IMPACT OF COST SHIFTING ON PRIVATE INSURANCE

Prepared for:
Alaska State Hospital and Nursing Home Association

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IMPACT OF MEDICAID EXPANSION ON PRIVATE INSURANCE

Executive Summary

This study of the potential impact of cost-shifting in Alaska non-tribal hospitals on the cost of private insurance premiums was prepared by the Department of Health Management and Informatics (HMI) in the School of Medicine at the University of Missouri for the Alaska State Hospital and Nursing Home Association (ASHNHA). The results of this study show that payment shortfalls due to uncompensated care (charity care and bad debt) and contractual allowances (the difference between established rates/charges and the amounts received from third-party payers under contractual agreements) are passed on to private payers of hospital care. In this analysis of the potential impact of cost shifting in Alaska, only the impact of non-tribal hospitals’ cost shifting on private health insurance was examined.

Cost shifting is the term used to describe setting different prices for the same services based upon the individual or entity paying the bill. In the U.S., hospitals provide charity care and incur bad debt. Public programs, such as Medicare and Medicaid, negotiate contractual allowances that do not always fully cover the costs of providing hospital services. In order to cover their total operating expenses, these payment shortfalls to hospitals are often shifted to privately insured payers.1

As a result of cost shifting, there is an inverse relationship between public payer and private payer reimbursement.2 As the reimbursement rate from public payers decrease, the rate charged to private payers increase. In addition to the gap between revenue and expenses from public programs, hospitals also provide care for which they do not receive compensation (bad debt and charity care combined are referred to as uncompensated care). Since 1986, federal law has required hospitals to provide care in the emergency department (ED) through the Emergency Medical Treatment and Active Labor Act (EMTALA). Unlike other types of providers, hospitals cannot turn away people needing medical care. The uncompensated costs incurred by hospitals are often shifted to the private payer.

The key findings of this study are as follows:

- Figure ES-1 illustrates the cost-shift payment hydraulic for Alaska non-tribal hospitals in 2009. Each payer group is represented by a bar. The height of the bar reflects the payment level of that group relative to the costs of treating their patients. The width of the bar reflects the percentage of the costs in the

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hospitals associated with each payer; this indicates the relative importance of each payer to total hospital patient volume.

The hydraulic cost-shift analysis demonstrates that private payers in Alaska pay 53 percent above the costs of treating their patients to cover the payment shortfalls incurred from Medicare, Medicaid, Other Government Programs, and uncompensated care.

As shown, Medicare pays 84 percent of its costs, Medicaid pays 93 percent of its costs, and other government programs pay 97 percent of their costs.

Uncompensated care accounts for 7.1 percent of total costs in non-tribal hospitals in Alaska.

The underpayment to non-tribal hospitals by public programs and the provision of uncompensated care by these hospitals potentially increased private health insurance premiums in Alaska by $628 per privately insured individual in Alaska in 2009.

Uncompensated care provided by non-tribal hospitals increased private health insurance premiums in Alaska by $257 per privately insured individual in 2009.

Cost shifting contributed $531 to the $16,074 family policy premiums in 2009 and $98 to individual policy premiums of $6,477.
If Alaska implements Medicaid Expansion, then the following are expected:

- If Alaska implements the Medicaid expansion program, combined with those projected to be insured through the Health Insurance Exchange (HIE), then the number of uninsured is projected to decrease from 129,702 in 2013 to 18,102 in 2014 and to 17,288 in 2019.

- With Medicaid expansion and the HIE, the amount of uncompensated care provided by non-tribal hospitals is projected to decrease to $19.8 million in 2014. Without Medicaid expansion and the HIE, uncompensated care is projected to be $131 million in 2014.

- The need to shift costs because of uncompensated care in non-tribal hospitals to the privately insured individuals is projected to decrease, from $301 to $45 in 2014, due to Medicaid expansion and the HIE.

- It is projected that the premiums of an individual policy will need to include only $7 additional dollars instead of $47, and the family plan premium will need to include only $38 additional dollars instead of $254 to cover uncompensated care, if Medicaid is expanded and HIE occurs.

