAN GEPHARDT'S HEALTH PROPOSAL

December 27, 1994

The Congress of the United States
Congressional Budget Office

INTRODUCTION

The Congressional Budget Office (CBO) and the Joint Committee on Taxation have prepared this analysis of House Majority Leader Richard Gephardt's health proposal. The analysis is based on the text of the proposal as printed in the *Congressional Record* on August 10 and on subsequent revisions specified by the Leader's staff. It comprises a review of the financial impact of the proposal and a brief assessment of its economic effects and factors that could affect its implementation.

FINANCIAL IMPACT OF THE PROPOSAL

Congressman Gephardt's proposal would assure universal health insurance coverage with a guaranteed package of benefits. People not eligible for the existing Medicare program (Hospital Insurance and Supplementary Medical Insurance, Medicare Parts A and B) would be required to enroll in a private health plan or in a new public program (Medicare Part C). Employers would be required to offer health insurance coverage to their workers and would generally be required to pay 80 percent of the premiums. Individuals would be required to pay that portion of the premium not covered by their employer, but low-income people would be eligible for federal subsidies.

Medicare Part C would replace the current Medicaid program for acute health care services. Benefits under the current Medicare program would be enhanced by adding some new benefits and expanding others. Spending for all parts of Medicare would be subject to stringent limits on growth.

The estimated federal budgetary effects of Congressman Gephardt's proposal are displayed in Table 1 at the end of this document. Tables 2 and 3 show its effects on the budgets of state and local governments and national health expenditures, respectively. In the process of extending health insurance coverage to the entire population, the proposal would significantly increase national health expenditures. The estimated changes in mandatory spending, revenues, and the discretionary spending limits, however, would not add to the federal budget deficit.

Coverage and Benefits

Congressman Gephardt's proposal would achieve universal health insurance coverage by requiring people to purchase health insurance for themselves and their families starting in 1999. People not enrolled in Medicare Part A could obtain coverage by enrolling in Medicare Part C or in a certified health plan offered by their employer or purchased individually. The mandate on

individuals would be accompanied by a mandate on employers requiring them to offer coverage to employees and their dependents and to contribute at least 80 percent of the cost of that coverage.

Certified health plans and Medicare Part C would both offer a guaranteed national benefit package. That package would include the benefits currently covered under Medicare plus several enhancements, including unlimited hospital care without coinsurance, a prescription drug benefit, and a cap on out-of-pocket spending. The annual deductible amount would be $500 for an individual and $750 for a family (indexed after 1994), with a separate $500 deductible for prescription drugs.

The Congressional Research Service and CBO estimate that such a benefit package would initially be 3 percent more costly than the average benefit package of privately insured people today. This estimate assumes that the management of services for mental illness would hold the cost of the expanded mental health benefit to the levels projected under the current system. To cover benefits not included in the guaranteed benefit package, individuals and employers could purchase a standardized package of supplemental insurance; they could choose from up to 10 such packages.

Employers' Responsibilities

The proposal would impose different requirements on large and small firms. Within a firm, the requirements would vary with the characteristics of the workers and their families.

Beginning in 1997, large firms (those with more than 100 employees) would be required to offer qualified employees a choice of at least one managed care plan (if available) and one health plan with an unlimited choice of providers. Those firms would generally be required to pay at least 80 percent of the cost of the plan for each enrollee, with payment prorated for employees working less than 35 hours a week. Beginning in 1999, small firms would be required to offer their full-time workers Medicare Part C or a choice of private health plans, and would generally pay 80 percent of the premium. They could, however, be eligible for a temporary tax credit that would defray part of the cost.

Employers offering a choice of private health plans could, but would not have to, enroll certain part-time or seasonal workers in those plans. If they did not, they would be required to pay 80 percent of the Medicare Part C premium for qualified workers who earned more than $100 a month. The contribution would be prorated according to the number of hours worked.

Employers could also offer an alternative benefit package that combined a high-deductible version of the guaranteed benefit package and a tax-favored medical savings account. Employers would not be required to offer high-deductible plans to their workers, and workers covered under Medicare or receiving a premium subsidy would be ineligible for the option, even if their employer offered it.

Married couples with children and with both spouses working could choose to purchase health insurance through either spouse's employer, termed the enrolling employer. Married couples without children could designate one employer as the enrolling employer or could enroll separately as individuals. For each worker who obtained coverage through a spouse, the nonenrolling employer would be subject to a tax equal to 80 percent of the Medicare Part C premium for a single individual. After a phase-in period, that tax would ultimately be rebated to employers who paid premiums for two-parent families. (CBO also assumed that the credit would be available to employers of any married workers whose spouses did not work.) For the first few years, however, a significant portion of the revenue from the tax would be retained by the Treasury.

Changes in the Insurance Market

Congressman Gephardt's proposal would change the market for health insurance in several ways that would become fully effective in 1999, when the individual mandate came into force. In the meantime, various transitional rules would apply.

Health plans would be required to sell coverage to all eligible individuals and groups and provide for an annual period of open enrollment. They would be prohibited from excluding or limiting coverage on the basis of preexisting conditions and from imposing waiting periods for coverage. Plans other than group- and staff-model health maintenance organizations would be required to include in their network any health care provider that was willing to accept the plan's terms for participation. All plans would be required to contract with an extensive list of "essential community providers." National quality standards for health plans would be established, and each plan would be evaluated annually with respect to access to care, effectiveness and appropriateness of care, and consumers' experience and satisfaction. An individual or a health care provider would be able to bring legal action against a health plan for failure to comply with the terms of the plan or with federal or state law.

In effect, the market for health insurance would be divided into three sectors: Medicare Part C, a large-employer market, and a community-rated market. Individuals and small firms that did not participate in Medicare Part C would purchase insurance in the community-rating area in which they were located. Small employers and multiple-employer welfare associations would be prohibited from self-insuring. Associations meeting federal standards would be allowed to sell community-rated insurance plans to their members. Within the community-rated market, premiums could vary only by class of enrollment (single adult, one-parent family, or two-parent family). A risk-adjustment mechanism would be developed to even out risks among insurance plans in the community-rated market, but no adjustment of risks would be made among the three market sectors.

Small employers and eligible individuals could also obtain coverage through a new universal Federal Employees Health Benefits Program (universal FEHBP), which would contract with and offer a variety of health plans in each community-rated market. Plans offered through the universal FEHBP would charge enrollees the same premiums as they charged others in the community-rated market but could offer an administrative discount. Federal employees would be fully integrated into the universal FEHBP after a seven-year transition period, which could start no earlier than 2000. Initially, federal employees would remain in the existing FEHBP, but the benefits would be conformed to the guaranteed national benefit package and the government's average contribution would increase to reflect the provisions of the mandate on employers. In the fifth through seventh years of the transition period, federal employees could enroll in either the current program or the universal FEHBP.

States would have considerable flexibility to set up their own health reform programs as long as they assured universal coverage, provided the guaranteed national benefit package, and controlled costs. They could establish a single-payer system, voluntary or mandatory consumer purchasing cooperatives, or an all-payer system to reimburse health care providers.

Medicaid

Medicaid would no longer cover acute care services, except for emergency benefits for illegal aliens through 2001, but would continue to cover long-term care. States would be required to make maintenance-of-effort payments to the federal government based on the amount by which their Medicaid spending was reduced. The maintenance-of-effort amounts would be computed separately for Medicaid beneficiaries who received benefits from Supplemental Security Income (SSI) or Aid to Families with Dependent

Children (AFDC) and for those who did not receive cash benefits. States would pay 100 percent of the full maintenance-of-effort amounts in 1999 through 2001, 96 percent in 2002 and 2003, and 86 percent thereafter.

Medicare Parts A and B

The existing Medicare program (Parts A and B) would be expanded by adding a prescription drug benefit and various preventive benefits, increasing coverage of mental health services, eliminating the lifetime limit on inpatient hospital days, and capping out-of-pocket expenditures starting in 2004. Savings would be achieved by imposing 20 percent coinsurance on home health services, reducing disproportionate share adjustments for hospitals, scaling back payments for the indirect costs of medical education, and making other, smaller changes. The rate of growth of Medicare spending would also be tightly limited, as described below.

Medicare Part C

Medicare Part C would begin in 1999. Net of subsidies for low-income families, the program would be financed largely by premiums paid by enrollees and their employers. For the first four years, however, premiums would be established under the assumption that 60 percent of the eligible population was enrolled in the program.[1] Also, disabled SSI recipients would be excluded in calculating the premium. General revenues would be used to make up the shortfall resulting from these two constraints on premiums.

Enrollment in Part C would be open only to people (and their families) who did not work full time, worked full time for a small employer that did not offer coverage under a private certified health plan, worked for a small employer and were eligible for a federal subsidy of their premium, or received benefits from SSI or AFDC. Alternatively, nonworking people, subsidized employees of small firms, and SSI or AFDC recipients could enroll in a certified health plan offered in the community-rated market.

Because no one would be required to enroll in Medicare Part C, estimating the number of people covered by the program, their use of health care services, and the required premiums is particularly difficult. The estimates assume that 80 percent of nonworking people and former Medicaid beneficiaries and 50 percent of people connected to small firms and part-time

1. This percentage is lower than the percentage in the bill and reflects a revised CBO estimate of the long-run rate of enrollment in Medicare Part C.

employees in large firms would ultimately enroll in the program. They also assume that the participation rate of small employers, some of whom might initially be reluctant to enter the new public program, would rise from 10 percent in 1999 to 50 percent in 2004.

Reimbursement of health care providers under Medicare Part C would follow the approaches currently used by Medicare Parts A and B. The estimates assume that Medicare payments would initially be 10 percent below the amounts that would be paid on behalf of Part C enrollees if they had private insurance. Under these assumptions, the estimated average premiums in 1994 for the three classes of enrollment are as follows:

	Medicare Part C	Outside Medicare
Single Adult	$2,221	$2,316
One-Parent Family	$4,331	$4,515
Two-Parent Family	$5,886	$6,136

With similar premiums inside and outside Medicare, as the estimates assume, private health insurance could continue to compete and coexist alongside Medicare Part C. Such a scenario would also require premiums inside and outside Part C to have similar rates of growth. If Part C became the insurer for disproportionate numbers of high-risk people, its premiums could soar and it could end up dealing with a smaller group of high-cost enrollees, much like the present Medicaid program. At the other extreme, if premiums for Medicare Part C were low and small employers wished to simplify their administrative costs for insurance by not offering private insurance, Part C could become dominant and drive private health insurance out of the small-group market. Neither of these alternative outcomes can be ruled out.

Cost Containment

The proposal would set target rates of growth for the Medicare program (Parts A, B, and C, together) and for the private sector. It would set Medicare's payment rates accordingly and would establish a standby system of cost containment for the private sector.

Medicare's cost controls would go into effect in 1996 for Parts A and B and in 1999 for Part C. The target for total Medicare spending per capita would increase by the rate of growth of gross domestic product (GDP) per capita plus 1.8 percentage points in 1996 and by lesser amounts thereafter. In 2000 and beyond, the target would increase by the five-year average rate

of growth of GDP per capita. The per capita estimates would be allocated among 10 or more classes of health care services using complex procedures specified in the proposal. The Secretary of Health and Human Services (HHS) would set reimbursement rates for providers, with the goal of meeting the targets.

Spending targets would also be established for the private sector. The per capita targets would be allocated by class of service, as in Medicare, and by state of residence, and the Secretary of HHS would determine maximum payment rates that corresponded to the targets. The maximum payment rates would be only advisory through 2000. Starting in 2001, however, they would become mandatory in states that exceeded their per capita spending target.

The Congressional Budget Office believes that expenditure limits enforced by rate setting could be reasonably but not totally effective in controlling Medicare spending. The Health Care Financing Administration collects most of the data necessary to set rates and track spending relative to the targeted amounts for Parts A and B. It also has considerable experience in setting payment rates and estimating the responses of providers. Nonetheless, the history of cost control efforts both in this country and abroad strongly suggests that setting payment rates is not sufficient for achieving full control over health expenditures.[2]

CBO's estimates assume that the limits on Medicare spending would ultimately prove to be 75 percent effective and that providers would shift one-fourth of the Medicare savings to private payers. Although the limits would apply jointly to Parts A, B, and C, initially they would probably be more successful in Parts A and B than in Part C, which would be new and untested. In Parts A and B, the 75 percent rate of effectiveness is assumed to apply from the start. In Part C, however, the maximum rate would be reached only gradually, as the quality of data improved and experience with the program grew. The estimates assume that the expenditure limits in Part C would be ineffective in 1999 and 2000, 25 percent effective in 2001 and 2002, and 50 percent effective in 2003 and 2004.

The limits on non-Medicare spending are more likely to be breached and to be less effective. The task of establishing a reporting system for national health expenditures as specified in the proposal would be formidable. States would be permitted to operate their own payment systems as long as the growth in health care spending did not exceed what it would have been under the maximum rates--a difficult calculation to make. The estimates

2. See Congressional Budget Office, *Estimates of Health Care Proposals from the 102nd Congress*, CBO Paper (July 1993).

assume that the limits on private health spending would be ineffective in 2001 through 2003 and 25 percent effective in 2004.

