THIRD-PARTY PAYMENT

Learning Objectives
1. Review the history of third-party reimbursement.
2. Classify managed care organizations.
3. Examine new methods of financing and delivering healthcare.
4. Identify methods of payment, including bad debt and charity care.
5. Compute cost-shifting and cost-cutting practices.

Introduction
Third-party payers are agents of patients who contract with providers (the second party) to pay all or a part of the bill to the patient (the first party), and they have had an important effect on healthcare organizations over the last 70 years. As mentioned in Chapter 1 and illustrated in Figure 4.1, third-party payment, including payments from the federal government, private insurance,

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**FIGURE 4.1**
Percentage of Total Personal Healthcare Expenditures in the United States by Source of Funds, 2005

and state and local government, represented 81.3 percent of total personal healthcare expenditures in 2005 (Catlin et al. 2007).

**History of Third-Party Payment**

Third-party payment started in the 1920s, but not without significant opposition. Although labor unions supported compulsory health insurance for their members as early as 1915, their efforts failed as a result of opposition by the American Medical Association (AMA) and the antisocialist mood of the country during and after World War I. Physicians were wary of approving a payment system that would change the second-party payment system already in place (see Figure 4.2).

The second-party payment system was economically efficient in that patients sought only the amount and quality of care they could afford. However, the second-party payment system created ethical concerns because some patients who needed care could not afford care, and it prompted some employers to begin paying providers directly for the care received by their employees. The second-party system also created bad-debt concerns because some patients sought emergency care and could not afford to pay the bill after the care was provided. This concern prompted Baylor University Hospital in Dallas to offer schoolteachers prepaid hospital care for $6 per year. Prior to this arrangement, teachers would deliver their babies in the emergency room and would be unable to pay the resulting hospital bills. In the next few years, several other hospitals offered similar arrangements to remain competitive with the Baylor plan, which later became the first Blue Cross plan. In 1933, Dr. Sidney Garfield began providing prepaid medical care to employees who worked on the California aqueduct system, and in 1938 he provided prepaid medical care to workers on the Grand Coulee Dam. Garfield’s plan was later called the Kaiser-Permanente health plan (Henry J. Kaiser was the employer who contracted with Dr. Garfield) (Starr 1982).

The Great Depression in the 1930s made it difficult for employers to pay providers directly for the care received by their employees and for hospitals like Baylor to accept the risk associated with offering prepaid plans. AMA softened its position on health insurance during the mid-1930s by accepting voluntary health insurance if hospital and medical benefits were separate. For example, Blue Cross provided hospital benefits, and Blue Shield later provided medical benefits. AMA remained adamantly opposed to compulsory health insurance and helped defeat proposals to include compulsory health insurance in President

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**FIGURE 4.2**
Second-Party Payment

Patient → Seeks care from Provider

→ Provides care and bills Pays bill to

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Roosevelt’s Social Security Act in 1935. In 1945, President Truman introduced his health plan that if passed would provide health insurance to every citizen; increase funding for public health and maternal and child health services; initiate federal funding for medical education and research; and provide significant funding to build new, and expand existing, hospitals. In 1946, President Truman signed into law the only part of his plan that Congress passed: the Hospital Survey and Construction Act, which provided significant funding for hospital construction. The Republicans took control of Congress in 1946 and characterized Truman’s health plan as socialized medicine, or publicly funded health benefits. Even with President Truman’s surprising reelection in 1948, antisocialist sentiment and strong lobbying by AMA prevented President Truman’s plan from becoming reality (Starr 1982; Hepner and Hepner 1973).

**Direct Service Plans**

The defeat of compulsory health insurance in 1935 under President Roosevelt and again in the late 1940s under President Truman meant that health insurance in America would be largely voluntary and private. The early plans by Baylor University Hospital and Henry J. Kaiser were called direct service plans (employers prepaid specific hospitals and physicians to provide care to their employees) and were characteristic of most health insurance plans through the 1940s. Direct service plans were really an extension of second-party payment in that the employer prepaid the provider on behalf of the employee (see Figure 4.3).

In the mid-1940s, plans called “commercial indemnity plans” allowed employers and/or employees to prepay to an insurance company that would reimburse a hospital or physician of the employee’s choosing. These plans initiated the concept of the third party in that the insurance company was relatively independent from both the employer/employee and the provider (see Figure 4.4).

Between 1945 and 1949, group commercial indemnity plans increased from 7.8 million subscribers to 17.7 million subscribers, and individual commercial indemnity plans increased to 14.7 million subscribers. By 1953,
commercial insurance plans, which were for-profit, provided coverage to 29 percent of Americans. Blue Cross, which was a not-for-profit plan, provided coverage to 27 percent of Americans. Through the 1950s, use of commercial indemnity plans grew steadily, often at the expense of the less aggressive Blue Cross plans.

Blue Cross typically set premiums using community rating (i.e., groups paid essentially the same premium, resulting in low-risk groups subsidizing high-risk groups). Commercial insurance companies like Prudential and Metropolitan, which had had significant histories in life insurance, set premiums using experience rating (i.e., groups paid different premiums based on their risk). Commercial insurance companies often solicited low-risk Blue Cross groups by offering lower premiums.

