WHY A PUBLIC PLAN WILL ENCOURAGE UNFAIR COST SHIFTING

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Proponents of a public health insurance plan concede that Medicare and Medicaid pay much lower rates to providers than private insurers. For example, on average, hospitals are paid 9% below the costs of care by Medicare and 15% under costs by Medicaid. Similarly, Medicare pays physicians 22% less than they are paid by private insurers, while Medicaid pays 47% less. Yet public plan enthusiasts do not view Medicare's pricing power as a problem; instead, it is part of their publicly stated rationale for a public plan: to leverage purchasing power on behalf of members to get the best rates and lower premium costs.[1] In fact, the House Tri-Committee bill explicitly ties provider payment rates to Medicare levels for the first three years and allows for nationally negotiated rates thereafter. While Senate bills do not legislate where to set rates relative to Medicare, there are likely to be strong political pressures to keep payment rates under new public plan as close to Medicare rates as possible.

However, while experts disagree on the amount, most evidence suggests that for hospitals and pharmaceuticals, at least some portion of the sizable discounts obtained by public plans such as Medicare and Medicaid are passed along to private health insurers. While some experts have suggested that there is no cost shifting of Medicare underpayments (or negligible amounts), the available evidence does not entirely resolve the issue. This claim contrasts with more than a half dozen empirical studies suggesting hospitals recover at least 28 cents of every dollar of Medicare underpayments in the form of higher prices for private patients (and a more typical figure may be closer to 40 cents). Similarly, there is good evidence that for every dollar saved by Medicaid due to mandatory price rebates, the savings are more than made up by increased prices for private patients. But by lowering its own costs at the expense of private plans, a public plan will amplify its competitive advantage unfairly.

By the very nature of the politics required to sustain it, a public plan also is likely to keep its true costs hidden by subtly shifting burdens onto its own members. These are not hypothetical concerns. They are based on decades of actual experience with the largest public plan ever run by the U.S. government: Medicare. Medicare has grown increasingly stingy over time, with the consequence that the financial burden imposed on Medicare beneficiaries by medical expenses relative to their income has grown in the past and is projected to rise dramatically in the decades ahead. Within 75 years, the

premiums, deductibles and copayments that seniors will have to pay for their Medicare benefits will absorb 97% of the average Social Security check; for the average 85-year-old, the share will have risen to 117%. This reinforces the view that the federal government should focus its energies on fixing the public plans it already manages rather than taking on the responsibility of a new public plan.

Here's the evidence to support those conclusions.

COST SHIFTING OF MEDICAL COSTS

WHAT IS COST SHIFTING?

It is undisputed that private patients pay more than public patients for hospital and physician services. But this could simply reflect *price discrimination*: in general, any firm with some monopoly power will be more profitable if it charges different prices to different sets of purchasers that reflect differences in their willingness to pay. Such price discrimination is common in the service industry;[2] for example, airlines charge higher ticket prices to business passengers (who may have less flexibility in choosing when to fly) but generally offer much lower prices to passengers with greater flexibility and less "need" to fly (e.g., could substitute driving or forego flying altogether). Consequently, differences in payment rates across different types of health plans do not prove per se that costs have been shifted from one class of payers to another. So long as each payer covers at least the marginal cost of services provided to them (e.g., the extra gas used to fly the last passenger induced by a huge price discount to fill an airline's last empty seat), there is no economic loss that "needs" to be made up through higher revenues from other payers.

What matters is whether "underpayments" by public payers induce a compensating increase in prices charged to private patients--a phenomenon termed "dynamic" cost-shifting.[3] The strength of the evidence about the existence and magnitude of such cost-shifting varies by type of medical service, as assessed below. The weight of the evidence (mostly related to Medicare) suggests that public plans impose at least some degree of cost-shifting. However, such dynamic cost shifting evidently "does not completely counterbalance losses associated with charging one group less than another."[4] Moreover, the ability to cost shift is considerably reduced as the extent of competition among providers increases. Thus, the degree of cost-shifting will depend on local market conditions, but even under the most advantageous circumstances, providers are not able to *fully* recover whatever revenue losses they experience from public plan underpayments.

Note, however, even if one concluded there were *no* such cost shifting for any type of medical service, these payment differentials may adversely affect access to care for public plan patients.[5] There also is some evidence that quality of hospital care varies by

the generosity of payments.[6] In short, sizable public plan payment differentials would be problematic even if cost shifting is a mythical beast.

HOSPITAL COST SHIFTING

PUBLIC PLAN UNDERPAYMENTS

In 2006, Medicaid paid hospitals 14.7% below the estimated costs of care for Medicaid patients; similarly, Medicare in 2007 paid on average only 91.4 percent of the actual cost of hospital care for its patients.[7] Careful empirical work has established that average per diem hospital costs do not vary significantly across Medicare, Medicaid and private patients;[8] therefore, these large payment differences cannot be explained by differences in the costs of providing their care.

Nevertheless, from Medicare's perspective, the latter figure exaggerates its degree of underpayment since not all hospital costs are recognized by Medicare.[9] Yet even using Medicare's more restrictive definition of costs, the Medicare margin in 2007 was -3.7%.[10] However, this figure arguably *understates* the underpayment since it includes not only direct reimbursement on behalf of Medicare patients, but also Medicare payments to hospitals intended to cover the costs of graduate medical education (GME), bad debts and disproportionate share (DSH) payments intended to help cover uncompensated costs from non-Medicare patients. If such payments de facto are being used simply to cover the actual costs of hospital care for Medicare patients rather than for the stated purposes, then the Medicare program is circumventing the intent of policymakers. For hospitals not receiving any GME or DSH payments, the total Medicare margin was -16%,[11] so the inclusion of such payments can mask the true extent of underpayment substantially; in 2006, across all hospitals, such non-patient Medicare revenues amounted to 5.1% of Medicare patient revenues.[12] Without such revenues, the 2007 Medicare margin would have been -9.3%, implying that Medicare paid 7.5% below average costs.[13]

AVERAGE VERSUS MARGINAL COSTS

However, the foregoing figures are based on average costs. But so long as they have sufficient patients to cover their fixed costs, hospitals will not lose money on additional patients so long as payments exceed the marginal cost of their care. For emergency room care, the lowest reported estimate[14] of marginal costs using monthly data from six Michigan hospitals shows them equal to only 42% of average costs.[15] An earlier study using U.S. cross-sectional data for 1981 found this ratio to be 61%.[16] The first figure can be viewed as an estimate of very short-run marginal costs (i.e., based on changes in monthly ER visits), whereas the second can be viewed as an estimate of long-run marginal costs. However, an update of the latter study (improved with the inclusion of additional regulatory variables) estimated the ratio of long-run marginal costs to average costs was 82% for ER visits and 92% for other outpatient hospital visits.[17] The long-run

ratios arguably are most relevant for purposes of determining the appropriate level of Medicare reimbursement.[18]

For inpatient care, early estimates of short run marginal costs, using time series data, pegged them at 40 to 75% of average costs.[19] But the reimbursement levels that hospitals will need in the long run to both serve each category of patients and survive must equal or exceed *long-run* marginal costs, i.e. allowing for hospitals to adjust the number of beds to attain an optimal size in light of prices paid by each payer. Various estimates of long-run marginal costs range from 58 to 105% of average costs.[20] Moreover, many hospital cost studies have not accounted for the fact that hospitals face uncertain demand and hence deliberately maintain excess capacity to avoid having to turn away patients. A study of U.S. hospitals showed that marginal costs that take demand uncertainty into account are 31% higher than estimates that do not.[21] In short, properly estimated long-run marginal costs for hospitals may not be that much below the observed level of short-run average costs. Thus, measuring "underpayment" relative to average costs will not appreciably distort the picture of whether public plans pay their fair share of costs.

