Public-Private Cost Shifts in Nursing Home Care

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A recent article in this *Review* argued that policymakers trying to tame Medicaid spending might want to reexamine how they regulate and pay nursing homes. The article (Little 1992) made four main points. First, differences in Medicaid nursing home reimbursement rates contribute significantly to the large cross-state differences in Medicaid payments per recipient—for all services as well as for long-term care.

Second, Medicaid nursing home reimbursement rates vary much more across states than do per capita personal health care expenditures or average pay for all health care workers. In other words, broadly defined state health care costs do not appear to explain the differences in per diem reimbursement rates.

Third, by contrast, nursing home worker pay, and thus "costs" narrowly defined, do appear to justify much of the variation in nursing home reimbursement rates. However, as the article argued, the direction of causality is not clear. Indeed, it seems likely that relatively generous reimbursement rates permit above-average expenditures which, in turn, justify above-average per diems in an interactive cycle. The ease with which nursing homes can charge private patients more than they receive for comparable Medicaid patients may contribute to this cycle, the article suggested.

Finally, differences in Medicaid payments per recipient do not necessarily reflect relative efficiency. Below-average payments per recipient may indicate efficiency, but they may also reflect below-average quality, or above-average use of cross-subsidies. Although anecdotal evidence suggests that nursing home residents paying privately often pay more than—and thus subsidize—similar residents supported by the public, most states do not publish data on average charges to private patients; thus, it has not been easy to measure the amount of cost-shifting activity by state.

Table 1
Ratio of Estimated Average Private Revenue to Medicaid Reimbursement per Nursing Home Patient Day, 1989

	Private Rate/ Medicaid Rate		Private Rate/ Medicaid Rate
Alabama	1.56	Montana	1.14
Alaska	n.a.	Nebraska	n.a.
Arizona	n.a.	Nevada	2.04
Arkansas	n.a.	New Hampshire	n.a.
California	1.25	New Jersey	1.61
Colorado	1.13	New Mexico	1.26
Connecticut	1.68	New York	.51
Delaware	1.08	North Carolina	1.09
D.C.	1.76	North Dakota	n.a.
Florida	1.16	Ohio	1.06
Georgia	1.82	Oklahoma	n.a.
Hawaii	n.a.	Oregon	.99
Idaho	1.19	Pennsylvania	n.a.
Illinois	1.23	Rhode Island	.41
Indiana	n.a.	South Carolina	1.10
Iowa	n.a.	South Dakota	n.a.
Kansas	n.a.	Tennessee	.97
Kentucky	.88	Texas	1.10
Louisiana	1.11	Utah	1.96
Maine	1.58	Vermont	1.50
Maryland	n.a.	Virginia	1.20
Massachusetts	1.25	Washington	n.a.
Michigan	.93	West Virginia	n.a.
Minnesota	.86	Wisconsin	1.25
Mississippi	n.a.	Wyoming	1.13
Missouri	1.46		

n.a. = not available

Source: Health Care Investment Analysts, Inc. and Arthur Andersen (1991); HCFA State Medicaid Data Disk for FY1989; and National Governors' Association (1989).

Within the last two years, however, Health Care Investment Analysts, Inc. and Arthur Andersen have begun compiling and publishing a wealth of information on nursing home operations.[1] Combining this information with previously available data permits *estimating* average daily revenue per private nursing home resident for most states.

This article presents such estimates and compares them with the average Medicaid per diem in the same state. In most cases, the ratio of estimated private to public reimbursement is well above one. The article then discusses what these ratios suggest about long-term care in this country and in particular states. It ends by arguing that for reasons of equity and effective cost control, nursing home patients supported by private funds should not be asked or, indeed, allowed to subsidize Medicaid's long-term care program. In other words, all comparably disabled individuals in a given institution should be charged the same rate, regardless of the source of their support. These findings also underscore the need to reconsider the way this country finances long-term care.

Private/Public Reimbursement per Nursing Home Day

Table 1 presents the ratio of private to Medicaid reimbursement for all states for which average private revenue per nursing home patient day can be estimated.[2] These ratios suggest that private payors may be subsidizing the Medicaid program in most states. (Alternative interpretations of these ratios are discussed in the next section.) In 27 of the 34 states for which estimates can be made, the ratio is above 1. Within the 27, private daily revenue exceeds the Medicaid reimbursement rate by an average of 36 percent. For all 34 states, estimated private revenue exceeds the Medicaid reimbursement rate by an average of 21 percent.

Table 2 presents the same data but with the states ranked according to the amount of cost-control pressure the state regulators seem to be exerting on the nursing homes. This pressure is measured by the difference between two ratios, the ratio of the state's Medicaid reimbursement rate to the U.S. median reimbursement rate, and the ratio of the state's personal health care expenditures per capita to the U.S.

[1] The 1990 and 1991 volumes of *The Guide to the Nursing Home Industry* contain a great deal of detailed data compiled from publicly available sources, primarily the Medicaid and Medicare cost reports filed by the nursing homes. The earliest year covered is 1987. The author is indebted to Bob Moran of the Pioneer Institute for bringing this valuable source to her attention.

