



Who Were the Primary Payers of Inpatient Acute Care Hospital Charges, FYs 1991 to 1999?

This is the third report in a series that explores recent trends shaping Connecticut's hospitals. The first report detailed changes in the delivery of care that followed the 1994 deregulation of the hospital industry and the subsequent development of a more competitive health services market. Specifically, care was increasingly shifted to outpatient settings, as the number of outpatient visits leapt by 19% and inpatient discharges fell by over 5%. In addition, the average hospital stay fell from seven days to five days.

The second report in this series revealed that despite the drop in the number of inpatients, total inpatient charges rose from \$3.4 billion in FY 1991 to \$4.4 billion in FY 1999 (the hospital fiscal year runs from October 1st through September 30th). During this time, the median patient charge expanded from nearly \$5,000 to \$7,000. Hospital charges grew due to a number of factors including an increase in the severity of inpatient illnesses, an aging patient population, the burgeoning cost of medical technology, inflation and other factors. Net operating expenses for all of Connecticut's acute care hospitals climbed from \$3.3 billion in FY 1992 to \$3.9 billion in FY 1999. During this period, hospitals' net revenue barely kept

pace with costs, rising from \$3.4 billion to \$3.9 billion.

This report identifies the primary payers of inpatient charges and examines the changing patterns of hospital reimbursements. Although there may be several payers responsible for a patient's total charges, the primary payer is the one expected to reimburse the largest share of those charges. The Office of Health Care Access' (OHCA) inpatient database records the top three payers for every discharge and ranks their relative importance. It does not, however, record the payers' shares of each discharge's total charges. In FY 1991, about one in every three hospital discharges had a secondary payer but by FY 1999 this had grown to one in every two. During that time frame, the proportion of those with a third payer leapt from a mere 3% to 22%.

Significant Primary Payers of Inpatient Hospital Charges*

Medicare (Title II of the Social Security Act): Established in 1965 to provide health insurance coverage to those 65 years and

* For more information, see OHCA's *The Health of Connecticut's Hospitals.*)

older as well as the disabled, Medicare is the nation's largest payer of inpatient charges. Hospital Insurance (Part A) covers inpatient care and for Connecticut's hospitals in FY 1998, Medicare gross revenue was \$3 billion, just less than half of their total gross revenue. In 1983, Medicare moved from reimbursements based upon fee-for-service to the Prospective Payment System (PPS).

Under the PPS, hospitals are reimbursed a fixed, predetermined amount based upon a patient's diagnosis using the Diagnosis Related Group classification system. These reimbursements are adjusted to account for local wages, urban versus rural location, and whether or not the hospital is a teaching hospital. In FY 1996, Connecticut introduced Medicare Managed Care. However, its development has been slow and only 11% of hospitals' Medicare revenues (FY 1998) were from its managed care component.

Medicaid (Title XIX of the Social Security Act): Within federal guidelines, states administer their own Medicaid programs, which provide health insurance coverage for low-income families and the disabled. In FY 1998, Medicaid payments to hospitals represented 10% of Connecticut hospitals' gross revenue (\$792 million). Connecticut's reimbursement rate relative to costs is 71% -- the nation's third lowest.

The state also pays 50% of its Medicaid program's total costs, the largest share that any state is required to contribute.

Connecticut introduced Medicaid Managed Care in FY 1995. As of mid-1999, 71% of

enrollees were in managed care, however, 60% of the program's costs were in its fee-for-service portion.

HMO/PPO: Managed care rapidly expanded in Connecticut following the establishment of the competitive health care market in the mid-1990s. From the early 1990s to the decade's end, HMO enrollment grew from 24% to 43% of the state's population. Managed care is a broad term encompassing many types of plans, but is generally characterized by a network of providers and financial incentives for enrollees to stay within this network.

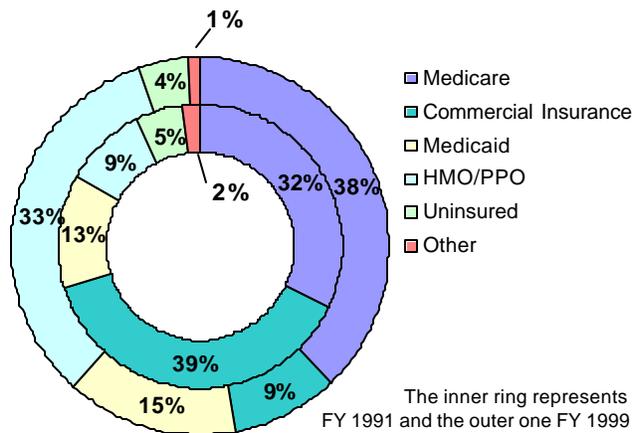
Managed care organizations seek to limit their costs through gatekeepers, utilization reviews, and practice protocols. They reimburse hospitals upon the basis of negotiated fee schedules (predetermined amounts based upon diagnoses), or capitated rates. From FY 1994 to FY 1998, aggregate managed care discounts for all of Connecticut's acute care hospitals grew from 9% to 30% of all charges, or \$2.25 billion.