Low-Income Assistance

The proposal would offer three types of low-income assistance: premium subsidies, cost-sharing subsidies, and wraparound benefits.

Premium Subsidies. Low-income people would be eligible for federal subsidies to reduce their liability for health insurance premiums. Qualified Medicare beneficiaries--those with income up to 120 percent of the poverty level--would be eligible for special subsidies for Part B premiums. (Currently, Medicaid pays those premiums for qualified Medicare beneficiaries.) Temporary subsidies would be provided to certain early retirees and to employers required to pay for the health benefits of retirees. Small firms with low average wages would be eligible for a tax credit.

A family with modified adjusted gross income (AGI) below a threshold (approximately equal to the federal poverty level) would receive a subsidy equal to its portion of the Medicare Part C premium. From 1999 through 2001, the subsidy would phase out between 100 percent and 200 percent of poverty. The upper limit of the phaseout range would increase to 220 percent of the poverty level in 2002 and to 240 percent in 2004 and thereafter. People participating in Part C would have their tax liability reduced. People participating in certified health plans would be given a premium certificate, or voucher, equal to the appropriate percentage of the premium for Part C or the certified health plan, whichever was lower.

In addition to receiving any regular premium subsidies for which they were eligible, certain early retirees would have their premium liability limited to a percentage of modified AGI. The provision would apply to people ages 55 to 64 in 1994 who did not work full time and had income below $30,000 for an individual and $40,000 for a couple. The cap would equal 7 percent of modified AGI in 1997 and 1998 and fall to 4 percent in 2001 and thereafter. As a result of this provision, the federal government could pay 50 percent or more of the costs of health insurance for some early retirees who would not otherwise have received subsidies. Moreover, similar retirees who were not members of the specified age cohort would receive no additional financial assistance from the government.

Employers who paid anything for retirees' health coverage in January 1994 would be required to make maintenance-of-effort payments and would be eligible for special subsidies. Employers subject to this requirement would

have to pay 80 percent of the cost of coverage (or 80 percent of the Part C premium, if less) for all retirees ages 55 to 64 in 1994 and their dependents, regardless of the amount they previously paid. Such employers would be eligible for a federal subsidy, however, equal to 40 percent of the applicable Part C premium.

From 1999 through 2005, small firms with low average wages would be eligible for a tax credit to reduce their liability for the costs of health insurance. Employers with no more than 25 employees and an average wage of no more than $14,000 per full-time-equivalent employee would receive a credit of 50 percent in 1999 through 2003, 30 percent in 2004, 15 percent in 2005, and nothing thereafter. For employers with 26 through 50 employees, the credit would equal 37.5 percent in 1999 through 2003, 20 percent in 2004, and 10 percent in 2005. The credit would be reduced proportionately for small employers with an average wage between $14,000 and $26,000.

Cost-Sharing Subsidies and Wraparound Benefits. Cost-sharing subsidies would be available to qualified Medicare beneficiaries as under current policy. Qualified Medicare beneficiaries with income below 100 percent of the poverty level would receive assistance for paying deductibles and coinsurance under Parts A and B of Medicare.

Cost-sharing subsidies and wraparound benefits would also be provided for other people with income below the poverty level, children and pregnant women with income below twice the poverty level, and AFDC and SSI recipients. Those beneficiaries would be relieved of all cost-sharing requirements, and payments would be made to certified health plans based on the cost-sharing amounts for Medicare Part C. In addition, those beneficiaries would receive wraparound benefits--that is, benefits not included in the guaranteed benefit package. Among those benefits would be early and periodic screening, diagnostic, and treatment services for children and vision and hearing care for adults. CBO's estimates assume that children covered by this provision would receive benefits equivalent to those currently provided by Medicaid.

Other Spending and Revenues

The proposal would increase spending on various public health programs, establish a capped entitlement program to provide grants to states for long-term care, and provide for enrollment in certified health plans offered by the Department of Veterans Affairs and the Indian Health Service. Outlays for Social Security retirement benefits would increase slightly because the assurance of access to health insurance and the provision of subsidies to low-

CBO PAPERS

RESPONSES TO UNCOMPENSATED CARE AND PUBLIC-PROGRAM CONTROLS ON SPENDING: DO HOSPITALS "COST SHIFT"?

May 1993

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

NOTES

Unless otherwise indicated, all years referred to in this paper are calendar years.

Numbers in the text, tables, and figures may not add to totals because of rounding.

PREFACE

This Congressional Budget Office (CBO) paper examines the extent to which hospitals were able to cover their costs of uncompensated care and their unreimbursed costs of treating Medicare and Medicaid patients during the 1980s with subsidies from state and local governments, revenues from sources other than patient care, and higher charges to private payers. The paper was prepared in response to requests from the Senate Committee on Finance and the Subcommittee on Health of the House Committee on Ways and Means. In accordance with CBO's mandate to provide objective and impartial analysis, the paper contains no recommendations.

Harriet L. Komisar of CBO's Human Resources and Community Development Division prepared this paper under the direction of Nancy Gordon and Kathryn Langwell. Susan Hilton Labovich provided computer programming assistance, and Julia C. Jacobsen provided research assistance. Computing support was also provided by Brian Rowland, Ben Steffen, and Pierre Verroye at ARC Professional Services Group.

The primary data used for the paper come from the American Hospital Association's (AHA's) Annual Survey of Hospitals. CBO gratefully acknowledges the assistance of the numerous hospitals that permitted CBO to use the financial data collected in the survey and the assistance of the AHA in making these data available to CBO.

Jack Ashby, Alan Fairbank, T.H. Gindling, Jim Highland, Peter Kralovec, Jeff Lemieux, Jay Noell, and Murray N. Ross provided valuable comments. Chris Spoor edited the manuscript, and Leah Mazade provided editorial support. Sharon Corbin-Jallow provided administrative assistance and prepared the final version of the paper.

Robert D. Reischauer
Director

May 1993

CONTENTS

TABLES (continued)

FIGURES

SUMMARY

During the 1980s, the revenues that hospitals received for treating Medicare and Medicaid patients declined, on average, relative to what it cost hospitals to treat those patients. For Medicare, the costs that hospitals incurred grew more rapidly than payments between 1985 and 1991. For Medicaid, the ratio of revenues to costs declined throughout the 1980s, but increased somewhat after 1989. In 1991, revenues from Medicare--which account for about one-third of hospitals' total revenues--were equal to 88 percent of the associated costs incurred by hospitals. Revenues from Medicaid were equal to approximately 82 percent of the associated costs.

Hospitals' costs of uncompensated care (charity care and bad debt) generally also increased during the 1980s. As a result of these trends, hospitals' total unreimbursed costs from uncompensated care and publicly insured patients rose from an average of about 7 percent of hospitals' total costs during the first half of the 1980s to 11 percent in 1989, and to nearly 13 percent in 1991.

During the 1980s, hospitals were able to cover most of their unreimbursed costs with revenues from three sources: subsidies from state and local governments; sources other than patient care, such as revenues from parking facilities and donations; and revenues from private patients. The portion of unreimbursed costs that hospitals recovered was relatively constant over the 1980-1989 period, averaging about 94 percent. (Since excess revenues at one hospital cannot offset losses at another, this amount is less than 100 percent, even though for the industry as a whole total revenues were greater than total costs throughout the period.)

The contributions of the different sources used to cover unreimbursed costs changed over time. The share of unreimbursed costs offset by private payers increased from 37 percent in 1980 to 55 percent in 1989, and the proportion offset by state and local subsidies decreased from 27 percent in 1980 to 10 percent in 1989.

Hospitals offset most of the rise in unreimbursed costs during the 1980s by generating higher revenues from private payers, a practice commonly known as "cost shifting." The revenues from private payers that were used to cover unreimbursed costs increased over the period--from a 6 percent average markup over the costs of treating private patients in 1980 to a 15 percent

markup in 1989. (These amounts are a conservative estimate of the contributions of private payers to covering hospitals' unreimbursed costs, because the analytic method that produced the estimates fully exhausted all other sources of revenues before applying those from private payers.)

These results suggest that, in the current multiple-payer health care system, actions taken by one payer to control health spending can have a significant impact on spending by other payers--and therefore a more limited effect on total spending. As a consequence, in the absence of other changes, further attempts to control public-sector spending would probably produce additional cost shifting to the private sector, although it is not known whether past rates of cost shifting could continue.

CHAPTER I
INTRODUCTION

The effectiveness of any health reform plan will depend on how hospitals and other health care providers respond to the new incentives the plan creates. Estimating future responses always involves considerable uncertainty. But examining how providers responded to major changes in their incentives in the past can shed some light on the possible effects of future reform. The modifications made during the 1980s in the way Medicare and Medicaid pay for hospital services represent a recent major change in providers' incentives.

During the 1980s, Medicare and most state Medicaid programs replaced retrospective, cost-based reimbursement methods for inpatient care with prospective systems. Under retrospective reimbursement, hospitals are paid an amount based on the actual costs they incur in providing covered services, with the costs usually subject to certain tests of reasonableness. In contrast, prospective systems use predetermined reimbursement rates. For example, Medicare's prospective payment system (PPS), which started in 1983, pays a specified amount for each Medicare patient that varies according to the patient's diagnosis and treatment and certain characteristics of the hospital providing the care.

By October 1985, the Medicaid programs in more than 40 states were also using some form of prospective payment for hospitals, and by July 1991, all but four states' programs were doing so.[1] These systems vary. For example, some pay a fixed amount for each patient that is based on the hospital's actual costs in a past year and does not depend on the patient's diagnosis. Some others pay a specified amount that is based on the patient's diagnosis. Compared with retrospective, cost-based reimbursement, prospective systems give public programs more control over the rates they pay. Such systems also provide greater incentives for hospitals to control their costs and deliver care efficiently.

Evidence indicates that the growth in hospital costs slowed in 1984 and 1985 compared with earlier years, after adjusting for inflation. Since then, however, the rate of growth has increased to levels only slightly lower than those of the early 1980s. For Medicare, the growth in the costs that hospitals incurred in treating covered patients exceeded the growth in payments between

1. Prospective Payment Assessment Commission, *Medicaid Hospital Payment*, Congressional Report C-91-02 (October 1, 1991).

1986 and 1991 (the most recent year for which data are available). As a result, even though hospitals' Medicare revenues were greater than the associated costs during the early years of the PPS, by the end of the 1980s, Medicare revenues were less than those costs. Although generalizations about Medicaid are difficult to make because each state's program is different, Medicaid's payment rates also declined, on average, during the 1980s relative to what it cost hospitals to treat Medicaid patients. Since 1989, however, the rates have increased somewhat relative to the costs. Between 1987 and 1991, hospitals' total unreimbursed costs associated with treating publicly insured patients increased rapidly.

The uncompensated care that hospitals provide also increased during the 1980s. Between 1986 and 1988, the cost of uncompensated care (charity care plus bad debt) represented an average of 6.5 percent of the industry's total costs, compared with an average of 5.4 percent between 1980 and 1985. From 1989 through 1991, uncompensated care was about 6 percent of hospitals' total costs.

Despite these trends, the financial condition of hospitals has remained relatively stable. Between 1987 and 1991, the total revenue margin for community hospitals fluctuated between 3.3 percent and 4.3 percent, compared with a range of 5.1 percent to 6.0 percent between 1984 and 1986, and a range of 3.6 percent to 4.2 percent in the early 1980s.[2] Based on this pattern, many observers believe that one way hospitals responded to controls on reimbursements by Medicare and Medicaid was by increasing the prices they charged privately insured patients--a practice commonly known as "cost shifting."

BACKGROUND

In general, cost shifting refers to the supposed practice by hospitals or other health care providers of raising the amounts charged to some groups of patients in order to offset lower amounts paid by other groups.[3] Most hospitals, for example, provide some care free of charge to patients who are unable to pay for it, and hospitals generally use private contributions and

2. The total revenue margin is defined as the difference between total revenues and costs for all hospitals, expressed as a percentage of total revenues. See Appendix B, Figure B-1.

3. Throughout this paper, unless otherwise stated, "amounts charged" and "prices" refer to the effective prices after any discounts are applied.

subsidies from state and local governments to help finance this care. However, it is widely believed that, in order to subsidize charity care and bad debt, hospitals also set their prices higher than they otherwise would. In this way, some of the costs of uncompensated care are passed along (or shifted) to other patients--in particular, privately insured ones.

In addition to helping to cover the costs of uncompensated care, hospitals may also use some of the payments from privately insured patients to cover costs that are not fully reimbursed by Medicare and Medicaid. More generally, if a public program's payments are sufficient to cover its related costs but generate a lower "profit" than the hospital seeks, a hospital might charge private patients more than it otherwise would to achieve a desired overall revenue amount or profit margin.[4]

A key concern is that hospitals may link their prices to uncompensated care or government payment rates. In particular, if a hospital raises its rates because its volume of uncompensated care has increased or its revenues from government programs have fallen relative to the costs of treating those programs' patients, this response is described as cost shifting. It is actually pricing policy, however. For this reason, some analysts prefer the term "revenue management" to describe these practices. This paper uses "cost shifting," however, because it is the more common phrase.