[2] Average revenue per private patient day was estimated according to the following equation:

Average Revenue per Private Patient Day = [Net Patient Revenue − (Medicaid Share of Resident Days * Weighted Average Medicaid Per-Diem)] / [1.00 − Medicaid Share of Resident Days].

The Medicaid per diem is a weighted average of the rates reported for skilled nursing facilities and for intermediate care facilities other than those for the mentally retarded. The weights were the number of Medicaid recipients in each type of facility in 1989. The Medicaid reimbursement rates reported to the National Governors' Association may themselves have been means, weighted means, or medians. While these differences would distort cross-state comparisons, the mean and the median of a large group of numbers converge. Just as an example of the numbers involved, in 1991 Maryland had 105 nursing facilities with over 10,000 beds.

Table 2

Comparisons of Personal Health Care Expenditures per Capita and Nursing Home Reimbursement per Patient, FY1989

State	Medicaid Nursing Home Reimbursement Rate/ U.S. Average (1)	Personal Health Care Expenditures per Capita/ U.S. Average (2)	Difference: Relative Medicaid Nursing Home Reimbursement Rate and Relative Personal Health Care Expenditures (3) = (1) − (2)	Private Rate/ Medicaid Rate[a] (4)	Medicaid Payments per Nursing Home Recipient[b]/ U.S. Average (5)
New York	1.80	1.16	.64	.51	2.42
New Hampshire	1.20	.82	.38	n.a.	1.55
New Jersey	1.18	.92	.26	1.61	1.58
New Mexico	.97	.74	.23	1.26	1.01
Vermont	1.03	.81	.22	1.50	1.08
Wyoming	.93	.72	.21	1.13	.81
Idaho	.90	.71	.19	1.19	.85
Delaware	1.12	.94	.18	1.08	1.63
North Carolina	.93	.76	.17	1.09	.89
Maine	1.03	.90	.13	1.58	1.32
Pennsylvania	1.16	1.05	.11	n.a.	1.24
South Carolina	.79	.70	.09	1.10	.93
Connecticut	1.19	1.11	.08	1.68	1.25
Oregon	1.02	.95	.07	.99	.76
Virginia	.92	.86	.06	1.20	1.00
Utah	.80	.74	.06	1.96	.89
Kentucky	.83	.77	.06	.88	.80
Florida	1.05	1.00	.05	1.16	.92
Minnesota	1.07	1.02	.05	.86	1.19
Indiana	.94	.91	.03	n.a.	.94
Montana	.88	.85	.03	1.14	.98
Massachusetts	1.27	1.25	.02	1.25	1.76
Rhode Island	1.13	1.12	.01	.41	1.11
Mean:	1.05	.90	.15	1.18	1.17
Ohio	.99	1.03	−.04	1.06	.98
Colorado	.94	1.00	−.06	1.13	.68
Wisconsin	.92	1.01	−.09	1.25	.85
California	1.02	1.19	−.17	1.25	.98
Tennessee	.75	.93	−.18	.97	.71
Michigan	.88	1.06	−.18	.93	.78
Arkansas	.60	.80	−.20	n.a.	.69
Georgia	.64	.85	−.21	1.82	.76
Texas	.67	.90	−.23	1.10	.66
Oklahoma	.64	.88	−.24	n.a.	.76
Nevada	.87	1.14	−.27	2.04	1.05
Louisiana	.62	.90	−.28	1.11	.73
North Dakota	.82	1.10	−.28	n.a.	.88
Nebraska	.73	1.01	−.28	n.a.	.78
Alabama	.65	.94	−.29	1.56	.72
Missouri	.77	1.06	−.29	1.46	.79
Iowa	.67	.97	−.30	n.a.	.63
Illinois	.72	1.08	−.36	1.23	.80
South Dakota	.58	.96	−.38	n.a.	.82
Mean:	.76	.99	−.23	1.30	.79

[a]Ranked by the difference between the relative Medicaid nursing home reimbursement rate and the relative personal health care expenditures per capita.

[b]Medicaid recipients of services provided by skilled nursing facilities and intermediate care facilities other than those for the mentally retarded.

Source: Health Care Investment Analysts, Inc. and Arthur Andersen (1991); HCFA State Medicaid Data Disk for FY1989; Families USA Foundation (1990); and National Governors' Association (1989).

average. If a state has comparatively expensive personal health care, its nursing home reimbursement rate presumably ought to reflect these costs. Accordingly, if a state's relative personal health care costs greatly exceed its relative Medicaid reimbursement rate, its regulators are probably pushing the nursing homes to control Medicaid costs. By contrast, a large positive gap would suggest relative generosity on the part of the regulators.