By the late 1950s, 66 percent of Americans had some form of health insurance that was usually provided by the employer (Starr 1982). Part of this increase is attributable to the federal government’s tax policies that allowed employers to deduct the cost of health benefits to employees. Medicare and Medicaid were introduced in 1966 (Medicare and Medicaid are discussed in more detail in Chapter 5); the percentage of covered Americans subsequently increased to 87 percent by 1968 (Harris 1975). Changes in federal Employee Retirement Income Security Act (ERISA) laws during the early 1980s allowed large employers to self-insure and gain the full benefit of any reductions in costs. Some of these reductions in costs were actually a transfer of costs to employees.1 With the Deficit Reduction Act of 1984, the federal government began limiting the amounts employers could deduct for health benefits. As a result, the out-of-pocket costs to the patient grew, and the percentage of Americans covered by some form of health insurance dropped to its 2002 level of 85 percent.

While 85 percent of the total population has been insured with at least some health insurance coverage since 1995, there has been a significant decrease in the percent of nonelderly insured, offset by a significant increase in the percent of elderly insured as the country ages and more people become eligible for Medicare. The number of nonelderly people with health insurance decreased by 1.4 million in 2001 and 2.4 million in 2002—the largest single decrease in ten years. All of the decrease occurred among adults; children with health insurance actually increased slightly during 2002. The reason for the decrease among adults is attributed to decreases in the number of adults covered by employer-sponsored insurance. Decreases in the rates of employer-sponsored insurance are believed to be attributable to shifts in employment from large firms to small firms or self-employment and to the rising cost of healthcare (Holahan and Wang 2004).

Managed Care Organizations

Although the Baylor and Kaiser experiences with direct service plans were limited in the healthcare services they delivered, they were the first managed
care organizations (MCOs). MCOs are organizations that manage the cost of healthcare, the quality of healthcare, and the access to healthcare. One way to classify MCOs is with Wagner’s continuum (see Figure 4.5) (Wagner 1996). At one end of the continuum is the commercial indemnity plan, which requires precertification of elective admissions and case management of catastrophic illnesses.

Service plans, like the typical Blue Cross plans, add contractual relationships with providers that often include maximum fee schedules and prohibitions on balance billing (i.e., providers cannot bill the patient for amounts over the fee schedules agreed to with the service plan). Preferred provider organizations (PPOs) are organizations that provide discounted provider services to insurance carriers and employers.

Providers usually agree to discount their prices in exchange for large volumes of patients. Health maintenance organizations (HMOs) are organizations that integrate the financing and delivery of healthcare into one organization (see Figure 4.6). Financial risk, and opportunity, shifts from the employer/employee under the managed indemnity plans (i.e., the employer/employee pays for inappropriate use through increased premiums) to the HMOs (i.e., under prepayment, the HMO assumes the financial risk, and opportunity, for inappropriate use).

While most would agree that managed care reduced the rate of increase of healthcare costs, managed care is not without its critics. Aggressive utilization review, including the requirement of pretreatment authorization practiced by most managed care organizations, is often criticized. In response to the criticisms, UnitedHealth Group, which insured 14.5 million people in 1999, found that medical reviews of physicians’ treatments resulted in higher

--- Greater control and complexity
--- Greater administrative costs
--- Greater potential for cost containment

costs for the insurer. In December 1999, UnitedHealth decided to let its physicians have the final authority on medical treatments for its patients, even in cases where UnitedHealth might consider the medical treatments unnecessary. UnitedHealth found that it was spending over $100 million per year reviewing the physicians’ orders and expected the new policy to save over $25 million per year. While UnitedHealth physicians still must notify UnitedHealth if they admit their patients, order home healthcare, or order expensive equipment, the final decision on medical necessity still rests with the patient’s physician (HFMA 1998). Apparently this radical departure from convention has had little impact on UnitedHealth’s bottom line. At the end of 2002, UnitedHealth reported 18 straight quarters of double-digit profit increases (Rauber 2003a).

In response to a growing anti–managed care sentiment and in the face of possible legislation designed to hold managed care companies legally accountable for directly managing care through preadmission authorizations and utilization review, managed care companies like UnitedHealth are pursuing new methods to finance/deliver improved healthcare while holding down costs. One method is evidence-based case management, where managed care companies partner with providers to determine the best, and thereby the most efficient, way to manage a case based on current evidence. For instance, Anthem Blue Cross and Blue Shield’s Midwest Hospital Quality Program has been in effect for several years at more than 330 hospitals in Indiana, Ohio, and Kentucky. After Anthem collaborated with physicians and hospitals, the collaboration resulted in several targets being established: one was to increase the use of ACE inhibitors for health plan members diagnosed with congestive heart failure to 60 percent. In Indiana hospitals from 1998 to 2001, the use of ACE inhibitors increased from 52 percent to 60 percent. Hospitals and physicians who met the targets were reimbursed more than hospitals and physicians who did not meet the targets (Nowicki 2003).