The only study to measure this directly is an analysis using California data from 1994, showing that reimbursement for Medicare patients was 7% below long run marginal costs if it was assumed that there was no excess bed capacity, while Medicaid reimbursement was 2% below such costs.[22] However, when long run marginal costs were projected assuming an "optimal" occupancy rate is 80% (rather than the 50.3% observed), Medicare reimbursement was found to be 35% higher than long run marginal costs, while Medicaid payments were 14% higher.[23] In short, public plans underpaid hospitals relative to their actual long-run marginal costs, but "overpaid" relative to the hypothetical costs that would be observed if hospitals eliminated excess beds. It is not clear how the figures just cited would change using more recent data (California's hospital occupancy rate is now 68%[24]) or how well these findings can be generalized to other states (California's cost per inpatient day is one third higher than the national average[25]).

TRENDS IN PUBLIC PLAN UNDERPAYMENT

One thing is for certain: even using Medicare's own figures, Medicare reimbursement has tightened steadily over the past decade:

- For inpatient hospital care, the Medicare margin plummeted from +18% in 1997 to -3.7% by 2007.[26]
- The total margin for Medicare patients (inclusive of all forms of inpatient and outpatient care) declined from +11.9% in 1997 to -5.9% by 2007[27] and is projected to hit -6.9% in 2009.[28]

PUBLIC PLAN BARGAINING LEVERAGE

Why do hospitals accept such low payment from public plans? As a practical matter, they have little choice: across all hospitals, in 2009 Medicare will account for 28.6% of

hospital revenues and Medicaid will account for 17.6%.[29] But "in many markets Medicare and Medicaid comprise over 65 percent of the payments to hospitals."[30] But with these two programs alone accounting for nearly half of hospital revenues, no other private payer comes close to being able to dictate prices in this fashion except perhaps in very rare and isolated circumstances. Thus, despite the sharp decline in Medicare margins since 1997, virtually all hospitals in the U.S. continue to participate in Medicare.[31]

Evidence Related to Hospital Cost Shifting

Passive Cost Shifting

If hospitals made sizable profits, they hypothetically could absorb losses related to public plan patients. But the average hospital's operating margin for all patients averaged only 3.8% in 2006.[32] Nationally, from 1980 to 2003, average total hospital margins ranged from 4-6%.[33] Thus many facilities would have difficulty absorbing unreimbursed costs related to public patients exclusively through lower profits. Instead, de facto, the average hospital is able to cover its losses on public plan patients from the surpluses earned on paying patients. As an example, in 2007, hospital payments for the care of privately insured people were equal to about 132% of their actual costs of care.[34] This is the functional equivalent of a hidden sales tax of 32%.

Of course, such a wide gap between private payments and the costs of their care reflects *hospital market power* that arguably would be exercised even if there were no "need" to cost shift due to Medicare and Medicaid. But whether cost shifting is "passive" (using surplus revenues from private patients that arise "automatically" from setting prices at profit-maximizing levels) or "dynamic" (using unexercised market power to set prices for private patients higher than they would be otherwise to recover some or all of losses due to public patient underpayments), it is worth asking how much of the surplus revenues produced by this 32% differential implicitly are used to cover public plan underpayments?

The actuarial firm Milliman has calculated that in 2006, if Medicare and Medicaid cost-shifting had been eliminated, privately insured hospital payments could have been reduced by 18%.[35] These are still sizable "hidden taxes," but this calculation also assumes that hospitals face a zero-sum situation in which there is a dollar-for-dollar transfer of public plan "underpayments" to higher costs paid by privately insured patients. Is this really what happens?

Dynamic cost shifting is possible only where hospitals have sufficient market power to raise prices to private payers, *and* have not have been fully exercising that power. Conventional models of hospital behavior imply that in *theory*, profit-maximizing hospitals should never engage in dynamic cost shifting: that is, if hospitals already have set their prices for private patients at levels that maximize profits, any attempt to raise them further in response to reductions in public patient revenues will decrease rather than

increase their private patient revenues. This is as true for hospitals that are monopolists as it is for hospitals in highly competitive markets.[36] In theory, hospitals may hold unexercised market power over private patients, but it is difficult to account for why a hospital would do this since even nonprofit hospitals theoretically should seek to maximize their revenues in pursuit of whatever mission they have adopted.[37] However, at least one model of hospital behavior when they have a local monopoly shows that "under plausible assumptions, the Medicare / Medicaid reimbursement policy does lead to higher private-sector hospital charges, even when the government pays the full (average or marginal) cost of hospital services."[38] Likewise, plausible reasons have been advanced for why both nonprofit and for-profit hospitals may have a motivation not to fully exploit their pricing power.[39] Thus, the existence and extent of dynamic cost shifting cannot be resolved by theory, but instead based on empirical evidence.

EVIDENCE FOR DYNAMIC COST SHIFTING

Efforts to detect and measure dynamic cost shifting in hospitals span two decades:

- Two early studies (using data that preceded adoption of Medicare's prospective payment system in the early 1980's) showed that at least half of government plan hospital payment shortfalls are cost-shifted;40
- However, two other studies using data from the same period showed that hospital cost-shifting was much more limited, though not entirely absent;[41]
- An analysis of California hospitals using data from 1983-1991 (a time of increasingly intense price competition) showed that for each 1% reduction in Medicare prices, prices to private patients rose from 0.17% to 0.586% depending on whether the hospital was for-profit and the degree of competition in the local area.[42] Based on the relative share of Medicare and private patients, these figures imply that hospitals were able to recover anywhere from 28 to 97 cents of each dollar of Medicare price reductions.[43] Reductions in Medicaid prices generally showed smaller amounts of cost shifting (and in some cases, no significant change in private patient prices at all). Surprisingly, the authors found no significant change in cost shifting behavior over time, even though the hospital market had grown much more competitive by the end of the study period.[44]
- An analysis of California hospitals three time intervals from early 1980s to the early 1990s also found that hospitals did practice dynamic cost shifting, but that their ability to shift costs decreased over time.[45]
- An analysis conducted in late 1995 found that 40% of hospital payment shortfalls in public programs were passed-on to private-payers in the form of higher prices;[46]
- A study using California data from 1993-2001 found that a 1% relative decrease in the average Medicare price was associated with a 0.17% increase in the corresponding price paid by privately insured patients; similarly, a 1% relative reduction in the average Medicaid price was associated with a 0.04% increase for private patients.[47] These figures imply that hospitals recovered roughly 28 cents of each dollar of Medicare underpayment and about 15 cents of each dollar of Medicaid underpayment.[48] Since the study was conducted in the one of the most

competitive markets in the nation, these estimates should be viewed as lower bound measures of the likely size of the cost shift for the nation as a whole.

- Nationally, average annual aggregate hospital payment-to-cost ratios for private payers have varied inversely with the payment-to-cost ratio for Medicare patients over the period 1981-2005: the former increases as the latter decreases.[49] Likewise, at the state level, there is a strong positive correlation between the size of the aggregate burden of underpayments from Medicare, Medicaid and uncompensated care (measured as a percent of hospital costs) and the private payer payment-to-cost ratio.[50] Both patterns are consistent with dynamic cost shifting even though neither definitively proves it.