Of course, hospitals are not unique in providing their services at different prices to different customers. Various types of for-profit and not-for-profit firms--such as book shops, bus systems, and theaters--often give discounts to senior citizens, students, or frequent customers. In addition, sectors other than health care, such as higher education, often provide services at reduced rates, or for free, to some people. For example, because colleges offer various types of student aid, different students effectively pay different amounts for the same services.

Instead of--or in addition to--cost shifting, a hospital might respond to higher costs of uncompensated care or reduced government reimbursements in other ways. For example, a hospital might absorb the changes through a lower profit margin. Or it might alter the mix of patients it treats--for example, by treating fewer uninsured patients or expanding its more profitable types of

---

4. For convenience, this paper uses the term "profit" to refer to the excess of revenues over costs and "profit margin" to refer to that excess as a percentage of costs. Approximately 85 percent of community hospitals operate on a not-for-profit basis and therefore do not actually distribute profits to their owners. Regardless of ownership type, however, a hospital might seek an excess of revenues over costs--for example, to replace capital or make new capital purchases in the future.

services. Or, instead of raising prices, a hospital might reduce its costs of providing care by increasing efficiency or decreasing quality. In that case, however, cost shifting could also increase if, for example, the costs of treating all categories of patients were reduced but private prices were unchanged. Although evidence suggests that some hospitals have acted in these ways, the analysis in this paper indicates that hospitals also significantly expanded their use of cost shifting during the 1980s.

The practice of cost shifting from the public sector to the private sector does not imply that public-program payment rates are inappropriate or "too low," or that the costs hospitals incur are "too high." Those judgments are a separate issue and are beyond the scope of this paper. Nor does it mean that hospitals' incurred costs are not influenced by payment methods or by the mix of payers represented by differing populations of patients. Rather, evidence of cost shifting indicates that one important way hospitals have responded to public-program controls on spending has been to generate higher revenues from the private sector. Some observers argue that if this response were not possible, hospitals would lower their costs by providing care more efficiently. Others contend that if cost shifting were not possible, the quality of care would fall or access to care would be reduced because of hospital closures or because less care would be available to some uninsured and publicly insured patients.

DATA AND METHODS

This paper uses data from the 1980 through 1989 versions of the Annual Survey of Hospitals conducted by the American Hospital Association. The analysis was based on a sample of community hospitals that, in terms of size, location, and other characteristics, is generally representative of hospitals nationwide (see Appendix A for details).

The analysis relies on certain financial information collected in the annual survey, including each hospital's revenues from Medicare, Medicaid, private insurers, and other sources. An important limitation of the data is that the survey does not report the costs that hospitals actually incur in treating the patients in each group. Instead, the Congressional Budget Office estimated those amounts by using each hospital's ratio of costs to charges (RCC) to convert the full charges (based on list prices) for each patient group into an estimate of incurred costs for that group. The RCC is defined as the ratio of the hospital's total costs to the sum of its full charges for patient care and its operating revenues from sources other than patient care (excluding subsidies from state and local governments). This method apportions the hospital's expenses among the different patient groups according to their relevant shares

of total full charges. (See Appendix A for more details about the method used to estimate costs.)

Because the costs attributed to each source are estimated, specific numerical results in this paper--such as the estimated revenue-to-cost ratios for specific payers--are not as accurate as they would be if data on actual costs were available. Readers should therefore view specific numerical estimates with caution. However, because any distortions caused by using estimated costs are probably similar from year to year, they are unlikely to have much effect on the analysis of changes over time or on the paper's conclusion that cost shifting by hospitals increased during the 1980s.

CHAPTER II

SOURCES OF HOSPITALS' REVENUES AND COSTS

Nearly all hospitals treat a mix of publicly and privately insured patients. In 1991, community hospitals derived 33 percent of their revenues from the Medicare program, 10 percent from Medicaid, just over 1 percent from other publicly insured patients, and 49 percent from privately insured patients or those paying for their own care.[1] The remaining revenues came from sources other than patient care. On average, hospitals report that the payments they receive from Medicare and Medicaid do not fully cover the estimated costs of treating those programs' enrollees. In addition, most hospitals provide some free care to patients who cannot pay for it. Together, these unreimbursed costs totaled over $28 billion in 1991, or nearly 13 percent of hospitals' total costs. Most hospitals, however, earn enough income overall to more than cover their costs. For the hospital industry as a whole, revenues were 4 percent greater than costs in 1991.

SOURCES OF REVENUES AND COSTS

A look at the sources of hospitals' revenues and costs provides an overview of how hospitals finance their services. More than 90 percent of revenues are payments for patient care services, including inpatient and outpatient care. Sources other than patient care include subsidies from state and local governments, philanthropic contributions, and income from other hospital operations, such as cafeterias and parking facilities.

Medicare, Medicaid, and Other Government Payers

About three-quarters of all Medicare payments to hospitals are determined by the prospective payment system, which covers the operating costs related to inpatient care for beneficiaries.[2] Under the PPS, Medicare pays a

1. In this paper, Medicare payments, revenues, or reimbursements refer to the payments made for services provided to Medicare beneficiaries, including beneficiaries' deductible and copayment amounts--which might be made by a private "medigap" insurer--as well as payments by the federal government. Similar definitions apply to Medicaid, other government payers, and private payers.

2. The PPS for operating costs does not cover capital-related expenses, outpatient care, and certain other types of services. Beginning in October 1991, capital-related expenses have also been determined prospectively on a per-discharge basis; during a 10-year transition period, payments will be based on a combination of hospital-specific and national rates.

predetermined amount for each patient that varies according to the patient's diagnosis-related group (DRG) and certain characteristics of the hospital. For example, Medicare adjusts payments to compensate hospitals with teaching programs for their higher costs. The PPS payment rates are generally designed to reflect variations in costs among hospitals that result from factors considered to be beyond a hospital's control and not related to its efficiency. In addition, the PPS payments incorporate other goals. For example, the "disproportionate share" adjustment provides additional payments, beyond the levels justified by their higher costs of treating Medicare patients, to hospitals that treat relatively large shares of low-income and uninsured patients. Another example is the special provisions for "sole community hospitals." These are designed to help maintain access to hospital care in some rural areas by improving the financial condition of some facilities that are the sole hospitals in their geographic areas.

In 1991, for the industry as a whole, Medicare payments covered approximately 88 percent of the costs that hospitals incurred in treating covered patients (see Table 1). As noted above, the available data do not break down the hospital's actual costs of treating patients by payer groups; instead, those costs are estimated for each payer using data on the hospital's full (list price) charges. There is some limited evidence that the estimating method, combined with hospitals' accounting practices, may result in a small underestimate of the actual revenue-to-cost ratio for Medicare. The size of the underestimate, if any, is uncertain, however (see Appendix A).

Medicaid is a state-administered program, jointly funded by federal and state governments, that covers eligible low-income people. Until 1981, state Medicaid programs were required to pay for inpatient hospital care using Medicare's retrospective, cost-based reimbursement methods, unless they received a waiver. Since 1981, when the Congress permitted states to develop their own systems for paying hospitals without applying for waivers, the number of states with prospective systems has increased markedly. In July 1991, 46 states were using some type of prospective payment method, compared with 16 states in October 1981.[3]

Medicaid programs vary considerably in their specific payment methods. In a number of states, the systems base their rates on the patient's diagnosis. In some other states, Medicaid pays each hospital a fixed rate for each day of hospital care, or for each patient treated, that does not depend on the diagnosis; these rates are typically based on the hospital's actual costs in a

3. Prospective Payment Assessment Commission, *Medicaid Hospital Payment*, Congressional Report C-91-02 (October 1, 1991).

TABLE 1. HOSPITALS' REVENUES AND COSTS, BY PAYER OR OTHER SOURCE, 1991

Payer or Other Source	Revenues		Costs		Ratio of Revenues to Costs
	In Billions of Dollars	As a Percentage of Total	In Billions of Dollars	As a Percentage of Total	
Medicare	76.3	32.8	86.3	38.4	0.88
Medicaid	22.7	9.8	27.8	12.4	0.82
Other Government Payers	3.2	1.4	3.2	1.4	1.00
Private Payers	113.9	49.0	87.8	39.1	1.30
Uncompensated Care[a]	n.a.	n.a.	13.4	6.0	n.a
Nonpatient Sources					
State and local subsidies	2.6	1.1	n.a.	n.a.	n.a.
Other operating[b]	8.9	3.8	6.0	2.7	1.47
Nonoperating[c]	4.9	2.1	n.a.	n.a.	n.a.
Total	232.6	100.0	224.5	100.0	1.04

SOURCE: Congressional Budget Office based on analysis by the Prospective Payment Assessment Commission of data from the American Hospital Association's Annual Survey of Hospitals for 1991.

NOTES: The data are based on all community hospitals. n.a. = not applicable.

a. Uncompensated care is defined as charity care plus bad debt.

b. Includes operating revenues and costs for sources other than patient care, such as cafeterias and gift shops.

c. Includes revenues from donations, grants, earnings on endowments, and other sources. Nonoperating revenues are assumed to have no associated costs.

previous year or those of a group of similar hospitals. In a few states, Medicaid payments are based on costs, but they are subject to prospectively determined limits.

In 1991, the total payments that hospitals received for treating Medicaid patients equaled about 82 percent of the costs hospitals incurred in treating those patients. The revenue-to-cost ratio for Medicaid varies among states--for example, the Prospective Payment Assessment Commission found that, in 1989, Medicaid revenue-to-cost ratios by state ranged from less than 0.60 to more than 1.[4]

Based on revenue-to-cost ratios of less than 1, some observers have argued that the Medicare and Medicaid programs are not paying their "fair share." Other observers have justified the payment rates of the public programs, however, on several grounds. First, the costs attributed to each payer come from estimates of the hospital's average costs for treating covered patients. They may include some costs that would not meet the criteria for allowable costs established by Medicare or Medicaid. In fact, in the early 1980s, under cost-based reimbursement, hospitals' revenue-to-cost ratio for Medicare averaged about 0.96, approximately the same as in 1988 under the PPS.

Second, some observers argue that Medicare's payment rates are intended to create incentives for efficient provision of care.[5] If a hospital's costs are above the standard incorporated in the rates, then it will--by definition--have unreimbursed costs. For example, average costs can be driven up by costly equipment that is not fully used or by other types of excess capacity.

Third, for Medicare's PPS, total payments exceeded total costs during the first several years of the system. Through 1991, the industry's cumulative surpluses from the first several years under the PPS were greater than its cumulative losses from more recent years.[6]

---

4. Ibid.

5. This justification might be applied to some Medicaid programs as well, but it is difficult to generalize about Medicaid since the states' programs vary widely.

6. This estimate is based on data for PPS margins and growth in PPS payments taken from Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (June 1992). The underlying data are from the Medicare cost reports.

Other publicly insured patients include those covered by workers' compensation, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and state and local governments (other than by Medicaid). In all, this category accounted for less than 2 percent of hospitals' costs in 1991. It reflects a mixture of payment methods, including cost-based and charge-based ones. In 1991, total payments from these other government payers were approximately equal to the associated costs.

Private Payers

The private-payer category combines private insurers and individuals who pay for their own care. In 1991, hospitals' total revenues from private payers exceeded the associated costs by 30 percent.[7]

In contrast to public programs, the amounts paid by private payers are generally determined by hospitals, subject to market forces, although some states have regulated private-payer rates at different times. In particular, competition for patients may affect hospitals' prices or discounts. The presence of health maintenance organizations, large employers, or excess capacity among several hospitals, for example, might increase price competition in one location more than in others, enabling some payers to negotiate discounts.

Uncompensated Care

Uncompensated care is care for which no payment is received. It is measured in the data as the sum of charity care and bad debt. Charity care refers to services for which the hospital did not expect to be paid, based on its determination that the patient could not afford to pay. In contrast, bad debt occurs when the hospital expected to be paid but was not. In practice, charity care and bad debt cannot be separated accurately using the available data because hospitals vary in the methods they use to determine a patient's ability to pay.[8] Thus, charity care and bad debt are not consistently defined among hospitals. Most uncompensated care probably consists of services to patients

---

7. An implication of the possibility that Medicare's revenue-to-cost ratio may be understated in the data is that, based on the method used to break down costs by payers, the revenue-to-cost ratio for private payers may be overstated (see Appendix A).

8. American Hospital Association, "Unsponsored Hospital Care and Medicaid Shortfalls, 1980-1991: A Fact Sheet Update" (Chicago, November 1992).

who are uninsured, but some is based on unpaid deductible or copayment amounts for insured patients.