- Figure ES2 illustrates the projected cost shift from uncompensated care in 2014 for individual and family policies, both with and without Medicaid Expansion.
Across the period 2014-2019, privately insured individuals and families could, potentially, save $717 million in premiums, if the reductions in uncompensated care were all passed to privately insured individuals.

As shown in Figure ES3, without Medicaid expansion in 2014, $131 million of uncompensated care would be shifted to private insurance, compared to $20 million if Medicaid expansion is implemented.

Across the period 2014-2019, $841 million of uncompensated care would need to be shifted to private insurance without Medicaid expansion, compared to $124 million with Medicaid expansion.
Introduction

This study of the potential impact of the cost of uncompensated and contractual care in Alaska non-tribal hospitals on the cost of private insurance premiums was prepared by the Department of Health Management and Informatics (HMI) in the School of Medicine at the University of Missouri for the Alaska State Hospital and Nursing Home Association (ASHNHA). As Alaska considers the implications of Medicaid expansion on the state and its population, an area that requires additional investigation is the potential reduction in uncompensated care provided in non-tribal hospitals, if Medicaid is expanded.

The purpose of this study is to examine the extent of such cost shifting in Alaska non-tribal hospitals and to estimate the potential impact that expansion of coverage of individuals under Medicaid and the Health Insurance Exchange (HIE) would have on private insurance premiums. Because of the unique financial arrangements associated with tribal hospitals, they are not included in the analysis of cost-shifting in this report. Also, the following analysis and discussion evaluates only the impact of Alaska’s non-tribal hospitals’ cost shifting on private health insurance premiums and does not include the impact of the other sectors of the health care system or the tribal hospitals.

Cost Shifting in the United States

Unlike other providers, hospitals cannot turn away people needing medical care under the Emergency Medical Treatment and Active labor Act (EMTALA); this law requires hospitals to provide care in the emergency department (ED), and hospital if medically necessary, regardless of the ability of the individual to pay for the care received. In order to cover the costs of care provided to individuals who are unable to pay, or whose insurers pay less than the cost of care, hospitals typically increase the price charged to privately insured individuals, since all costs of providing care in the facilities must be covered if the hospitals are to remain financially viable.\(^1\)

Cost shifting in health care refers to the practice by health care providers, especially hospitals, of charging some patients a higher price for services than their costs in order to cover the costs of services provided to individuals who cannot pay or to patients who are covered by other insurance programs that do pay, but at a level below their total costs.\(^2\) These increased payments are often referred to as a hidden tax on privately insured individuals,\(^3\) since the premiums these individuals pay reflect not only the costs
of the privately insured members, but also the costs of uncompensated care and the payment shortfalls from other insurance programs, especially the government programs of Medicare and Medicaid, that are not fully covered by those programs. As a result, the insurance premiums of private insurance policy holders are higher, as payment shortfalls from health services provided to public program and non-paying patients are shifted to privately insured payers.4

Uncompensated care in hospitals reflects the cost of care provided for which the hospital does not receive any payment. It consists of two components—charity care and bad debt. Uncompensated care does not include the payment shortfalls associated with the contractual adjustments with Medicare, Medicaid, or other government payers. Charity care reflects the costs of care for which the hospital never expected to receive payment. Bad debt reflects the costs of care provided for which the hospital extended credit and anticipated payment, but either the patient was unable or unwilling to pay the bill. These uncompensated care costs then have to be covered in some way, since hospitals have to at least break even to remain financially viable.5

Hospitals continue to increase the amount of uncompensated care given to uninsured individuals, while also facing ever-stringent payment polices from public payers (Medicare, Medicaid, and others). Since the mid-1990s, the increase in hospital expenses in the United States has paralleled the increase in private health insurance premiums. Additionally, the private payer rates nationally have consistently followed an inverse relationship with Medicare and Medicaid payment policies; as the reimbursement rates from these public payers decrease, the reimbursement rates charged to private payers increase.6 Figure 1 shows the aggregate U.S. hospital payment-to-cost ratios for private payers, Medicare, and Medicaid between 1990 and 2010.

