

**Statement of**  
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**Before the**

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**Committee on the Budget**  
**U.S. House of Representatives**

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Mr. Chairman, Medicare's Prospective Payment System (PPS) for inpatient hospital care is thought by many observers to be this decade's most significant development in all U.S. health-care financing policy. By changing the basis of Medicare's payment from whatever costs a particular hospital incurs to a schedule of pre-set payments per admission, the system rewards hospitals that treat patients at low cost and penalizes those with high costs. Remaining policy issues within the PPS involve both adjustments to fine-tune the system and decisions about how the gains from improved efficiency are to be shared between the hospitals and the federal government.

My testimony today considers three main topics:

- o The objectives and operations of Medicare's PPS,
- o The outlook for Medicare's Hospital Insurance (HI) trust fund, and
- o Some possible further changes in the PPS.

Although my remarks focus in particular on the PPS, several other issues may have important implications for federal health policy decisions. Outlays under Medicare's Supplementary Medical Insurance trust fund continue to grow rapidly, largely because its current system of reimbursing physicians encourages higher fees and more treatment. The Congress may wish to turn next to this area. Also, because public and private insurers are lowering reimbursement rates for the care of insured patients, hospitals may encounter increasing difficulty in financing charity care. If, as a result, access to care for the uninsured and underinsured diminishes, pressure for

added federal spending could mount. Finally, the aging of the population will increase financial pressure on the federal government, not only through Medicare, but also for a modified system of financing long-term care.

I raise these points by way of caution: while federal health outlays are likely to be held down by the PPS, other factors operating in the opposite direction may make budgetary choices regarding federal health policy extremely difficult.

#### **THE PPS AND ITS FORERUNNER**

In passing the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress laid the groundwork for the PPS, introduced as part of the Social Security Amendments of 1983. Both actions were prompted by an unacceptably high rate of growth in Medicare's outlays for hospital costs, which averaged 18 percent a year between 1975 and 1982, or 8 percent a year above general price inflation. Moreover, concern was widespread that the cost-based reimbursement system now superseded by the PPS did not encourage economic efficiency, and that it was not producing health improvements in proportion to federal spending. In each case, the Congress's objective was to lower the rate of growth of Medicare's payments to hospitals, while promoting the provision of high-quality health care.

As a first step, TEFRA limited the growth of hospital reimbursement per admission to the rise in prices for hospital goods and services, plus one

percentage point for other factors. In the first two years of the PPS, Medicare payments to the hospital industry as a whole were designed to equal the aggregate outlays that would have occurred under TEFRA, but in the third year (fiscal year 1986), the Secretary of Health and Human Services (HHS) was given discretion over the rates.

Under the PPS, a fixed payment rate is set in advance for each of 468 categories known as diagnosis-related groups (DRGs), which were designed to reflect the value of resources used to treat different types of conditions. During a three-year transition, the prospective amounts are based on a combination of hospital-specific, regional, and national rates. 1/ The hospital-specific portion is based on each hospital's own pre-PPS costs. Eventually, the system will be based on national rates only, calculated separately for urban and rural areas. 2/ Each hospital's rates are also adjusted for differences in wage levels among geographic areas, and for the size of an institution's in-hospital training program for physicians.

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1. Some hospital costs and some institutions are exempt from the PPS. Capital-related costs, such as depreciation and interest payments, and the direct costs of graduate medical education programs continue to be reimbursed on a "reasonable-cost" basis. Moreover, children's hospitals, rehabilitation centers, and psychiatric hospitals are exempt from the PPS.
  2. All participating hospitals have now begun their second year under the PPS, meaning that 50 percent of their payments is based on a combination of regional and national rates, while the remainder is hospital-specific. On October 1, 1985, approximately one-fourth of these hospitals will enter their third PPS year, when 75 percent of their payments will be based on regional and national rates. The regional rates will be phased out for all hospitals by the end of fiscal year 1987.