Table 2 indicates that cost-shifting activity appears to be widespread even where regulators have not pursued particularly stringent reimbursement strategies. Nevertheless, the table provides some evidence that cost shifting is somewhat more pronounced in the high-pressure states. The mean ratio of private-to-Medicaid reimbursement is 1.18 for the states where the relative Medicaid reimbursement rate exceeds relative personal health care costs, but it is 1.30 for the states where the Medicaid reimbursement rate looks relatively low.

After presenting alternative interpretations of these ratios, this article will discuss how these measures help to clarify whether or not the long-term care portion of a state's Medicaid program is relatively low cost. The article will then explain why cost shifting matters.

Alternative Interpretations of These Ratios

When the average Medicaid reimbursement rate is less than the average daily revenue per private patient, Medicaid recipients are either 1) receiving lower-quality care in the same homes; or 2) are congregated in less expensive nursing homes; or 3) are on average less disabled (and, thus, less costly to care for)[3] than nursing home residents paying privately; or 4) are in a program subsidized by the private sector. In general, a ratio above 1 probably suggests some combination of these four interpretations.[4]

In most states it is not legal for a nursing home to give lower-quality care to a Medicaid recipient than to a private payor. In addition, once having accepted a patient, a nursing home usually cannot force that person to move if her savings are exhausted and she becomes a Medicaid recipient. In other words, the first rationale is probably not the primary explanation for the ratios.[5]

Nevertheless, some states do allow nursing homes to refuse admittance to individuals already dependent on Medicaid. As a consequence, Medicaid recipients may cluster in less expensive (lower quality?) institutions. In addition, Medicaid recipients may congregate in less expensive homes by happenstance rather than as a result of nursing home policy. For instance, a Medicaid recipient's family might prefer to have their relative in a nearby home that can be reached by public transportation, whereas private payors' families are able to drive to homes in relatively affluent suburbs or rural areas. Accordingly, a ratio above 1 could indicate that some Medicaid recipients are having trouble getting access to average quality long-term care or that Medicaid recipients are choosing less expensive homes.

Like the first, the third possibility—that Medicaid recipients are on average less disabled than nursing home residents paying privately—seems unlikely. After all, the frail elderly tend to become more disabled over time, and nursing homes are known to give some preference in the admissions process to applicants with private support. Moreover, a significant share of Medicaid recipients were originally private patients who, after some years in a nursing home, have exhausted their savings and "spent down" to Medicaid eligibility.[6] In addition, research on publicly supported home and community care programs generally concludes that they do not succeed in delaying Medicaid recipients' admissions to nursing homes. In other words, most Medicaid recipients admitted to nursing homes really need to be there; by the time they are admitted, there is simply no alternative to nursing home placement (Weissert 1991). Finally, as will be discussed further below, the ratio of 0.86 for Minnesota, where by law private patients cannot be charged more than comparable Medicaid patients, suggests that Medicaid recipients

[3] Because the cost of providing care rises with the disability of the patient, some states use a case-mix system in setting Medicaid reimbursement rates. Accordingly, if the average Medicaid recipient were less disabled than the average private patient, the ratio of the private to the Medicaid reimbursement rate could be above 1.

[4] A thorough investigation of these issues would require examining private/Medicaid reimbursement rates institution by institution with adjustments for case mix. Currently available data do not permit such an undertaking.

[5] On the other hand, even North Dakota, one of the three states that regulate private rates, permits nursing homes to charge more for private rooms and other services that Medicaid does not allow.

[6] States have the option of providing Medicaid coverage to "medically needy" people. Under this option, individuals who fit into Medicaid-eligible categories but are poor only because of high health care expenses may "spend down" to meet Medicaid income and asset criteria. They "spend down" by incurring medical or remedial care expenses that reduce their remaining income and liquid assets to a level below that allowed by their state's program.

are on average *more* disabled than their privately supported counterparts—contrary to the third hypothesis.

By contrast, the fourth possibility—that private payors are subsidizing the Medicaid program—is generally accepted to be a common occurrence (Health Care Investment Analysts, Inc. and Arthur Andersen 1991, p. 9). Within individual institutions private patients often pay more than comparable patients supported by Medicaid. Similarly, a given patient usually pays a higher rate when paying privately than he does once his savings are gone and he is forced to turn to Medicaid.

Why have private payors tolerated these cost shifts? For several reasons. Private applicants generally turn to nursing homes as a last resort, when they are desperate. Then they frequently face waiting lists because state regulators usually limit the supply of beds in order to control Medicaid spending. Moreover, these nursing home residents or their families tend to have a strong preference for a particular region; thus, they agree to pay high nursing home charges, without looking very far afield for lower-cost alternatives. Finally, they know that, should worst come to worst and their savings be exhausted, Medicaid will generally provide for their continued care.