Uncompensated care, as measured, is therefore somewhat greater than the amount of care that is provided to people who cannot afford it, because uncompensated care includes amounts that other patients failed to pay. In 1991, the costs of uncompensated care totaled $13 billion, or about 6 percent of hospitals' total costs.

Nonpatient Sources

State and local governments provided direct subsidies to about 15 percent of hospitals in 1989, most of which were government owned. Although these subsidies are often considered to be an offsetting revenue to uncompensated care, they fill a wider range of functions that cannot be distinguished in the data. For example, the subsidies might include funds for capital projects, as well as payments targeted toward charity care. In fact, for about 45 percent of hospitals receiving state and local subsidies, those subsidies exceeded the hospitals' costs of uncompensated care in 1989. In 1991, subsidies from state and local governments totaled $2.6 billion.

Other operating revenues come from cafeterias, gift shops, and additional activities that do not directly relate to patient care. Nonoperating revenues include philanthropic contributions and earnings on investments. In 1991, hospitals earned nearly $3 billion, after covering related costs, from other operating revenues and nearly $5 billion from nonoperating revenues.

VARIATION AMONG HOSPITALS

For many hospitals, the sources of revenues and costs differ markedly from national averages. For example, although, on average, hospitals lost money on Medicare and Medicaid patients in 1989, Medicare patients were profitable for about one-quarter of hospitals, and Medicaid patients were profitable for about 15 percent (see Table 2). In fact, 10 percent of hospitals had Medicare revenue-to-cost ratios of 1.06 or higher. Similarly, private payers do not always bring profits; in 1989, an estimated 7 percent of hospitals lost money on their private patients.

Furthermore, despite the overall profitability of the industry, numerous hospitals report financial losses. In 1989, 24 percent of hospitals incurred costs that were higher than their total revenues. The hospitals that are unable to

cover all their costs tend to be smaller, on average, than other hospitals. In 1989, the 24 percent of hospitals with losses accounted for only 15 percent of hospital admissions and 16 percent of the industry's total costs. Clearly, these hospitals were not able to generate sufficient revenues from private payers or other sources to cover their costs fully. Thus, even though industrywide revenues exceed costs, some costs of uncompensated care or of treating publicly insured patients were not recovered in 1989.

TABLE 2. DISTRIBUTION OF REVENUE-TO-COST RATIOS FOR HOSPITALS, BY SELECTED SOURCE, 1989

Source	Revenue-to-Cost Ratios by Percentile					Percentage of Hospitals with	
	10th	25th	50th	75th	90th	Revenues Greater Than or Equal to Costs	Revenues Less Than Costs
Medicare	0.77	0.85	0.92	1.00	1.06	24	76
Medicaid	0.45	0.60	0.77	0.93	1.04	15	85
Private Payers	1.04	1.14	1.24	1.37	1.50	93	7
All Sources[a]	0.95	1.00	1.04	1.07	1.11	76	24

SOURCE: Congressional Budget Office estimates based on data from the American Hospital Association's Annual Survey of Hospitals for 1989.

NOTE: Based on a sample of 1,527 hospitals for which data were available.

a. Based on hospitals' total revenues and total costs from all sources, including those not shown separately.

CHAPTER III

HOSPITALS' RESPONSES DURING THE 1980s

Hospitals vary in the amount of uncompensated care they provide and in their other sources of costs and revenues. Thus, aggregate data from the hospital industry, such as those presented in Chapter II, cannot provide a complete picture of how fully and in what ways hospitals are able to cover their unreimbursed costs. This chapter, therefore, analyzes data from individual hospitals to measure trends in unreimbursed costs and how hospitals responded to them during the 1980s.

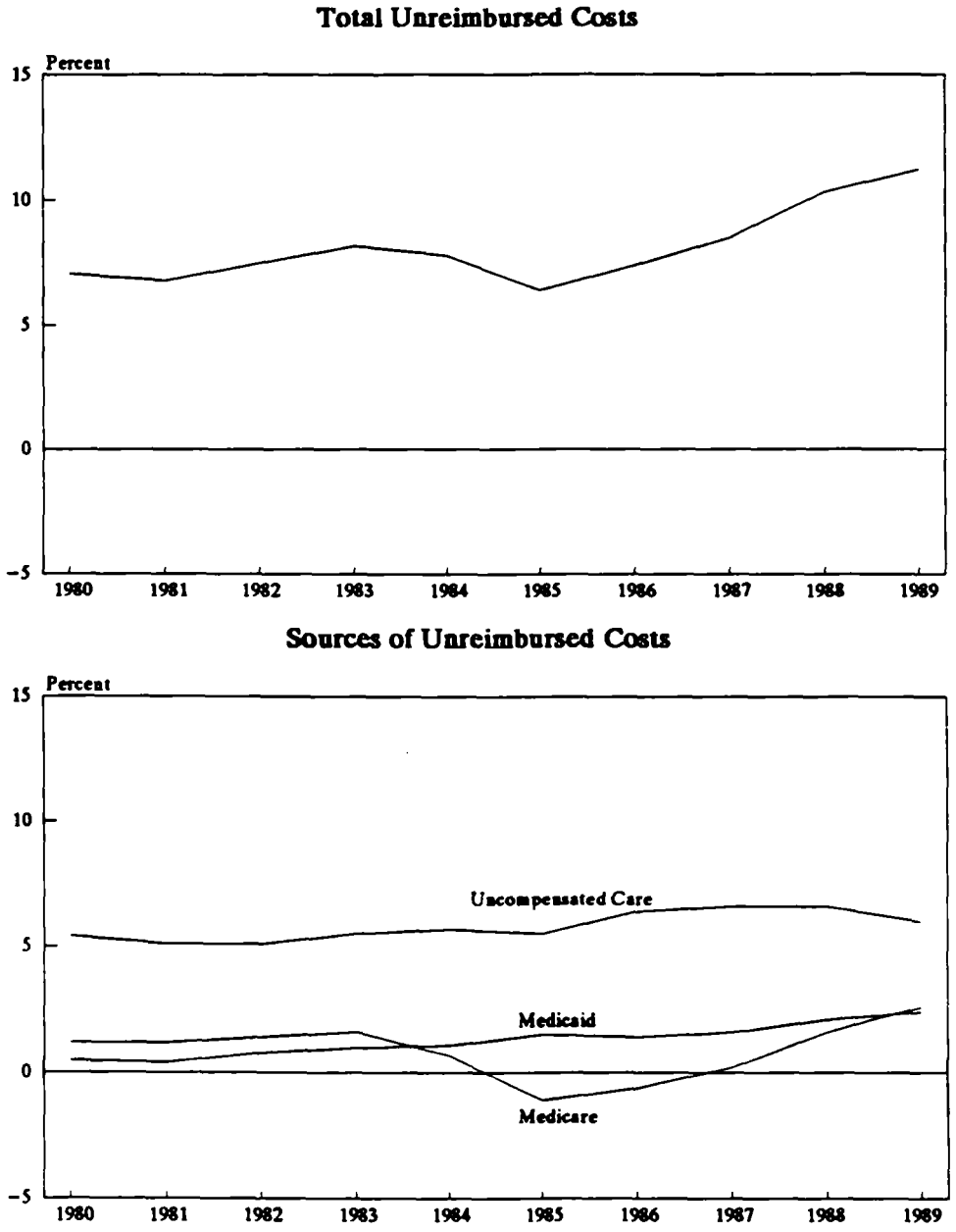
GROWTH IN UNREIMBURSED COSTS

This paper defines a hospital's unreimbursed costs as the difference between the costs it incurs for uncompensated care and publicly insured patients and the payments it receives from government programs. If those payments exceed those costs, its unreimbursed costs are zero. Thus, a hospital's unreimbursed costs measure the amount of surplus revenues that it needs to draw from private payers and sources other than patient care in order to cover the costs of uncompensated care and of any services to publicly insured patients that were not fully reimbursed.

This definition of unreimbursed costs combines the costs and revenues from uncompensated care and government payers; it therefore incorporates profits on publicly insured patients as well as losses. If a hospital has greater revenues than costs for public-sector patients, its unreimbursed costs will be lower than the costs of its uncompensated care by the amount of that profit. In 1989, for example, about 15 percent of hospitals had revenues from publicly insured patients that more than covered the associated costs, and those profits were, on average, equal to about 30 percent of these hospitals' costs of uncompensated care. Overall, however, hospitals' profits on publicly insured patients were equal to about 6 percent of the industry's total costs of uncompensated care in 1989.

As a percentage of hospitals' total costs, unreimbursed costs grew--with some fluctuations--between 1980 and 1989. Unreimbursed costs increased gradually during the first part of the decade, dropped in 1984 and 1985, and then increased rapidly (see Figure 1). By 1989, unreimbursed costs accounted for 11 percent of hospitals' total costs, compared with a low of 6 percent in 1985 and with 7 percent to 8 percent during the first part of the decade. By

Figure 1.
Hospitals' Unreimbursed Costs, by Source, 1980–1989 (As a percentage of hospitals' total costs)



SOURCE: Congressional Budget Office estimates based on data from the American Hospital Association's Annual Survey of Hospitals for 1980 through 1989.

NOTES: Unreimbursed costs are defined for each hospital as the costs incurred for uncompensated care (charity care plus bad debt) and for treating publicly insured patients minus the revenues received from all government payers; if those costs are less than those revenues, however, unreimbursed costs are zero.

The estimates shown are based on aggregate amounts using all sample hospitals. Negative entries indicate that aggregate revenues exceeded aggregate costs for that source. In addition to the sources shown, the total includes other government payers; unreimbursed costs for this category fluctuated between −0.1 and 0.2 percent of total costs over the period shown.

See Appendix B, Table B-2, for the data represented here.

1991, unreimbursed costs had increased to nearly 13 percent of hospitals' total costs.

Throughout the 1980s, uncompensated care represented the majority of unreimbursed costs. However, most of the growth in unreimbursed costs over the period came from unreimbursed Medicare and Medicaid costs. In 1980, uncompensated care accounted for three-quarters of total unreimbursed costs; by 1989, its share had fallen to just over one-half. By 1991, uncompensated care accounted for less than half of hospitals' total unreimbursed costs.

Uncompensated Care

As a percentage of hospitals' total costs, uncompensated care changed little during the first half of the 1980s, averaging about 5.4 percent of total costs. It increased to 6.6 percent in 1987 and 1988, before dropping back to 6 percent in 1989. From 1989 through 1991, uncompensated care remained at about 6 percent of hospitals' costs.[1] The recent level may result from expansions in the number of people eligible for Medicaid, which may have reduced the need for uncompensated care. Alternatively, hospitals may have cut back on uncompensated care because of increasing financial pressure from the growth in other unreimbursed costs.

Medicare

The pattern for Medicare was affected by the prospective payment system, which covers most of Medicare's payments to hospitals. Between October 1983 and October 1984, hospitals entered the PPS according to the start of their individual fiscal years. During the first few years of the system, revenues were substantially greater than the associated costs, for two reasons. First, total payments were higher than had been expected, primarily because the average case mix index, which is a weighting factor used to compute PPS payments, was higher than had been anticipated in setting the initial rates. Second, growth in hospitals' costs slowed significantly when the system was introduced. Hospitals appear to have responded to the incentives to control costs created by the system; they may also have been concerned about the effect of the new system on revenues. As a result, hospitals initially earned large positive margins under the PPS.

---

1. The 1991 estimate is shown in Table 1. See Appendix B, Table B-1, for hospitals' revenues and costs, by source, for 1990.

Those margins have eroded over time, however. One reason is that, partly because payment rates were high initially, the Congress has generally restricted the annual increase in the per-case rates to less than the growth in the average price of hospitals' inputs. In addition, subsequent rapid growth of costs contributed to the declining margins. Some of Medicare's non-PPS payments to hospitals, including those for capital-related expenses and for some outpatient services, have also been subject to various controls.

The overall Medicare revenue-to-cost ratio, which is based on all Medicare-covered hospital services, increased from an average of 0.96 during the early years of the decade to over 1 in 1985 and 1986. The ratio then fell from approximately 1 in 1987 to 0.93 in 1989. As a result, hospitals went from earning profits on Medicare patients in 1985 and 1986 to having unreimbursed Medicare costs. These accounted for 2.6 percent of total costs, or about one-quarter of total unreimbursed costs, in 1989.

Since 1989, Medicare's revenue-to-cost ratio has continued to decrease--to 0.90 in 1990 and 0.88 in 1991. Based on projections for the PPS, the overall Medicare margin is likely to have declined further in 1992.[2]

Medicaid

In contrast to Medicare, unreimbursed Medicaid costs increased throughout the 1980s, from 0.5 percent of hospitals' total costs in 1980 to 2.4 percent in 1989. In 1989, losses on Medicaid patients totaled nearly as much as losses on Medicare patients, even though Medicaid patients accounted for only 11 percent of hospitals' costs compared with Medicare's 39 percent. This trend reflects a declining payment-to-cost ratio for Medicaid--from 0.95 in 1980 to 0.77 in 1989.

