

HOSPITAL COST-SHIFTING: THE HIDDEN TAX EMPLOYERS PAY TO COMPENSATE FOR GOVERNMENT UNDERFUNDING

MAY 2015

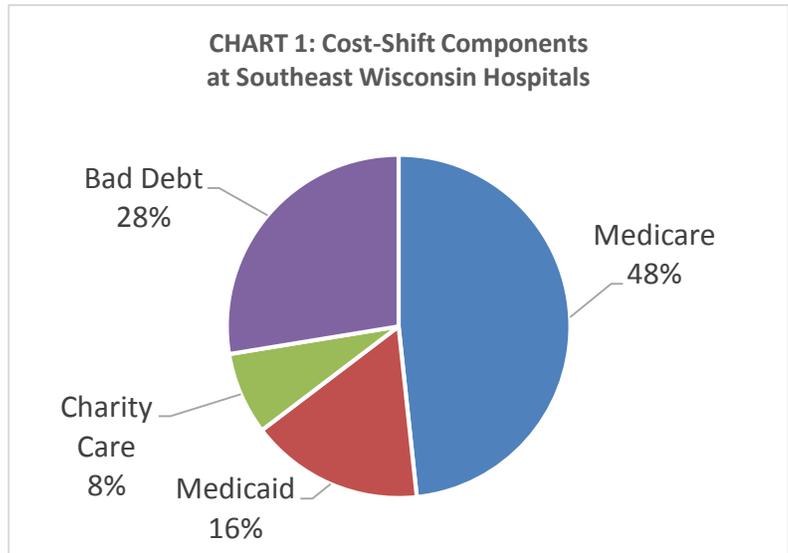
EXECUTIVE SUMMARY

- Federal and state payments for hospital care do not cover the cost of providing those services.
- Wisconsin hospitals would have to lay off more than 10,000 employees and cut an additional \$750 million in operating costs in order to remain financially viable at government reimbursement rates; this would severely impact the quality of care hospitals provide.
- In order to offset the underfunding, hospitals must reduce operating costs and increase the revenue they receive from private payers more for the same medical services; this process is commonly known as cost shifting.
- In southeastern Wisconsin, cost shifting is responsible for 35 percent of the overall commercial rates paid.
- Cost shifting is a hidden tax on employers that affects their ability to compete economically; it has a greater impact on smaller employers, which are the primary engine of job growth for the state.
- Completely eliminating cost-shifting is not politically realistic in the short-term, but public and private payers should be expected to pay their fair share of the nation's health care costs moving forward.
- Much of the existing cost-shifting research is focused on Medicare reimbursement rates; however, in Wisconsin, the Medicaid revenue shortfall is increasingly important as Medicaid is the most rapidly growing segment of hospitals' inpatient and outpatient business.

COST SHIFTING IS REAL

Wisconsin, like many states, has a dynamic and complex health care payment system in which health care providers and the business community continually strive to maintain Wisconsin's national leadership in health care quality¹ and constrain the increases in health care costs despite below-average – and declining – government payment.

Federal and state governments provided 42 percent of the net operating revenue at Wisconsin hospitals in 2013.² This market clout, combined with their regulatory power, gives them the ability to dictate the rates they will pay. At the same time, Medicare and Medicaid are among the fastest growing government entitlements. The federal government will spend close to \$900 billion on Medicare



and Medicaid programs this year, approximately one-fourth of the entire federal budget. The state will spend \$2.4 billion on Medicaid, a budget item second only to funding for public schools.³ When faced with budget challenges, legislators have often found the “savings” they need by reducing hospital payments for these two programs. These cuts are politically expedient because they do not directly impact beneficiaries (although they do impact access to care as well as the quality of care delivered). Both the Affordable Care Act and the Budget Control Act of 2011 (“the sequester”) relied on significant reductions in Medicare hospital payments to achieve their budget targets. In addition, the federal government has reduced its share of Wisconsin’s Medicaid funding by 18 percent between 2009 and today. In 2009, the federal government paid 70.6 percent of the state’s Medicaid costs. In 2015, it paid 58.3 percent.⁴

¹ The federal Agency for Healthcare Research and Quality (AHRQ) has recognized Wisconsin for five years in row as one of the top performing states based on the quality of health care provided in hospitals, medical clinics, nursing homes, and by home health agencies. In 2014, the state ranked third in quality overall, behind only Minnesota and Massachusetts, based on provider performance on 100 quality measures.