Figure 1: Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1990-2010

Source: Avante Health analysis of American Hospital Association Annual Survey data, 2010, for community hospitals.
(1) Includes Medicaid Disproportionate Share payments.
To cover the payment shortfalls from public payers and uncompensated care, hospitals shift the costs to privately insured patients. This shift results in insurance companies raising the premiums they charge individuals and employers. Since employers and their workers are the largest group of purchasers of private health insurance, they are the ones most impacted by the rising premiums. Individual purchasers are also impacted by these rising premiums, and the increased costs may force some of these individuals out of the insurance-covered population and into the uninsured population. Figure 2 illustrates the rate of increase in private health insurance premiums in the U.S. relative to the rate of increase in national health care expenditures and in median household incomes in the U.S. between 2000 and 2011.\textsuperscript{7,8,9}

![Figure 2: Growth in Private Health Insurance Premiums and in Total Health Expenditures and Median Household Income, 2000 - 2011](image)

As indicated by the data in this figure, individuals have been losing ground as health insurance premiums increase at a more rapid rate than does household incomes. Such increases continue to strain the budgets of families and employers. As indicated, there was a sharp increase in insurance premiums in 2011, even though the rate of increase in national health expenditures remained constant.

**Hospital Cost Shifting in Alaska**

Regardless of insurance status, nearly all individuals seek some type of health care services at some point in their lives. As mentioned previously, those individuals who are uninsured or underinsured often seek care through their local hospital emergency
department. Since 1986, federal law has required hospitals to provide care in the emergency department through the Emergency Medical Treatment and Active Labor Act (EMTALA). While the hospitals often provide these services at a loss, many institutions try to obtain payment for these services through alternative funding streams, as discussed below.

The federal government has such programs as the Medicare disproportionate share hospital (DSH) payment to partially cover this cost, although only two Alaska non-tribal hospitals receive such payment. Some states also provide disproportionate share hospital payments for Medicaid, although Alaska does not. However, under the ACA, those payments will be reduced, as this reduction was intended to be offset by newly covered individuals. Some hospitals also receive donations from charitable foundations, private donors, and other sources to partially offset their charity care. It is well understood that the remainder of the cost of care for the uninsured is shifted to other individuals with private insurance in the form of higher premiums, a phenomenon called cost shifting or a hidden health care tax.10,11,12,13,14,15,,16

Cost shifting can be seen by comparing the spending growth rates of Medicaid to the state’s spending growth overall. From 2005 to 2010, healthcare spending in Alaska increased by 42 percent, while Alaska’s Medicaid spending increased only 32 percent. While some of the slower growth in Alaska’s Medicaid can be attributed to physician’s writing generic scripts and other intentional cost reduction strategies, much of the slower growth is a result of reductions in reimbursement rates to health care providers. As a result, the cost to private insurance payers has increased. Single coverage insurance premiums grew by 51 percent in Alaska, and family coverage insurance premiums grew by 35 percent from 2003 to 2010.17

Additional evidence of the amount of cost shifting occurring in Alaska hospitals is provided in the following calculations. The Alaska State Hospital and Nursing Home Association (ASHNHA) provided 2009 data on Alaska hospitals for revenue and expenses by type of payer and uncompensated care. Data on the number of uninsured individuals in Alaska (total uninsured between the ages of 19 and 64 and the uninsured between 19 and 64 years of age and at or below 138 percent of poverty) were obtained from the U.S. Census Bureau, 2009 American Community Survey. Data on private insurance premiums were obtained from the Institute of Social and Economic Research at the University of Alaska Anchorage. Information regarding the Medicare and Medicaid Disproportionate Share Hospital (DSH) payment reductions was obtained from the Congressional Research Service.
Using the 2009 Alaska data as the base year, projections were made for 2010 through 2019 using an inflationary rate. Using Alaska hospital data, calculations were made for payer specific payment-to-cost ratios to illustrate the cost-shift payment hydraulic for Alaska hospitals. Figure 3 demonstrates the payment-to-cost ratios for each type of payer in 2009, as well as the percent of total costs accounted for by each type of payer.

As indicated by the data in Figure 3, private payers help cover the payment shortfalls from not only uncompensated care, but also from government payers in Alaska. Each bar in the figure represents a payer; the width of the bar represents the percentage of hospital costs associated with each payer, and the height of the bar reflects the payment-to-cost ratio of what the hospital receives in payment relative to the costs of treating the patients covered by that payer.

