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before the

Subcommittee on Health and Environment
Committee on Energy and Commerce
U.S. House of Representatives

November 22, 1982

This document must not be released before its delivery, scheduled for 9:45 a.m., November 22, 1982

Rising health care costs have been a growing burden to many. They have spurred a number of proposals to hold them down by using economic incentives. One suggestion has been to set the rate of reimbursement to hospitals in advance, rather than reimbursing them for costs after they have been incurred. A system of prospective payment would transfer some of the risk of increasing costs to the hospitals themselves.

In my testimony today, I will discuss briefly the likely impacts of prospective payments, and the experience with them to date. Then I will consider a number of key issues that must be taken into account in designing a specific prospective payment plan--

- o whether to include all payers,
- o whether to make patients responsible for charges in excess of the prospective rates, and
- o who should set the rates.

BACKGROUND

Spending on hospital care has been rising rapidly for a long time. Between 1970 and 1982, inpatient expenses per admission rose at an average annual rate of 12 percent, compared to a 9 percent rate of increase in the prices that hospitals pay for labor and supplies.[1] This 3 percent per year real increase in unit costs has been burdensome for many, but particularly for the federal budget. Rising hospital costs have meant rising outlays for Medicare and Medicaid and rising revenue losses--the latter primarily from the exclusion of employer contributions to health insurance from employees' taxable income.

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1. Data for 1982 are based on the first eight months of the year.

An important part of this real increase in hospital costs reflects increasing resources applied per patient. This increase, known as "intensity," reflects the larger numbers of more and more sophisticated diagnostic and therapeutic services being delivered per patient.

But many physicians and researchers have pointed out that intensity (and hence cost) need not increase so fast. The rate could be slowed without compromising the quality of care, if ineffective procedures were discontinued and other procedures used more judiciously. A lack of incentives to consider costs on the part of patients and physicians is one of the reasons why curtailing procedures that do not contribute much to better health gets little attention.

The current system of reimbursing hospitals is another reason incentives to contain costs are lacking. Little pressure to contain costs comes from the patients, since most are completely insured for hospital bills. Nor does much pressure come from the third-party payers, who either pay on the basis of incurred costs--as Medicare and many of the larger Blue Cross plans do today--or simply pay the hospital's charges, however high they may be.[2] These increased costs are passed on either automatically or almost so to the taxpayers, who support Medicare and Medicaid, and to the purchasers of private health insurance.

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2. Medicaid programs often use Medicare methods to reimburse hospitals, although an increasing number of programs are modifying their system or using a prospective payment method.

Earlier this year, the Congress enacted significant changes in the manner in which Medicare pays hospitals.[3] The Committee report described them as a short-term measure to hold down outlays while a prospective payment system is developed. The Secretary of Health and Human Services is to propose a prospective payment system for consideration by the Congress next year.

PROSPECTIVE PAYMENT PLANS

Prospective payment plans would promote containment of costs by severing the link between a hospital's incurred costs and its reimbursements. Unlike the current system, those hospitals reducing their costs would be rewarded, because their reimbursements would not fall as a result.

Issues in Implementation

While prospective payment is attractive in principle, the actual determination of rates would be a difficult technical process. Since individual hospitals have different mixes of patients that vary in costliness, and face different prices for the labor and the goods and services that they must buy, they would warrant different prospective rates. But figuring out how much one hospital's rate should differ from another's would require a great deal of data, and might still be subject to error.[4]

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3. The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248).

4. This technical problem is not unique to prospective payment, but would affect "pro-competitive" innovations as well. Managers of preferred-provider plans, for example, need to make similar calculations to determine which hospitals are really offering a lower price than their competitors.

An additional technical decision concerns how fast prospective rates should be increased over time. The extent to which the increase in rates exceeded what was required to adjust for general inflation would determine the rate at which intensity would be allowed to increase. Many proponents of prospective payment plans feel that the decision concerning the amount of intensity increase to allow need be confronted only in the distant future, because there are many ineffective procedures performed at present that could be dropped as part of the response to changed incentives. Many opponents, on the other hand, worry that governments would tend to set rates too low, since budget savings would be more visible than the adverse health effects of erring on the low side.