² HCTrends analysis of 2013 fiscal surveys submitted by Wisconsin’s 152 hospitals

³ NHE Fact Sheet, federal Centers for Medicare and Medicaid Services; Wisconsin Legislative Fiscal Bureau Analysis of 2015-2017 budget

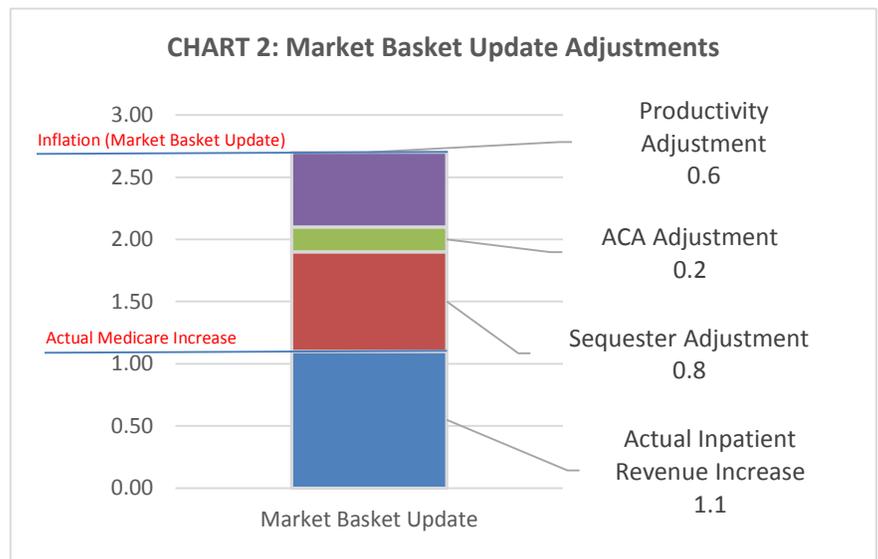
⁴ Federal Medical Assistance Percentages (FMAP): October 2009 to April 2015

A 2014 Milliman analysis conducted for the Greater Milwaukee Business Group found that cost shifting accounted for 35 percent of the commercial rate paid for hospital services in 2012.⁵ Milliman estimated that Medicare and Medicaid underfunding accounted for almost two-thirds of the cost shift, adding about \$782 million to commercial rates in 2012. Bad debt and charity care accounted for the remaining third (See Chart 1).

Much of the cost shift was built into the hospital pricing structure when the federal government implemented Medicare payment reforms that capped what hospitals could receive for inpatient services in the 1980s. As the growth in operating costs outpaced the growth in Medicare revenue, hospitals began offsetting the lost revenue by increasing the rates they charged insurers and other private payers.⁶

HOW COST-SHIFTING WORKS

Although the magnitude of cost-shifting has decreased over time due to changing market dynamics, it remains prevalent. Here is how it works, using FY 2016 numbers as an example. Every year, Medicare adjusts its base payment rate for inpatient hospital stays using a market basket update designed to keep Medicare's reimbursement rates even



with inflation. For FY 2016, the market basket update will be 2.9 percent.⁷ If all payers paid their fair share based on the market basket update, Medicare, Medicaid and commercial payers would need to see their rates increase 2.9 percent in order for hospitals to stay even with inflation.

Medicare, however, will pay less than half that amount due to specific budget cuts mandated by the Affordable Care Act and the sequester, and an assumed productivity adjustment implemented as part of the ACA (see Chart 2). Since its inception in FY2012,

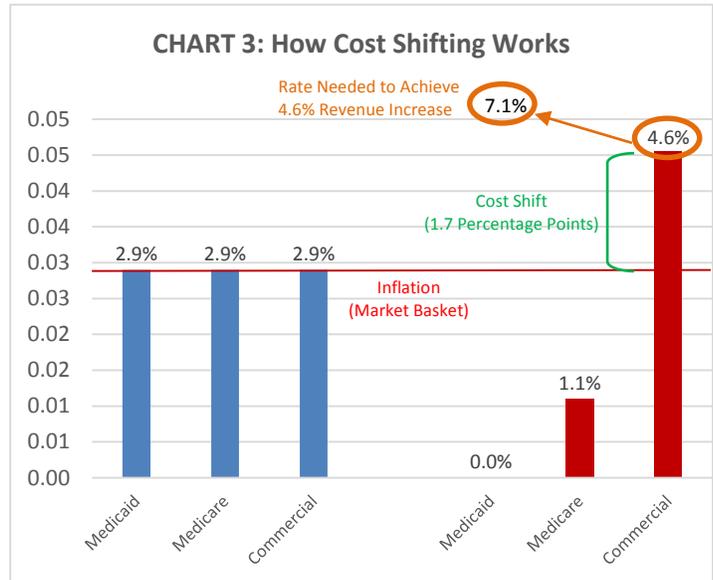
⁵ Report to the Greater Milwaukee Business Foundation on Health: Key Factors Influencing 2003-2012 Southeast Wisconsin Commercial Payer Hospital Payment Levels (Milliman PowerPoint, July 23, 2014)