Another method designed to give health plan members choices in coverage that also seems to save money is the move towards consumer-driven plans. As the cost of healthcare continues to rise, employers are passing more of the cost to their employees or not providing healthcare at all (about 37 percent of all employers and about 50 percent of small employers no longer offer health coverage). This economic phenomenon occurs at the same time as a demographic phenomenon—a large portion of the population, the baby boomers, are in their 50s and beginning to need and demand more healthcare. Baby boomers are used to getting what they want and should have large amounts of discretionary income to pay for what they want. Consumer-driven health plans allow consumers to select the coverage they need or want, much like selecting the options on a car, and then the health plan costs out the coverage and converts the cost to a premium (Millenson 2003).

Humana, one of the nation’s largest health plans, may have been the first to try a consumer-driven plan with its own employees. Humana’s
chief executive officer, Michael McCallister, said “I’m a big believer that the most powerful player in understanding and managing costs is going to be the individual consumer. When people are spending their own money, given good and actionable information, they’re going to do much better at controlling costs than the current model” (Rauber 2003b). From July 2001, when Humana replaced its traditional coverage with consumer-driven coverage for its Louisville-area employees and their dependents, through June 2002, Humana saved more than $2 million from its anticipated health benefits’ costs. That included $1.4 million in savings attributable to changes in consumer behavior (switching to generic drugs or scheduling fewer doctor’s visits); $400,000 attributable to a direct cost shift to employees through higher premiums, deductibles, and copays; and $200,000 attributable to the elimination of duplicated coverage between spouses. Originally, only about 6 percent of the employees selected the most “hard core” consumer-driven plan, which included high deductibles and copays in exchange for much lower premiums. More recently, 18 percent of the employees selected the hard core plan, leading Humana officials to believe that the hard core plan is becoming more popular (Rauber 2003b). To manage increased risk, MCOs contain costs with aggressive methods of controlling utilization that include carefully selecting subscribers and providers, providing physician incentives, and providing subscriber/employer incentives. Eastaugh (1992) reported that HMOs, the most aggressive form of MCOs, used 37 percent fewer hospital days (341 days per 1,000 enrolled) for their nonelderly enrolled populations than commercial indemnity plans, which used 542 days per 1,000 enrolled. By 1995, some HMOs in California, a state that has had significant HMO market penetration for several years, reported 170 hospital days per 1,000 enrolled (Robinson and Casalino 1995). Shortell and Hull (1996) reported that significant evidence exists that HMOs reduce the use of specialists and high-cost tests and procedures:

Because of their ability to control costs, MCOs have been attractive to employers that provide insurance coverage for their employees. As a result, MCOs have experienced growth since the passage of the HMO Act of 1973, which provided grant money to develop MCOs and required employers with 25 or more employees who already offered commercial indemnity insurance to also offer MCO coverage if an MCO plan was available. Rapid growth for MCOs occurred during the late 1980s and early 1990s as employers sought ways to reduce the healthcare costs for their employees. Group Health Association of America reported that 56 million people were enrolled in MCOs in 1995, compared to less than five million people that were enrolled in an MCO in 1973.

Historically, MCOs have been classified based on the degree of control they have over their physician providers. Point-of-service (POS) plans are MCOs that exert minimum to no control over their physician providers because they allow enrollees to seek care from providers not on contract with...
the POS plans (i.e., out of network). Although POS plans reimburse the provider’s fees, the POS plan usually requires the enrollee to pay out-of-network providers larger deductibles and coinsurance, as well as higher premiums to the POS plan, for the privilege of going out of network.

Enrollees have criticized MCOs for lack of choice, or lack of freedom of choice, in choosing physician providers; therefore, POS plans have been a popular option for MCOs. Gabel (1994) reported that MCOs offering a POS option grew from less than 20 percent of MCO plans in 1990 to almost 60 percent in 1993. Zelman (1996) reported that by mid-1995, POS plans had approximately 20 million enrollees. Although growth of POS plans has been substantial, future growth is questionable as enrollees find that their needs are met by network physicians and reduce their reliance on out-of-network physicians. Gabel found that only about 16 percent of enrollees in the POS plans used the out-of-network option.

**HMOs**

*Open-Panel HMOs*  Open-panel HMOs are HMOs that exert moderate control over physician providers; they contract with physicians to provide care for enrollees in the physicians’ offices. Open-panel HMOs include the direct contract model and the independent practice association (IPA) model. Direct-contract HMOs contract with individual physicians to provide care, and IPAs contract with associations of physicians. Member physicians are not employees of the association. IPAs may be previously existing associations of physicians that contract with multiple HMOs, or the HMO may organize the association to provide physician services. In either model, as well as in the direct-contract model, physicians see their own patients and HMO patients. The open-panel HMO reimburses the physicians either on a fee-for-service basis, often with a discount, or by capitation (Wagner 1996).