Heretofore, the extent of this cost-shifting activity has not been easy to measure. Only three states—Connecticut, Minnesota, and North Dakota[7]—currently regulate nursing home charges to private patients, and, as mentioned previously, most states do not publish average, let alone institution-specific, private rates. Nevertheless, previous research provides limited evidence of such practices (Birnbaum and others 1981, for example), and cross-subsidies are relatively well documented in hospital care. For example, at a Redwood City, CA hospital, commercial inpatient revenue exceeds the cost of care received by these private patients by roughly 50 percent; the hospital is shifting uncompensated Medicaid and Medicare expenses to the private payors in order to cover their operating costs by a slim margin (Marchasin 1991).

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But what about the four states—Kentucky, Minnesota, New York, and Rhode Island—where average private revenue appears to be well below the average Medicaid per diem? The possible explanations are most limited in Minnesota, one of the three states that regulate private rates. Minnesota nursing homes cannot charge private patients more than comparable Medicaid patients. Accordingly, the state's relatively low ratio of 0.86 suggests that Minnesota Medicaid recipients may be more disabled than the average private resident[8] or that Medicaid recipients may be living in relatively expensive institutions or areas.

Case mix differences and geography are also likely to play significant roles in other states, such as New York.[9] In that state, Medicaid recipients may be clustered in the metropolitan area where land is

[7] Connecticut regulates but does not necessarily equalize private and Medicaid rates. North Dakota equalizes rates for similar services but permits nursing homes to charge for single rooms and other services that Medicaid does not allow. In Minnesota, private patients cannot be charged more than comparable Medicaid patients.

[8] If Minnesota's Medicaid recipients really are more disabled than the average nursing home resident, and if that result is typical of other states, the implication is that the subsidization of the public sector by the private sector may be even greater than the ratios in Table 1 suggest. If, by contrast, Minnesota is atypical and Medicaid recipients are generally less disabled than the average nursing home resident paying privately, then that situation would help to explain why revenues per private patient day tend to be greater than Medicaid per diems. Perhaps, for example, private payors have the resources to pay for home care and, thus, are able to maintain their independence for longer than a similarly frail person without such resources. In fact, however, this second possibility seems unlikely, since public support for home and community care programs appears to be a (much-needed) supplement to but not a substitute for long-term care. These programs do not appear to delay an individual's entry into a nursing home; most states restrict the supply of nursing home beds to the point where applicants face waiting lists, and most people do not seek to enter a nursing home until there is simply no alternative. In other words, the implications of the Minnesota data should be kept in mind.

[9] A telephone call to the Medical Assistance Division of the New York State Department of Social Services yielded a figure for the 1992 average Medicaid reimbursement rate but no information on the average charge for private patients. Comparing the average private charge cited in a press report (Freudenheim 1992) with the Medicaid reimbursement rate provided on the phone results in a private/public ratio of 1.35. Such a ratio suggests that cost shifting currently is as prevalent in New York as it is nationally rather than well below average, as suggested by the figure in Table 1 for 1989. Although the author does not know how either of these "averages" was calculated, this result raises a red flag and underscores the difficulty of estimating and interpreting average revenue per private patient day from publicly available data.

relatively expensive and nursing homes must compete with big city hospitals for direct care staff.[10] By contrast, private patients may be more heavily represented in upstate nursing homes with below-average operating costs. As for case mix differences, New York is unusual in using RUG (resource utilization group) methods to adjust Medicaid reimbursement to reflect the intensity of care required by each recipient. The results again suggest that the average Medicaid recipient may be more disabled than the average private patient. In addition, New York is reputed to have an unusual number of very expensive, special-purpose facilities, such as those for people with head injuries or Alzheimer's disease.

Nursing home reimbursement ratios are rough indicators and must be interpreted with great care.

In addition, policymakers in both New York and Rhode Island have been concerned about an incipient shortage of nursing home beds. For example, a Rhode Island assessment projects a shortage of 2,250 beds, or 20 percent of the 1989 level, by 1995. Accordingly, policymakers in those states may have offered relatively generous Medicaid reimbursement rates to lure additional providers into the business. Similarly, in 1989 Minnesota had the highest ratio of nursing home beds to its elderly population of any state in the country.

Finally, as reported to the National Governors' Association, Medicaid reimbursement rates are not entirely comparable across states. For example, New York and Kentucky are two of 10 states that include (expensive) prescription drugs in Medicaid's per diem reimbursement rate for the nursing homes. Other states cover some of these services separately.

In sum, these ratios must be interpreted with great care. They are rough indicators and should be assumed to reflect a mix of geographic happenstance, quality/access/case mix issues, and cross-subsidization. Nevertheless, cost-shifting activity appears sufficiently widespread that the ratios shown in Table 1 can be used to flag the states where private subsidization of public responsibilities could be substantial.

What the Ratios Suggest about the States' Medicaid Programs

Cost-shifting efforts complicate the task of interpreting cross-state differences in Medicaid payments per recipient. As already mentioned, relatively low payments per recipient could suggest relative efficiency, but they could also suggest relatively poor quality or an above-average amount of cost-shifting activity. Alternatively, states with relatively high payments per Medicaid recipient may be shifting public costs onto private payors to a below-average extent. The ratios shown in Table 2 help to narrow the likely interpretations.