⁶ How Much Do Hospitals Cost Shift? A Review of the Evidence (Austin B. Frakt, Milbank Quarterly, Vol. 89, No. 1 2011 pages 90-130)

⁷ Centers for Medicare and Medicaid Services (CMS) market basket updates

the productivity adjustment has reduced the market basket update by between 0.5 and 1.0 percentage points each year.⁸ In addition, the 2015-2017 budget pending in Wisconsin calls for no increase in inpatient hospital reimbursement rates.⁹

Chart 3 illustrates how Medicare’s additional cuts to its market basket update impact commercial rates. The blue bars at left indicate the rate increase each payer would absorb to keep pace with inflation (as defined by the market basket update). The red bars on the right indicate the reality. Because Medicare increased its rates by 1.1 percent instead of 2.9 percent, hospitals would need to generate an additional 4.6 percent in net inpatient revenue to meet the 2.9 percent inflation target. The 1.7 percentage point difference between 4.6 percent and the 2.9 percent fair share rate is the cost shift or hidden tax passed onto health care providers, employers and health care consumers. In 2016 alone, this hidden tax will amount to \$155 million for Wisconsin hospitals.¹⁰ Based on the average commercial inpatient discount at Wisconsin hospitals, gross inpatient revenue would have to increase 7.1 percent in order to achieve the 4.6 percent target.¹¹ This is an average increase for all payers. It would have a greater impact on smaller employers – the engine of job growth in the state’s economy – because they lack the market leverage to negotiate more significant discounts.



The downward adjustments to the market basket are expected to continue through at least 2023 due to provisions in the ACA that seek to reduce Medicare spending by more than \$700 billion of dollars. In 2017, 2018 and 2019, for example, the ACA market basket adjustment will more than triple (from 0.20 to 0.75) meaning Medicare reimbursements will be reduced even further.¹²

⁸ Centers for Medicare and Medicaid Services FY 2015 final market basket update

⁹ Legislative Fiscal Bureau budget documents

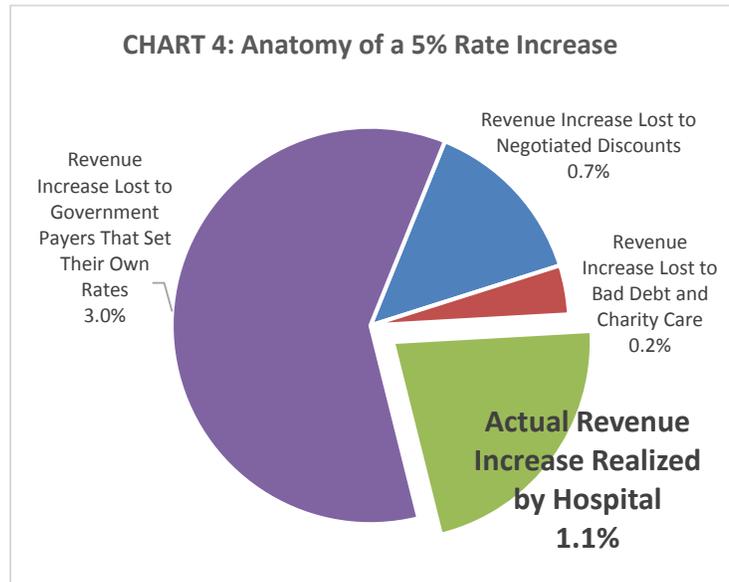
¹⁰ Based on FY2013 net commercial revenue for Wisconsin hospitals

¹¹ Average commercial inpatient discount was 37 percent in 2013 based on HCTrends analysis of hospital fiscal surveys

¹² Provisions related to ACA’s market basket adjustments as outlined in House Resolution 4872

COST SHIFT FROM A RATE INCREASE PERSPECTIVE

Another way to look at cost-shifting is from the hospital's rate-setting perspective. Each year, Wisconsin hospitals are required to publish their rate increases for the coming year. While these increases have typically been in the 4 percent to 8 percent range, the revenue increases they generate for hospitals are substantially less. This is because more than half of the typical hospital's gross revenue comes from government payers that ignore the rate increase. Their



regulatory power allows them to dictate what they will pay hospitals. The effective rate is also reduced by the discounts negotiated between providers and insurers and the amount of charity care and bad debt hospitals incur to provide medical services to the poor and indigent. In the end, an advertised rate increase of 5 percent generates approximately 1.1 percent in additional revenue for the hospital (Chart 4).¹³

