

Estimating the Impacts of a DRG Hospital Tax

John McConnell, PhD
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Overview

- Provider tax offers opportunity to leverage federal funds
- Every \$1.00 collected can be matched with at least \$2.00 in federal funds
- E.g., \$250M in taxes collected from DRG hospitals will produce the equivalent of \$750M (in total) available for an Oregon Health Plan (OHP) expansion

Modeling the tax

- This study aims to quantify the effects of the tax, considering
 - The tax each hospital is expected to pay
 - The increases in revenues (primarily from OHP patients, but also including changes in commercial patients)
 - The changes in the cost for caring for patients (primarily from increased OHP patients and reduced uninsured patients)
 - The net effect of all of these changes
- Most useful in estimating *aggregate* effects
 - Greater margin of error at the hospital-specific level
- Most useful in estimating tax impacts (comparing *tax* to *no tax*)
 - As opposed to estimating the exact net income or net revenue under each scenario
- Individual hospital estimates are posted on HFB web site
 - <http://healthfundboard.oregon.gov>

Some terminology

- Charges: undiscounted, gross charges
 - Rarely paid
- Revenues: actual amount received by hospital, also called “net revenues”
 - Revenues = charges – “contractuals”
- Cost: estimated cost of caring for patients
 - Based on “cost-to-charge” ratio and assumptions about variable vs. fixed cost
- Net Income: Revenues – Cost
 - Analogous to “profit”
 - We only examine “operating” revenues and cost
 - Exclude non-operating revenue (e.g., foundations and investments)

Data

- Primary data source is 2007 Databank
- Each hospital reports charges and contractals by payer
- Also includes other data (total operating expenditures)
- We have identified some hospitals who have now confirmed that their reporting was incomplete and we are expecting new data from them
- I also use the public Oregon Hospital Discharge Data to develop measures of market share

Exclusions & Limitations

- I exclude Kaiser from detailed analysis since they do not report charges and contractuals in the Databank data
- Analysis focuses on 24 DRG hospitals and 32 non-DRG (small and rural) hospitals
 - For this presentation, just estimate changes in uncompensated care
- Disproportionate Share Hospital (DSH) or related payments are considered but difficult to model
- Ambulatory Surgery Centers are not included in this model

Modeling

- There are many ways to model a hospital tax
- My estimates do not reflect the views or opinions of OHSU
- At the request of the Oregon Association of Hospitals and Health Systems (OAHHS), Health Management Associates (HMA) have developed a model
- I have met twice with HMA
- In the interest of transparency and cooperation, I have provided HMA with my model, documentation, and all updates

Some key differences between HMA model vs. McConnell model

- Data
 - I use Databank data, submitted monthly to the state
 - HMA uses a combination of audited and survey data
- Different approaches to utilization, cost, and revenues
 - I generally estimate larger changes in revenues and cost
 - Change in net income may be similar
- Their estimates focus on GRB reimbursement rates and do not consider potential for higher reimbursement from commercial payers
- Some initial differences on what we are comparing...

Today:

Small tax
25K OHP Std.
Higher reimbursement rates

Tomorrow (with tax):

Many possibilities
4% tax
100K OHP Std. Adults
60K OHP Kids
20K Commercial Kids
Reimbursement rates higher?

Tomorrow (do nothing):

0% tax
0K OHP Std.
Lower (GRB) reimbursement rates



Assumptions I: OHP expansion

- 1.5% tax on Medicaid and commercial MCOs
 - 80,000 uninsured children
 - 60K in OHP
 - 20K in commercial insurance
- 4% DRG Hospital Tax
 - 100,000 uninsured adults
 - 100K in OHP Standard

Assumptions II: Changes in commercial rates

- Hospitals can raise rates to commercial plans in response to new tax
 - Baseline: about half of tax (4% tax -> 2% increase in rate)
- Depends on market share
- With increase in rate, assume
 - Some (small) decrease in utilization
 - Some (small) decrease in individuals covered through commercial insurance

Estimates

1. First I will show you the impact of doing nothing (compared to today)
2. Then I will show you the impact of imposing a 4% tax (compared to today)
3. Then we will compare 1 & 2
 - (Economists would call this the estimated effect of the tax, conditional on the policy choice)
4. Then we will examine the effect of a 4% tax with higher reimbursement rate, compared to doing nothing

What happens if we do nothing? (compared to today)

- Estimated loss to DRG hospitals:
 - \$66M
- Estimated increase in uncompensated care to A& B hospitals:
 - \$1.6M
- Compares “current world”
 - 25K OHP Standard
 - Higher reimbursement rates
- To “world without any tax or expanded coverage”
 - 0 OHP Standard
 - GRB reimbursement rates

What happens if we tax at 4%, expand coverage, and pay GRB reimbursement rates? (compared to today)

- Estimated loss to DRG hospitals:
 - \$202M
 - -\$224M from tax
 - -\$12M from more Medicaid at lower reimbursement rates
 - +\$34M from higher commercial rates
- Estimated decrease in uncompensated care to A& B hospitals:
 - \$6.4M
 - Compares “current world”
 - 25K OHP Standard
 - Higher reimbursement rates
 - To “world without 4% tax and expanded coverage”
 - 100K OHP Standard Adults
 - 60K OHP Kids
 - 20K Commercial Kids
 - GRB reimbursement rates

Estimating the effect of the tax policy with reimbursement rates at GRB level

- Compare 4% tax to “do nothing”
- Impact:
 - Reduces DRG hospitals’ net income by \$136M
 - \$202M with tax, \$66M without tax
 - Decreases A&B hospitals uncompensated care by \$8M
- In other words, hospitals pay a tax of \$224M, but net effect is less (-\$136M)
 - Reduced uncompensated care
 - Greater OHP coverage
 - Some offset to commercial payers
 - All of this in comparison to “do nothing”

Raising reimbursement rates

- Provider tax offers opportunity to expand coverage and pay higher reimbursement rates
- Let's examine the impact of the provider tax if Medicaid reimbursement rates are 10% *higher* than today (about 30% higher than GRB)
 - About 88% of Medicare cost

Estimating the effect of the tax policy with OHP reimbursement rates at 10% higher than today

- Compare 4% tax to “do nothing”
- Impact:
 - Reduces DRG hospitals’ net income by \$27M
 - \$93M with tax, \$66M without tax
 - Decreases A&B hospitals uncompensated care by \$8M
- In other words, hospitals pay a tax of \$230M, but net effect is less (-\$27M)
 - Reduced uncompensated care
 - Greater OHP coverage and reimbursement
 - Some offset to commercial payers
 - All of this in comparison to “do nothing”

Summarizing I

- If OHP reimbursement rates go to GRB level, impact of 4% hospital tax is to reduce DRG hospitals' net income by \$136M
- If OHP reimbursement rates are 10% higher than today, impact of 4% hospital tax is to reduce DRG hospitals' net income by \$27M
 - Comparison is to world without tax
 - Assumes some of the tax is passed on to commercial payers

Summarizing II

- Assuming OHP reimbursement rates are 10% higher than today,
 - Hospitals pay \$230M in taxes
 - But recover over 90% of this through OHP coverage, reduced uncompensated care, some higher commercial reimbursement
 - I estimate the actual impact to be -\$18.5M in the aggregate (DRG plus A and B)
 - In other words, hospitals (in aggregate) recover the great majority of the tax

Thank you...

...and questions?

kjohnmccconnell@gmail.com

Oregon Health Fund Board

Carol Robinson
Interim Executive Director
(503) 373-1817