For example, as Table 2 indicates, among the 14 states where Medicaid payments per recipient of nursing home services appear low relative to the U.S. average (with a ratio of 0.80 or less) *and* to their own personal health care costs, only three—Michigan, Oregon, and Tennessee—do not appear to be shifting costs to the private sector. In these three states, nursing home care appears to be truly low-cost, either because the industry is relatively efficient or because the quality of care is relatively spartan—for everyone. For another three states, Colorado, Louisiana, and Texas, the data suggest that the cost shifts may be quite modest. But the other "low-cost" states appear to be shifting part of the burden supposedly carried by the state's taxpayers onto specific members of the private sector, individuals paying privately for long-term care.

Among the "high-cost" states, New York and Minnesota may seem to be high cost in part because they are *not* shifting public costs to the private sector; in these states, the taxpayers appear on average to be bearing the full cost of the Medicaid long-term care programs, even if these programs are of unusually high quality or below-average efficiency. By contrast, the other high-cost states have expensive Medicaid programs (high-quality/inefficient?) *despite* sizable cost shifts to private payors.

[10] According to the associate commissioner of the Medical Assistance Division of the New York State Department of Social Services, nursing homes in New York currently charge private patients $62,000 per year, on a statewide average basis, and $69,000 in the metropolitan area. In other words, the metropolitan area rate is 11 percent above the state average rate for private patients (Freudenheim 1992).

[11] Many citizens also do not realize that Medicaid beneficiaries generally pay for a significant share of their nursing home care from their own income. Except for a very small personal allowance, a Medicaid recipient's Social Security, pension, or other income is devoted to paying as much as possible of the Medicaid reimbursement rate set by the state; Medicaid pays the balance.

Why Does Cost Shifting Matter?

Cost shifting matters because it is inequitable. It also encourages inflation of nursing home costs.

To start with the issue of equity, when an individual requires nursing home care, the emotional and financial burdens facing that person and his family are substantial. On top of these burdens, a relatively small number of private patients are then asked to finance a significant part (often 20 to 30 percent) of the cost of the Medicaid long-term care program, a program that citizens believe to be broadly tax-funded.[11]

Furthermore, asking a private patient to provide one-third, say, of a Medicaid recipient's care in addition to supporting herself will only hasten the day when the private payor exhausts her savings and spends down to Medicaid eligibility—a painful transition for all involved. Indeed, the realization that cross-subsidies are commonplace could very well encourage resort to the asset protection schemes that are currently so widely advertised.[12] Such schemes have led some members of the press to describe Medicaid's long-term care provisions as a "middle-class entitlement program." While some families may benefit from these divestment efforts, others are forced by cross-subsidies to contribute disproportionately to the nation's long-term care program.

In addition, permitting nursing homes to shift Medicaid costs onto private payors undermines policymakers' efforts to slow the rise in Medicaid expenditures. Let's assume, for example, that a state's rate-setters wish to encourage nursing home operators to control costs and become more efficient. To this end, they raise the Medicaid reimbursement rate by slightly less than the increase in nursing home operating costs during the previous year. However, the nursing home operators remain free to increase the gap between the Medicaid per diem and the private rate and do so. Accordingly, the nursing home managers retain the ability to give their employees a slightly bigger pay increase, or hire an extra aide, or plant an extra tree. These "extras" become incorporated into the costs on which Medicaid rates are based the following year.

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To see whether cost-shifting activity appears to contribute to higher-than-expected nursing home operating costs to a statistically significant extent, this study uses simple regression analysis. The dependent variable is state average annual pay for nursing home workers, relative to the U.S. average; wages, which represent roughly half of nursing homes' total operating costs, are a proxy for "costs."[13] The independent variables are the state's relative Medicaid reimbursement rate, the ratio of the average revenue per private patient day to the Medicaid reimbursement rate, and relative average annual pay for individuals working in the retail sector. This last variable represents local wage costs in a sector where wages are set by market forces.[14] In each case the relationship between the independent and the dependent variables was expected to be positive: holding the other explanatory variables unchanged, the higher the relative Medicaid rate, the local retail wage, or the greater the amount of cost-shifting activity, the

[12] Federal and state legislation limit a Medicaid recipient's ability to shift assets, but loopholes exist and should be closed at the federal level. For example, federal legislation limits the "look-back" period to 30 months. For progressive conditions like Alzheimer's, however, such a look-back period is too short.

[13] The regression presented in this article uses average annual pay as a proxy for costs, because total nursing home operating costs are very closely related to total revenue, from which the estimates of revenue per private patient day were derived. In other words, a regression equation using total operating costs and the ratio of private to Medicaid reimbursement appeared to involve a near identity. Nevertheless, a regression in which the ratio of state operating costs to U.S. average costs is the dependent variable, and the independent variables are the relative Medicaid reimbursement rate, relative per capita personal health care costs, and the ratio of private to Medicaid reimbursement, yields results similar to those shown in Table 3. Holding relative Medicaid reimbursement rates and personal health care costs unchanged, a greater amount of cost-shifting activity is positively associated with higher total operating costs to a statistically significant extent. Interestingly, however, in this case, relative personal health care costs do not appear to have a statistically significant link with relative nursing home operating costs.