SURVIVING ON MEDICARE

Cost-shift skeptics contend that hospitals could make money with Medicare reimbursement rates if they focused more on cutting costs. This theory was put forth in a 2010 white paper by Jeffrey Stensland, Zachary Gaumer and Mark Miller.¹⁴ Their analysis of hospital market share and Medicare payment growth over a seven-year period suggested that many hospitals haven't focused on costs because the higher commercial rates they leverage with their market dominance allows them to mask the growth in expenses. This conclusion rests on two assumptions:

- Hospitals have sufficient market power to leverage higher-than-necessary rates
- Hospitals could be financially sustainable on Medicare reimbursement rates

In Wisconsin, neither of these assumptions appears to be true. HCTrends tested the first assumption in each of the state's nine economic regions. If the Stenson analysis is correct, we would expect to see the disparity between Medicare and commercial

¹³ HCTrends analysis of 2013 hospital fiscal surveys

¹⁴ "Private-Payer Profits Can Induce Negative Medicare Margins" (Jeffrey Stensland, Zachary Gaumer and Mark Miller), *Health Affairs*, Vol. 29, No. 5, 2010 (1045-1051)

discounts increase as hospitals gained market dominance.¹⁵ While the market share of the dominant hospital system varied significantly – from a low of 28 percent in northeastern Wisconsin to a high of 100 percent in far northern Wisconsin, there was minimal correlation between the dominant hospital’s market share and discount disparity in eight regions of the state. The far northern region did have the greatest disparity in Medicare and commercial discounts as well as a dominant health system with 100 percent market share as the Stenson hypothesis would suggest, but it is one of the more rural areas of the state and includes several critical access hospitals.¹⁶ In addition, the most competitive region of the state – northeastern Wisconsin – also had one of the greatest disparities in discounts, something the Stenson hypothesis would not predict.

The Stenson analysis also fails to take into account the nature of non-profit hospitals. Non-profits don’t have to leverage higher rates and maximize profits in order to provide shareholders a return on investment. In addition, non-profits are typically overseen by a board that includes community business leaders who would not be inclined to work against their own interests by leveraging higher-than-necessary commercial rates.

Finally, the Stenson analysis implies that hospitals could make money on Medicare reimbursements if they did a better job focusing on costs. But is this feasible? Medicare reimburses Wisconsin hospitals at a rate that is, on average, 33 percent of billed charges. Commercial payers pay almost twice as much – 63 percent of billed charges.¹⁷ If commercial payers paid Medicare rates in 2013, Wisconsin hospitals would have lost \$2.4

TABLE 1: IMPACT OF REDUCING COMMERCIAL PAYMENTS TO MEDICARE RATES	
ECONOMIC REGION	REVENUE LOST
Southeast	\$1,278,206,386
Northeast	\$443,189,200
South Central	\$630,804,745
North Central	\$86,177,375
Eau Claire Area	\$84,388,866
La Crosse Area	\$51,369,254
Far North	\$10,415,056
Northwest	\$2,971,253
Southwest	\$10,058,942
STATE	\$2,360,294,122

¹⁵ HCTrends analyzed 2013 fiscal data submitted by Wisconsin hospitals. The Medicare discount (the difference between Medicare billed charges and Medicare allowed charges) was calculated as the baseline discount for each region. Similar calculations were made for commercial discounts in each region.

¹⁶ Critical Access Hospitals are small facilities (25 or fewer beds) that provide outpatient and inpatient hospital services to people in rural areas. The designation was established by law in 1997. In order to be designated as a CAH, a hospital must be located in a rural area, provide 24-hour emergency services; have an average length-of-stay for its patients of 96 hours or less; be located more than 35 miles from the nearest hospital or be designated by the state as a "necessary provider."

¹⁷ HCTrends analysis of hospital fiscal surveys for FY 2013.

billion in revenue. Instead of generating a positive operating margin of \$1.6 billion, they would have lost \$772 million. The findings are summarized by region in Table 1.

ABSORBING MEDICARE AND MEDICAID REDUCTIONS

It is inconceivable that hospitals could offset this lost revenue through cost-cutting initiatives without impacting the quality of care provided. In order to achieve a 5-percent margin at Medicare reimbursement rates, HCTrends calculated hospitals would have to reduce their operating costs by \$1.6 billion.¹⁸ If the cuts were made proportionally based on existing budget expenses, more than 10,000 hospital jobs would be eliminated statewide.¹⁹ Quality, service and patient experience would likely be impacted by a staffing reduction of this size. That hospitals could not sustain their current quality standards without cost-shifting has been noted by others. “Medicare pays rates that do not support the level of quality its beneficiaries receive,” researcher Austin Frakt noted in a recent review of cost-shifting studies.²⁰

Providing quality care and maintaining hospital services is even more challenging at Medicaid’s reimbursement rates, which are 20 percent lower than the Medicare reimbursement rate.²¹ While Medicaid represents a significantly smaller revenue pool for hospitals, it is the fastest-growing segment of inpatient hospital business. Between 1995 and 2013, Medicaid inpatient stays increased 42 percent, which was double the growth rate of Medicare admissions. Commercial inpatient stays declined 15 percent during this same time period.²² Medicaid as a share of total hospital business is expected to increase even more in the next few years following the state’s decision to provide Medicaid to all childless adults living below the poverty level. This is significant because hospitals lose approximately 35 cents in revenue for every dollar shift in the payer mix from commercial payer to Medicaid.