In summary, a number of studies have demonstrated the existence of dynamic cost shifting. While they differ on the share of public plan underpayments that are recovered through higher prices for private patient, they are consistent in showing that it is less than 100%. Since all these studies measure public plan shortfalls relative to average costs, it is conceivable that hospitals cost shift only in instances that Medicare or Medicaid payments fall below short- or long-run marginal costs. There generally was a consensus from these studies that a hospital's ability to cost shift would be much more constrained in markets where there was a lot of hospital and/or health plan competition.

In modeling the impact of health reform efforts, the Lewin Group[51] has concluded from the foregoing evidence that "payments under private insurance are inflated by the cost of covering uncompensated care and payment shortfalls under public health coverage programs." But the Lewin analysts also concede: "Not *all* of the shortfalls in payments are shifted to private insurers. The literature indicates that only about 40 percent of uncompensated care and payment shortfalls are passed-on as higher prices for the privately insured. The remainder (60 percent) appears to be absorbed through reductions in costs and net income."[52] Thus, the Lewin Health Benefits Simulation Model (which has been used to estimate the cost of various House and Senate reform bills for committees working on these proposals[53]) assumes that 40 cents of every dollar of Medicare/Medicaid underpayment (reimbursement less than average costs) is shifted to patients with private insurance.

EVIDENCE AGAINST DYNAMIC COST SHIFTING

The Medicare Payment Advisory Commission (MedPAC) has studied Medicare cost shifting carefully. It has concluded that high-performing hospitals (having low costs coupled with high quality) have costs that are 11% below average. In such facilities, the median Medicare margin was 0.5% in 2007 (compared to -7.4% for all other hospitals[54]), leading MedPAC to conclude that "Medicare payments are still adequate for efficiently run hospitals."[55] Since only 12% of hospitals were characterized as "relatively efficient" in 2004-2006 by MedPAC's criteria, one might view these figures as indicating that Medicare payments are by design adequate only for a small minority of hospitals.

MedPAC further determined that "hospitals under financial pressure tend to control their costs, which makes it more likely that they profit from Medicare patients."[56] In such hospitals (where median non-Medicare patient margins are -2.4%, inclusive of uninsured, Medicaid and privately insured patients), median Medicare margins are +4.2%.[57] Conversely, MedPAC found "that Medicare margins are lowest in the hospitals with abundant resources." Hospital in this group had a median private patient margin of 13.5%, but a median Medicare margin of -13.5%. MedPAC has inferred from these findings "it appears that hospitals are raising prices when they have the market power to do so." [58] In this view, the low Medicare margins are the result of high costs (induced by generous private payer reimbursement) rather than Medicare "underpayment." Had these facilities held their costs per discharge to the same level as hospitals under financial pressure (i.e., 10.3% lower), their Medicare margins would have been -0.1% (author's calculation). MedPAC has concluded that "while causation may flow in both directions to a degree, the data suggest that the *primary* reason Medicare margins are inversely related to private-payer profits is that high non-Medicare profits are followed by high hospital costs."[59]

Unfortunately, the picture painted by MedPAC is muddied by counting GME and DSH payments as part of hospital revenue from Medicare. MedPAC concedes that compared to the actual impact that medical residents have on the costs of care for Medicare patients, it is paying teaching hospitals double the amount that can be empirically justified, steering $3 billion in extra payments to the 30 percent of hospitals who qualify for them.[60] This is part of the reason that politically favored teaching hospitals have a 1.1% Medicare margin, whereas non-teaching hospitals had a -9.3% margin.[61] The DSH payments are intended to cover uncompensated costs for hospitals that serve a significantly disproportionate number of low-income patients; by law, these DSH payments to individual DSH hospitals are not higher than their actual uncompensated costs.[62] While DSH payments originally were justified because Medicare costs appeared higher in facilities with a high percentage of Medicaid patients, it was subsequently determined by 1990 that this no longer was true.[63] Thus, such payments are not intended to cover care for Medicare patients at all, so including them as a source of Medicare revenue distorts the picture of how much hospitals actually have available to cover Medicare patient costs.

Unfortunately, there is no way of telling from the figures provided by MedPAC how this picture would have changed if these payments were excluded from the analysis. If GME and DSH payments constitute 5.1% of revenues in efficiently run hospitals (as they do in facilities overall), then even MedPAC's figures imply that Medicare underpays relative to average costs by 4.6% for the median hospital. This deficit may be even larger for efficiently run hospitals whose costs are above the median for such facilities, but the MedPAC estimates provide no indication of how average costs are distributed around this median. Hence, there is no way of estimating how many "efficiently run" hospitals might

nevertheless be experiencing sizable Medicare underpayments exceeding, for example, 10% of costs.

PHYSICIAN COST SHIFTING

PUBLIC PLAN UNDERPAYMENTS

In 2007, Medicare paid doctors 22% less than rates paid by private insurers for the same services.[64] In the same year, Medicaid paid physicians 60% of their average rates, while private insurers paid 114% of average rates (making Medicaid rates 47% below private rates overall).[65] But the generosity of Medicaid physician payments varies substantially across states. A study of 21 states showed that in 2003, average physician fees under Medicaid were as low as 36% of Medicare fees in New York but as high as 100% of Medicare fees in North Carolina.[66]

For a typical physician, 55% of Medicare fee payments under its original physician fee schedule were designed to cover the physician's time, with the remainder to cover practice expenses (non-physician clinical labor, medical supplies, medical equipment, administrative labor, office supplies and other) and expenses for professional liability insurance.[67] Medicare subsequently has moved to a resource-based method of calculating practice expenses, so the exact share of fees allocated to physician time vs. all other practice costs has changed. But more importantly, actual practice expenses have risen nearly five times as rapidly as Medicare payments between 1991 and 2007,[68] reflecting the growing stringency of Medicare physician payments. Thus, the implicit share of Medicare fees used to cover all other practice expenses is far higher than the 45% originally intended and apparently exceeds 100% for many physicians. A 2008 survey of practicing physicians in the U.S. found that 65% said Medicaid reimbursement is less than their cost of providing care, 36% reported that Medicare reimbursement falls below their costs for care and 14% said that SCHIP payments fall below costs.[69]

PUBLIC PLAN BARGAINING LEVERAGE

On average, Medicare accounts for 20% of physician and clinical services revenue, while Medicaid/SCHIP account for 7%.[70] But these percentages vary widely depending both on a physician's specialty and mix of patients. For example, primary care physicians rely on Medicare and Medicaid for 40% of their revenue,[71] and in "many markets" Medicare and Medicaid payments account for "more than 80 percent" of revenues in some physician specialties.[72] As noted earlier, the DOJ recognizes that where a health plan accounts for more than 30% of a physician's practice revenue, the health insurer can have monopsony power to the detriment of patients.[73] If a new public plan is permitted to link its fees to Medicare rates, this would give it bargaining leverage unavailable to any private plan.

EVIDENCE RELATED TO PHYSICIAN COST SHIFTING

PASSIVE COST SHIFTING

The actuarial firm Milliman has calculated that if Medicare and Medicaid cost shifting had been eliminated, privately insured physician payments in 2006 could have been reduced by 12%;[74] (recall the equivalent figure for hospitals was 18%). Thus, the "need" to cost shift due to lower payment rates by public plans appears to be lower among physicians than hospitals, but this does not answer the question of whether physicians actually engage in dynamic cost shifting.