Since 1989, however, Medicaid payments have improved relative to costs, largely because of disproportionate share payments for hospitals that treat a large percentage of low-income patients, and because of states' expanded use of financing mechanisms that increase the federal government's matching payments. The effects of these changes vary from state to state, but Medicaid's overall revenue-to-cost ratio for hospitals increased from 0.77 in 1989 to 0.80 in 1990, and to 0.82 in 1991. Rapid growth in Medicaid spending

2. Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (June 1992).

for hospitals in 1992 suggests that the revenue-to-cost ratio may have continued to increase.

Other government programs have had little effect on total unreimbursed costs, primarily because they involve only a small proportion of hospitals' costs. Between 1980 and 1989, these programs' unreimbursed costs fluctuated between 0.2 percent and negative 0.1 percent of hospitals' total costs.

HOW HOSPITALS COVER THEIR UNREIMBURSED COSTS

Hospitals have several potential sources of revenues to help cover unreimbursed costs. Nearly all hospitals earn surplus revenues from sources other than direct payments for patient care. For about 15 percent of hospitals, state and local governments provide subsidies that help finance uncompensated care. More than 90 percent of hospitals earn profits on privately insured patients.

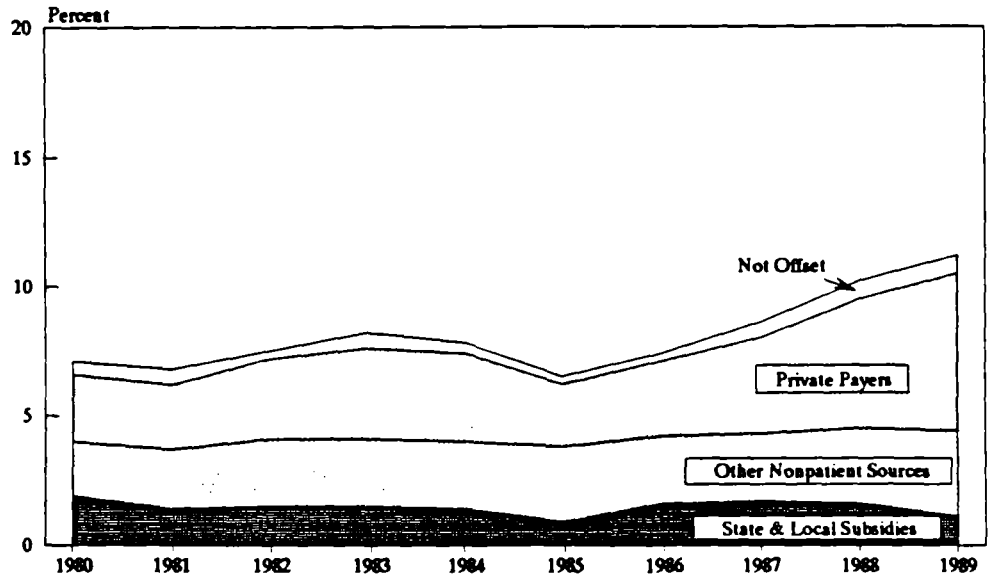
Sources of Offsetting Revenues

To measure the extent to which hospitals were able to cover their unreimbursed costs, the Congressional Budget Office analyzed data for each hospital and then totaled the results. By definition, the maximum amount of unreimbursed cost that a hospital can cover is 100 percent. In the analysis, any revenues beyond those needed to cover costs that were earned by one hospital were not allowed to offset unreimbursed costs at another hospital, since in actuality they do not. Because not all hospitals were able to offset all of their unreimbursed costs, less than 100 percent of industrywide unreimbursed costs were offset each year.

In 1989, for example, 94 percent of hospitals' total unreimbursed costs were offset by revenues from other sources. About one-fourth of hospitals were unable to cover all of their unreimbursed costs in that year; they offset about 75 percent of their unreimbursed costs. The total amount of unreimbursed costs that these hospitals could not offset represented the other 6 percent of the industry's total unreimbursed costs.

The percentage of industrywide unreimbursed costs that hospitals could cover changed little over the 1980-1989 period (see Figure 2 and Table B-3 in Appendix B). Though unreimbursed costs increased rapidly after 1985, the portion that was offset did not change much, falling slightly from 95 percent between 1984 and 1986 to 93 percent or 94 percent between 1987 and 1989.

Figure 2.
Hospitals' Unreimbursed Costs, by Source of Offsetting Revenues, 1980–1989 (As a percentage of hospitals' total costs)



SOURCE: Congressional Budget Office estimates based on data from the American Hospital Association's Annual Survey of Hospitals for 1980 through 1989.

NOTES: Unreimbursed costs are defined for each hospital as the costs incurred for uncompensated care (charity care plus bad debt) and for treating publicly insured patients minus the revenues received from all government payers; if those costs are less than those revenues, however, unreimbursed costs are zero.

Because most hospitals have revenues that exceed their costs, the order in which the sources of offsetting revenues are applied to cover unreimbursed costs affects the results. This analysis applied the sources in the order shown, going from the bottom up, so state and local subsidies were used first, and revenues from private payers were used last. Thus, the proportion attributed to private payers is lower than it would be if another order had been chosen.

The estimates shown are based on aggregate amounts using all sample hospitals.

See Appendix B, Table B-3, for the data represented here.

The contributions of the different offsetting revenue sources did change over time, however. For each hospital, CBO applied the potential sources of offsetting revenues to unreimbursed costs in the following order: state and local subsidies, revenues from sources other than patient care, and revenues from private payers. In other words, revenues from state and local subsidies were used first to offset unreimbursed costs. If the hospital had any remaining unreimbursed costs, then other nonpatient revenues were applied. Finally, if unreimbursed costs still remained, profits from private payers were used.

Because most hospitals were profitable overall, the ordering affects the results. This ordering is a natural one because state and local subsidies are largely intended to help hospitals cover their costs, and at least some of the other nonpatient revenues, such as donations, are intended to support charitable activities. The ordering is also analytically useful because it yields a lower-bound estimate of the contribution of private payers by completely exhausting the surplus revenues from other sources before turning to private payers.

Although the contribution of state and local subsidies decreased over the decade--from a high of 27 percent in 1980 to 10 percent in 1989--private payers played an increasing role. In 1989, revenues from private payers offset 55 percent of total unreimbursed costs, compared with 37 percent in 1980. The proportion of unreimbursed costs that were covered by other nonpatient sources stayed relatively constant over the 10-year period, averaging about 33 percent.

As unreimbursed costs increased rapidly during the latter half of the 1980s, hospitals were able to cover nearly all the increase with revenues from other sources. Most of that rise was offset with revenues from private payers. However, between 1987 and 1989, a small part of the increase in unreimbursed costs was offset with revenues from nonpatient sources other than subsidies from state and local governments.

The proportion of hospitals that were not able to cover all their costs increased near the end of the decade. From 1980 through 1982, the proportion dropped from 21 percent to 17 percent; it stayed at 17 percent through 1986, except for a low of 15 percent in 1985 (see Table 3). The proportion grew to 24 percent of hospitals in 1987, and peaked at 27 percent in 1988 before dropping back to 24 percent in 1989. Thus, although the share of total unreimbursed costs that were not covered stayed about the same, those costs were spread out, at the end of the decade, among a somewhat larger number of hospitals.

TABLE 3. EXTENT TO WHICH HOSPITALS WERE ABLE TO OFFSET UNREIMBURSED COSTS WITH REVENUES FROM OTHER SOURCES, 1980-1989 (In percentage of hospitals)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Hospitals with No Unreimbursed Costs	5	5	4	3	7	15	9	6	4	4
Hospitals with Costs Fully Offset	74	76	79	80	76	70	74	70	69	72
Hospitals with Costs Not Fully Offset	21	19	17	17	17	15	17	24	27	24

SOURCE: Congressional Budget Office estimates based on data from the American Hospital Association's Annual Survey of Hospitals for 1980 through 1989.

NOTE: Unreimbursed costs are defined for each hospital as the costs incurred for uncompensated care (charity care plus bad debt) and for treating publicly insured patients minus the revenues received from all government payers; if those costs are less than those revenues, however, unreimbursed costs are zero.

Perhaps not surprisingly, the facilities that were not able to fully cover their costs tended to have greater unreimbursed costs, as a percentage of total costs, than other hospitals. In 1989, for example, unreimbursed costs accounted for 15 percent of the total costs for this group compared with 10 percent for other hospitals (see Appendix B, Table B-4.) The costs of uncompensated care were higher for these hospitals--8 percent of total costs compared with 6 percent for other hospitals. Hospitals in this group also provided relatively more care to Medicaid patients than did other hospitals--19 percent of inpatient days compared with 14 percent. But they provided slightly less care to Medicare patients--42 percent of inpatient days compared with 44 percent for other hospitals.

Cost Shifting to Private Payers

As unreimbursed costs increased during the 1980s, hospitals generated higher revenues from their private payers to cover most of the increase in those costs. As seen earlier, unreimbursed costs increased during two periods: 1981 through 1983, and 1985 through 1989. During each of these periods, hospitals' aggregate revenue-to-cost ratio for private payers also rose.

Between 1980 and 1983, the average markup of revenues over costs for private payers rose from 13 percent to 17 percent--an increase of 4 percentage points, or about 1 percentage point per year (see Figure 3). Over the same period, the revenues from private payers that were needed to just offset unreimbursed costs increased from 6 percent over costs to 8 percent, or 2 percentage points in all.[3] This pattern indicates that during this period the prices paid by private payers increased by more than the amount necessary to offset the growth in unreimbursed costs, thereby raising hospitals' overall margins, on average.

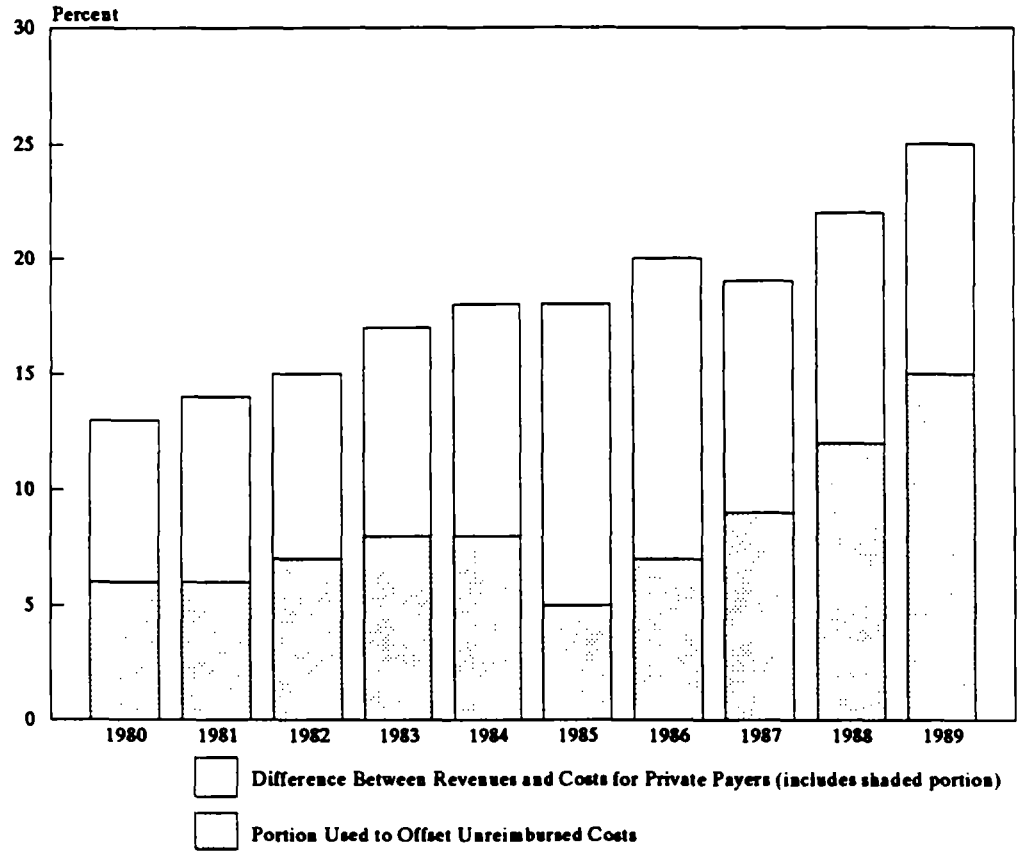
Unreimbursed costs grew more rapidly after 1985 than in the early part of the decade. Between 1985 and 1989, the percentage markup over costs for private payers that was needed to just offset unreimbursed costs increased from 5 percent to 15 percent, or over 2 percentage points per year. At the same time, the actual markup for private payers increased from 18 percent to 25 percent. Between 1985 and 1987, the increase in the markup was less than the increased contribution of private payers to offsetting unreimbursed costs. Between 1987 and 1989, however, the increase in the markup was approximately equal to the growth in those contributions. For the decade as a whole, the total increase in markups for private payers was larger than the increase in those payers' contributions to unreimbursed costs.