Reducing expenses is a key response to lower reimbursement rates and Wisconsin hospitals have been nationally recognized for their cost-savings efforts. Milliman’s 2014

¹⁸ For the sake of this analysis, HCTrends assumed a 5 percent margin would provide hospitals with sufficient capital to invest in new equipment and offset their charity care costs.

¹⁹ In 2013, staffing costs represented 54 percent of total operating costs at Wisconsin hospitals according to the fiscal surveys. A proportional cut in staffing costs would be \$860 million. The average per-person FTE staffing cost (including benefits) in 2013 was approximately \$80,000; therefore an \$850 million reduction in staffing costs, would result in a loss of approximately 10,500 jobs.

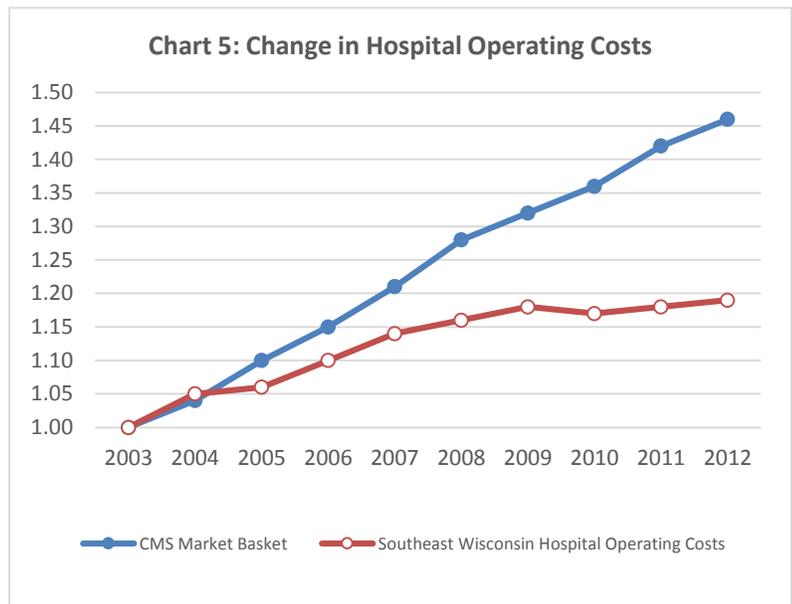
²⁰ *How Much Do Hospitals Cost Shift? A Review of the Evidence* (Austin B. Frakt, *Milbank Quarterly*, Vol. 89, No. 1 2011 pages 90-130)

²¹ Based on the 2013 hospital fiscal surveys, Medicare pays 33 percent of billed charges and Medicaid pays 26 percent of billed charges (based on actual Medicaid payments less the special Medicaid hospital tax assessed hospitals). This is similar to the Kaiser Family Foundation’s analysis of Medicaid and Medicare reimbursement, which found Medicaid reimburses at 77 percent of the Medicare rate in Wisconsin.

²² HCTrends analysis of 1995 and 2013 hospital fiscal surveys

analysis of the southeastern Wisconsin hospital market found that operating costs at area hospitals increased an average of 2 percent per year from 2003 to 2012, which was roughly half the increase in the Hospital Producer Price Index and the CMS market basket during same decade (see Chart 5).²³

Constraining the growth of operating costs is challenging given the stringent regulatory environment in which hospitals operate. In addition to maintaining government required accreditations, hospitals are subjected to government audits and inspections. At the same time they are making significant investments to meet government mandates – electronic health records and ICD-10 coding, for example – and to strengthen quality programs that will prevent them from losing additional revenue under several new Medicare purchasing programs targeting the reduction of hospital readmissions and hospital-acquired infections.



Making actual, year-to-year reductions is even more difficult than constraining growth in operating costs. In order to reward hospitals that reduce the cost of treating Medicare patients, the Centers for Medicare and Medicaid Services (CMS) implemented two incentive programs – the Medicare Shared Savings Program and the Pioneer ACO Pilot Program. Less than one-third of the 243 participating hospitals achieved any savings at all, and the combined nationwide savings of both programs totaled \$472 million over two years.²⁴ That savings from a nationwide program is slightly more than one-third the amount Wisconsin hospitals alone would have to cut to make their existing Medicare business profitable.