For example, in 2009, Medicare beneficiaries accounted for 29.1 percent of total costs in Alaska hospitals, but Medicare payments only covered 83.8 percent of the costs required to treat those beneficiaries. Similarly, Medicaid recipients accounted for 16.9 percent of total costs, but Medicaid payments only covered 92.6 percent of their costs. As a result, while private paying individuals accounted for 41.0 percent of hospital
costs, their payments covered 152.5 percent of the costs. This indicates that for each dollar of cost incurred by hospitals in Alaska, they receive $1.53 from private payers because they received less that cost from other payers, including individuals covered through charity care and bad debt.

Uncompensated care (charity care plus bad debt, for which the hospitals receive no revenue) accounted for 7.1 percent of the total costs in Alaska non-tribal hospitals in 2009. These unpaid costs were then shifted to other payers in the system, and since Medicare, Medicaid, and other government payers also did not pay full costs, the coverage of these costs were left to the private payers of hospital care, and especially to the payers through private health insurance. Self-pay patients paid 100% of their costs, but didn’t contribute additional payment for the costs of others. The other non-government payers required some of their costs to be shifted to others, since they paid only 96.0 percent of their costs.

Another component of payment shortfalls in hospitals are contractual adjustments. The contractual adjustments reflect the difference between the revenue that would have been received at an established rate and the revenue that is actually realized from the third-party payers under contractual arrangements. In 2009, contractual adjustments totaled $1,534,615,240 in Alaska non-tribal hospitals, which was 50.6 percent of the total gross patient revenue ($3,032,074,983) of these hospitals.

To calculate the amount of hospital cost shifting that occurs in Alaska non-tribal hospitals, the model developed by the Lewin Group for Arizona was used as the basis for the calculations in this report (see appendix for details of formulas used in calculations). In this report, however, the focus and analysis is on the potential impact of Medicaid expansion and implementation of private health insurance exchange coverage on private health insurance premiums due to cost shifting in non-tribal hospitals in Alaska. It is not a comprehensive analysis of the impact of cost shifting on health insurance premiums from all sectors.

To quantify the current amount of non-tribal hospital cost shifting in Alaska, revenues, costs, and payment-to-cost ratios for each payer group was used, including the amount of uncompensated care costs provided by hospitals. For example, the gross uncompensated care (bad debt plus charity care) expenses of Alaska non-tribal hospitals were $222,397,850 in 2009. These costs reflect the charges reported by hospitals, and have not been adjusted by the cost-to-charge ratio of hospitals. The cost-to-charge ratio in Alaska hospitals is approximately 50 percent (49.3%). When
adjusted by the cost-to-charge ratio, the uncompensated care costs in Alaska non-tribal hospitals were $100,574,666 in 2009.

The average payment-to-cost ratio across all payer groups was 108.29 percent, which includes only revenues and costs from patient-care activities. This 108.29 percent indicates that Alaska hospitals, on average, received 8.29 percent more from patient care activities than the costs associated with providing those patient-related activities, reflecting a positive return on investment (ROI) from patient-related activities in 2009, a condition necessary for sustainability of the hospitals. Table 1 provides a summary of the elements impacting the need for cost shift activities in Alaska hospitals in 2009.

<table>
<thead>
<tr>
<th>Table 1: Cost Shift Calculations for Alaska Non-Tribal Hospitals in 2009</th>
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<tr>
<td>(A)</td>
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<tr>
<td>Net Patient Revenue</td>
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<td>Medicaid</td>
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<td>Third Party Payers</td>
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<tr>
<td>Other Non Gov't</td>
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<tr>
<td>Uncompensated</td>
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<tr>
<td>Total</td>
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</tbody>
</table>

Data for net patient revenue and net patient cost by payer were obtained from ASHNHA for the project. The last column (F) reflects the calculated amount of cost shift for each type of payer, assuming all payers reimbursed Alaska hospitals the average payment-to-cost ratio (E); these patient-generated revenues are insufficient to cover total costs of providing patient care. Using this methodology, it is estimated that private payers paid an additional $267 million for non-tribal hospital care in order to cover payment shortfalls from other payers ($158 million) and uncompensated care ($109 million).