[14] The retail sector is broadly defined and includes drug stores, fast food restaurants and gas stations. These establishments employ many low-skilled, part-time workers. In other words, nursing homes and retail establishments employ similar types of labor; however, while retail wages are set competitively, market forces do not operate very freely in the nursing home industry.

Table 3
Relationship between the Ratio of Average Private[a] to Average Medicaid Reimbursement Rates and the Average Annual Pay of Nursing Home Workers, 33 States,[b] FY1989

Dependent Variable:	
Average Annual Pay for Nursing Home Workers	
Independent Variables:	
Constant	−.46**
	(−4.79)
Medicaid Reimbursement Rate Relative to the U.S. Median	.58**
	(8.68)
Ratio of Private[a] to Medicaid Reimbursement Rates	.08*
	(2.32)
Average Annual Pay for Retail Workers	.81**
	(6.58)
R^2 (adjusted)	.91

Numbers in parentheses are t-statistics.
**Statistically significant at the 1 percent level.
*Statistically significant at the 5 percent level.
[a]Estimated.
[b]All states except Alaska, Arizona, Arkansas, Hawaii, Indiana, Iowa, Kansas, Maryland, Mississippi, Nebraska, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Dakota, Washington, and West Virginia.
Source: Health Care Investment Analysts, Inc. and Arthur Andersen (1991); HCFA State Medicaid Data Disk for FY1989, Families USA Foundation (1990); National Governors' Association (1989); and U.S. Bureau of Labor Statistics, ES202 Data Tape.

higher the relative average annual pay for nursing home workers was expected to be.[15]

Table 3 presents the results of this very simple regression analysis. The results suggest that additional cost-shifting activity does appear to be associated with relatively high nursing home costs to a statistically significant extent. In other words, cost-shifting activity appears to contribute to the process by which nursing home costs are driven higher than can be justified by the state's relative wage rates. The results of most regression analysis should be taken with a large pinch of salt; these results undoubtedly require a larger pinch than usual, because the ratio of the estimated private to Medicaid reimbursement rate is subject to the many interpretations already discussed. Nevertheless, the results are suggestive.

Policy Implications

The ratios presented in this article could reflect happenstance, access problems, case mix differences, or cost-shifting activity. Whatever the cause, a ratio significantly different from 1 has implications that deserve policymakers' attention. If the explanation for a ratio above 1 is case mix differences, for instance, the state's taxpayers might benefit from better screening and case management procedures. If the problem is access, Medicaid recipients may be left in hospitals where beds are even more expensive than they are in nursing homes. Thus, wherever the private-public ratio is significantly different from 1, policymakers ought to know why.

If, after further investigation, a ratio above 1 turns out to indicate a significant amount of cost-shifting activity, policymakers may want to require nursing homes to charge the same (institution-specific) rate for comparable patients, whether these individuals are supported by their own resources or by the public sector. In other words, policymakers may want to establish an all-payor system comparable to those frequently advocated in the context of acute or hospital care. For the average state, such a one-time change in policy would raise Medicaid expenditures by roughly 5 percent.[16] At least half of the additional expenditure would be reimbursed with federal matching funds. In return for a net 2.5 percent increase in Medicaid expenditures, policymakers would reduce some sizable inequities, slow the pace at which private payors spend down to Medicaid eligibility, improve observers' ability to measure relative efficiency across state Medicaid programs, and enhance the regulators' ongoing ability to control Medicaid costs.

[15] Of course, the direction of causality—from cost-shifting to relative costs or from relative costs to cost-shifting—is not clear. However, if the direction of causality is the reverse of that assumed in this regression, then relatively high nursing home costs not validated by the regulators appear to lead to additional cost-shifting activity. Accordingly, policymakers would probably want to take account of any positive link between relative costs and cost-shifting activity, whatever the direction of causality.

[16] Assumptions: the ratio of the average private charge to the average Medicaid reimbursement rate is 1.21 and this ratio reflects cost shifts rather than geographic or case mix differences; Medicaid accounts for 63 percent of the total resident days and for 44 percent of payments to nursing homes made for Medicaid recipients; Medicaid must pay all of the increase in the Medicaid reimbursement rate required to bring the Medicaid per diem up to the average revenue per patient day; and nursing home care accounts for 28 percent of total Medicaid vendor payments.

At a time when total state Medicaid payments have been rising 19 percent per year, a one-time increase of 2.5 percent does not seem like an exorbitant price to pay for these advantages. But, of course, these are difficult days for state budget makers, who have been under great pressure to cut Medicaid spending, one of the fastest-growing items in most state budgets. Under these circumstances, state policymakers may conclude that they would rather ask moderate-income families to subsidize the long-term care portion of the Medicaid program than 1) cut Medicaid coverage of acute care for poor children and others or 2) raise state taxes.