The 1983-1985 period also shows an interesting pattern. Unreimbursed costs fell during this time, and along with them the amount of private-payer revenues that were needed to offset unreimbursed costs. However, hospitals did not, on average, pass these reductions to private payers in the form of lower markups. Instead, those markups increased from 17 percent in 1983 to 18 percent in 1984, and then stayed at 18 percent in 1985, despite the fact that the amount needed to cover unreimbursed costs dropped from 8 percent above costs in 1983 and 1984 to only 5 percent in 1985. When hospitals' unreimbursed costs subsequently increased after 1985, the average markup for private payers also grew.

The increasing markups paid by private payers caused their spending to increase more rapidly than it might otherwise have done. In general, the growth in the total level of spending by private payers is determined by both the average markup over costs that they pay and the rate of increase of those costs. However, during the 1980s, the underlying trend in the growth of the costs incurred by hospitals changed little, except for a brief slowing in 1984 and

3. As noted earlier, the analytic method used to offset unreimbursed costs completely exhausted all revenues from other sources before applying revenues from private payers.

Figure 3.
Difference Between Hospitals' Revenues and Costs for Private Payers, and the Portion Used to Offset Unreimbursed Costs, 1980–1989 (As a percentage of the private–payer costs)



SOURCE: Congressional Budget Office estimates based on data from the American Hospital Association's Annual Survey of Hospitals for 1980 through 1989.

NOTES: Private payers refers to privately insured patients and individual patients who paid for their own care.

Unreimbursed costs are defined for each hospital as the costs incurred for uncompensated care (charity care plus bad debt) and for treating publicly insured patients minus the revenues received from all government payers; if those costs are less than those revenues, however, unreimbursed costs are zero.

Before calculating the portion of private payers' revenues used to offset unreimbursed costs, each hospital's unreimbursed costs were reduced by any state and local subsidies and by other revenues (in excess of costs) received from sources other than patient care.

See Appendix B, Table B-5, for the data represented here.

1985. Between 1986 and 1991, hospitals' costs per patient grew an average 4.5 percent a year, adjusting for inflation, compared with average annual growth of 3.8 percent in 1984 and 1985, and 4.9 percent in the 1978-1983 period (see Appendix B, Figure B-2).

IMPLICATIONS

The trends analyzed here suggest that in the current multiple-payer setting, actions taken by one group of payers to control spending can have significant effects on other payers. During the 1980s, hospitals were able to offset nearly all of the increases in uncompensated care and unreimbursed costs related to public programs with increased revenues from other sources. This pattern appears to have continued more recently. In particular, between 1989 and 1991, the hospital industry's overall profit margin remained relatively stable, even though unreimbursed costs increased because of declining Medicare margins.

Further attempts to control public-sector health costs would probably produce further cost shifting to the private sector, unless those attempts were combined with other changes. Although the maximum extent of such cost shifting is unknown, the evidence from the 1980s indicates that cost shifting might be considerable, at least in the short run. Not all facilities would be able to recover their costs fully in this way, however. The patients treated by facilities that were least able to cost shift--because of patient mix or market conditions--could be adversely affected. For example, hospitals with a large share of uninsured or publicly insured patients might be less able to cover their unreimbursed costs, both because those costs are a larger share of their total costs and because they have a smaller pool of privately insured patients.

Proposals to change the health care system need to take into account the extent to which the private sector now subsidizes uninsured and publicly insured patients. For example, if reforms expanded the number of people with insurance, so that uncompensated care fell, private-sector hospital rates might fall relative to costs. However, such a response might be delayed, because hospitals would probably not adjust immediately--for example, hospitals did not lower private rates in the mid-1980s when their Medicare revenues increased relative to costs. Alternatively, if price controls were adopted for hospitals but did not incorporate the costs of uncompensated care, some hospitals might cut back the amount of free care they provide. As a consequence, uninsured people might receive less care than they do now.

APPENDIX A

DATA AND ANALYTIC METHODS

The data for this paper come from the American Hospital Association's (AHA's) Annual Survey of Hospitals for 1980 through 1989. The surveys provide data about the characteristics of individual hospitals, including size, location, available services, and finances. The analysis was based on community hospitals, which are defined by the AHA as nonfederal, short-term hospitals that are open to the general public.[1]

Hospitals' individual reporting periods vary. In general, the data reported in each year of the survey correspond to hospitals' reporting periods that ended during that calendar year. Consequently, the results of the analysis do not correspond exactly to calendar years.

COMPARISON OF HOSPITALS IN THE SAMPLE WITH ALL COMMUNITY HOSPITALS

The analysis was based on data from the hospitals that permitted the Congressional Budget Office (CBO) to use the financial information they reported in the annual survey. In all, data from approximately 2,300 hospitals, or over 40 percent of all community hospitals, were used. In any given year, however, a number of hospitals did not report certain financial variables needed for the analysis. The data were also screened to eliminate extreme or implausible values. Because data were available for different hospitals in different years, the specific set of hospitals used in the analysis varies from year to year. The number ranged from a low of approximately 1,000 hospitals for 1985 to more than 1,900 for 1988.

In using a sample of hospitals, such as this one, it is important that the sample represent the patterns that occur in the full universe of hospitals. That way, conclusions based on the sample can be considered valid for the entire group. To verify the representativeness of the sample, CBO compared a number of characteristics of the hospitals used in the analysis with those of all community hospitals.

---

1. Excluding psychiatric hospitals, hospitals for treating alcoholism and chemical dependency, hospitals for tuberculosis and other respiratory diseases, chronic-disease hospitals, facilities for the mentally retarded, and hospital units of institutions.

Based on location, patient mix, size, and other characteristics, the hospitals in the sample appear to be generally representative of all community hospitals. As an example, the 1989 sample consisted of 1,527 hospitals, or 28 percent of all community hospitals (see Table A-1). About 55 percent of the sample were located in urban areas, compared with 54 percent nationally. Hospitals in the two groups were similar in their distributions by size, although the sample hospitals were somewhat larger on average--194 beds compared with 170 beds nationally. The shares of patient days and discharges attributable to Medicare were nearly identical for the two groups. Similarly, Medicaid's shares of days and discharges were the same for the two groups. In addition, uncompensated care accounted for 6 percent of total costs for each group.

One exception to this similarity is the type of ownership. In 1989, for example, for-profit hospitals constituted only 3 percent of the sample, compared with 14 percent nationally; nongovernment, not-for-profit hospitals accounted for 69 percent of the sample but only 59 percent of all community hospitals. Government-owned hospitals were a similar proportion of both categories--28 percent of the sample and 27 percent of all community hospitals.

METHOD OF ESTIMATING COSTS

The analysis relies on various financial data collected in the AHA's annual survey, including information about hospitals' revenues from different sources and their provision of uncompensated care. In general, revenues for patient care are categorized into the various sources based on the patient's primary payer.

Two measures of revenue from each group of patients are reported: the hypothetical revenue based on full (list price) charges and the actual revenue received. For Medicare and Medicaid, for example, the actual revenues are the reimbursements for patients insured by those programs, while the full charges are based on the hospitals' list prices for the services provided. In addition, actual revenues from sources other than patient care are reported.

The survey does not break down the hospital's actual costs of treating patients by payer groups. To estimate costs for each group of patients--for example, private patients--the full charges for that group were multiplied by the hospital's ratio of costs to charges (RCC). Similarly, each hospital's costs of uncompensated care were estimated by multiplying the full charges attributed to charity care and bad debt by the hospital's RCC. The RCC for each hospital is defined as the ratio of its total costs to the sum of its total full-charges

TABLE A-1. SELECTED CHARACTERISTICS OF HOSPITALS IN THE SAMPLE FOR CBO'S ANALYSIS AND ALL COMMUNITY HOSPITALS, 1989

	Sample for 1989 Analysis[a]	All Hospitals[b]
Number of Hospitals	1,527	5,512
Percentage of Hospitals	28	100
Percentage of Discharges	33	100
Average Number of Beds	194	170
Average Occupancy (In percent)[c]	60	56
Medicare's Share of Days (In percent)	43	42
Medicare's Share of Discharges (In percent)	34	34
Medicaid's Share of Days (In percent)	15	15
Medicaid's Share of Discharges (In percent)	13	13
Total Revenue-to-Cost Ratio	1.040	1.035
Uncompensated Care (As a percentage of total costs)[d]	6.0	6.0
Percentage of Hospitals		
Total	100	100
Rural	45	46
Urban	55	54
Urban Hospitals by Population of City		
Less than 250,000	12	10
250,000-1 million	20	19
1 million-2.5 million	13	14
2.5 million or more	10	11
Ownership		
Nongovernment, not for profit	69	59
Government	28	27
For profit	3	14
Number of Beds		
50 or fewer	17	24
51-100	22	23
101-200	24	24
201-400	26	20
401 or more	12	9
Teaching[e]	27	23
Nonteaching	73	77

(Continued)

TABLE A-1. CONTINUED

	Sample for 1989 Analysis[a]	All Hospitals[b]
Percentage of Hospitals (continued)		
Disproportionate Share[f]	28	26
Nondisproportionate Share[g]	72	74
Disproportionate Share Hospitals by Teaching Status		
Teaching	13	11
Nonteaching	15	15
Region		
New England	8	4
Middle Atlantic	12	10
South Atlantic	14	15
East North Central	17	15
East South Central	5	9
West North Central	18	14
West South Central	10	14
Mountain	5	7
Pacific	11	12

SOURCE: Congressional Budget Office calculations based on data from the American Hospital Association's Annual Survey of Hospitals for 1989.

NOTES: Characteristics are generally based on data from the Annual Survey of Hospitals for 1989. Teaching and disproportionate share are exceptions; these were based on data from the Health Care Financing Administration.

In the upper panel, the term "average" indicates the average amounts per hospital. Entries not designated as "average" are the percentages or ratios based on total amounts for hospitals in each category--for example, Medicare's share of discharges is the percentage of total discharges for hospitals in the category that were discharges of Medicare patients.

a. All of the hospitals used in the analysis for 1989 were community hospitals.

b. The category consists of all community hospitals in the 50 states and the District of Columbia for which data were available from the Annual Survey of Hospitals for 1989.

c. The occupancy rate for each hospital is defined as the ratio of the hospital's average daily number of patients to its average number of beds during the reporting period.

d. Uncompensated care is defined as charity care plus bad debt.

e. Hospitals that receive an adjustment under Medicare's prospective payment system (PPS) for the indirect costs of medical education.

f. Hospitals that receive the disproportionate share adjustment under Medicare's PPS for treating a large proportion of low-income patients.

g. The nondisproportionate share category includes 2 percent of hospitals in the sample and 4 percent of all community hospitals for which data on disproportionate share status were not available.

revenue and other operating revenue (excluding subsidies from state and local governments). The use of this conversion factor assumes that the full charges for a given patient reflect the relative resource use compared with other patients--for example, that two patients with the same charges have the same underlying treatment costs. One justification for using the RCC to convert charges to costs is that relative charges probably reflect relative costs. In addition, a hospital's list prices are the same for all patients.

A shortcoming of this approach is that markups probably vary from service to service within a hospital. If a hospital applied higher markups to services more frequently used by Medicare patients than by other groups, for example, the estimated costs of treating Medicare patients would be greater than the actual costs, and the estimated costs of treating other patients would be less than the actual costs.

Hospitals may also have adapted their accounting methods in ways that result in overstating the costs incurred in treating publicly insured patients. In the past, retrospective, cost-based reimbursement by Medicare and Medicaid provided an incentive for hospitals to overstate their reported costs, because payments were based on those costs. Generalizing about Medicaid programs is difficult because the state systems vary widely. For Medicare, these considerations are most relevant to the cost data reported on its cost reports, because Medicare used them to determine the cost-based reimbursements (and continues to use them to determine the remaining cost-based payments). However, full charges may also have been affected by these incentives, because Medicare used information on full charges to determine its share of certain costs.

Under the prospective payment system (PPS), such accounting practices could well have persisted. For one thing, they were already in place. For another, even though most payments are no longer directly based on reported costs, costs may still play a role in determining future payments by influencing annual updates in Medicare's rates and other changes in the PPS over time.

In addition, data from the Medicare cost reports suggest somewhat higher revenue-to-cost ratios for Medicare than the AHA data suggest.[2] In particular, the revenue-to-cost ratios based on cost-report data for the PPS (which applies to about 75 percent of Medicare's payments) were higher over the 1984-1991 period than the revenue-to-cost ratios (for all services to

2. No national data exist for Medicaid that would permit a similar comparison with the AHA data.

Medicare patients) from the AHA data.[3] If the services not covered by the PPS are taken into account to estimate total Medicare ratios, those ratios would probably still be larger than the ones based on the AHA data. This limited evidence suggests that the Medicare revenue-to-cost ratio, which was estimated to be 0.88 in 1991 using the AHA data, could range from 0.88 to 0.96. A closer comparison of data from the two sources might be useful in evaluating these issues, but is beyond the scope of this analysis.