*Closed-Panel HMOs*  Closed-panel HMOs are HMOs that exert maximum control over physician providers because the HMO contracts with or employs physicians to provide care for enrollees on an exclusive basis. Closed-panel HMOs include the group model and the staff model. Group-model HMOs contract with a multispecialty group of physicians to provide all physician care to enrollees, typically on capitation. In the group-model HMO, physicians are employed by the group, not the HMO. Staff-model HMOs employ individual physicians to provide all physician care to enrollees; primary care physicians are always employed, and some specialty and subspecialty physicians may actually be on contract. Closed-panel HMOs provide incentive payments to physician providers based on performance (Wagner 1996).

*Network HMOs*  Network HMOs exert moderate to maximum control over physician providers because they contract with physician groups to provide care for enrollees. Network HMOs may be either open panel or closed panel. Typically, the
network HMO relies on groups of primary care physicians and reimburses the groups on capitation. The primary care groups are often responsible for referring and reimbursing referrals to specialty physicians (Wagner 1996).

**Post-Managed Care**

When the managed care industry had a tough few years in the late 1990s with declining enrollments, poor public relations, and threatened anti–managed care legislation, many were predicting managed care’s demise (Clarke 2000). The managed care industry adjusted with a “softer image” and more popular methods of controlling costs. Managed care continues to be a reliable method for payers, including employers and the government, to control healthcare costs. Managed care is also a cornerstone of President Bush’s attempt to reform the Medicare program. However, employers and the government will continue to investigate new ways to control costs, like defined-contribution plans, direct contracting, a more generous interpretation of consumer-driven plans than previously mentioned, and national health insurance. Depending on the configuration, these new ways of controlling healthcare costs might be considered under the managed care umbrella of products.

**Defined- Contribution Plans**

Employers, faced with the reality that employees who face no personal economic consequences regarding healthcare spending will want, not necessarily need, more healthcare and higher-quality healthcare, are turning from defined-benefit plans to defined-contribution plans. Under defined-benefit plans, the employee receives a defined-benefit package, and the employer/employee pays the premium, which is adjusted each year based on experience. Employers have absorbed large, unpredictable premium increases for several years under these plans. Under defined-contribution plans, employees typically choose from a variety of healthcare options, with a specified amount of the premium paid for by the employer. Any healthcare costs above this amount are paid for by the employee. Defined-contribution plans shift more of the financial responsibility to the employee, who will become more utilization and price conscious as a result. Employees will request more information about providers to evaluate more closely the benefit and risk associated with different treatment options before the employees agree to be treated. Defined-contribution plans put more pressure on providers of health services to be more price- and quality-competitive while at the same time more receptive to the idea of providing patients with information about treatment risks and options (Emery 2001).

**Direct Contracting**

As employers continue to seek strategies to reduce healthcare costs and as providers continue to consolidate resources in reaction to market forces, the
answer may well be direct contracting, or large employers contracting directly with integrated delivery systems or systems of healthcare providers capable of accepting a financial risk and delivering a full range of healthcare services. Realizing that by transferring financial risk to HMOs, they have also transferred financial opportunity, many large employers or coalitions of smaller employers have decided to resume the financial risk and opportunity by self-insuring and then contracting directly with an integrated delivery system. Because ERISA regulates direct contracting arrangements by large, self-insured employers, the employers are exempt from state insurance regulation and therefore avoid the associated costs that HMOs incur. Direct contracting also stimulates competition between integrated delivery systems and encourages local control and innovation. It also reduces administrative costs, which in turn reduces employer health plan costs (Burrows and Moravec 1997).

In 1996, Motorola hired an outside company to create a network of providers that included over 118,000 physicians by the end of 2000. Since Motorola, rather than the insurer, was in charge of credentialing, it set higher standards for physician participation than the standards set by previous health plans that had contracted with Motorola. Motorola estimated that every dollar it spent on its network saved $3 to $9 on medical care. Motorola's healthcare costs rose less than 5 percent per year from 1996 to 2000, and Motorola projected no increase in healthcare costs for 2001. More than 70 percent of Motorola's 70,000 employees chose the company's plan over other options, and the overall satisfaction rating was above 95 percent. In 1999, General Motors hired a pharmacist to track prescription drugs taken most by employees. The pharmacist used the information to negotiate discounts from drugmakers. In 1994, Safeway, Chevron, Bechtel, and other large San Francisco area companies used Pacific Business Group on Health to negotiate directly with providers for discounts to their 400,000 employees (Cohn, Eliopoulos, and Weintraub 2000).

Many healthcare organizations are positioning themselves for life after managed care. According to Zelman (1996), healthcare organizations are pursuing two major goals: access to and control over premium dollars, especially capitated premium dollars; and reorganizing to function as, or be a part of, an integrated delivery system. Zelman identifies the following strategies healthcare organizations are developing to accomplish these goals:

- Increase market power by making an organization and its affiliates more indispensable and influential.
- Expand the capacity of the organization to enable it to do what it could not do before, including expanding products and services and geographic markets.
- Increase capacity to accept capitated contracts.
- Improve administrative performance.
Third-Party Payment

- Increase organizational efficiency.
- Generate economies of scale.
- Reduce duplicative costs.
- Improve information systems necessary to coordinate and integrate new, larger, and more complex systems, and to assist in integration.
- Secure access to capital.
- Improve clinical performance and ability to compete on quality of care.