The public should be aware of the choices being made. One problem with subsidies is that they are largely invisible.

Nevertheless, the United States Congress and most state legislatures have agreed that society has a responsibility to support elderly and disabled individuals who need nursing home care and meet Medicaid income and asset eligibility criteria. If those responsibilities are not being fulfilled in certain states, the public should be aware of the choices being made. One problem with subsidies is that they are largely invisible.

Requiring nursing homes to charge comparable publicly and privately supported patients the same rates would end the inequity of asking individuals paying privately to subsidize a public responsibility. It would also help state regulators to get a better handle on Medicaid costs. However, it would not alleviate other problems inherent in the U.S. approach to long-term care. In particular, because the need for long-term care is uncertain, and the actuality is extraordinarily expensive, most families do not or cannot save enough to pay for more than a brief stay in such an institution.

To start with the first point, only a relatively small fraction of the population ever actually requires long-term care. In 1990 nursing home residents of all ages (but almost 85 percent are aged 75 and above) equaled less than 1 percent of the entire population, less than 5 percent of the population aged 65 and above, and 11 percent of the population aged 75 and over. But for those comparatively few individuals who do require nursing home care, the cost is staggering—with the average charge to private payors approaching $30,000 per year. Accordingly, families who are unfortunate enough to need long-term care and who play by the rules of the game often end with their savings exhausted and their relative a "burden to society." Others may succeed in hiding their assets, but their relative still becomes a burden to society.

When people tend to undersave for or underinsure against a risk that can produce a significant liability for the taxpayers, governments generally intervene: they either create tax incentives for purchasing private insurance, or they establish a social insurance program to pay for the required services directly.[17] The United States has followed both approaches in dealing with acute medical care, for which individuals also tend to underinsure. For workers and their families, the government has created tax incentives that encourage employers to provide health insurance as a fringe benefit. For the elderly and the disabled, who are not expected to work, the government has established Medicare, an extremely popular social insurance program. But, as already discussed, Medicare provides very limited coverage of long-term care.[18]

[17] New York state is introducing a somewhat different approach to this problem. The new program will encourage state residents to buy private insurance covering three years of nursing home care and six years of home care. Those who do so but require additional care will be allowed to become eligible for Medicaid without spending down their assets. Connecticut and Indiana have started, and California is applying for federal approval to start, somewhat similar programs (Freudenheim, May 3, 1992).

In the absence of a federal initiative, this innovative program is clearly a step in the right direction: it will probably save the taxpayers some money and will stimulate a market for (more) affordable long-term care insurance. More people will have an incentive to buy, thereby reducing the problem of adverse selection, and the state will limit the insurers' liability. Nevertheless, this program will primarily benefit upper- and middle-income people, while lower-income individuals may not be able to afford the private insurance (with estimated annual premiums of $1,500 to $2,000 for policies bought at age 65) and will have to spend down to become eligible for Medicaid. Moreover, this approach still does not spread the burden of paying for long-term care as widely as would a federal social insurance program. Should many states follow this approach, the insurance companies will undoubtedly force a reduction in the ratio of private to Medicaid reimbursement rates. These private insurers will not want to subsidize the Medicaid program for very long.

[18] Medicare coverage of nursing home care is currently limited to 100 days and requires prior hospitalization and the need for skilled services. In other words, it covers convalescent or terminal care, not long-term care.

What, then, should be done about individuals' tendency to underinsure against the risk of needing long-term care? One solution would be to expand Medicare coverage to include long-term care and to transfer the long-term care portion of Medicaid to that program. Congress did not provide Medicare coverage for long-term care when the program was first established because members were concerned about incurring an open-ended fiscal liability. Now that the country has had 25 years' experience with Medicaid coverage of long-term care, however, it seems clear that the demand for nursing home services will not surge merely because Medicare coverage has become available. Rather, it seems that individuals generally resist going into a nursing home as long as any viable alternative remains. Nevertheless, predictable demographic changes indicate that the need for long-term care will continue to grow unless health care providers find a way to prevent or alleviate such disabling conditions of aging as Alzheimer's disease and arthritis.

Once government limited an individual's liability for costly nursing home care, the private market for Medigap insurance for long-term care would develop rapidly.

Expanding Medicare to cover even the current use of long-term care would have a major impact on the Medicare program. In 1989 such a change would have meant expanding Medicare expenditures by 50 percent. However, because federal, state, and local taxes already pay for one-half of all long-term care through Medicaid, the net impact on U.S. citizens' tax burden would have amounted to 25 percent of 1989 Medicare expenditures.[19] It is worth remembering, moreover, that such a change would most likely have had little impact on society as a whole, since society pays, one way or another, for required long-term care.[20] The change would simply have spread the burden more evenly across society instead of focusing half of the total cost on the relatively few individuals (less than 1 percent of the population) who now pay for all or some of their nursing home care from private sources.