Commercial/Indemnity Insurance: Traditional fee-for-service reimbursement has increasingly been discarded over the last decades of the 20th century. Commercial insurers have for the most part adopted managed care practices. As a result the distinction between commercial insurers and managed care organizations has been largely eroded.

Other Payers: These include Title V, the Maternal and Child Health Block Grant; the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Worker's Compensation; and Other Federal Programs.

Uninsured: This refers to those whose payer categories were either “Self-pay,” “Other,” or “No charge.” The number of uninsured may be under-counted because hospitals may retroactively enroll in the Medicaid program those without health insurance coverage who qualify.

Fig 1: Primary Payers' Share of Total Discharges, FYs 1991 to 1999



In Figure 1, the varying sizes of the color bands on the inner (FY 1991) and outer (FY 1999) rings illustrate changes in the primary payers' share of discharges. The most striking change has been the growth of HMO/PPOs (from 9% to 33%) and the precipitous decline of commercial/indemnity insurance (from 39% to 9%). In FY 1991, Blue Cross/Blue Shield of Connecticut was a mutual insurance company but in FY 1997, Anthem Inc., an HMO, acquired it.

The graph understates the extent of managed care, because the differences between traditional commercial insurers and HMOs

vanished as commercial insurers adopted managed care practices. Furthermore, by FY 1999, 71% of Medicaid enrollees were in managed care plans, as were increasing numbers of Medicare recipients. The proportions of Medicare and Medicaid patients increased slightly so that by FY 1999, public programs were the primary payers for over half of all inpatient discharges.

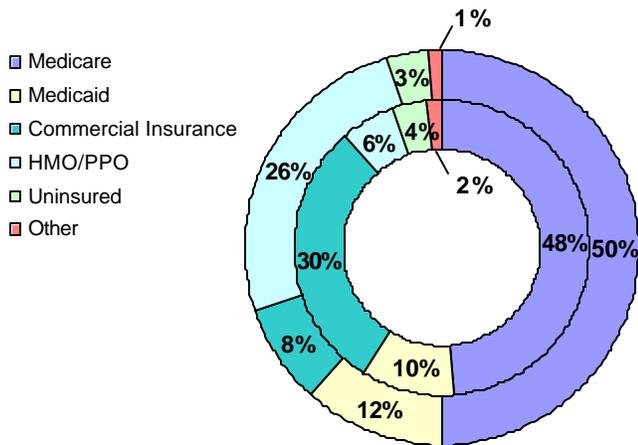
Primary Payers' Share of Total Charges

Charges are the amounts that hospitals billed payers, whether HMOs, the government, or individual patients. They are not, however, identical with either the hospitals' actual cost of care or the reimbursements that they collected. Discounts to public and private payers reduce reimbursements.

OHCA's inpatient database records up to three payers for each discharge and identifies the primary payer. It does not record the proportion of a patient's charges that each payer was responsible for.

For the following analysis of total charges by primary payer, the patient's entire charge was imputed to the primary payer. For example, if a patient's charges totaled \$10,000 and an HMO was the primary payer but there was also a secondary payer, the HMO was considered the sole payer for the entire \$10,000. In FY 1999, 47% of all discharges had a secondary payer and 22% had a tertiary payer.

Fig 2: Total Inpatient Charges by Primary Payer, FYs 1991 and 1999



The inner ring represents total charges in FY 1991 and the outer ring represents those in FY 1999

In Figure 2, the changes in total charges by primary payer from FY 1991 (inner ring) to FY 1999 (outer ring) reflect those for total discharges, namely the dramatic expansion of HMO/PPOs and the concurrent decline of commercial insurance. It also reflects the dominance of public programs as primary payers for inpatient care.

Comparing Figures 1 and 2, Medicare and Medicaid were the primary payers for *half of all discharges* in FY 1999, but were the primary payer for *two-thirds of total charges*. These programs cover the elderly and the disabled who are more likely to have higher

average charges than other types of patients (See OHCA's *Rising Acute Care Inpatient Hospital Charges, FYs 1991 to 1999*). In contrast, HMO/PPOs were the primary payers for 33% of all discharges but only 26% of total charges.

Conclusion

From FY 1991 to FY 1999, the number of acute care hospital patients whose primary payer was an HMO or PPO swelled significantly as traditional indemnity insurance coverage evaporated. During this time, public payers such as Medicare and Medicaid became the primary payers for the majority of inpatient care. The spread of managed care includes the establishment of Medicaid and Medicare managed care in the mid-1990s and the commercial insurers' adoption of managed care practices.

In one form or another, most Connecticut residents are covered by managed care as public and private payers have sought to limit their costs. Since the mid-1990s, average annual growth for inpatient charges was less than 2% and net revenue averaged 1%, while hospital net operating expenses grew at an average of 3%.