According to Zelman, functioning as or being a part of an integrated delivery system requires the following core elements:

- A certain level of clinical, not just administrative or financial, coordination among providers in a full continuum of care
- A focus on the performance of the system as a whole, especially by the primary care physicians
- Achievement of some level of physician integration or commitment of the physicians to the system, especially by the primary care physicians
- System emphasis on prevention and primary care
- Achievement of geographic and service breadth
- Development of a sophisticated information system
- Capacity to identify, improve, and compete on quality

The level of clinical coordination among physicians explains the rapid growth of physician-hospital organizations (PHOs) or joint ventures between hospitals and groups of physicians. In 1995, the Physician Payment Review Commission reported that 85 percent of all hospitals either had established a PHO or were in the process of establishing a PHO.

**Consumer-Driven Plans**

The more generous interpretation of consumer-driven health portrays it as a movement that includes empowering healthcare consumers with control, choice, and information (Herzlinger 2004). As a result, consumer-driven plans share enhanced methods of enabling consumers to support informed choice of providers and treatments while managing their own healthcare and strong financial incentives for consumers to control their healthcare spending. These common characteristics are present in two primary models: spending account models and tiered models. Spending account models include some type of health reimbursement account, like health savings accounts, which provides consumers a fund to spend on healthcare expenditures. Once a consumer has depleted the account, and for some expenses not eligible to be reimbursed from the account, a high-deductible PPO-style coverage applies to future healthcare needs. Tiered models have more varieties than spending account models but typically include tiered premiums to the consumer based
on annual selections of healthcare delivery systems. Flexible tiered models allow the consumer, at enrollment, to customize cost-sharing parameters, such as the amounts of deductible and coinsurance, with commensurate adjustments to the amount of premiums paid by the consumer (Rosenthal et al. 2005).

**State and National Health Insurance Plans**

As healthcare is increasingly viewed as a social good and right, businesses and states are increasingly looking to the federal government to provide for that right under some type of national health insurance. Businesses are beginning to see national health insurance funded by taxes as a more equitable way of financing and a more comprehensive way of delivering healthcare than the current method of voluntary coverage provided by employers. Businesses are hoping that spreading the tax burden for national health insurance would result in their tax increases being less than their healthcare costs now, which would make American business more competitive in an increasingly global economy.

At the same time, state governments are concerned about their increasing Medicaid costs and providing healthcare to uninsured people who are not eligible for Medicaid. In the absence of national health insurance, several states are following the lead established by Massachusetts in enacting state health plans designed to control Medicaid costs and to provide coverage to the uninsured.

**Methods of Payment**

Third parties and patients use a variety of methods to pay providers for healthcare services. Methods of payment to healthcare organizations and other providers can be classified according to the amount of financial risk assumed by the healthcare organization.

**Charges**

Every healthcare organization has a list of charges (also called prices or rates) for care provided to patients. The organization may set charges based on the care provided; several other methods of setting charges are discussed in Chapter 7. If the healthcare organization sets charges correctly, and if the third party or patient pays the charges, the organization assumes no financial risk by accepting this method of payment. When patients responsible for their own bill do not pay and become a financial risk as a bad debt, it is assumed that the bad debt would result regardless of the method of payment. From the perspective of the third-party payer or patient, using set charges as the method of payment provides no financial incentive for the healthcare organization to provide only what is medically appropriate.
Charges Minus a Discount

Healthcare organizations offer discounted charges to third parties for several reasons, including as a return for large volumes of patients from a provider or to remain competitive with other organizations. If the healthcare organization does not discount its charges below its costs, the organization assumes very little financial risk accepting this method of payment. From the third-party payer’s or patient’s perspective, charges minus a discount as a method of payment provides no financial incentive for the healthcare organization to provide only what is medically appropriate.

Cost

Healthcare organizations receive the cost for care provided to the patients of third-party payers, plus a small percentage that allows the organization to develop new services and products. Typically, the healthcare organization bills charges to the third party, which reimburses the organization for the projected cost, often expressed as a percentage of the charges. At the end of the year, the third party audits the healthcare organization to determine actual cost and adjusts accordingly what it has reimbursed to the organization. Because the third party determines the final reimbursement after the organization delivers the care to the patient, this method of reimbursement is retrospective and therefore inflationary, because no incentive exists for the healthcare organization to contain costs. If the third party recognizes and approves the costs of the organization, the organization assumes very little financial risk accepting this method of payment. However, many third-party payers do not recognize the full costs incurred by healthcare organizations. As a result, the organization assumes financial risk for the patient and must pass on losses to other third parties and patients who pay more than cost (usually those paying charges and discounts from charges).