Finally, some analysts have questioned the workability of prospective payments for hospitals because of the lack of specific incentives for physicians. While physicians order the procedures that play a major role in hospital costs, most are not employees of the hospital that they practice in, and have no direct financial interest in the hospital. The extent of this problem is probably overstated, however. Since hospitals are their workshops, physicians are concerned about their hospitals' financial well-being. The growing number of practicing physicians in relation to population is also putting the individual staff physician in a weaker position to resist pressure from hospital management to order services in a more cost-conscious manner.

Recent Experience

During the past ten years, a significant amount of experience with prospective payment plans has been gained in this country, and the results have been encouraging. Seven states set either hospital rates or limits on reimbursements for some or all payers, and a number of Blue Cross plans and groups of hospitals set prospective rates privately.

While the states had little success in controlling costs during the early years of prospective payment plans, substantial cost reductions have been achieved since 1976. From 1976 to 1981, per capita inpatient expenses in community hospitals grew by 11 percent per year in these seven states, compared with 14 percent in all other states. Indeed, the cumulative reduction over the five-year period totals 24 percent. Of course, these results do not tell us much about how other states or the federal government would do with rate setting, or how the seven states will do in the future.

ISSUES IN FEDERAL POLICY

If the federal government is to proceed with changing Medicare and Medicaid hospital payments to a prospective system, a number of major issues must be addressed.

How Should Payers Other Than Medicare Be Treated?

Perhaps the most important issue is whether to limit the prospective rates to Medicare or to apply them to all payers. P.L. 97-248 is limited to Medicare, having no provisions dealing with reimbursement from private payers.[5]

Some favor a Medicare-only system because they oppose government regulation of the hospital industry. Many of these persons oppose regulation in general, and while they acknowledge that the potential of markets is more limited in health care than in other areas, they feel that efficient regulation would also be more difficult. To them, Medicare-only prospective payment is prudent purchasing on the part of government, rather than regulation.

The line between prudent purchasing and regulation is not so clear in this case, however. Medicare and Medicaid are responsible for such a large portion of hospital revenues now--about 45 percent in community hospitals--that their reimbursement policies have a profound impact on hospital decisions. In this sense, going from a Medicare-only system to an all-payer system would only affect the degree of government influence. Those opposed to regulation may find only limited comfort in restricting a prospective payment plan to Medicare.

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5. Those Medicaid programs using Medicare reimbursement principles are likely to adopt the reimbursement changes in P.L. 97-248.

A Medicare-only system would result in somewhat less cost containment than an all-payers system, but in the process leave a financial safety valve for some hospitals. Hospitals would be able to make up some of the reimbursement reductions in a Medicare-only system by raising charges to private patients, most of whom are well insured. While this would protect hospitals somewhat against a prospective rate inadvertently set too low, it also would reduce incentives to contain costs.

Such "cost shifting" to other payers would be limited, however. Given the high proportion of revenues coming from Medicare and Medicaid, most hospitals would find it difficult to shift the entire revenue reduction in Medicare reimbursement to other payers. As a result, incentives to reduce costs, while diluted, would nevertheless be substantial, so a Medicare-only prospective payment plan would likely result in both cost reductions and cost shifts.[6]

Bringing other payers into a prospective payment plan is not the only way to minimize the potential for "cost shifting," however. Steps to increase competition among hospitals for private patients could lead to the private sector increasing incentives to contain costs. For example, reducing tax subsidies to employment-based health insurance would make private patients more sensitive to hospital prices through increased cost sharing and additional use of preferred-provider clauses in insurance contracts.

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6. While Medicare reimbursements to hospitals would be lower than under cost reimbursement, charges to private patients might be higher or lower, depending on the offsetting effects of two factors--reduced actual costs and cost shifting to private payers.

The issue of which payers to include brings up the question of whether "two-class" medical care is acceptable. If Medicare and Medicaid reimbursements were tightly constrained, but reimbursements from well-insured private patients were not, in the long run hospitals might tend to specialize in serving either private patients or Medicare and Medicaid patients. The latter could end up with access only to a less expensive, possibly inferior, style of care.