Given the strained state of the hospital insurance trust fund (the primary source of funding for Medicare)[21] and the negative reaction to and eventual repeal of The Medicare Catastrophic Coverage Act of 1988, paying for an expansion of the Medicare program might present political difficulties. Nevertheless, several options exist. For example, the government could raise FICA rates, or it could raise the maximum income subject to FICA taxes. It could raise federal estate tax rates (which are lower than those in most other industrial countries) and earmark the revenue for the long-term care portion of Medicare. It could tax relatively wealthy Medicare recipients on these benefits.

To limit the fiscal burden and give consumers some incentive to shop for efficient institutions and consider alternatives to institutionalization, the government could also require moderate co-payments for nursing home services. These co-payments could be calculated on a sliding scale or they could be capped.

Once the government had limited an individual's liability for costly nursing home care, the private market for Medigap insurance for long-term care would undoubtedly develop rapidly. At present, the private insurance market for long-term care coverage is severely underdeveloped[22] because of the huge potential liabilities involved and the problem of adverse selection. Only the individuals who know that they are most at risk of needing long-term care are likely to buy the expensive and limited policies currently available. Indeed, the contrast between Medigap health and long-term care insurance coverage is dramatic: 75 percent of the elderly have Medigap health insurance policies; only 3 percent of the elderly have long-term care insurance (Health Care Investment Analysts, Inc. and Arthur Andersen, 1991, pp. 8–9). These figures suggest that the private insurance market could expand rapidly once Medicare entered the long-term care picture.

[19] Presumably, thus, an individual paying the maximum FICA tax (on $48,000) in 1989 would have had to pay $174 more to the hospital insurance trust fund. The supplemental medical insurance premiums and the contributions from general revenue would have been proportionately greater as well.

[20] This assertion assumes that the demand for nursing home care is not very price-elastic. Because most people resist institutionalization, this assumption seems reasonable in the case of nursing home care, but it may well not apply to the demand for home or community care.

[21] The primary sources of funds for Medicare are the hospital insurance trust fund (which, in turn, is largely funded by payroll taxes), general revenue, and Medicare premiums.

[22] At present, private insurance provides only 1 percent of payments to nursing homes.

Conclusions

This article has presented estimates of the extent to which individuals paying privately for nursing home services are being asked to subsidize their state's Medicaid program. Although anecdotal evidence has long indicated that such cross-subsidies are widespread, measuring the extent of this activity has been very difficult because states do not publish data on nursing home charges to private patients. Now, however, recently published data permit researchers to make rough estimates of the ratio of nursing home revenues per private patient day to the Medicaid per diem reimbursement rate across states. Although these ratios undoubtedly reflect differences in access and degree of disability as well as cost shifts, these data suggest that cost-shifting activity may be occurring in over three-fourths of the states for which these calculations can be made. And it is occurring in states where policymakers have been relatively open-handed as well as in states where policymakers have been relatively unaccommodating. In states where the private sector appears to be subsidizing the Medicaid program, the subsidies amount, on average, to one-third of a Medicaid recipient's care.

Combined with previous research, these data help to distinguish between states where the Medicaid long-term care program is actually relatively low-cost and states where the long-term care program only appears to be low-cost because private individuals are subsidizing the public sector. Similarly, some states' Medicaid expenditures may appear relatively high partly because the taxpayers are paying the full cost of the program. Unfortunately, the data still do not permit researchers to distinguish differences in quality from differences in efficiency other than through institution-by-institution inspection.

Having found evidence of widespread cost-shifting activity, this article argued that such behavior is highly inequitable and may be self-defeating from a policymaker's perspective. It clearly hastens the absorption of private payors' resources and either encourages middle-income people to use asset protection schemes or speeds their transition to Medicaid dependence. It also complicates the task of regulating nursing home operating costs and curbing the rapid rise in Medicaid expenditures.

Accordingly, policymakers may want to investigate more thoroughly than is currently possible using publicly available data why a state's average private reimbursement rate differs from its Medicaid rate. Any ratio substantially different from 1 could indicate a situation requiring policy action. If the explanation turns out to be cost shifting, the authorities may want to require nursing homes to charge comparable patients the same amount. Such a change would restore the social contract and help to slow spiraling Medicaid costs. For the average state, the one-time transition cost would be a fraction of recent (albeit painfully large) increases in its annual Medicaid bill.

Expanding Medicare to cover long-term care most likely would have little impact on society as a whole, since society pays, one way or another, for required long-term care.

However, requiring nursing homes to charge all comparable residents the same rate would not address the private sector's tendency to undersave or underinsure against the uncertain but very costly risk of needing long-term care—with the consequence that a significant number of people become dependent on public support. In dealing with this issue in the context of acute care needs, the government has chosen to use tax incentives to encourage employers to provide health insurance as a fringe benefit in the work place. For the elderly and disabled, it has established Medicare, an extremely popular social insurance program. The data in this article bolster the case for including long-term care coverage in Medicare.

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