Per Diem

Healthcare organizations receive a per day reimbursement for care provided to the patients of third-party payers. Because the third-party payer sets the per diem rate prospectively, or prior to the provision of care, per diem as a method of payment provides both financial risks and financial incentives to the healthcare organization. In the event that the organization provides care for a cost greater than the per diem rate, the organization incurs a loss. In the event that the organization provides care for a cost less than the per diem rate, the organization realizes a profit. However, if the third-party payer does not monitor lengths of stay, the healthcare organization can extend lengths of stay to recover excessive per diem costs. Because per diem rates are generally the same for each day of a length of stay, this method of reimbursement assumes that costs are the same for each day of a length of stay. This
assumption is true for many extended care organizations, but not for acute care organizations in which the patient incurs a greater proportion of the costs during the early days of the admission because of diagnostic testing.

**Per Diagnosis**

Healthcare organizations receive a per diagnosis reimbursement for care provided to the patients of third-party payers. Also prospective in nature, per diagnosis provides financial risks and financial incentives for the healthcare organization to control costs in a manner similar to per diem as a method of payment. However, organizations cannot extend lengths of stay to recover excessive per day costs. As a method of payment, per diagnosis adjusts for variable per day costs by reimbursing the diagnosis instead of the day.

**Capitation**

Healthcare organizations receive a fixed amount per person as compensation for providing care to a defined population in the future (AICPA 1996). Capitation as a payment method provides the most financial risk and opportunity to the healthcare organization because the fixed amount is based on the cost of care projected to be used by the covered population, rather than the cost of care actually used. Previously mentioned payment methods provide financial incentives to healthcare organizations to contain costs after the patient seeks care primarily by controlling use, but capitation also provides financial incentives to healthcare organizations to contain costs before the patient seeks care, primarily by encouraging prevention. Third-party payers and healthcare organizations negotiate capitated payments, often called premiums, based on their perceptions of the actuarial experience of the covered population. Whether the healthcare organization realizes a profit or incurs a loss depends on its ability to project demand for care by the covered population, and then to contain costs when a member of the enrolled population—a subscriber—seeks care.

**Bad Debt and Charity Care**

Although they are not actually methods of third-party payment, bad debt and charity care are important concepts to discuss in this context because the amounts are substantial in healthcare organizations.

**Bad Debt**

Healthcare organizations that use accrual accounting assume bad debt expense when the organization bills and expects payment from a patient or a third party, the organization receives no or partial payment, and the organization writes off all or part of the account. The *AICPA Audit and Accounting Guide for Health Care Organizations* (1996) requires that healthcare organizations report bad debt expense as an operating expense based on charges, not costs. While reporting charges overstates the value of bad debt, AICPA requires the reporting of charges because hospitals can uniformly report
chances for bad debt whereas hospitals would have some difficulty reporting costs for bad debt due to the variety of ways to determine cost.

Healthcare organizations assume charity care expense when the organization provides care to a patient who the organization knows is unable to pay at the time of service. The *AICPA Audit and Accounting Guide for Health Care Organizations* (1996) requires that healthcare organizations do not report charity care as revenue, a deduction from revenue, or an operating expense. However, it requires that healthcare organizations do report the level of charity care (either charges, costs, or units) in a note to the statement of operations along with the organization’s policy for providing charity care.

**Uncompensated Care**

According to American Hospital Association (AHA) data for 2005 (see Table 4.1), hospital spending for uncompensated care, which is the total of bad debt and charity care, continued to climb from its low point in 2002. Uncompensated hospital care as a percent of total expenses was 5.6 percent in 2005. A relatively strong economy before the 9/11 attacks and the relative success of public programs like the State Children’s Health Insurance Program (SCHIP) were likely reasons for the decrease beginning in 2001. Rising numbers of uninsured will likely cause the uncompensated hospital care cost to go up in the future (Reilly 2003). To the extent they could, hospitals shifted these costs to paying patients through increased charges. To the extent they could not shift these costs, hospitals were forced to cut costs in other areas of the hospital. In releasing the 2005 uncompensated care amounts, AHA for the first time also released amounts that hospitals lost in caring for Medicare patients, $15.5 billion in 2005, and Medicaid patients,

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<th>Year</th>
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<th>Medicaid Loss (in billions)</th>
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$9.8 billion in 2005. To the extent they could, hospitals shifted these costs to paying patients through increased charges.

**Cost Shifting**

Cost shifting is the practice of shifting costs to some payers to offset losses from other payers. It occurs in every industry, usually to offset losses from bad debt and charity care. Evidence of cost shifting in healthcare is based on the fact that different payers pay different effective prices (charges minus a negotiated discount) for similar services. For instance, in 1990, Medicaid paid an average of 79.7 percent of the hospital’s costs for caring for Medicaid’s patients, Medicare paid an average of 89.2 percent of the hospital’s costs for caring for Medicare’s patients, and private payers paid an average of 126.8 percent of the hospital’s costs for caring for private pay patients. Employers believe that cost shifting is unfair and the elimination of cost shifting is the primary reason that large employers favor an “all payer” system where each payer pays the same price for similar services. Cost shifting should not be confused with price discrimination, which is the practice of setting prices based on what the market will bear (Feldstein 2003). However, according to a study by Lewin-ICF, a healthcare policy think tank, released by the Healthcare Financial Management Association in 1992 (Dobson and Roney 1992), most of the losses shifted in hospitals relate to losses attributed to Medicare and Medicaid. In a 2006 study released by PriceWaterhouseCoopers, it was reported that 8.4 percent of the insurance premiums paid by the insured goes to provide care to the uninsured. AHA reported that uncompensated care, or the total of charity care and bad debt, was $26.9 billion for hospitals in 2004 and represented 5.6 percent of hospital total expenses (AHA 2005).