Theoretical models of physician behavior have been driven by the empirical observation that they do not set their fees at the maximum level possible.[75] It has been suggested that rather than maximizing income, physicians instead seek a target income or focus on their incomes relative to their peers; at least one study has found empirical support for this hypothesis.[76] Whether they seek a target income or relative income, there are circumstances under which reductions in administered prices for public patients may induce physicians to raise fees for other patients.[77]

While their high market shares clearly give Medicare and Medicaid plans the market power to command deep discounts for many physicians, the empirical question is whether some or all of this underpayment to physicians is shifted to private insurers, a question that has been much less studied than in the case of hospitals:

A 2008 survey of physicians found that in response to a hypothetical 10% reduction in Medicare fees, 25% reported they would seek other sources of revenue; 24% said they would reduce their number of Medicare patients and 14% said they would stop seeing Medicare patients altogether.[78] Presumably, if physicians had the power to fully shift the entire cost of Medicare fee reductions onto private patients, none would see the need to reduce the amount of care provided to Medicare patients.

Preliminary findings from a study of physician pricing using 1989-1990 data from 76 geographic areas in 32 states showed that for each one percent reduction in physician payments under public programs, private sector prices generally increased by 0.1 to 0.3 percent, depending on procedure.[79] However, more careful analysis and modeling by these researchers ultimately concluded that there was no evidence of cost-shifting in response to Medicare fee reductions that for some procedures exceeded 30 percent.[80]

Likewise, a study focused only on coronary-artery bypass grafts in two states found no significant increase in private physician fees for various types of CABG procedures in the aftermath of reductions in Medicare payments for them.[81]

Note that this study did find that physicians doing CABG procedures responded to a reduction in Medicare payments with an increase in the volume of such surgeries to privately insured patients,[82] a finding also found for many (but not all) procedures in the

32-state study.[83] However, such a response is quite different from cost shifting, which is raising prices without a commensurate increase in the quantity or quality of services provided.

Despite the paucity of evidence regarding physician cost shifting, the Lewin model described earlier, assumes that 40% of physician underpayments are shifted to private patients.[84]

PHARMACEUTICAL COST SHIFTING

One of the driving motivations behind a public plan is the opportunity to use it to bargain directly for drug prices, as is done in Canada, Britain and many other national health systems.[85] Proponents argue that because of direct bargaining, drug prices are 58% cheaper under the Veterans Health Administration (VHA) than under Part D and that branded drugs are 60% more expensive in the U.S. compared to Canada.[86]

It is undeniable that drug prices under six public programs, including Medicaid and VHA, are 36-59% below the average wholesale price of those drugs.[87] But we also have known for more than a decade that the Medicaid discounts enacted in 1990, for example, "succeeded in lowering drug costs to Medicaid but resulted in higher prices to other drug purchasers,"[88]--a finding confirmed by the Congressional Budget Office.[89] That is, because Medicaid discounts are tied to prices paid in the private market, drug manufacturers have an incentive to increase the latter. The most recent study to examine this carefully showed that "the average price of a non-Medicaid prescription would have been 13.3 percent lower in 2002 in the absence of Medicaid's pricing rule."[90] The same authors found that every 10% increase in Medicaid market share was associated with a 7-10% increase in the price of a prescription.

These deep discounts have by law now been extended to virtually all public programs except Medicare. Given the extraordinary fiscal pressures Medicare will face in the next decade, it may be only a matter of time before the expediency of short-term Medicare savings outweighs concerns about any adverse long-term impacts on longevity.[91] But if a new public program's hospital and physician payments already are linked to Medicare (as proposed in the House Tri-Committee bill[92]), it seems likely that prescription drug price discounts also would be extended to the new public program too, in which case the aforementioned cost shifting would increase in amount. While the exact number who might end up on a public plan is unknown,[93] 59 million individuals currently are covered through Medicaid.[94] Thus, if a public plan given access to the Medicaid drug discount covered 30 million new members (as projected by CBO for the year 2019[95]) this would imply a 35 to 50% increase in drug prices for privately insured individuals.

PRIVATE INSURER COST SHIFTING

CURRENT COST SHIFTING FROM MEDICARE AND MEDICAID

Milliman calculates that for a typical family of four with private insurance, the *current* cost shift by hospitals and physicians attributable to Medicare and Medicaid amounted to about $1,800 in higher premium and out-of-pocket costs in 2007.[96] This increased their health care spending (inclusive of premiums and cost-sharing for all services, not just hospital and physician care) by 10.7%. If cost shifting as a share of Medicare and Medicaid payments for hospitals and physicians remained unchanged in 2009 and the additional increase in private patient costs attributable to Medicaid prescription drug discounts is added, this total would increase to about $2,600 or 13.9% of spending.[97] This is the equivalent of a hidden excise tax of 13.9% on health services used to finance services for Medicare and Medicaid recipients (above and beyond the explicit taxes and premiums used to pay for these public programs). Put a different way, these two public programs together cost providers 15.8% more than they were paid for services, leaving the difference either to be cost shifted or absorbed.

The Milliman analysis implicitly assumes that 100% of Medicare and Medicaid underpayments are shifted to private patients in the Milliman analysis. But if, the evidence suggests, the actual hospital cost shift is only 40% and there is no cost shifting by physicians, the total cost shift per family figure would be reduced to just over $1,000 or 5.6% of their medical spending.[98]

PROJECTED COST SHIFTING FROM A NEW PUBLIC PLAN

Taking into account cost-shifting from all sources, what would the net impact on private insurers be from a new public plan? The House Tri-Committee bill explicitly ties provider payment rates to Medicare levels for the first three years (with an additional 5% bonus paid to those accepting Medicare and public plan patients as well as pediatricians and other providers that don't typically participate in Medicare). In subsequent years, the Secretary may establish a process for setting rates. The House Energy and Commerce Committee version includes a provision requiring the public health insurance option to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities.[99]

The Senate HELP Committee bill permits the public plan to negotiate rates with providers, but does not explicitly tie payment rates to Medicare. But for the same reasons Medicare payments to hospitals and physicians have grown steadily more stringent over time, it can be expected that there would be strong political pressures for the public plan to keep payment levels as close to Medicare levels as possible. The firestorm of protest that has erupted among the elderly in the face of perceptions that health reform will be financed through cuts in Medicare illustrates the political risks of having a new public plan that is visibly more generous than Medicare. This will be especially true if continued

reductions in Medicare fees relative to private payers results in growing access problems for Medicare beneficiaries.

Using their 40% cost shift assumption for hospital and physician underpayments, the Lewin Group estimates that had the mid-July House plan been in place in 2010, it would result in an *additional* cost shift from the public plan to private plans amounting to 9.7% of private plan premiums, or about $650 annually per private policyholder.[100] This likely overstates cost shifting by physicians for reasons noted earlier, but excludes any cost shifting related to pharmaceutical discounts. There is not sufficient detail in the Lewin figures to make an exact adjustment, but if the overall distribution of cost shifting by service for a new public plan is roughly similar to the 2009 levels estimated from Milliman above, then correcting the Lewin figures to reflect more realistic levels of cost shifting would approximately cut their estimates in half.[101]

MEMBER BURDEN-SHIFTING

MEDICARE'S STINGY COVERAGE

But Medicare is an equal opportunity offender when it comes to dumping costs on others. It even shortchanges its own members through notable gaps in coverage less common in private plans:

- For example, Medicare has no upper limit on out-of-pocket spending; in contrast, only 26% of health plans offered by small firms and 18% offered by large firms provide no maximum limit on family out-of-pocket spending.[102]
- A recent analysis of Medicare's gaps in coverage concluded that Medicare coverage was 13% less valuable than the median private plan offered by large employers and 10% less valuable than the most popular plan chosen by federal employees.[103]