The estimated $267 million payment shortfall in non-tribal hospitals transfers to private health insurance members in the form of higher premiums. In 2009, there were 424,561 individuals insured by private health insurance. As a result, the $267 million in payment shortfall translates into an additional cost for services provided in non-tribal hospitals of approximately $628 per privately insured individual.
Alternatively, there were 128,896 individuals enrolled in Medicaid in 2009, and it cost non-tribal hospitals $1,843 per enrollee for care, for which they received $1,707 in revenue, resulting in payment shortfalls of $136. There were 52,866 Alaskans enrolled in Medicare in 2009. These individuals cost hospitals $7,742 per enrollee for which they received $4,161, resulting in payment shortfalls of $3,581 per enrollee. There were 226,780 individuals enrolled in other government programs; these enrollees cost hospitals $365 per enrollee, for which hospitals received $354, resulting in a payment shortfall of $11. Given the small difference for these patients ($11), they, like self-insured individuals, can be viewed as paying their costs, but not as a recipient of cost-shifting activities. There were also 118,842 uninsured individuals in 2009, costing non-tribal hospitals $846 per individual, and for which hospitals received no revenue.

To the extent possible, the shortfalls in payments to hospitals are passed on to individuals covered by private health insurance in the form of higher premiums, paid for either by individuals or employers. It is estimated in this study that payment shortfalls in non-tribal hospitals by Medicare, Medicaid, other government programs, other non-government programs, and the costs of providing uncompensated care increased private health insurance premiums by $628 per privately insured individual in 2009.

As a result of the cost shifting to compensate for total payment shortfalls in non-tribal hospitals in Alaska, a typical family policy costing $16,074 included $531 to cover payment shortfalls, and an average individual policy costing $6,477 included $98 for payment shortfalls to non-tribal hospitals. Private health insurance premiums in Alaska are higher than the national average for both family and individual policies. Table 2 provides more detailed information on the impact of non-tribal hospital cost shifts on private insurance premiums in Alaska in 2009.

| Table 2: Impact of Alaska Non-Tribal Hospital Cost Shifts on Private Insurance in 2009 |
|---------------------------------|----------------|----------------|----------------|----------------|-----------------|
| Cost Shift Amount               | Medicare      | Medicaid      | Other          | Uncompensated  | Private Payers  |
|                                 | ($100,292,095)| ($37,216,378)| ($9,254,491)   | ($108,909,221) | $266,731,390    |
| Cost Shift per Privately Insured Person | | | | | |
| Number Privately Insured in Alaska | | | | | 424,561 |
| Cost Shift per Private Insured  | ($236.23)     | ($87.66)     | ($21.80)      | ($256.52)     | $628.25         |
| Cost Shift as a percentage of Total Premiums | | | | | $1,380,000,000 |
| Total Private Insurance Premiums in Alaska | 7.3% | 2.7% | 0.7% | 7.9% | 19.3% |
Potential Impact of Medicaid Expansion and Health Insurance Exchange on Private Health Insurance Premiums

In this section, the potential impact of the Medicaid expansion program and the Health Insurance Exchange on private insurance premiums is estimated based on an anticipated reduction in uncompensated care with increased insurance coverage of the population. Earlier, the total impact of cost shifting was presented for 2009, which included the payment shortfall by public programs as well as the cost of uncompensated care.

In the analysis here, it is assumed that payment shortfalls from other payers will continue to occur, and that Medicaid expansion and HIE participation will have an impact only on the amount of uncompensated care provided in non-tribal hospitals. Included in the projections of the impact of Medicaid expansion for the period 2014 through 2019 are findings from a previous study by Northern Economics on the number of uninsured individuals who will enroll in Medicaid or private health insurance exchanges. A more detailed discussion of the assumptions in the report is provided in the Appendix.

