

risk contracting program, and in fact may increase Medicare spending as a recent evaluation indicated. In addition, Medicare's policy of allowing beneficiaries to disenroll on a monthly, rather than annual, basis may contribute to biased selection. It could also disrupt the continuity of care.

- Determining the AAPCC annually on a county basis results in substantial payment variation among neighboring counties and from year to year. As a result, many HMOs are discouraged from participating in the risk contracting program because of low payments in their service areas and payment variability from one year to the next. In addition, the AAPCC methodology does not account for the costs of services provided to Medicare beneficiaries by Department of Veterans Affairs and other military facilities. Consequently, Medicare capitated payments in some areas may be inappropriately low, further discouraging HMO participation.
- The Medicare program needs to provide beneficiaries with more information regarding available plans and how they compare. This information should include findings regarding the quality of care delivered to beneficiaries by HMOs in their area and data on enrollee satisfaction with alternative plans.

Alert 3: Changing Patterns of Subsidies Across Payers and Providers

A price competitive health care system will alter past patterns of subsidies across payers and providers. The ability of providers to cover losses from Medicare and Medicaid patients with excess revenues from private payers will diminish as competition intensifies.

- Hospitals have always used gains from some payers to cover losses from others. They have also relied on direct and indirect subsidies to help finance the care they furnish to the uninsured. These practices have spread rapidly in recent years. But as competition accelerates, payers will become less willing to finance these extra costs.
- Over the past decade, Medicare and Medicaid have curtailed the rise in their per case payments to hospitals. Instead of reducing cost growth as public payers constrained payments, however,

hospitals responded by increasing revenue from private payers. In 1992, hospitals spent \$26 billion more than they received for furnishing services to Medicare, Medicaid, and uninsured patients. In the same year, they took in \$29 billion in revenue above their costs of providing care to privately insured patients. Because hospitals could get additional revenue from private payers, Medicare was able to slow payment growth without a commensurate decrease in the cost of furnishing care to its beneficiaries.

- Many hospitals will have difficulty securing extra revenues from private payers to subsidize losses from public programs because of accelerating price competition. To remain financially viable, therefore, they will have to constrain the growth in the costs of furnishing care to all patients.
- This deceleration in hospital costs per case began in late 1992. Contributing to this trend were improved labor productivity, smaller wage and salary increases, and a more gradual rise in the cost of supplies and services that hospitals purchase. In addition, hospital length of stay has declined for elderly and nonelderly populations alike. Consequently, growth in the average cost per case is moderating for Medicare and other payers.
- Medicare's payments relative to the costs of services provided to beneficiaries continue to be below those of most private payers. Because of the recent slowdown in cost growth, however, subsidies from private payers that offset these losses will not need to increase. Indeed, though still substantial, these subsidies appear to have dropped in 1994.
- Surplus revenue from private payers also has been used to subsidize losses from Medicaid and uninsured patients. If hospitals are unable to continue to obtain these additional revenues, they may avoid providing care to some public program beneficiaries and to the uninsured. Moreover, the pressure to do so is likely to rest most heavily on certain hospitals.

Alert 4: Assessing Further Reductions in Medicare Hospital Updates

While the growth in Medicare hospital per case payments can be reduced further, it is important