Because Medicare covered only 51% of the average medical expenses for members not in nursing homes (2005),[104] more than 90% of these non-institutionalized beneficiaries rely on some form of supplemental health coverage.[105] All told, they rely on private supplemental plans to cover 21% of their spending, which is more than two-fifths of the share of costs covered by Medicare.[106]

But it gets worse: Medicare has been providing its members with coverage that has gotten less generous over time, i.e., covering a shrinking share of its members' health spending.[107] This has resulted in a higher burden borne by families in the form of higher out-of-pocket spending and premiums for supplemental coverage. This burden is projected to get substantially worse in the decades ahead:[108]

Including the costs of both Part B and Part D, the average cost of SMI premiums and cost sharing for Part B and Part D were estimated to absorb about 27 percent of Social Security benefits in 2007.[109] Yet by 2078, these same out-of-pocket health expenses for a

typical 65-year-old Medicare beneficiary will absorb 97% of the average Social Security check; for the average 85-year-old, the share will have risen to 117%.[110]

Whatever happened to coverage you could count on? Is there any good reason to think a new public plan would be different? These trends reinforce the view that the federal government should focus its energies on fixing the public plans it already manages rather than taking on the responsibility of a new public plan.

EMPLOYER MANDATE

One other form of cost shifting worth mentioning relates to the hidden costs imposed by an employer mandate. Both the House bill and Senate Health, Education, Labor and Pensions committee plan impose a penalty on employers who do not offer coverage.[111] The Senate Finance committee bill may require employers to pay a "free rider" penalty if their workers purchase coverage through the exchange.[112] However, such employer mandates are "a political expedient that conceals who actually pays for the required benefit. Economists generally agree that employee benefits ultimately are paid for by the employee. A worker's total compensation depends on his or her productivity to the firm, regardless of the split between wages and benefits. When an insurance mandate is imposed on all employers, the added cost of labor is covered through a combination of lower wages or other benefits or reduced employment. According to one study, 83–100 percent of the cost of coverage is shifted to employees through reduced wages."[113]

An employer mandate is not an intrinsic feature of a public plan. Nevertheless it perpetuates a lack of transparency about financing health care that historically has led to so much wasteful spending. For example, the current tax exclusion cost taxpayers more than $250 billion in lost revenues in 2008,[114] but most workers have no idea their employer-based coverage is subsidized, much less how they personally benefit (the average worker receives a subsidy of 35%[115]). By encouraging employees to have more comprehensive health coverage than is necessary, the tax subsidy spawns overutilization of health services that actually makes everyone worse off than if the subsidy did not even exist. It has been estimated that without this tax exclusion, average premiums for group health insurance would be 45 percent lower.[116] Thus, to the degree that a public plan is bankrolled by giving employees or the public the illusion that the lion's share of premium costs is being paid by employers, it likewise will dissipate the economic discipline that might otherwise arise were increases in the generosity of coverage paid more directly in the form of higher taxes or higher premiums. Thus, the risks of a public plan over-promising and then underpaying for more generous benefits are much greater with an employer mandate than without it.

Conclusions

The House Tri-Committee bill explicitly ties provider payment rates to Medicare levels for the first three years and allows for nationally negotiated rates thereafter. While Senate bills do not legislate where to set rates relative to Medicare, there are likely to be strong political pressures to keep payment rates under new public plan as close to Medicare rates as possible.

However, while experts disagree on the amount, most evidence suggests that for hospitals and pharmaceuticals, at least some portion of the sizable discounts obtained by public plans such as Medicare and Medicaid are passed along to private health insurers. While some experts have suggested that there is no cost shifting of Medicare underpayments (or negligible amounts), the available evidence does not entirely resolve the issue. This claim contrasts with more than a half dozen empirical studies suggesting hospitals recover at least 28 cents of every dollar of Medicare underpayments in the form of higher prices for private patients (and a more typical figure may be closer to 40 cents). Similarly, there is good evidence that for every dollar saved by Medicaid due to mandatory price rebates, the savings are more than made up by increased prices for private patients. But by lowering its own costs at the expense of private plans, a public plan will amplify its competitive advantage unfairly.

By the very nature of the politics required to sustain it, a public plan also is likely to keep its true costs hidden by subtly shifting burdens onto its own members. These are not hypothetical concerns. They are based on decades of actual experience with the largest public plan ever run by the U.S. government: Medicare. Medicare has grown increasingly stingy over time, with the consequence that the financial burden imposed on Medicare beneficiaries by medical expenses relative to their income has grown in the past and is projected to rise dramatically in the decades ahead. This reinforces the view that the federal government should focus its energies on fixing the public plans it already manages rather than taking on the responsibility of a new public plan.

Next Installment: Why a Public Plan Will Have an Unfair Advantage

Notes

[1] J.S. Hacker, *The Case for Public Plan Choice in National Health Reform*, (Berkeley, CA: Center for Health, Economic & Family Security, U.C. Berkeley School of Law; and Institute for America's Future, December 17 2008), 6-7

[2] P.B. Ginsburg, "Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?," *Health Affairs* (2003): W3-473.

[3] M.A. Morrisey, *Cost Shifting in Health Care: Separating Evidence from Rhetoric* (Washington DC AEI Press, 1994), J.P. Clement, "Dynamic Cost Shifting in Hospitals: Evidence from the 1980s and 1990s," *Inquiry* 34, no. 4 (1997-1998).

[4] T. McLaughlin, "Cost Shifting in Health Care: Separating Evidence from Rhetoric," *New England Journal of Medicine* 332, no. 19 (1995): 1313

[5] See 3. Why a Public Plan Will Create Access Problems http://conoverc.wordpress.com/top-10-reasons-to-oppose-a-public-plan/8-a-public-plan-will-create-access-problems/.(accessed August 29 2009).

[6] A. Dor and D.E. Farley, "Payment Source and the Cost of Hospital Care: Evidence from a Multiproduct Cost Function with Multiple Payers," *Journal of Health Economics* 15, no. 1 (1996), J. Seldon and W. Khandker, "Quality of Care and Cost-Shifting in the for-Profit Hospital," *Atlantic Economic Journal* 18, no. 3 (1990).

[7] W. Fox and J. Pickering, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*, (Seattle, WA: Milliman, December 2008), Chart 5.

[8] This evidence is carefully reviewed in Morrisey, *Cost Shifting in Health Care: Separating Evidence from Rhetoric*, Chapter 4. A more recent addition to this literature is Dor and Farley, "Payment Source and the Cost of Hospital Care: Evidence from a Multiproduct Cost Function with Multiple Payers."

[9] Lewin Group estimates that Medicare allowable costs were 7 percent to 8 percent less than hospitals' reported costs in 2007. Non-allowable costs include items such as advertising, entertainment, penalties, gifts, donations, employee education, etc. J. Sheils, *The Impact of the House Health Reform Legislation on Coverage and Provider Incomes. Testimony before the Energy and Commerce Committee, U.S. House of Representatives*, (Falls Church, VA: The Lewin Group, June 25, 2009; updated July 9, 2009), Note 5.

[10] Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program*, (Washington, DC, June 2009), Chart 7-10. Note: Medicare margin = (revenue minus costs) divided by revenue, taking into account all sources of Medicare revenue--including payments for graduate medical education and bad debts--but including only Medicare-allowable costs. A 3.7% margin implies Medicare paid 3.6% less than costs.

[11] Ibid., Chart -17.

[12] Fox and Pickering, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*, Chart 5.

[13] Calculations by author.

