

STATEMENT OF

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Mr. Chairman, the Congressional Budget Office is pleased to have the opportunity to testify on the subject of the cost-effectiveness of Professional Standards Review Organizations (PSROs) and on the Administration's proposal to phase out the program. As you are aware, CBO has studied the issue of PSRO effectiveness for some time and has issued a number of reports, the most recent of which appeared in January of this year. Since there has been much discussion of the topic during the past year, I will give only a brief summary of our latest study, which has been submitted to the Committee, and will then concentrate on the Administration's proposal to phase-out the program.

The CBO study examined the effects of PSROs on hospital utilization and costs in 1978, the last year for which data are available. The study assessed only the program's efforts to restrain hospital use. I will refer to those activities as "PSRO review." Limited data prevented our evaluating PSROs' quality-assurance activities in general or assessing any incidental impacts of PSRO utilization review on quality. Accordingly, the costs and effects of PSROs' quality-assurance activities were excluded from our evaluation.

The CBO study reached three basic conclusions:

- o PSRO review does reduce Medicare days of hospitalization --by about 1.5 percent. There is no good information, however, concerning the program's effect on hospitalization of Medicaid recipients.
  
- o PSRO review of Medicare patients costs more than it saves society as a whole. Since PSROs are themselves part of the health-care system, this means that as a result of PSRO review, society devotes slightly more resources to health care than it otherwise would.
  
- o Nonetheless, PSRO review of Medicare patients saves the federal government slightly more than it costs. In 1980, the net savings to the government from such review were about \$18 million--less than one-tenth of one percent of Medicare outlays for hospital care.

PSRO Medicare review generates a small net savings to the federal government while producing a net loss to society as a whole because some of the savings to the government are costs that have been transferred to private patients. This transfer occurs because of the way the Medicare reimbursement system treats fixed

costs. When a Medicare day of hospitalization is avoided because a PSRO has had a patient discharged earlier, some of the hospital's costs that Medicare would have paid for remain. Interest on the hospital's mortgage debt, for example, remains unchanged. The Medicare reimbursement system apportions these remaining--or fixed--costs proportionately among all patients, and since private patients account for about two-thirds of all patient days, they are charged for most of these costs.

#### The Administration's Proposal

I would like to turn now to the Administration's proposal for the PSRO program and to assess the effects that proposal would have.

The Administration is proposing a phase-out of federal support for PSROs, beginning in the current fiscal year and ending in 1984. Individual PSROs could continue some review activities if they were able to obtain private funding for them, but their role in the Medicare and Medicaid programs would be terminated. PSROs' quality-assurance activities would be terminated along with their utilization-control efforts. At the same time, the Administration proposes to eliminate the requirement under Titles XVIII and XIX of the Social Security Act that providers not under PSRO authority conduct their own utilization review. Without those legislative

changes, utilization review of that sort--usually called "UR"--would resume when PSROs terminated their activities.

The Administration proposes fiscal year 1981 funding for the PSRO program of \$135 million, which would be \$39 million, or 22 percent, less than the level in the Continuing Resolution. The Administration's 1982 request is for \$70 million, which is \$104 million below both the 1981 Continuing Resolution and the Carter request for 1982.

To accomplish this reduction, the Administration would stop funding a large number of PSROs rather than cut funding across the board. The Administration suggests that they will be able to select the least effective PSROs to stop funding first, giving the most effective PSROs time to develop private funding that they would need in order to continue operation.

The effect of the Administration's proposal on the federal budget would be quite small. Total elimination of both the program and the UR requirements would save about \$60 million relative to the 1981 Continuing Resolution. The Administration's smaller reductions in 1981 and 1982 would save somewhat less, depending on the Administration's success in selecting the least

effective PSROs for earlier termination. It might be reasonable to expect a net budgetary savings of about \$20 million in 1981 and perhaps \$50 million in 1982.

There is one unknown factor that might make these estimates of budgetary savings too large. While we have estimated the costs of UR and PSRO review, and we have estimated the impact of PSRO review on utilization, we are not aware of any reliable estimate of the effects of UR on utilization and costs. There has been a widespread consensus--though not based on firm data--that UR has little or no effect. Both our estimates and those of the Administration assume this to be the case. If, however, UR has some effect, eliminating it would further increase utilization and costs, offsetting some or all of the estimated savings from the Administration's proposal.

