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The rapid rise of Medicare payments to hospitals has been of major concern in recent years. These increases, averaging 18 percent annually between 1970 and 1982, add to the size of the budget deficit and threaten the solvency of the Hospital Insurance (HI) Trust Fund.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) sought to reduce Medicare outlays and to provide hospitals with incentives to bring costs down--incentives that had been absent under the system of retrospective cost-based reimbursement. To this end, TEFRA established limits on reimbursement. Relatively costly hospitals, and those with relatively high rates of cost growth, get lower reimbursement under TEFRA. Hospitals that have costs lower than their reimbursement limits receive a small bonus payment.

The Congress intended these changes as a first step toward a system of prospective reimbursement of hospitals under Medicare. Now, as directed in TEFRA, the Administration has submitted its proposal for a full-fledged prospective reimbursement system.

My testimony will begin with an overview of the Administration's proposal, and then discuss more specifically its potential effects--on hospitals, on beneficiaries, and on the federal budget.

OVERVIEW OF THE ADMINISTRATION'S PROPOSAL

The Administration has proposed for Medicare a system of prospective payments to hospitals based on Diagnostic Related Groups (DRGs). Under this system, a national payment level would be determined for each of 467 diagnostic groups that are relevant to the elderly and disabled. Except for adjustments to reflect geographic differences in wage levels, every hospital would face the same rate for each diagnosis. Additional payments would be made for unusually costly cases, and for the indirect costs associated with graduate medical education and nurse training programs.

The Administration's plan would work to reduce growth in overall hospital costs. Evidence from state programs that affect all third-party payers of medical care expenses indicates that prospective reimbursement has been successful there--the seven states with cost control programs in conformance with the 1981 reconciliation act experienced an 11 percent annual rise in costs between 1976 and 1981, compared to 14 percent for other states. 1/

As with other full-fledged prospective payment plans, the Administration's plan would increase hospitals' incentives to reduce costs. Bonuses to hospitals that keep costs below their reimbursement levels would not be limited--that is, they could keep the entire difference between their costs and their reimbursements, whereas under TEFRA they keep only a portion of the difference.

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1. The comparison is for per capita inpatient hospital costs reported in the American Hospital Association's Annual Survey.

In addition, the Administration's proposal offers three potential advantages over other prospective payment methods. First, by not basing payment on each hospital's previous costs, it would avoid the problem of paying more to relatively less efficient hospitals. Second, because payment would be based on diagnosis, the system would take account of differences in the mix of patients and in their costliness--both among hospitals and within each hospital over time. Third, the DRG system, by identifying services for which costs are relatively high in a hospital, could be a valuable internal management tool, enabling hospitals and physicians to find ways to lower costs without reducing the quality of care.

Despite its advantages, the proposal has certain drawbacks. First, because it would cover only Medicare, cost reductions would be more limited than if all other payers, including private health plans, were covered. Moreover, as under TEFRA, hospitals would be able to make up part of the reduction in their reimbursement from Medicare by raising charges to private payers.

Second, the Administration's proposal would radically change the system of hospital reimbursements on the basis of a methodology that has not been tested and that at present appears to be insufficiently refined. The proposed sudden transition from the current reimbursement system--which is based heavily on hospital-specific costs--to one based entirely on DRGs

would mean that some hospitals would receive payments greatly in excess of their costs and others would incur substantial losses. Such major shifts might be justified if there were reason to believe that the bonuses would go to relatively efficient hospitals, and the penalties to inefficient ones. But the Congressional Budget Office analysis discussed below raises serious doubts about the sensitivity of the proposed DRG system to actual differences in the cost of treating different types of patients.

Another reason for caution is the limited experience with DRGs to date. New Jersey is the only state that has based reimbursement on DRGs, and its system places less emphasis on them than would the Administration proposal. In New Jersey, payment for each DRG is a blend of the individual hospital's incurred costs for patients in that category and the average among all hospitals. Moreover, the particular set of DRGs that the Administration proposes to use is new and has only recently been employed to determine reimbursement rates. Studies of this system are under way, but conclusive results will not be available for some time.