Should Hospitals Be Allowed to Bill Patients for Additional Charges?

Another major issue concerns the role of additional charges to patients by hospitals. Under current law, hospitals must accept the Medicare reimbursement as payment in full.[7] Such a policy could be continued under a prospective payment plan, or hospitals could be permitted, within prescribed limits, to charge the patient more.

Allowing additional charges has two rationales. First, it would provide a measure of protection to hospitals against the government setting prospective rates too low. Hospitals would potentially have an additional source of revenue, as well as political support from the elderly--who would have to pay the additional charges--against lowering the amounts paid by the federal government. The second rationale is that it would establish

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7. Technically, Medicare subtracts any deductible and coinsurance that the patient is responsible for from its reimbursement and the hospital collects them from the patient.

some competition among hospitals on the basis of price. Differences in patient charges among hospitals would influence choice of hospitals to some extent, thereby pressuring hospitals to hold down additional charges and, ultimately, costs. Requirements that patients be informed of additional charges in advance would increase these competitive effects.

Allowing charges to patients could lead to a significant transfer of resources from Medicare beneficiaries to hospitals, however, and might substantially dilute hospitals' incentives for cutting costs. Allowing such charges would involve Medicare relinquishing its power as a large purchaser of care to obtain a good price on the basis of an "all or nothing" offer to hospitals. Beneficiaries, reacting in a decentralized manner to hospitals' additional charges, would have much less economic power over hospitals. Elderly persons requiring hospitalization might not be in a good position to compare hospitals on the basis of price, especially if their physician had staff privileges only in hospitals requiring extra charges. Indeed, if private supplemental insurance, which the majority of Medicare beneficiaries now purchase, covered the extra charges to patients, many would have no incentive to choose the less expensive hospital. To the extent that allowing hospitals to make extra charges did not yield the hoped-for competition, incentives for cost containment would be lost.

Who Should Set Prospective Rates?

Prospective rates could be set by the federal government, state governments, or private entities. The advantage of a federal system is that with the federal government fully responsible for Medicare outlays, it has the appropriate incentives to determine how high Medicare reimbursements to hospitals should be. But the idea of developing a prospective payment system in a more decentralized manner, the approach emphasized in Congressman Wyden's bill (H.R. 5084), appeals to many. For one thing, a decentralized system could be tailored to local economic conditions and attitudes concerning regulation and competition. When all or most payers are included--the case in much of the state-level experience to date--steps could be taken to spread the costs of delivering care to the indigent across a wider range of payers. It also would afford a natural laboratory to experiment with different techniques for setting rates.

Now that the federal government has embarked on a course in the direction of prospective payment, at least for Medicare, the interaction of federal policy with state-level prospective payment programs has changed. Prior to P.L. 97-248, whether or not a state had a program determined whether reimbursement in that state would be prospective or retrospective. Now, with state programs being a substitute for federal reimbursement, the key feature of having a state program is whether or not other payers are included. Indeed, P.L. 97-248 requires state programs seeking to set rates applying to Medicare to include payers responsible for at least 75 percent of hopsital revenues for patient services.

A major determinant of the extent to which states will decide to have their own programs will be the Health Care Financing Administration's interpretation of the requirements of P.L. 97-248. The law says that state determination of Medicare payments should not result in higher payments than would otherwise be the case. How this requirement is made operational will affect the attractiveness to states of setting rates for hospital care.

CONCLUSION

A prospective payment system for hospitals has the potential of slowing the rate of increase in hospital costs by altering hospitals' incentives. Such cost reductions would permit budget savings for Medicare and Medicaid without directly increasing burdens on beneficiaries.

A number of problems would have to be worked out, however. These include finding an appropriate unit of service for which to set the prospective payments, and deciding the rate at which prospective rates should be permitted to increase. Moreover, if hospital costs are to be controlled in the long run, ways will have to be found to change the incentives of physicians and patients as well as those of hospitals.