If Medicare's revenue-to-cost ratio is underestimated by the AHA data, then hospitals' total unreimbursed costs and the amount of cost shifting to the private sector would both be less than estimated by the analysis. In addition, because of the method used to apportion costs among payer groups, an underestimate of Medicare's revenue-to-cost ratio would imply that the ratio for private payers was probably overestimated.

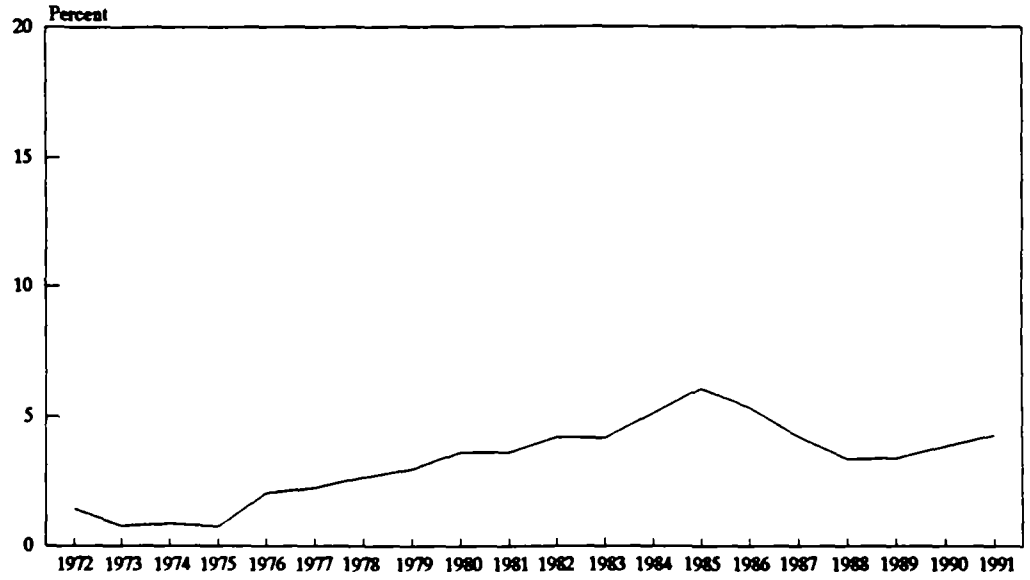
Although these considerations indicate that the revenue-to-cost ratios for specific years and payer groups should be viewed with caution, they would not have much effect on the analysis of change over time. As a result, they would not affect the paper's finding that cost shifting to private payers increased during the 1980s.

3. For PPS margins based on cost-report data, see Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (forthcoming, June 1993).

APPENDIX B

ADDITIONAL FIGURES AND TABLES

Figure B–1.
Total Revenue Margin for Hospitals, 1972–1991

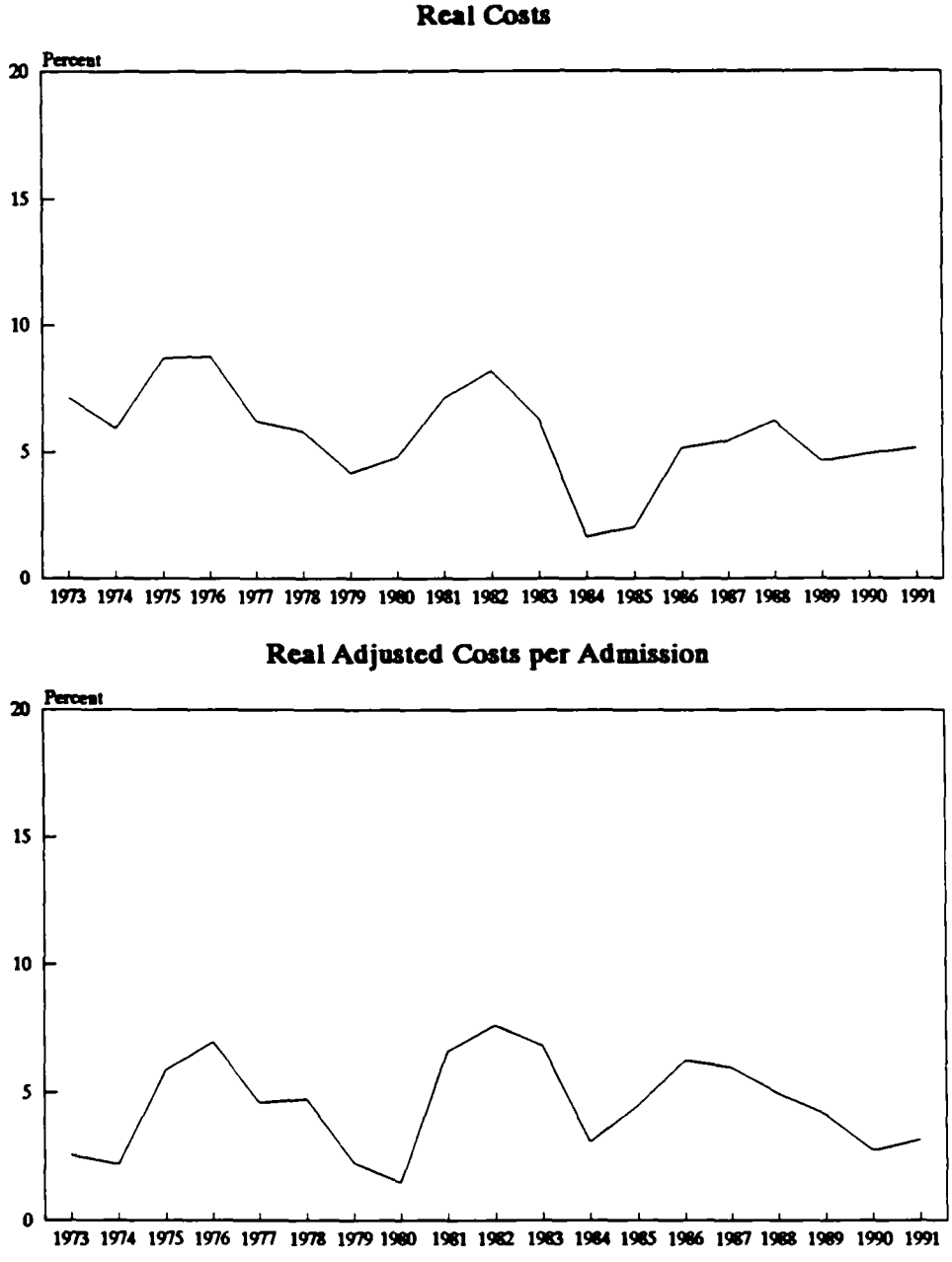


SOURCE: Congressional Budget Office estimates based on data from *American Hospital Association Hospital Statistics* (Chicago: AHA, 1972 through 1992–1993 editions).

NOTES: The total revenue margin is defined as the difference between total revenues of all hospitals and total costs, expressed as a percentage of total revenues.

The data were based on all community hospitals.

Figure B–2.
Annual Change in Hospitals' Real Costs and Real Adjusted Costs per Admission, 1973–1991



SOURCE: Congressional Budget Office estimates based on data from *American Hospital Association Hospital Statistics* (Chicago: AHA, 1972 through 1992–1993 editions).

NOTES: The term "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Hospitals' real costs are calculated in 1991 dollars using the consumer price index for all urban consumers.

Adjusted cost per admission is the average expense to the hospital to provide care for one hospital inpatient stay. It is estimated by subtracting the estimated costs incurred for the provision of outpatient care from total costs.

The data were based on all community hospitals.

TABLE B-1. HOSPITALS' REVENUES AND COSTS, BY PAYER OR OTHER SOURCE, 1990

Payer or Other Source	Revenues		Costs		Ratio of Revenues to Costs
	In Billions of Dollars	As a Percentage of Total	In Billions of Dollars	As a Percentage of Total	
Medicare	69.8	33.2	78.0	38.4	0.90
Medicaid	18.4	8.7	23.0	11.3	0.80
Other Government Payers	3.4	1.6	3.2	1.6	1.06
Private Payers	104.1	49.5	81.6	40.1	1.28
Uncompensated Care[a]	n.a.	n.a.	12.1	5.9	n.a.
Nonpatient Sources					
State and local subsidies	2.5	1.2	n.a.	n.a.	n.a.
Other operating[b]	7.8	3.7	5.5	2.7	1.43
Nonoperating[c]	4.6	2.1	n.a.	n.a.	n.a.
Total	210.6	100.0	203.2	100.0	1.04

SOURCE: Congressional Budget Office using data from Prospective Payment Assessment Commission (ProPAC), *Medicare and the American Health Care System: Report to the Congress* (June 1992). Data were calculated by the American Hospital Association using its Annual Survey of Hospitals for 1990, based on ProPAC's specifications.

NOTE: The data are based on all community hospitals. n.a. = not applicable.

a. Uncompensated care is defined as charity care plus bad debt.

b. Includes operating revenues and costs for sources other than patient care, such as cafeterias and gift shops.

c. Includes revenues from donations, grants, earnings on endowments, and other sources. Nonoperating revenues are assumed to have no associated costs.

TABLE B-2. HOSPITALS' UNREIMBURSED COSTS, BY SOURCE, 1980-1989
(As a percentage of hospitals' total costs)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Total Unreimbursed Costs[a]	7.1	6.8	7.5	8.2	7.8	6.4	7.4	8.5	10.3	11.2
Source[b]										
Uncompensated care	5.4	5.1	5.1	5.5	5.7	5.5	6.4	6.6	6.6	6.0
Medicare	1.2	1.2	1.4	1.6	0.7	-1.1	-0.6	0.2	1.6	2.6
Medicaid	0.5	0.4	0.8	1.0	1.1	1.5	1.4	1.6	2.1	2.4
Other government payers	-0.1	0.1	0.1	c	0.1	0.2	c	-0.1	-0.1	c

SOURCE: Congressional Budget Office estimates based on data from the American Hospital Association's Annual Survey of Hospitals for 1980 through 1989.

NOTES: Unreimbursed costs are defined for each hospital as the costs incurred for uncompensated care (charity care plus bad debt) and for treating publicly insured patients minus the revenues received from all government payers; if those costs are less than those revenues, however, unreimbursed costs are zero.

The estimates shown are based on aggregate amounts using all sample hospitals. Negative entries indicate that aggregate revenues exceeded aggregate costs for that source.

a. The amounts shown for the individual sources do not sum exactly to the total unreimbursed costs because for individual hospitals the latter are constrained to be zero or positive.

b. For Medicare, Medicaid, and other government payers, the amounts shown equal the differences between costs and revenues for the respective source. For uncompensated care, there are no revenues, so the amounts shown are the costs of uncompensated care.

c. Between -0.05 percent and 0.05 percent.

TABLE B-3. HOSPITALS' UNREIMBURSED COSTS, BY SOURCE OF OFFSETTING REVENUES, 1980-1989

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
As a Percentage of Hospitals' Total Costs										
Total Unreimbursed Costs	7.1	6.8	7.5	8.2	7.8	6.4	7.4	8.5	10.3	11.2
Source of Offsetting Revenues[a]										
State and local subsidies	1.9	1.4	1.5	1.5	1.4	0.9	1.6	1.7	1.6	1.1
Other nonpatient sources	2.1	2.3	2.6	2.6	2.6	2.9	2.6	2.6	2.9	3.3
Private payers	2.6	2.5	3.1	3.5	3.4	2.4	2.9	3.7	5.0	6.1
Total Amount Offset	6.6	6.2	7.2	7.6	7.4	6.1	7.1	7.9	9.6	10.5
As a Percentage of Hospitals' Unreimbursed Costs										
Source of Offsetting Revenues[a]										
State and local subsidies	27	21	20	18	17	14	21	20	16	10
Other nonpatient sources	29	34	35	32	33	44	35	30	28	30
Private payers	37	37	41	43	44	37	39	43	49	55
Total Amount Offset	93	91	95	93	95	95	95	94	93	94

SOURCE: Congressional Budget Office estimates based on data from the American Hospital Association's Annual Survey of Hospitals for 1980 through 1989.

NOTES: Unreimbursed costs are defined for each hospital as the costs incurred for uncompensated care (charity care plus bad debt) and for treating publicly insured patients minus the revenues received from all government payers; if those costs are less than those revenues, however, unreimbursed costs are zero.

The estimates shown are based on aggregate amounts using all sample hospitals.

a. Because most hospitals have revenues that exceed their costs, the order in which the sources of offsetting revenues are applied to cover unreimbursed costs affects the results. This analysis applied the sources in the order shown, so state and local subsidies were used first, and revenues from private payers were used last. Thus, the proportion attributed to private payers is lower than it would be if another order had been chosen.