EFFECTS OF THE ADMINISTRATION'S PROPOSAL ON HOSPITALS

Individual hospitals would experience large changes in their reimbursements under the Administration's specific DRG proposal. Preliminary analysis indicates that approximately 34 percent of hospitals

would have reimbursements at least 25 percent higher than under TEFRA, while 4 percent would have reimbursements at least 25 percent lower.

The proposal would have very uneven effects on different types of hospitals as well--for example, small hospitals would do much better than large ones, and rural hospitals much better than urban hospitals. As shown in Table 1, hospitals with less than 100 beds would, as a group, receive a 23 percent increase in reimbursement from levels under TEFRA, while those with over 300 beds would face a 6 percent reduction. Hospitals in rural areas would gain 19 percent as a group, whereas urban hospitals would lose 4 percent.

Several factors may contribute to these disparities among groups of hospitals. First, hospitals that are small or in rural areas may serve patients who tend to be less severely ill than the average in a particular DRG. Second, the adjustment for geographic wage differentials may not be sufficient to correct for all differences in operating costs between urban and rural areas. Finally, the regional variation may reflect differences in patterns of practice.

Even if a more refined DRG system was developed, individual hospitals might still receive unwarranted bonuses or penalties. To the extent that a hospital treated patients who were more or less costly than the average for

TABLE 1. ESTIMATED AVERAGE PENALTIES AND BONUSES UNDER THE ADMINISTRATION'S PROPOSED DRG-BASED PAYMENT SYSTEM, BY TYPE OF HOSPITAL a/

	All Hospitals		Hospitals That Would Gain		Hospitals That Would Lose	
	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements b/	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements c/	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements d/
All Hospitals	100	0 e/	61	+23	39	-12
Bed Size						
Less than 100	49	+23	80	+35	20	-10
100-299	34	+2	50	+21	50	-11
300+	17	-6	30	+17	70	-13
SMSA						
SMSA	52	-4	43	+20	57	-13
Non-SMSA	48	+19	81	+29	19	-6
Region						
Northeast	15	-4	45	+19	55	-12
North Central	28	-4	60	+21	40	-13
South	37	+8	72	+26	28	-9
West	20	-2	57	+23	43	-13
Teaching Status						
Teaching	18	-7	29	+18	71	-13
Nonteaching	82	+7	69	+24	32	-10
Ownership						
Nonprofit	57	-2	55	+20	45	-12
Government	31	+9	78	+29	22	-12
Proprietary	12	-1	48	+22	52	-13

SOURCE: Preliminary CBO estimates based on Medicare Cost Reports for 1980.

a. Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.

b. Average calculated for all hospitals.

c. Average calculated for hospitals that would gain.

d. Average calculated for hospitals that would lose.

e. Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments to others.

a DRG, it would lose or gain accordingly. The fewer Medicare cases in a hospital, the greater the chance that random variation of this sort would produce unwarranted effects, although the total impact on the hospital would be small.

EFFECTS OF THE ADMINISTRATION'S PROPOSAL ON MEDICARE BENEFICIARIES

Medicare beneficiaries could experience reduced access to quality care under the Administration's proposal--a risk that exists under the TEFRA limits as well.

One reason for this is that if hospitals faced lower payments they might respond by admitting fewer Medicare patients--particularly those most costly to treat. Moreover, some hospitals with a large proportion of Medicare patients might experience serious financial problems and be forced to postpone modernization or to close. These problems would become more serious if payment levels were tightened over time, thereby widening the distance between payment for Medicare patients and private patients.

Access might also be reduced if hospitals responded to the DRG system by specializing in particular services. A hospital might decide to eliminate a particular service if the payment level was too low compared to its average cost of treatment. If this was because the relative payment

level had been set incorrectly, other hospitals might not be anxious to meet the demand for that service either, so that a whole area might experience access problems.

On the other hand, increased specialization of services might improve the quality of care in some circumstances. Studies have shown that the health outcomes for some difficult procedures are best when they are performed in hospitals that perform them frequently. These types of procedures might not be the only services cut back, however.