[14] A.P. Bamezai and G.P. Melnick, "Marginal Cost of Emergency Department Outpatient Visits: An Update Using California Data," *Medical Care* 44, no. 9 (2006): 839

[15] R.M. Williams, "The Costs of Visits to Emergency Departments," *New England Journal of Medicine* 334, no. 10 (1996). For non-urgent visits—constituting 32% of visits in this study—marginal costs were 38.7% of average costs, compared to 42.1% for semi-urgent visits and 42.2% for urgent visits.

[16] T. Grannemann, R. Brown, and M. Pauly, "Estimating Hospital Costs: A Multiple-Output Analysis," *Journal of Health Economics* 5 (1986).

[17] S.R. Eastaugh, *Health Care Finance: Economic Incentives and Productivity Enhancement* (Auburn House, 1992), Table 1

[18] Bamezai and Melnick, "Marginal Cost of Emergency Department Outpatient Visits: An Update Using California Data."

[19] B. Friedman, "Commentary: Excess Capacity, a Commentary on Markets, Regulation, and Values.," *Health Services Research* 33, no. 6 (1999): 1676

[20] J. Lipscomb, I. Raskin, and J. Eichenholz, "The Use of Marginal Cost Estimates in Hospital Cost-Containment Policy," in *Hospital Cost Containment: Selected Notes for Future Policy*, ed. Michael Zubkoff, Ira E. Raskin, and Ruth S. Hanft, (New York: Prodist, 1978), 531

[21] M. Gaynor and G.F. Anderson, *Uncertain Demand, the Structure of Hospital Costs, and the Cost of Empty Hospital Beds*, (Cambridge, MA: National Bureau of Economic Research, November 1995), Table 4

[22] Even though Medicaid reimbursement per day was lower than for Medicare, the authors calculated that the long run marginal cost per day for Medicaid patients was 38% lower than for Medicare, which more than offset the difference in per diem payments. S. Ennis, M. Schoenbaum, and T. Keeler, "Optimal Prices and Costs for Hospitals with Excess Bed Capacity," *Applied Economics* 32, no. 9 (2000): Table 5

[23] Author's calculation from cost and revenue estimates reported in Table 5. Ibid.: Table 5.

[24] Author's calculation from data reported in The Kaiser Family Foundation, "Inpatient Days Per 1,000 Population, 1999-2007," in *statehealthfacts.org* (Data Source: Calculation based on 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, and 2007 AHA Annual Surveys. Copyright 2009 by Health Forum LLC, an affiliate of the American Hospital Association, available at http://www.ahaonlinestore.com/ProductDisplay.asp?ProductID=637; Annual Population Estimates by State, July 1, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, and 2007 Populations, U.S. Census Bureau, available at http://www.census.gov/popest/states/NST-ann-est.html., accessed August 25, 2009). 2009 The Kaiser Family Foundation, "Beds Per 1,000 Population," in *statehealthfacts.org* (Data Source: Calculation based on 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, and 2007 AHA Annual Surveys. Copyright 2009 by Health Forum LLC, an affiliate of the American Hospital Association, available at http://www.ahaonlinestore.com/ProductDisplay.asp?ProductID=637; Annual Population Estimates by State, July 1, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, and 2007 Populations, U.S. Census Bureau, available at http://www.census.gov/popest/states/NST-ann-est.html., accessed August 25, 2009).

[25] Author's calculation from The Kaiser Family Foundation, "Hospital Adjusted Expenses Per Inpatient Day, 1999-2007," in *statehealthfacts.org* (Data Source: 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, and 2007 AHA Annual Surveys. Copyright 2009 by Health Forum LLC, an affiliate of the American Hospital Association, available at http://www.ahaonlinestore.com/ProductDisplay.asp?ProductID=637., accessed August 25, 2009). 2009

[26] Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program*, Chart 7-10.

[27] Ibid.

[28] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, (Washington, DC, March 2009), 56.

[29] NHE Projections 2008-2018, Forecast Summary and Selected Tables. http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf.(accessed August 20 2009).

[30] U.E. Reinhardt, "The Medicare World from Both Sides: A Conversation with Tom Scully," *Health Affairs* 22, no. 6 (2003): 169-170.

[31] There were 6,163 participating hospitals as of December 2007: Social Security Administration, *Annual Statistical Supplement, 2008*, U.S. Social Security Administration, Office of Retirement and Disability Policy, March 2009), Table 8.C.1 The American Hospital Association lists 5,708 hospitals (member and non-member) in 2007 inclusive of all types of hospitals and ownership: Fast Facts on Us Hospitals http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html.(accessed July 15 2009).

[32] Fox and Pickering, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*, Chart 5. Note: operating margin = (net revenue minus operating expense) divided by net revenue).

[33] A. Dobson, Joan DaVanzo and Namrata Sen, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," *Health Affairs* 25, no. 1 (2006): Exhibit 4 Note: total margin = (net revenues minus total costs) divided by net revenue).

[34] J. Sheils, *Testimony before the House Committee on Ways and Means*, (Falls Church, VA: The Lewin Group, April 29 2009), Fig. 9. For historical data on the payment-to-cost ratio for private patients from 1980-2003, see Dobson, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," Exhibit 3.

[35] Fox and Pickering, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*, Chart 3a.

[36] J.W. Hay, "The Impact of Public Health Care Financing Policies on Private-Sector Hospital Costs " *Journal of Health Politics, Policy and Law* 7, no. 4 (1983): 950

[37] M.A. Morrisey, "Cost-Shifting: New Myths, Old Confusion, and Enduring Reality," *Health Affairs* (2003).

[38] Hay, "The Impact of Public Health Care Financing Policies on Private-Sector Hospital Costs ": 946.

[39] Ginsburg, "Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?."

[40] Based on national hospital data for 1979 and after accounting for cost containment savings, $1.5 billion of $1.9 billion (78.9%) in Medicare and Medicaid underpayments in 1979 was estimated to be shifted to commercial insurers in F.A. Sloan and E.R. Becker, "Cross-Subsidies and Payment for Hospital Care," *Journal of Health Politics Policy and Law* 8, no. 4 (1984): 677 Based on Illinois hospital data for 1981 and 1983, the average hospital was estimated to shift 51% of Medicare and Medicaid losses to private patients in D. Dranove, "Pricing by Non-Profit Institutions: The Case of Hospital Cost-Shifting," *Journal of Health Economics* 7, no. 1 (1988): 56

[41] S. Zuckerman, "Commercial Insurers and All-Payer Regulation," *Journal of Health Economics* 6, no. 2 (1987): 165 J. Hadley and J. Feder, "Hospital Cost-Shifting and Care for the Uninsured," *Health Affairs* 4, no. 3 (1985): 68

[42] J. Zwanziger, G.A. Melnick, and A. Bamezai, "Can Cost Shifting Continue in a Price Competitive Environment?," *Health Economics* 9, no. 3 (2000): Table 4

[43] Calculations by author assuming from figures reported in Table 2 that Medicare and Medicaid patients accounted for 30% and 14% of discharges respectively. It was assumed that uninsured patients accounted for no more than 6% of the total.

[44] Zwanziger, Melnick, and Bamezai, "Can Cost Shifting Continue in a Price Competitive Environment?."

[45] Clement, "Dynamic Cost Shifting in Hospitals: Evidence from the 1980s and 1990s."

[46] J. Sheils and G. Claxton, *Potential Cost-Shifting under Proposed Funding Reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995. Report to the National Coalition on Health Care*, (Fall Church, VA: The Lewin Group, December 6 1995). Cited in Sheils, *Testimony before the House Committee on Ways and Means*, Note 12.