Although the uninsured account for a relatively small share of hospital services utilized, they account for most of the uncompensated costs that hospitals incur. In 2009, there were 118,842 uninsured individuals in Alaska, and the costs (not charges) in non-tribal hospitals for uncompensated care associated with these uninsured individuals were almost $109 million. This $109 million imposes a significant hidden health care tax on the privately insured individuals and their employers in Alaska. The medical care provided by hospitals with no compensation is a significant driver of cost shifting among payers. As a consequence, to cover these losses incurred by treating uninsured...
patients who default on payments for services previously provided in good faith, these hospitals shifted the uncompensated care costs to privately insured individuals, resulting in an increase of approximately $257 in insurance premiums per insured individual. This amount of premium cost from uncompensated care is projected to increase to $301 per privately insured individual in 2014, because of increased costs of providing hospital care and the growth in the number of the uninsured from 118,842 to 129,702 between 2009 and 2014.

As indicated earlier, uncompensated care accounts for approximately 41 percent of total payment shortfalls in non-tribal hospitals. The uncompensated care in non-tribal hospitals is estimated to increase to $131 million in 2014; this increase in uncompensated care assumes a growth in the number of uninsured in Alaska as the population increases, an increase in costs associated with the provision of hospital care between 2009 and 2014, and the reduction in disproportionate share hospital (DSH) payments to non-tribal hospitals in 2014.

If Medicaid expansion is implemented in Alaska, along with projected enrollment in the Health Insurance Exchange, the number of uninsured individuals is projected to decrease to 18,102 in 2014. This projected increase in the number of insured in Alaska (and the subsequent decrease in the number of uninsured) is attributed to 32,240 newly eligible Medicaid expansion enrollees (approximately 30%) and 77,000 individuals enrolling in the HIE (approximately 70%). The amount of uncompensated care provided by non-tribal hospitals is projected to decrease to $19.8 million in 2014, from the projected $131 million without Medicaid expansion and HIE coverage. Assuming comparable costs incurred per Medicaid expansion enrollee and HIE covered individual, then $33 million of the $111.2 million reduction in uncompensated care could be attributed to Medicaid expansion and $78.2 to HIE coverage.

As a result, the need to shift costs because of uncompensated care in non-tribal hospitals to the privately insured individuals will also decrease, from $301 per privately insured individual to $45 per insured individual in 2014. If this reduction in uncompensated care occurs, then it is projected that the premiums of an individual policy would only need to include $7 additional dollars instead of $47, and the family plan premium would need to include only $38 additional dollars instead of $254. Figure 4 illustrates the projected reduction in cost shifting from uncompensated care in 2014 for individual and family policies.
With a reduction in the amount of uncompensated care provided by hospitals, the need for hospitals to increase prices to privately insured individuals to cover these costs is reduced. While there is no guarantee that all these savings would be passed on to privately insured individuals through premium reductions, the ACA places restrictions on the size of the difference between the premiums collected and the benefits paid out by insurance companies. These “profit” restrictions should be reflected in the premiums charged by private insurance companies.

Across all private insurance premiums in Alaska, this reduction in the cost shift to private insurers from the uninsured due to increased Medicaid enrollment and HIE coverage could result in approximately $111 million in savings in 2014 to individuals and families, as private insurance premiums no longer need to absorb the uncompensated costs of the uninsured. Across the period 2014-2019, privately insured individuals and families could potentially save $717 million due to reductions in premiums.

As shown in Figure 5, without Medicaid expansion and HIE, in 2014, $131 million of uncompensated care would be shifted to private insurance, compared to $20 million if Medicaid expansion and HIE are implemented. Across the period 2014-2019, $841 million of uncompensated care could be shifted to private insurance without Medicaid expansion and HIE, compared to $124 million with Medicaid expansion and HIE.
Summary

Cost shifting occurs when hospitals are paid a higher rate for privately insured patients to cover the losses incurred by treating uninsured or underinsured patients who default on payments for services previously rendered in good faith. This cost shifting imposes a substantial hidden health care tax on privately insured individuals.

In 2009, there were 118,842 uninsured individuals in Alaska. Non-tribal hospitals in Alaska provided over $109 million of uncompensated care to patients in 2009; this is projected to increase to over $131 million by 2014.

If the number of uninsured in Alaska is decreased through Medicaid expansion and HIE plans, the need to shift costs because of uncompensated care in non-tribal hospitals to the privately insured individuals will also decrease, from $301 per privately insured individual to $45 per insured individual in 2014.