EFFECTS OF ADMINISTRATION'S PROPOSAL ON THE FEDERAL BUDGET

In examining the budget impact of the Administration's proposal, two distinct periods must be considered--the 1984-1985 period, when the proposal would replace current reimbursement limits enacted as part of TEFRA, and later years when the growth-rate limitations under TEFRA would have expired.

The Congressional Budget Office cannot at this time estimate the 1984-1985 budget impacts of this proposal because key details, such as the base reimbursement level and the rate at which it would increase over time, have not been specified. The Administration has made it clear, however, that it intends total Medicare reimbursements to be the same as under current law.

Achieving this budget neutrality would be technically complex, but possible. For example, since both the TEFRA reimbursement limits and the DRG-based payments imply reimbursements far below allowable costs for some hospitals, the appeals policy would be an important determinant of total reimbursements.

In addition, changes in hospital behavior would occur in response to the new reimbursement policies. These would affect federal outlays in a number of ways that would have to be taken into account when setting the base reimbursement level. For one, hospitals would have an incentive to admit more patients whose need for inpatient care was marginal, although they would gain less from such behavior than under the TEFRA limits, because the DRG reimbursements would reflect the costliness of the diagnosis. Also, some analysts have raised the prospect of DRG "creep"--that is, a tendency for patients with chronic illnesses or multiple diagnoses to be placed in the most expensive DRGs. This effect would probably be small, though, because the diagnostic categories have been designed to make this difficult and because the utilization review by Medicare intermediaries proposed by the Administration could identify some of these cases.

For 1986 and beyond, the Congress would have to decide upon a goal for budget savings. It could direct that reimbursements be set to continue

the level of stringency in the third year of TEFRA--that is, about 9 percent below what reimbursements would have been under pre-TEFRA policies--or it could tighten reimbursements further in each successive year.

Successive tightening of reimbursements--for example, by continuing the TEFRA growth rate formula that uses the increase in the cost of the hospital market basket plus one percentage point--would cut federal outlays substantially, but at the risk of reducing beneficiaries' access to quality care. The nature of this potential tradeoff would depend on the extent to which hospitals responded to lower reimbursements by cutting costs rather than by raising charges to private patients. The smaller the eventual difference between the Medicare reimbursement and private reimbursement, the smaller the reduction in access for Medicare beneficiaries.

While the Administration's proposal would ease the long-range financing problems of Medicare somewhat by cutting reimbursements from 1986 on, serious financial problems would remain. Under current law, the HI trust fund is projected to be exhausted by 1987. 2/ If the Administration's

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2. This estimate assumes no further borrowing by the Old Age and Survivors Insurance trust fund from HI, but no repayment of the $12.4 billion in outstanding loans.

   The proposals of the National Commission on Social Security Reform would have only a slight effect on the HI trust fund, an issue that it did not address. Revenues would be increased slightly by requiring all employees of private nonprofit organizations to pay the HI tax and by preventing state and local governments from withdrawing from Social Security.

proposal continued the projected 1985 degree of reimbursement stringency, exhaustion would be delayed only until 1988. Successive tightening year after year, at the same rate as under TEFRA, would postpone exhaustion until 1989.

CONCLUSION

Any prospective payment system would offer hospitals greater incentives to reduce costs than exist under TEFRA, and the Administration's DRG approach has important advantages over other prospective payment plans. Most importantly, it would not build in inefficiencies that now exist in some hospitals. On the other hand, the specific design of its proposal would lead to a substantial reallocation of Medicare payments among hospitals that would not reflect merely differences in efficiency.

A number of options are available that would address the proposal's shortcomings. For example, adjusting the payment level to take more account of variation in costs between urban and rural areas, or among regions, would reduce the systematic differences in impact by group. The reallocation would also be less traumatic if it went into effect more gradually. One phase-in method, for example, would average a hospital's reimbursement under the DRG system with that under the current system of TEFRA limits, with the DRG payment given increasing weight over time. Although administratively more complex, this approach would allow additional refinements in the DRG system on the basis of experience and further research, before a complete transition was made.