TABLE B-4. SELECTED CHARACTERISTICS OF HOSPITALS WITH TOTAL REVENUES LESS THAN COSTS AND HOSPITALS WITH TOTAL REVENUES EQUAL TO OR GREATER THAN COSTS, 1989

	Revenues Less than Costs	Revenues Equal to or Greater than Costs
Percentage of Hospitals	24	76
Average Occupancy (In percent)[a]	55	62
Medicare's Share of Days (In percent)	42	44
Medicaid's Share of Days (In percent)	19	14
Revenue-to-Cost Ratios		
Total	0.96	1.06
Medicare	0.89	0.94
Medicaid	0.77	0.77
Private payers	1.18	1.26
Uncompensated Care (As a percentage of total costs)[b]	7.9	5.7
Unreimbursed Costs (As a percentage of total costs)[c]	15	10
Percentage of Unreimbursed Costs That Were Offset	75	100
Percentage of Hospitals		
Total	100	100
Rural	54	42
Urban	46	58
Ownership		
Nongovernment, not for profit	62	71
Government	34	27
For profit	4	3

(Continued)

TABLE B-4. CONTINUED

	Revenues Less than Costs	Revenues Equal to or Greater than Costs
Percentage of Hospitals (continued)		
Number of Beds		
50 or fewer	28	13
51-100	27	21
101-200	23	24
201-400	16	29
401 or more	6	13
Teaching[d]	20	30
Nonteaching	80	70
Disproportionate Share[e]	27	28
Nondisproportionate Share[f]	73	72

SOURCE: Congressional Budget Office estimates based on data from the American Hospital Association's Annual Survey of Hospitals for 1989. Teaching and disproportionate share status were based on data from the Health Care Financing Administration.

NOTES: Based on a sample of 1,527 hospitals for which data were available.

In the upper panel, the term "average" indicates the average amounts per hospital. Entries not designated as "average" are the percentages or ratios based on aggregate amounts for hospitals in each category--for example, Medicare's share of days is the percentage of aggregate days for hospitals in the category that were days of care for Medicare patients.

a. The occupancy rate for each hospital is defined as the ratio of the hospital's average daily census to its average number of beds during the reporting period.

b. Uncompensated care is defined as charity care plus bad debt.

c. Unreimbursed costs are defined for each hospital as the costs incurred for uncompensated care and for treating publicly insured patients minus the revenues received from all government payers; if those costs are less than those revenues, however, unreimbursed costs are zero.

d. Hospitals that receive an adjustment under Medicare's prospective payment system (PPS) for the indirect costs of medical education.

e. Hospitals that receive the disproportionate share adjustment under Medicare's PPS for treating a large proportion of low-income patients.

f. Nondisproportionate share category included 2 percent of hospitals in each group for which data on disproportionate share status were not available.

TABLE B-5. DIFFERENCE BETWEEN HOSPITALS' REVENUES AND COSTS FOR PRIVATE PAYERS, AND THE PORTION USED TO OFFSET UNREIMBURSED COSTS, 1980-1989 (As a percentage of the private-payer costs)

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Difference Between Revenues and Costs for Private Payers	13	14	15	17	18	18	20	19	22	25
Revenues from Private Payers Used to Offset Unreimbursed Costs	6	6	7	8	8	5	7	9	12	15

SOURCE: Congressional Budget Office estimates based on data from the American Hospital Association's Annual Survey of Hospitals for 1980 through 1989.

NOTES: Private payers refers to privately insured patients and individual patients who paid for their own care.

Unreimbursed costs are defined for each hospital as the costs incurred for uncompensated care (charity care plus bad debt) and for treating publicly insured patients minus the revenues received from all government payers; if those costs are less than those revenues, however, unreimbursed costs are zero.

Before calculating the portion of private payers' revenues used to offset unreimbursed costs, each hospital's unreimbursed costs were reduced by any state and local subsidies and by other revenues (in excess of costs) received from sources other than patient care.

PRESIDENT WILLIAM JEFFERSON CLINTON
REMARKS TO THE BUSINESS COUNCIL
WASHINGTON, D.C.
FEBRUARY 22, 1995

[Acknowledgements:TBD]

As a gesture of goodwill I decided to leave my golf clubs at home tonight. Actually I didn't hit anyone last week, but I had a bad round. As many of you know, national television exposure is not necessarily a great thing if you're a weekend golfer.

I'm glad to be here again. I see several old friends, including many who helped us with NAFTA, GATT and reducing the deficit. We may not always agree, but we have been productive partners on many things, and I thank you.

I've argued hard that to preserve the American Dream we must come together in a new national partnership. That's what I mean when I talk about a New Covenant.

The government's part of this bargain is to help empower people to make the most of their own lives. It's to enhance American security abroad, but also on our streets. And as we move into a new century and a new economy, it's to expand opportunity while shrinking bureaucracy. At the same time, this will only work if every citizen takes more responsibility for themselves, their communities and their country.

A big part of our job here is to cut yesterday's government and replace it with one that is flexible and entrepreneurial enough to meet tomorrow's challenges. You have been downsizing and modernizing your companies for more than a decade to meet global competition. Your successes have been recognized around the world. To help more Americans meet the demands of this new economy, the government must be as bold, imaginative, and entrepreneurial as you have been.

It was clear when we got here two years ago that the government wasn't doing enough to be a good partner. We had to make some very tough decisions to prepare for the future. There was too little growth, too few jobs and too much debt for the economy to pass the American Dream on to our children. No one was bringing Americans together in partnership.

I know many of you didn't agree with everything we did. But the truth is we stepped up to the plate where others hadn't. It is worth remembering just what we have been able to accomplish.

We began by passing the largest deficit reduction package in history; the deficit will go down more than $600 billion in five years. We cut more than 300 programs. We cut the federal

government by more than 100,000 positions -- on our way to cutting a total of 272,000. We cut taxes for 15 million working families and made 90 per cent of small businesses eligible for a tax cut. We lowered export barriers, passed GATT, passed NAFTA, engaged the APEC nations, hosted the Summit of the Americas, and have created a big emerging markets strategy to help us remain strong. This has been the most successful period for opening markets in decades.

It is important that you continue to support our historic efforts to stay engaged in the world. I'll talk more about this when I speak before the Canadian Parliament tomorrow. But let me say now, we face great new opportunities to increase security and prosperity, here and around the world. And we must resist any attempt to have us retreat from these great opportunities.

We cut government, and we made it work better -- doing things others only talked about for decades. We de-regulated trucking. We de-regulated interstate banking. We lowered dramatically export controls on high-tech products. We reformed the federal procurement system. We cut the SBA loan to one page. We support the end of un-funded mandates. My Labor Department did something unheard of in the annals of government: Before issuing an asbestos regulation they talked to EPA and now business won't face conflicting rules.

After we reduced the deficit, we did what every smart businessman would do with the savings. We invested more in things that create opportunity for our people: in technology and in the education and training of our children and our workers. We used savings from cutting 100,000 bureaucrats to pay for putting 100,000 more police on the streets. We are giving people the security they need to prosper.

I am proud our strategy is working. The projected deficit has dropped from almost $400 billion to under $200 billion. The federal government is on its way to its smallest size in 30 years. Last year the economy grew the most it has in a decade. We have the lowest combined rate of unemployment and inflation in twenty-five years. And the economy has generated nearly six million new jobs -- 93 per cent in the private sector.

We have made tough decisions to get to this point. But our challenge is to keep moving in the right direction, to keep creating new partnerships between business, government, and citizens, and to keep working to make America stronger.

It is critical that we continue to streamline government. This economy is based on knowledge, technology, and flexibility. Top-down bureaucracies won't work anymore. Bureaucrats and businessmen glaring across a table at each other can't work. Only our competitors gain when we do this.

So we have to keep working at this. That is why yesterday I called together the Heads of sixty-nine of the biggest regulatory agencies to announce a broad new initiative to reinvent the way we regulate.

I called for an immediate review of all their rules to see if they are obsolete or whether the private sector or local government can do the job better. I want this review on my desk by June 1.

Beyond that, I want to measure all regulations by whether they are doing the job intended, not by how much delay or red-tape they generate. I have asked our regulators to convene meetings in the field right away between regulators and those they regulate, to give us a better sense of reality. I want each agency Head to submit to the White House a list of pending procedures that can be converted to consensual negotiations. Finally, the Vice President is conducting a review of regulations covering food, health, the environment, worker safety, and financial institutions. As he gives me his recommendations for reform, I will act on them promptly.

I am ready to work with the Republicans on reform. But not on rolling back or wrecking what works. We need standards to protect food and air and water, to make sure cars are safe and that medical procedures like mammograms are accurate. These are safeguards that were put in place to protect our children, our workers, and our families. They help maintain public confidence in our entire economic system.

It is very troubling to me that the Republican Congress is trying to freeze all federal regulation. They would over-ride every single health and safety law on the books. This is unacceptable. I hope the business community will work to bring common sense into regulation and not gut it. We've must stay away from the extreme and stay in the mainstream.

We've got to lower our voices and talk sensibly about the things that really affect Americans. I know that you've been told the budget I've submitted this year does not cut the deficit enough. First off, that overlooks what it does. It continues to impose historic restraints on Washington. It consolidates or eliminates 400 programs. It contains $144 billion in hard savings. For every dollar in tax cuts in the Middle Class Bill of Rights the budget provides more than a dollar in deficit reduction -- $80 billion worth. And if the Congress gives me the line item veto, I'll find even more cuts.

All of you know that we must get entitlement spending under control -- and that Medicare and Medicaid are the principle entitlements adding to the deficit. But there is a right way and a wrong way. I still believe the right way is to reduce federal

health care spending, while bringing down costs throughout the entire health care system. And the wrong way is to slash Medicare and Medicaid to pay for tax cuts or simply to shift costs from the public sector to the private sector. Arbitrary cuts -- without real reform and more efficiency -- will only raise premiums and fees for hundreds of thousands of small businesses and millions of Americans. It won't work.

I want to work with Congress to bring down costs. But we have to do it by expanding coverage and reforming our health care system -- including more managed care. Last year, we bit off more than we could chew at one time. Now, we must take a step-by-step approach to cutting and improving the overall system. I hope Congress will join me to get this job done.

All of this -- cutting the deficit, restoring our economy, reinventing our government -- are part of my commitment to our partnership. I will do everything in my power to finish the job. But, as I said at the beginning, our work together is about building opportunity and taking responsibility -- responsibility that each one of you must take as well.

For your businesses to remain competitive and for America to remain the strongest nation on earth, we must manage change so that we bring both economic growth and economic security to hardworking Americans. I believe the core of this is our commitment to our children, to helping them have stronger and more secure futures.

For all that we have accomplished, we know there are much greater strains on our working families than ever before. For 15 years only a relatively small percentage of Americans have seen their incomes grow. Every other group has stalled or dropped. This is perhaps the most profound fact of our current social and political life.

That is why, instead of rolling back, we must keep investing in the things that will raise the living standards of our people. That is the best way to ensure that our children inherit the American Dream. And in this new economy, more than ever, the key is education and training.

We have pushed hard to improve educational opportunities: Expanding Head Start; creating national standards for our schools; and reforming the college loan system to get rid of costly middle-men, save the taxpayers billions of dollars, and give millions of middle class children a chance at college.

These concerns are why my proposed tax cuts -- the Middle Class Bill of Rights -- might be better be called the Middle Class Bill of Rights and Responsibilities. It provides tax relief for people willing to invest in themselves and their

children's future, and in particular in education and training.

For years I have worked with business leaders on these issues. No businessman I've ever dealt with wants a workforce that can't read, handle the technology of the twenty first century, or can't adapt to changing times.

But while we agree on this, unfortunately some in Congress do not. It's nice to talk about the third wave information revolution. But all the talk means nothing if our children are not prepared to ride that wave.

Our commitment has to begin with the fundamentals. Earlier today the Chairman of the relevant House Committee introduced a bill that eliminates the federal commitment to food and nutrition for children, throws the money into one block grant, and sends it to the states. That would include the School Lunch Program which has been a remarkable success and feeds 25 million of our children every day.

No one has done more than my Administration to give states flexibility to make what we do work better. But when it comes to the ability of our children to go to school alert and ready to learn, and when a federal program is acknowledged by all to be a success for children of all races, incomes, and regions, we cannot walk away from it. If it isn't broke we shouldn't fix it. You and I have a responsibility to stand together on this one.

This has been done before in the spirit of bipartisanship. In 1991 the issue was continuing the funding for the Women, Infants and Children Program so it would really help people. Five major CEO's appeared before Congress to say that they knew feeding low income pregnant mothers and infants saved lives and was a good idea. Three of these men are here tonight: Robert Allen of AT&T; John Clendenin of BellSouth; and, Robert Winters of Prudential Insurance. They called WIC "a triple A rated investment" in the future, and they were right. Their support helped lead to bipartisan support then -- with help from people like Senator Leahy and Senator Dole. I hope you will stand up to help us now and that we will have the same kind of bipartisan support.

I ask you to stay with me in on all these concerns. We cannot back away. We can harness the forces of change and begin a new era of greatness. We must think of everything we do as preparing us to be a great nation 100 years from now. We can do that if we expand opportunity, demand responsibility, and empower people to reach their God-given potential. Our job is stay together to make this happen. And when we do our children will inherit the American Dream. Thank you very much.