If this reduction in uncompensated care occurs, then it is projected that the premiums of an individual policy would only need to include $7 additional dollars instead of $47, and the family plan premium would need to include only $38 additional dollars instead of $254.
### Table 1A

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<th>Total Uncompensated Care</th>
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<td>South Peninsula Hospital</td>
<td>$1,583,974</td>
<td>$602,912</td>
<td>$2,186,886</td>
</tr>
<tr>
<td>Wrangell Medical Center</td>
<td>$912,895</td>
<td>$251,530</td>
<td>$1,164,425</td>
</tr>
<tr>
<td>Total, All Hospitals</td>
<td>$128,483,096</td>
<td>$99,208,685</td>
<td>$227,691,781</td>
</tr>
</tbody>
</table>

The amount of uncompensated care provided by each hospital can be used to estimate the impact that the changes projected in health care finances could have on each hospital in Alaska.
Methodology

The following calculations were used to perform the cost shift analyses presented in this study.\(^2\)

**Ratio of Costs to Charges (RCC):**
\[ \text{RCC} = \frac{\text{Total Operating Expenses} - \text{Bad Debt Expense}}{\text{Gross Charges} + \text{Other Operating Revenue}} \]

**Costs by Payer**
- Private = \((\text{Total Private Gross Charges} - \text{Bad Debt Expense} - \text{Charity Care}) \times \text{RCC})\,
  \text{(Total private includes self-pay, private third party payers, and other non-gov't payers)}
- Medicare = Medicare Gross Charges \times \text{RCC}
- Medicaid = Medicaid Gross Charges \times \text{RCC}
- Other Gov't = Other Gov't Gross Charges \times \text{RCC}
- Uncompensated Care = \((\text{Bad Debt} + \text{Charity Care}) \times \text{RCC})

**Revenues by Payer (Gross Charges - Contractual Allowances)**
- Private = Total Private net patient Revenues - Bad Debts
- Medicare = Medicare Net Patient Revenues
- Medicaid = Medicaid Net Patient Revenues

**Payment-to-Cost Ratios**
Payment-to-Cost Ratios = Revenues per payer / Costs per payer

**Percentage of Hospital Costs**
Percentage of Hospital Costs = \(\frac{\text{Costs per Payer}}{\text{(Total Operating Expense} - \text{Bad Debt Expense})}\)
Basic Model Assumptions

We used several different data sets to obtain the information used to conduct the estimation of the impact of Medicaid expansion on private insurance premiums in Alaska due to cost shifting in non-tribal hospitals in Alaska.

1. We collected the number of new enrollees under Medicaid expansion and the number of current Medicaid enrollees from Medicaid Project Group\(^{21}\).

2. We collected the number of privately insured, other government, and uninsured from 2009 to 2011 from the Current Population Survey\(^{22}\). We assumed that the number of privately insured, other government, and uninsured in 2011 would remain constant over 2012 to 2019. In doing so, we measure how much cost shift current privately insured will bear if they remain in private health insurance, under Medicaid expansion and DSH cuts.

3. In 2014, we assume that 77,000 of the uninsured will purchase health insurance through health insurance exchanges\(^{23}\), and that 2,360 of currently eligible Medicaid but not enrolled individuals will join Medicaid (woodwork effect)\(^{24}\); of the remaining uninsured, we subtract the number that Medicaid Project Group is projecting for Medicaid expansion.

4. We collected total premiums on Alaska privately insured to estimate the percentage of cost shift as a percentage of total premiums\(^{25}\); finally we collected family and individual insurance premiums\(^{26}\) and the number of policy holders of each group for 2011\(^{27}\). We computed the cost shift impact of each group as a weight of total privately insured. For instance, in 2011, there are 434,907 privately insured, out of those, 65,952 are single policy holders, which is 16% of the total privately insured; the remaining 84% are covered under family plan policies. Then, we use these weights to assess the cost shift impact on premiums of both groups.

5. Finally, we assume that non-tribal hospitals will care for the entire newly qualified Medicaid beneficiaries, and also for those who purchase health insurance through health insurance exchanges.
References


5 Ibid.


16 Robinson J. (2011). Hospitals respond to Medicare payment shortfalls by both shifting costs and cutting them, based on market concentration.” Health Affairs 30(7): 1265-1271.

17 Ibid.


Ibid