Two aspects of these estimates warrant some discussion.

First, changes in funding for the PSRO program--without changes in the UR requirements--have only negligible effects on the federal budget. The small net savings to the federal government generated by PSRO review are roughly offset by the cost of PSRO quality-assurance activities. Thus the net budgetary effect

of eliminating the entire PSRO program would be, for all practical purposes, zero. It is the additional elimination of the UR requirements that cause us to estimate budgetary savings, and that estimate is a very soft one.

Second, CBO's estimates take into account the fact that it is not feasible to reduce the program to the extent proposed by the Administration without denying funding to some moderately effective PSROs. In contrast, the Administration's budget estimates assume that the proposed 60 percent funding reduction in 1982 would be accomplished by denying funding only to PSROs that are completely ineffective in reducing hospital use.

There are two reasons why the Administration's assumption is unrealistic. First, there is no evidence to suggest that so many PSROs are totally ineffective. Second, there is no reliable way to sort out the most and the least effective PSROs, and consequently any group of PSROs that the Administration selects for termination is likely to include a number that are in fact moderately effective.

The limited ability to distinguish effective from ineffective PSROs stems in large part from limitations in the available data

about individual PSROs. Much of the data that the Department of Health and Human Services (HHS) has collected consists of so-called "process" data--that is, measures of the activities that PSROs have engaged in, but not of their effects on utilization and costs. Examples of process measures include information on whether PSROs are following regulations and have worked out agreements with fiscal intermediaries. Unfortunately, HHS still lacks some of the most important process measures, such as the proportion of cases that PSROs actually review or the criteria they use in selecting cases for review. Nonetheless, it is likely that PSROs that fail in terms of the available process measures are in fact relatively ineffective, and HHS has been able to use these data to weed out a handful that were not doing even a minimally acceptable job. The problem is that many of the remaining PSROs may still be relatively ineffective.

To further weed out ineffective PSROs, it is necessary to have "outcome" measures--measures of actual PSRO impact--that are more reliable than those that are currently available. Many of the available outcome measures represent PSROs' self-evaluations. Among other problems, these data are often incomplete--for example, sometimes reporting changes in length of stay without reporting possibly offsetting changes in admission rates. While



high-quality outcome data have been developed by HHS for the national evaluations of the program, these are not suited to evaluating the effectiveness of individual PSROs, and past attempts to use them for that purpose have been highly misleading.

#### Alternative Methods of Reducing the Program

The Administration's proposal to terminate the funding of a substantial number of PSROs within the next six months raises two issues about alternative ways of phasing down or eliminating the program:

- o Whether a phase-down could be structured to allow evaluations of alternative methods of utilization review, and
- o Whether certain parts of the program should be retained.

If the Congress agrees with the Administration that the PSRO program should be phased down, the process could be used to test out alternative, possibly more cost-effective, methods of review. As an example, the Western Massachusetts PSRO has for some time been experimenting with an alternative review system in which cheaper, retrospective review is coupled with the potential sanction of removal of hospitals' waivers of liability. The PSRO

system could provide a reliable test of the cost-effectiveness of this or other alternatives, provided that the system was scaled down in the appropriate manner. For example, the process of selecting which PSROs would be terminated would be crucial, and it would be necessary to have a stable--even if reduced--level of funding for a period of at least two years.

Should PSRO review be terminated, a decision would have to be made about whether data collection or quality-assurance activities should be continued. PSROs currently collect detailed data that can be used to generate profiles of the medical-care practices of individual physicians and hospitals. At least one PSRO--Baltimore City--in an effort to enhance the competitive pressure on hospitals, is making public detailed information about lengths of hospitalization for specific diagnoses at various hospitals. Although the effectiveness of the Baltimore approach has not been well tested, it might be worth maintaining PSROs' data-collection capacity and testing it further as a part of a strategy to increase competition in health care.

Comprehensive data on the effectiveness of quality-assurance activities are not yet available. Such activities might be continued, however, at least in some PSROs, in order to assess their effectiveness or to improve them.

### Conclusion

At past hearings on the PSRO program, CBO and the previous Administration debated the cost-effectiveness of PSRO review. Despite these disagreements, it is clear that the program has had only a small impact on the budget and on society's expenditures of resources for health care. Changes in the level of funding for the program would have an even smaller net effect. Accordingly, in deciding the future of this program, the Congress might want to give weight to other considerations.