Recent evidence provided in Figure 4.7 shows that cost shifting was on the decline in the late 1990s as healthcare organizations lowered their costs in response to the Balanced Budget Act of 1997 and as competition lowered prices to private payers, thus making it more difficult for healthcare organizations to shift large losses to private payers. However, in the early 2000s, as Medicare margins declined for hospitals as evidenced in Figure 4.8, cost shifting increased again as evidenced in the most recent years in Figure 4.7.

Figure 4.9 demonstrates the impact of the cost shift in what is described as the cost-shift payment hydraulic for the average hospital. As payments for Medicare, Medicaid, other government programs, and uncompensated care decrease below cost, the charges to private payers (including patients not covered by insurance) must increase to avoid a loss to the hospital. (It should be noted here that patients not covered by insurance might be covered by the hospital’s charity care policy and may have part of their charges written off as a result.) The amount of the increase to private payers is a function of not only the loss to Medicare, Medicaid, other government programs, and
FIGURE 4.7
Hospital Payment-to-Cost Ratios by Source of Revenue, 1980–2003


FIGURE 4.8
Hospital Medicare Margins, 2001–2004

uncompensated care, but also the amount of payers available and the amount of operating margin desired by the hospital.

In the event that hospitals cannot shift the costs of uncompensated care and government program losses to private payers because the private payers either refuse to pay increased charges through competition or because the private payers refuse to pay for costs unrelated to their patients, the hospital must cut costs. Problem 4.1 demonstrates cost shifting first and then cost cutting. It is important to note that the following problems project how much cost must be shifted or cut. The actual shifting takes place in the pricing of the products and services that make up a patient day and will be discussed in Chapter 7 on Setting Charges (see Appendix 7.1 on Cost-Shift Pricing).

**FIGURE 4.9**
Cost-Shift Payment Hydraulic

![Cost-Shift Payment Diagram]


**PROBLEM 4.1**
Cost-Shifting/Cost-Cutting Problem

Cost Shifting
Next year, ABC healthcare organization will serve 100 patients in the following manner:

30 Medicare patients who pay $850 per diagnosis
20 Medicaid patients who pay $900 per diagnosis
15 managed care patients who pay charges minus a 20 percent discount
15 managed care patients who pay $700 per subscriber
5 private insurance patients who pay charges
5 self-pay patients who pay charges
5 bad debt patients who pay nothing
5 indigent patients who pay nothing

Next year, ABC’s costs will be $1,000 per patient.

Calculate the charge necessary to recover ABC’s cost (called cost-led pricing).

Step 1: Calculate the total projected loss by assuming the charge per patient equals the cost per patient.

<table>
<thead>
<tr>
<th>Financial Class</th>
<th>No.</th>
<th>Costs</th>
<th>Charges</th>
<th>Collections</th>
<th>Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>30</td>
<td>30,000</td>
<td>30,000</td>
<td>25,500</td>
<td>-4,500</td>
</tr>
<tr>
<td>Medicaid</td>
<td>20</td>
<td>20,000</td>
<td>20,000</td>
<td>18,000</td>
<td>-2,000</td>
</tr>
<tr>
<td>Managed care #1</td>
<td>15</td>
<td>15,000</td>
<td>15,000</td>
<td>12,000</td>
<td>-3,000</td>
</tr>
<tr>
<td>Managed care #2</td>
<td>15</td>
<td>15,000</td>
<td>15,000</td>
<td>10,500</td>
<td>-4,500</td>
</tr>
<tr>
<td>Private</td>
<td>5</td>
<td>5,000</td>
<td>5,000</td>
<td>5,000</td>
<td>0</td>
</tr>
<tr>
<td>Self-pay</td>
<td>5</td>
<td>5,000</td>
<td>5,000</td>
<td>5,000</td>
<td>0</td>
</tr>
<tr>
<td>Bad debt</td>
<td>5</td>
<td>5,000</td>
<td>5,000</td>
<td>0</td>
<td>-5,000</td>
</tr>
<tr>
<td>Indigent</td>
<td>5</td>
<td>5,000</td>
<td>5,000</td>
<td>0</td>
<td>-5,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
<td>100,000</td>
<td>100,000</td>
<td>76,000</td>
<td>-24,000</td>
</tr>
</tbody>
</table>

Step 2: Calculate the charge necessary to recover ABC’s cost by dividing the loss by the number of patients who will pay an increased charge, or portion thereof, and then add the cost per patient to the answer.

\[
\frac{24,000}{15(0.80) + 5 + 5} + 1,000 = 2,091
\]

Step 3: Check the answer by calculating the loss using the new charge.
### Cost Cutting

For the previously referenced cost-shifting problem, assume that those payers that pay charges, or charges minus a discount, limit ABC’s charges to $1,070 per patient. Calculate the amount of costs that ABC will need to cut, or cover with additional revenues, to break even (i.e., realize no profit or loss).

