CBO TESTIMONY

Statement of
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before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

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NOTICE

This statement is not available for public release until it is delivered at 1:00 p.m. (EDT), Wednesday, April 8, 1992.

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Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss the use by private payers of Medicare-based payment rates for hospital and physician services--the diagnosis-related group (DRG) methodology for hospitals and the resource-based relative value scale for physicians. This approach has been incorporated into section 402 of H.R. 3626, the Health Insurance Reform and Cost Control Act of 1991.

Under section 402, private payers would have the option of adopting Medicare-based rates or not. The effects of this approach, then, would depend on the specific level at which the rates were set for private payers and on the proportion of private payers who chose to use them. The provisions of section 402 could affect no more than 30 percent of national health expenditures so long as they applied only to hospital and physician services. The effect is limited because private payers account for only about 50 percent of spending for hospital and physician services, and these two types of services make up 60 percent of national health expenditures.

Recent studies by the Prospective Payment Assessment Commission (ProPAC), the Physician Payment Review Commission (PPRC), and the Congressional Budget Office (CBO) provide some evidence about the potential effects of provisions like those in section 402. The findings reflect alternative assumptions about the level at which rates would be set and about the proportion of private payers who would adopt the Medicare-based rates.

PROPAC AND PPRC ESTIMATES FOR AN OPTIONAL PLAN IN 1994

ProPAC has suggested three alternative levels at which hospital rates might be set--at the level of current Medicare rates, which are below hospitals' costs; at a level that would just cover costs; or at a level that would, on average, just equal the payments now made by private payers. In other words, relative payments for the DRGs would be similar to those under Medicare, but the level of rates would be set below costs, at costs, or above costs for privately insured patients.

ProPAC estimates that setting rates to cover costs would lower private insurers' payments for hospital services by 7 percent to 14 percent.[1] This result assumes that from 50 percent to 80 percent of private payers would adopt the new rates. Some payers might refuse to use the Medicare-based rates because they could negotiate lower rates with hospitals, because they would not want to change the way they bundled services for payment to match Medicare's diagnosis-related groups, or for other reasons.

Because hospital payments by Medicare and Medicaid are now only about 90 percent and 80 percent of costs, respectively, reducing payments by private payers to cover costs would leave hospitals with negative margins, on

1. Prospective Payment Assessment Commission, *Optional Hospital Payment Rates* (March 1992).

average. To correct this problem, hospitals would have to cut costs or enhance revenues. Some methods by which hospitals might enhance their revenues--such as inflating the reported case mix for privately insured patients using Medicare-based rates, or increasing rates for privately insured patients not using Medicare-based rates--would partially offset the estimated reduction in private insurers' payments. Another alternative that would not affect private payments would be for governments to increase the amounts paid by Medicare and Medicaid to cover costs.

PPRC also suggests that the current level of Medicare's rates might not be appropriate if applied to private payers, but for its estimates it uses Medicare's rates without adjustment. The PPRC report indicates that private insurers' payments for physician services might be as much as 25 percent lower using Medicare's rates.[2] This estimate assumes that all payers would adopt the option of paying at Medicare's limiting charge, which in 1994 would be 115 percent of Medicare's payment rate for each physician service.

PPRC notes, however, that the estimated reduction in private insurers' payments for physician services may overstate the impact, for two reasons. First, some insurers--such as health maintenance organizations--might opt not to use Medicare's rates. Second, there would be some offsetting increase in

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2. Physician Payment Review Commission, *Optional Payment Rates for Physicians* (March 1992).

either the number or complexity of services billed by physicians in response to the fall in payment rates for privately insured patients (commonly known as a volume offset).

CBO'S ESTIMATES FOR A MANDATORY PLAN IN 1989

In December 1991, the Congressional Budget Office released *Universal Health Insurance Coverage Using Medicare's Payment Rates*, a study requested by this Subcommittee. This study examined the likely effects on health spending for 1989 if Medicare-based rates had been used to pay for all hospital and physician services under either a single-payer or an all-payer system. (An all-payer system is one with multiple private and public payers who would all pay the same rates for specified health care services.)

The CBO study examined a plan that would require all payers--both private and public--to use Medicare-based rates. Hence, its results are not entirely applicable to section 402, which would involve no change in rates paid by Medicaid and would permit, but not require, private payers to use Medicare-based rates.

The CBO results that are comparable with findings reported by ProPAC and PPRC are those showing the change in payments for privately insured patients. They indicate that payments for hospital services to privately insured patients would fall by about 12 percent, and payments for physician services would fall by about 8 percent. These results assume that all private payers would adopt the Medicare-based rates and that the hospital rates would be set to cover costs.

CBO's estimates differ from those made by ProPAC and PPRC, but the differences would be much smaller if the more recent information used by ProPAC and PPRC were incorporated.[3] In particular, data unavailable to CBO at the time of the study indicate that Medicare-based rates would be lower, relative to rates currently paid by private insurers, than CBO assumed in its analysis. As a result, revised estimates would indicate a larger drop in payments for hospital and physician services to privately insured patients than shown in the CBO study.

In conclusion, although there is uncertainty about the size of the drop in payments for hospital and physician services that might result under section 402, it seems clear that payments would fall by a substantial amount.

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3. See the attached appendix for more information about the differences between CBO's analysis and those of ProPAC and PPRC.

Two factors largely explain the differences between CBO's midrange estimates for the reduction in payments for hospital services for privately insured patients and the estimates made by ProPAC (under its Option 2). First, CBO assumed a smaller excess of payments over costs for privately insured patients than ProPAC assumed. Using hospital data for 1989, CBO found that hospital costs for privately insured patients were about 88 percent of payments collected for them, permitting a 12 percent reduction in payments. Using hospital data for 1990, ProPAC found that costs were only 78 percent of payments collected for privately insured patients, permitting a 22 percent reduction in payments under cost-adjusted Medicare rates.

Second, use of Medicare-based rates was mandatory in the option examined by CBO, but it was optional in the ProPAC analysis. ProPAC's report suggests that, in general, the net effect would be a smaller reduction in payments under an optional plan than under a mandatory plan for a given rate differential.

CBO's midrange estimates of the reduction in payments for physician services for privately insured patients differ from those made by PPRC, also for two main reasons. First, CBO assumed a smaller excess of private insurance rates over Medicare-based payment rates than PPRC assumed.

Using survey data for 1984 and 1985 that covered only a few services paid both by Medicare and by Blue Cross, CBO found that Medicare's payment rates were about 84 percent of rates paid for privately insured patients, permitting a 16 percent reduction in payments. Using survey data for 1989 for a representative set of services billed by Blue Cross and commercial insurers, PPRC found that Medicare's rates were about 71 percent of rates paid for privately insured patients, and PPRC assumed that this ratio would be about 65 percent by 1994. This differential would lead to a 35 percent reduction in payments if all payers used Medicare's payment rates (as assumed by CBO), or a 25 percent reduction if they instead used Medicare's limiting charge (as assumed by PPRC).

Second, CBO included a volume offset in its estimates for physician payments and PPRC did not. Empirical studies have found that about half of any loss in revenues that would otherwise result from reductions in payment rates is offset by increased billings for physician services. Hence, CBO included only half of the potential reduction in payments to physicians for privately insured patients in its estimate; PPRC included all of the potential reduction.

The plan examined by PPRC also differed from the mandatory one analyzed by CBO in that it was optional. This difference was not a factor in

the differing estimates, though, because PPRC assumed that all private payers would adopt Medicare's rates.