Interestingly, one of the most successful hospital systems in the Pioneer ACO Pilot was Bellin-ThedaCare Health Partners, a joint venture between Bellin Health, ThedaCare and a 700-physician network, all of which are located in northeastern Wisconsin. It achieved

²³ Report to the Greater Milwaukee Business Foundation on Health: Key Factors Influencing 2003-2012 Southeast Wisconsin Commercial Payer Hospital Payment Levels (Milliman PowerPoint, July 23, 2014)

²⁴ Centers for Medicare and Medicaid Services Press Release: “Medicare ACOs continue to succeed in improving care, lowering cost growth” (Sept. 16, 2014; updated Nov. 7, 2014)

\$3.2 million in savings in the second year of the program, but that represented less than 1 percent of the two health systems combined operating expenses.²⁵

These results suggest that Wisconsin hospitals could not survive financially if insurers and self-funded employers paid them at their Medicare rates, nor can they sustain future Medicare reductions without offsetting at least some of their revenue loss with higher commercial rates that would be paid for primarily by the business community.

CAN LOWER MEDICARE RATES LEAD TO LOWER COMMERCIAL RATES?

Among the more novel theories put forward by cost-shifting skeptics is the concept that Medicare rate reductions lead to lower commercial rates. When government revenue drops, hospitals will lower their commercial rates to generate more demand from the private sector. An example used to illustrate this concept is a theater that sells both individual and bulk tickets. If revenue from bulk tickets (Medicare and Medicaid) declines, the theater will lower its individual ticket prices (commercial rates) to fill the seats. Even if this accurately depicted how a theater would actually respond to market changes of this kind, there are several flaws in using this analogy with hospital care:

1. People go to theaters because they want to; most people go to the hospital because they have to. They are motivated by their health care needs, not changes in prices.
2. Health care consumers don't know what hospitals charge until after the fact. Although health plans and providers have done a better job of estimating the potential average costs for certain procedures, the actual costs aren't known until after the services have been performed due to the many unpredictable factors that can occur while the medical services are being provided.
3. Health care consumers are insulated from price changes because of benefit plan designs. Even if a hospital reduced the cost of a \$20,000 inpatient admission by 40 percent, the health care consumer would face the same upfront costs (deductible) and their share of the savings would be about 1 percent.²⁶
4. Insurers and self-funded employers would have no incentive to promote the use of additional medical services because their costs would increase.

²⁵ Bellin-ThedaCare Partners Sept. 2014 press release: "Bellin-ThedaCare Health Partners are #1 in Improving Quality of Care and Reducing Costs in CMS Pilot Program"; HCTrends analysis of 2013 hospital fiscal surveys

²⁶ Based on average individual coverage plan design from the 2014 Greater Milwaukee Employer Health Care Benefits Survey: \$2,500 deductible, 20 percent co-insurance and \$4,500 maximum out-of-pocket expenses

- Hospitals could not quickly change their commercial prices because contracts with insurers are typically multi-year deals.

The idea that lower Medicare reimbursements lead to commercial rate reductions is based in large part on a 2013 analysis of Medicare and commercial claims. That study suggested that a \$10 decrease in Medicare cuts resulted in a reduction of between \$3 and \$8 in commercial rates between 1995 and 2009.²⁷ There are some significant issues with that study, however. It focused solely on changes in inpatient rates, ignoring the dramatic shift from inpatient to outpatient services that has occurred during the last two decades. In 1995, inpatient services accounted for three-fourths of an average

TABLE 2: CHANGE IN WISCONSIN HOSPITAL SERVICES 1995-2013			
ITEM	1995	2013	Change
Medicare Inpatient Revenue	\$2,340,277,808	\$9,121,075,145	290%
Medicare Inpatient as % of Medicare Revenue	74.1%	51.8%	-30%
Medicaid Inpatient Revenue	\$481,017,990	\$2,562,560,833	433%
Medicaid Inpatient as % of total Medicaid Revenue	69.0%	47.0%	-32%
Commercial Inpatient Revenue	\$1,823,042,657	\$5,408,327,851	197%
Commercial Inpatient as % of Commercial Revenue	57.3%	33.2%	-42%
Medicare Discharges	225,133	268,177	19%
Medicaid Discharges	66,343	94,177	42%
Commercial Discharges	265,893	226,362	-15%
Outpatient Revenue (All Payers)	\$2,585,734,821	\$22,328,406,784	764%
Outpatient Visits (All Payers)	8,559,748	16,695,548	95%