**Step 1:** Calculate the total costs to be cut by using the new charge per patient to determine profit/loss.

<table>
<thead>
<tr>
<th>Financial Class</th>
<th>No.</th>
<th>Costs</th>
<th>Charges</th>
<th>Collections</th>
<th>Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>30</td>
<td>30,000</td>
<td>32,100</td>
<td>25,500</td>
<td>-4,500</td>
</tr>
<tr>
<td>Medicaid</td>
<td>20</td>
<td>20,000</td>
<td>21,400</td>
<td>18,000</td>
<td>-2,000</td>
</tr>
<tr>
<td>MC #1</td>
<td>15</td>
<td>15,000</td>
<td>16,050</td>
<td>12,840</td>
<td>-2,160</td>
</tr>
<tr>
<td>MC #2</td>
<td>15</td>
<td>15,000</td>
<td>16,050</td>
<td>10,500</td>
<td>-4,500</td>
</tr>
<tr>
<td>Private</td>
<td>5</td>
<td>5,000</td>
<td>5,350</td>
<td>5,350</td>
<td>350</td>
</tr>
<tr>
<td>Self-pay</td>
<td>5</td>
<td>5,000</td>
<td>5,350</td>
<td>5,350</td>
<td>350</td>
</tr>
<tr>
<td>Bad debt</td>
<td>5</td>
<td>5,000</td>
<td>5,350</td>
<td>0</td>
<td>-5,000</td>
</tr>
<tr>
<td>Indigent</td>
<td>5</td>
<td>5,000</td>
<td>5,350</td>
<td>0</td>
<td>-5,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
<td>100,000</td>
<td>107,000</td>
<td>77,540</td>
<td>-22,460</td>
</tr>
</tbody>
</table>

**Step 2:** Check the answer by calculating the profit/loss using the new cost per patient, or $775.40. Remember, cost
1. According to Eastaugh (1992), the proportion of healthcare costs paid by the patient were a record low 12.9 percent in 1987. Since 1987, however, the proportion of healthcare costs paid by the patient has been climbing steadily to 13.7 percent in 2002. Although this increase in cost sharing (i.e., the transfer of costs to patients in the forms of increasing the employee share of premiums, and the existence of deductibles and coinsurance) reduces unnecessary demand for services by the patient, Eastaugh (1987) warns of Feldstein’s moral hazard (1981)—that the goal of cost sharing is to inhibit the worried well, but not the truly sick, from seeking care.

2. For a comprehensive discussion of integrated delivery systems, including horizontal integration, or the expansion of a product or service line at the same point in the production process (e.g., nursing homes integrating with other nursing homes); and vertical integration, or the expansion of a product or service line at more than one point in the production process (e.g., hospitals integrating with nursing homes), see Zelman’s *The Changing Health Care Marketplace: Private Ventures, Public Interests*, 1996.

3. To avoid antitrust claims of price discrimination, or the practice of charging different payers what the market will bear for the same service, healthcare organizations have typically charged different payers the same price for the same service and then discounted the price per agreement to some payers based on quantity. The healthcare organization records

<table>
<thead>
<tr>
<th>Financial Class</th>
<th>No.</th>
<th>Costs</th>
<th>Charges</th>
<th>Collections</th>
<th>Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
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<td>32,100</td>
<td>25,500</td>
<td>2,238</td>
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<tr>
<td>Medicaid</td>
<td>20</td>
<td>15,508</td>
<td>21,400</td>
<td>18,000</td>
<td>2,492</td>
</tr>
<tr>
<td>MC #1</td>
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<td>11,631</td>
<td>16,050</td>
<td>12,840</td>
<td>1,209</td>
</tr>
<tr>
<td>MC #2</td>
<td>15</td>
<td>11,631</td>
<td>16,050</td>
<td>10,500</td>
<td>-1,131</td>
</tr>
<tr>
<td>Private</td>
<td>5</td>
<td>3,877</td>
<td>5,350</td>
<td>5,350</td>
<td>1,473</td>
</tr>
<tr>
<td>Self-pay</td>
<td>5</td>
<td>3,877</td>
<td>5,350</td>
<td>5,350</td>
<td>1,473</td>
</tr>
<tr>
<td>Bad debt</td>
<td>5</td>
<td>3,877</td>
<td>5,350</td>
<td>0</td>
<td>-3,877</td>
</tr>
<tr>
<td>Indigent</td>
<td>5</td>
<td>3,877</td>
<td>5,350</td>
<td>0</td>
<td>-3,877</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>77,540</td>
<td>107,000</td>
<td>77,540</td>
<td>0</td>
</tr>
</tbody>
</table>

per patient day becomes $775.40, or $77,540/100, after reducing total costs by $22,460.
the difference between the price and the discounted price, or the amount collected per agreement, as a contractual allowance.

References