[47] J. Zwanziger and A. Bamezai, "Evidence of Cost Shifting in California Hospitals," *Health Affairs* 25, no. 1 (2006): 197

[48] Calculations by author using payer share assumptions described in footnote 33.

[49] Lewin Group, *The Health Benefits Simulation Model (HBSM): Methodology and Assumptions*, (Fairfax, VA: Lewin Group, March 31 2009), Figure 45

[50] Dobson, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," Exhibit 5.

[51] Some have impugned the accuracy of Lewin estimates by noting that the group is "part of Ingenix, which is owned by United Healthcare Group" T. Lieberman, "Hiding the Messenger: What's Lewin's Pedigree Anyway?," *Columbia Journalism Review* (2009). Others who support a public plan option concede that Lewin is a "respected policy research firm" U.E. Reinhardt, "Pricing a Medicare-Like Public Health Plan," *New York Times* 2009. The firm itself has stated: "The Lewin Group is committed to providing independent, objective and nonpartisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products." Sheils, *The Impact of the House Health Reform Legislation on Coverage and Provider Incomes. Testimony before the Energy and Commerce Committee, U.S. House of Representatives*. The Lewin Group Health Benefits Simulation Model (HBSM) is a micro-simulation model of the U.S. health care system designed to model the effect of policies designed to increase public and private health insurance coverage. It was originally developed in the late 1980's Lewin-ICF, *The Health Benefits Simulation Model: Technical Documentation. Report to the Office of Research, Health Care Financing Administration*, (Washington, DC, April 13 1990). It was used to estimate the impact of health reform proposals during the debate over the Clinton health plan: see J.F.

Sheils, L.S. Lewin, and R.A. Haught, "Potential Public Expenditures under Managed Competition," *Health Affairs* 12, no. Supplement 1 (1993), J.F. Sheils, R.J. Baxter, and R.A. Haught, "The Public Cost of Expanding Coverage," *Health Affairs* 14, no. 1 (1995).It has been continuously updated using the best available data and research and the developers have always been exceedingly transparent in making available extensive documentation of their sources and methods: Lewin Group, *The Health Benefits Simulation Model (HBSM): Methodology and Assumptions*.

[52] Sheils, *Testimony before the House Committee on Ways and Means*. Note that while most hospital cost shifting studies have not examined the issue, the first such study concluded that the residual elements of Medicare and Medicaid underpayment not cost shifted to private payers resulted in lower hospital profits rather than reductions in hospital costs: Sloan and Becker, "Cross-Subsidies and Payment for Hospital Care." However, a more recent study found evidence that marginal costs of inpatient treatment varied in proportion to payer generosity, suggesting that hospitals can offset at least some portion of underpayments through lower cost (less intensive) treatment of public patients: Dor and Farley, "Payment Source and the Cost of Hospital Care: Evidence from a Multiproduct Cost Function with Multiple Payers," 1

[53] Sheils, *Testimony before the House Committee on Ways and Means*, Sheils, *The Impact of the House Health Reform Legislation on Coverage and Provider Incomes. Testimony before the Energy and Commerce Committee, U.S. House of Representatives*, J. Sheils and R. Haught, *Analysis of the July 15 Draft of the American Affordable Health Choices Act of 2009. Memorandum to Stuart Butler (Heritage Foundation: Vice President, Domestic and Economic Policy Studies)*, (Falls Church, VA: The Lewin Group, July 17 2009).

[54] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Table 2A-9.

[55] G.M. Hackbarth, *Report to the Congress: Medicare Payment Policy. Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives*, (Washington, DC, March 17 2009), 7

[56] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, 62.

[57] Ibid., Table 2A-7.

[58] Ibid., 62.

[59] Ibid., 64.

[60] Ibid., 70.

[61] Ibid., Table 2A-5.

[62] Disproportionate Share Hospital (DSH) http://www.hhs.gov/recovery/cms/dsh.html.(accessed August 30.

[63] Medicare Disproportionate Share (DSH) Payments http://www.aamc.org/advocacy/library/teachhosp/hosp0003.htm.(accessed August 28 2009).

[64] Fox and Pickering, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*, Chart 8.

[65] Ibid.

[66] P.J. Cunningham and A.S. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?," *Health Affairs* 28, no. 1 (2009): Exhibit 1

[67] Medicare Payment Advisory Commission, *Report to the Congress: Impact of Resource-Based Practice Expense Payments for Physician Services*, (Washington, DC, December 2004).

[68] AMA Council on Medical Service, *Improving the Medicare Economic Index*, (Chicago: American Medical Association, 2008), Table 1

[69] The Physicians' Foundation, *The Physicians' Perspective: Medical Practice in 2008: Survey Summary and Analysis*, (Boston, MA, October 2008), 37

[70] Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program*, Chart 1-4.

[71] J.A. Rizzo and D. Blumenthal, "Is the Target Income Hypothesis an Economic Heresy?," *Medical Care Research and Review* 53, no. 3 (1996): 261

[72] Reinhardt, "The Medicare World from Both Sides: A Conversation with Tom Scully," 169-170.

[73] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2008 Update*, (Chicago, IL: American Medical Association, 2008), 2

[74] Fox and Pickering, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*, Chart 3b.

[75] Ginsburg, "Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?," W3-477.

[76] Rizzo and Blumenthal, "Is the Target Income Hypothesis an Economic Heresy?," 243.

[77] Ginsburg, "Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?," W3-477.

[78] The Physicians' Foundation, *The Physicians' Perspective: Medical Practice in 2008: Survey Summary and Analysis*, 40.

[79] T. Rice, S. Stearns, S. DesHarnais, D. Pathman, M. Tai-Seale, and M. Brasure, *Physician Response to Medicare Payment Reductions: Impacts on Public and Private Sectors. Final Report: Robert Wood Johnson Grant No. 20038*, (Chapel Hill, NC: Sheps Center, UNC-Chapel Hill, September 1994), Table 7.

[80] T. Rice et al., "Do Physicians Cost Shift?," *Health Affairs* 15, no. 3 (1996): 215

[81] W.C. Yip, "Physician Response to Medicare Fee Reductions: Changes in the Volume of Coronary Artery Bypass Graft (CABG) Surgeries in the Medicare and Private Sectors," *Journal of Health Economics* 17, no. 6 (1998): 686

[82] Ibid.: 675.

[83] T. Rice et al., "A Tale of Two Bounties: The Impact of Competing Fees on Physician Behavior," *Journal of Health Politics Policy and Law* 24, no. 6 (1999): 1311

[84] Sheils, *The Impact of the House Health Reform Legislation on Coverage and Provider Incomes. Testimony before the Energy and Commerce Committee, U.S. House of Representatives*, 12.

[85] Hacker, *The Case for Public Plan Choice in National Health Reform*, 7.

[86] Ibid.

[87] Congressional Budget Office, *Prices for Brand-Name Drugs under Selected Federal Programs*, (Washington, D.C.: The Congress of the United States, Congressional Budget Office June 2005), 8-9.

[88] C.D. Mullins, "Most-Favored-Customer Protection and Medicaid Rebates under OBRA 1990," *Journal of research in pharmaceutical economics* 7, no. 3 (1996): 49

[89] Congressional Budget Office, *How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry*, (Washington, D.C.: The Congress of the United States, Congressional Budget Office January 1996).

[90] M. Duggan and F.M.S. Morton, "The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing*," *Quarterly Journal of Economics* 121, no. 1 (2006): 4.