Wisconsin hospital’s total Medicare revenue. By 2013, it had dropped to about half. Meanwhile, hospital outpatient visits have almost doubled and revenue from outpatient services has grown nine-fold (Table 2).²⁸

In addition, the study did not factor in lower inpatient costs due to treatments that have shifted out of inpatient facilities. Between 1995 and 2009, for example, treatment for ischemic heart disease has evolved to consistently less expensive approaches – from open-heart surgery to catheterization to medication management. Similar progressions have occurred with dialysis and cancer. Shifts in treatment modalities for relatively

²⁷ “Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates” (Chapin White, Health Affairs 32, No. 5, (2013) 935-943

²⁸ HCTrends analysis of 1995-2013 Wisconsin hospital fiscal surveys

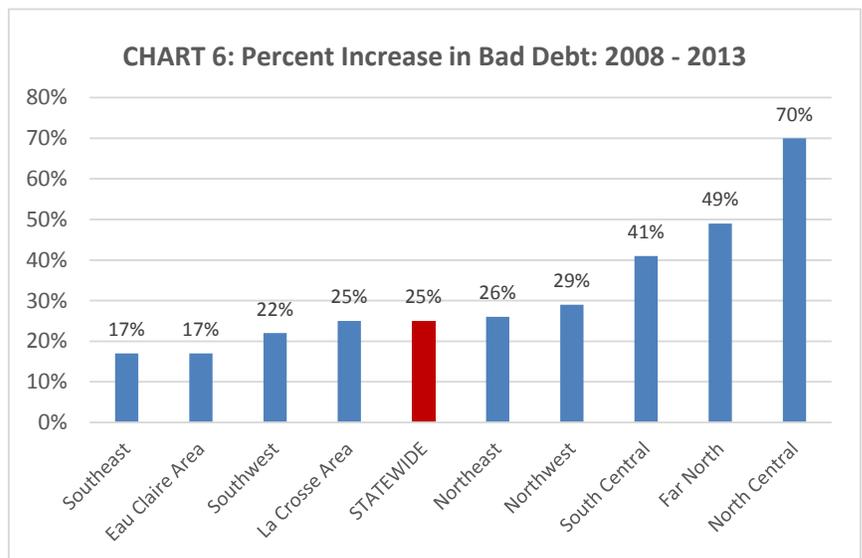
common diagnoses like these would lower inpatient revenues, clouding the correlation between changes in Medicare reimbursement and private-sector payments.

Finally, the analysis ignored other factors that can impact hospital costs and utilization, including the economy and changes in plan design. It did not take into account the impact of the rise and fall of managed care plans in the 1990s, the 2001 and 2007 recessions, and the significant increases in deductibles and copays. For example, since the financial collapse of 2008, commercial inpatient admissions at Wisconsin hospitals have dropped 20 percent, while Medicare admissions have remained the same and Medicaid admissions have increased 15 percent.²⁹ As a result, even if everything else stayed the same and all payers paid their fair share of future rate increases, cost-shifting would increase as their payer mix becomes increasingly dominated by government payers.

MOVING FORWARD

Given the financial pressures facing both health systems and governments, eliminating cost-shifting is not politically conceivable, at least in the short-term. At the same time, the business community should not be expected to further subsidize government-funded health care through additional cost-shifting. Cost-shifting may be built into the existing rate structure but, going forward, everyone should pay their fair share.

It can be argued that Wisconsin health care providers and the state's business community have done more than their "fair share" to help with the medical costs incurred by senior citizens and the poor. In addition to the hidden cost-shift tax built into the premiums paid by employers and employees, Wisconsin hospitals have contributed



money through a special hospital tax that increases Medicaid payments to hospitals and provides an additional \$140 million in annual revenue that the state uses to fund non-

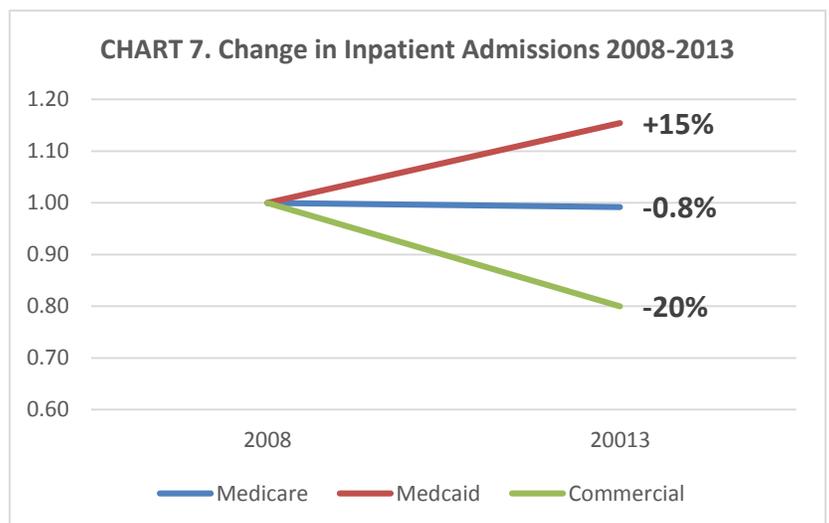
²⁹ HCTrends analysis of 2008-2013 Wisconsin hospital fiscal surveys

hospital Medicaid programs.³⁰ Without this tax, which is incurred by providers,³¹ taxpayers would have to fund this amount.

Changing demographics and Medicaid expansion ensures that the growth in medical services paid for by government programs will significantly outpace the growth in medical services paid for by the private sector. Charity care is expected to level off and decline as more of the uninsured received coverage through Medicaid or the health care exchanges, but bad debt and Medicaid shortfalls are expected to continue to increase as deductibles and out-of-pocket maximums increase. Between 2008 and 2013, bad debt at Wisconsin hospitals has increased 25 percent, with three regions experiencing increases in excess of 40 percent.³²

Hospitals are also coping with significant cuts in Medicare disproportionate share (DSH) payments, which help hospitals that serve higher-than-normal proportions of poor people. Two-thirds of Wisconsin hospitals receive Medicaid DSH payments.³³

Finally, hospitals must adapt to a payer mix that will soon be dominated by the government. Although commercial business still represents more than half of hospitals' net revenue, Medicaid is the fastest growing payer type. Between 2008 and 2013, Medicaid outpatient visits increased at twice the rate of Medicare and three times the rate of commercial outpatient



visits. And while commercial inpatient admissions declined significantly and Medicare admissions remained flat during the same time period, Medicaid admissions grew by 15 percent (Chart 7).³⁴ It is worth noting that this occurred prior to Wisconsin's Medicaid expansion, which has resulted in a net increase of more than 80,000 Medicaid enrollees since Jan. 1, 2014.³⁵

³⁰ Wisconsin Hospital Association analysis

³¹ The hospital tax is assessed on hospitals' gross revenue; most hospitals benefit from the tax through increased Medicaid reimbursements leveraged from the federal government; however, the tax negatively impacts hospitals with low Medicaid volumes who must absorb the loss through cost-shifting initiatives or increase the rates it charges commercial payers

³² HCTrends analysis of FY2013 hospital fiscal surveys

³³ Wisconsin Hospital Association Analysis; 2013 hospital fiscal surveys

³⁴ HCTrends analysis of 2008 and 2013 fiscal surveys

³⁵ ForwardHealth Badger Plus enrollment data

CONCLUSION

Adequately funding government health care programs is a serious challenge for the government, health care providers and the business community. Federal and state governments find it increasingly difficult to finance medical services for their growing Medicare and Medicaid populations. Revenue reductions or payment rates that fail to keep pace with inflation force health care providers to find more efficient ways to deliver care while simultaneously improving the quality of care delivered. If those initiatives do not completely offset their government revenue shortfall, providers make up the difference by increasing the rates charged by the business community – a process known as “cost shifting.” The degree to which a hospital can leverage the business community to subsidize government health programs depends on the market dynamics between health care providers and insurers. Wisconsin does not have a dominant health insurer that can dictate what hospitals charge and prevent them from cost-shifting. It’s also true that the state lacks a dominant health care provider that could force commercial insurers to completely absorb the government revenue shortfall. Cost-shifting is real and represents a hidden tax on employers that can threaten their competitiveness. In southeastern Wisconsin, the hidden tax accounts for 35 percent of commercial rates.

Although some studies have suggested that hospitals could sustain their operations at Medicare’s reimbursement rates, Wisconsin would have to lay off more than 10,000 employees and cut an additional \$750 million in operating costs in order to survive financially. This would adversely impact the quality and access to care provided by Wisconsin hospitals which are leaders in quality.

Cost-shifting is not a 1:1 proposition: Every \$1 in government funding is not offset by a \$1 increase in private payer funding. Some of it is absorbed by providers through cost-savings and other efficiency initiatives. But after years of flat or declining government revenues, hospitals have little choice but to offset these revenue losses by increasing commercial rates.

Completely eliminating existing cost-shifting is not a politically realistic short-term goal, but public and private payers should be expected to pay their fair share of the nation’s health care costs moving forward. Given the state’s demographics and slow-growing economy, legislators, health care providers and the business community can expect increasing financial challenges over the next few years. A collaborative approach that respects all stakeholders’ interests in addressing these challenges provides the best opportunity for a sustainable solution that will maintain the viability of both the state’s health care providers and the business community.