[91] For example, the the House Tri-Committee bill would extend the Medicaid rebates to dual eligibles enrolled in Part D plans and the House Energy and Commerce version of the bill would require the Secretary of DHHS to negotiate directly with pharmaceutical manufacturers to lower drug prices for Medicare Part D plans and Medicare Advantage Part D plans. Side-by-Side Comparison of Major Health Care Reform Proposals http://www.kff.org/healthreform/sidebyside.cfm.(accessed August 27 2009).

[92] The House bill specifies that the PHIP would pay providers at Medicare levels, i.e., 20 percent to 30 percent less than what private plans pay for the same services (though providers agreeing to serve both Medicare and PHIP members would be paid at Medicare levels plus 5%). Sheils, *The Impact of the House Health Reform Legislation on Coverage and Provider Incomes. Testimony before the Energy and Commerce Committee, U.S. House of Representatives*.

[93] 7. Why a Public Plan Will Crowd out Private Coverage http://conoverc.wordpress.com/top-10-reasons-to-oppose-a-public-plan/2-how-a-public-plan-will-create-an-unfair-playing-field/.(accessed August 27 2009).

[94] Medicaid: A Primer http://www.kff.org/medicaid/7334.cfm.(accessed August 27 2009).

[95] Congressional Budget Office, *Additional Information Regarding the Effects of Specifications in the America's Affordable Health Choices Act Pertaining to Health Insurance Coverage*, (Washington, D.C.: The Congress of the United States, Congressional Budget Office July 26 2009), 17

[96] Fox and Pickering, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*, Chart 4.

[97] Calculations by author based on applying the 13.3% higher prices attributable to Medicaid discounts to projected 2009 total prescription drug expenditures paid for by private payers (including out-of-pocket spending) and Medicare (where the discount does not apply), as reported in NHE Projections 2008-2018, Forecast Summary and Selected Tables. .(accessed.August 20, 2009) [estimated 2009 prescription drug cost shift=$27.3 billion]. The 2006 hospital cost shift as a share of Medicare hospital payments (17.8%) and Medicaid payments (23.9%) reported in Fox and Pickering, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers*, Chart 7. was applied to projected 2009 Medicare and Medicaid hospital spending respectively [estimated 2009 hospital cost shift=$73.5 billion]. Physician cost shifting (12.7% of Medicare payments, 66% of Medicaid payments) was calculated in a parallel fashion using Milliman figures from Table 9 [estimated 2009 physician cost shift=$39.9 billion]. The $2200 figure originally estimated by Milliman was based on an aggregate cost shift of $88.8 billion, so it was adjusted upward to reflect the adjusted total for 2009.

[98] Calculations by author assuming 100% of estimated 2009 prescription drug cost shifting and 40% of estimated 2009 hospital cost shifting reported in footnote 77 are offset by higher prices to private patients.

[99] Side-by-Side Comparison of Major Health Care Reform Proposals.(accessed.August 27, 2009).

[100] Sheils, *The Impact of the House Health Reform Legislation on Coverage and Provider Incomes. Testimony before the Energy and Commerce Committee, U.S. House of Representatives*, Figure 2.

[101] Calculations by author using figures calculated in footnote 97.

[102] Kaiser Family Foundation and Health Research & Educational Trust, *Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008*, September 24 2008), Exhibit 7.27

[103] D. Yamamoto, T. Neuman, and M.K. Strollo, *How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?*, (Menlo Park, CA: Kaiser Family Foundation, September 2008), Exhibit 3

[104] This is based on 2005 figures, the latest available: Medicare Payment Advisory Commission, *Report to the Congress: Impact of Resource-Based Practice Expense Payments for Physician Services*, Chart 6.3.

[105] Ibid., Chart 6.1.

[106] Ibid., Chart 6.3.

[107] The Medicare share of recipient spending declined about 2 percentage points over just 7 years according to P. Neuman et al., "How Much 'Skin in the Game' Do Medicare Beneficiaries Have? The Increasing Financial Burden of Health Care Spending, 1997 2003," *Health Affairs* 26, no. 6 (2007): Exhibit 6 Others have suggested a far more dramatic decline in Medicare generosity: in 1997, Medicare reportedly covered 72.2% of medical care for non-institutionalized members covered through its fee-for-service program. By 2005, that share had declined to 50.8% according R.A. Book, *Illusions of Cost Control in Public Health Care Plans*, (Washington, DC: Heritage Foundation, July 24 2009), 7 However, based on this author's analysis of the figures used to calculate the Medicare share in both years, this appears to be an apples-to-oranges comparison: the 1997 figure is artificially high because it excludes prescription drug expenses (the correct figure is 67%, but even this is artificially high, as it includes those in Medicare HMOs. In contrast, the 2005 figure is expressly limited to those in Medicare fee-for-service plans and excludes the 20% who are in Medicare Advantage plans. There appears to be no way with the publicly reported data to calculate the Medicare share of spending for conceptually equivalent groups of Medicare beneficiaries; in contrast the Neuman analysis cited above calculates changes in Medicare spending using a consistently defined set of beneficiaries, hence provides a more reliable picture of trends in Medicare coverage.

[108] In 2006, Social Security accounted for two-thirds of income for 60% of the elderly population--and 83% of income for the one fifth having the lowest incomes: Federal Interagency Forum on Aging Related

Statistics, *Older Americans 2008: Key Indicators of Well-Being*, (Washington, DC:, March 2008), Table 9b Consequently, the amount of out-of-pocket spending for Medicare beneficiaries relative to the average Social Security benefit is a useful metric for assessing the rising burden of Medicare on beneficiaries.

[109] Medicare Payment Advisory Commission, *Report to the Congress: Impact of Resource-Based Practice Expense Payments for Physician Services*, 18.

[110] S. Mussey, *Letter to the Honorable Pete Stark*, Centers for Medicare and Medicaid Services, Office of the Actuary, Medicare and Medicaid Cost Estimates Group, July 2 2004).

[111] The plan approved by the Senate HELP Committee would require employers to offer health coverage to their employees and contribute at least 60% of the premium cost or pay $750 for each uninsured full-time employee and $375 for each uninsured part-time employee who is not offered coverage. For employers subject to the assessment, the first 25 workers are exempted and employers with 25 or fewer employees are exempt from the requirement to provide coverage. The House Tri-Committee bill would require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. The version approved by the Energy and Commerce Committee includes a hardship exemption. Side-by-Side Comparison of Major Health Care Reform Proposals.(accessed.August 20, 2009).

[112] The Senate Finance Committee is considering a plan that would require employers with more than $500,000 in total payroll per year to offer coverage to their employees and contribute at least 50% of the premium or pay an assessment, but it also is considering a version that would eliminate this "pay-or-play" requirement.

[113] J. Antos, G. Wilensky, and H. Kuttner, "The Obama Plan: More Regulation, Unsustainable Spending," *Health Affairs* 27, no. 6 (2008): w467

[114] This includes $226.2 billion in federal income and payroll taxes avoided according to Joint Committee on Taxation, *Background Materials for Senate Committee on Finance Roundtable on Health Care Financing before the Senate Committee on Finance on May 12, 2009*, (Washington, DC, May 8 2009), Table 1 In 2006, each dollar of federal revenue losses attributable to the tax exclusion was associated with companion losses of 12.6 cents in state income tax revenues: T.M. Selden and B.M. Gray, "Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006," *Health Affairs* 25, no. 6 (2006): Exhibit 1 Assuming this ratio was the same in 2008, there was an additional $28.6 billion in state revenue losses in 2008.

[115] Selden and Gray, "Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006," Exhibit 1.

[116] C.E. Phelps, *Health Economics, Third Edition* (Addison-Wesley, 2003), 354.