The adjustment for hospitals with approved teaching programs, termed the indirect teaching adjustment, proportionately increases the national and regional rates used to calculate their payments from Medicare. Initially, the adjustment was intended to compensate these hospitals for the increased patient-care costs associated with teaching programs. Later, the estimated adjustment was doubled as an interim step to pay for a variety of other cost-increasing factors associated with large teaching hospitals and not otherwise accounted for by the PPS. These factors include greater severity of illness within DRGs, location in an inner city, and service to a disproportionately large share of low-income patients. As a result of how PPS payments are calculated, the additional payments for teaching hospitals were, in effect, financed by lowering payment rates for all hospitals. Because the rates were calculated separately for the nine Census regions, the reductions during the transition are largest in the areas with the greatest teaching activity. <sup>3/</sup>

Beginning in fiscal year 1986, the prospective payment rates can be adjusted annually at the discretion of the Secretary of HHS. This adjustment, known as the "update factor," has two components. The first reflects the change from the preceding year's prices of goods and services purchased by hospitals--often called the hospitals' "market basket." The

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3. Because almost all teaching hospitals are located in urban areas, rural hospitals are essentially unaffected. Once the system is fully phased in, urban hospitals in all regions will receive the same percentage reduction in their PPS rates.

second, called the "discretionary adjustment factor," is intended to reflect technological and scientific advances, productivity change, and improvements in the quality of care. While the cost of the market basket is generally expected to rise, the discretionary factor could be positive or negative. Rates for fiscal year 1985 were raised 5.6 percent above the 1984 level. Although in 1984 the Congress limited the update factor for 1986 to no more than the increase in the cost of the market basket plus one-quarter of a percentage point, Secretary Heckler has determined that no increase is necessary.

#### **THE OUTLOOK FOR THE HOSPITAL INSURANCE TRUST FUND**

The Congressional Budget Office's (CBO) projections of the status of the HI trust fund show it to be financially sound through the Congressional planning period of five years; year-end balances would rise over the 1986-1990 projection period from \$30 billion to \$42 billion (see Table 1). These projections assume that the PPS rates will rise each year by the increase in the cost of the market basket plus one-quarter of one percent. Moreover, if some of this year's proposals for modifying the PPS--such as those reported by the House Committee on Ways and Means--are enacted, the HI trust fund's financial soundness would be reinforced.

It should be emphasized, however, that the burden that Medicare places on the economy is better measured by the level of outlays than by the status of the trust fund. Between 1985 and 1990, hospital insurance outlays

are expected to grow by over 10 percent a year, a far greater rate than the assumed 7.8 percent annual rate of growth of our gross national product. Consequently, despite recent changes in the reimbursement system and the improvement in trust fund balances, hospital insurance will continue to impose an ever-growing burden on the economy.

TABLE 1. BASELINE BUDGET PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES: TO FISCAL YEAR 1990

	1986	1987	1988	1989	1990
<b>In billions of dollars</b>					
Outlays	52	58	64	71	79
Income	62	68 <sup>a</sup> / <sub>1</sub>	67	72	77
Year-End Balance	30	40	43	44	42
<b>As a percent of outlays</b>					
Balance	57.1	69.3	67.5	61.7	53.0

SOURCE: Congressional Budget Office, September 1985 estimates.

a. This figure reflects repayment from inter-fund borrowing.

Longer-term projections of trust fund balances depend on many difficult assumptions. Outlays are affected by factors such as changes in the rates that Medicare will pay hospitals, the number of beneficiaries, admission rates, complexity of diagnoses, and other factors. Since Medicare's rates for inpatient care are under the Secretary's discretion or can be legislated, they are extremely difficult to forecast. To illustrate,

this year's action by the Ways and Means Committee to limit the increase in PPS rates to 1 percent would change the 1990 trust fund balance from 53 percent of annual outlays to 68 percent, thereby reversing the slight decline shown in Table 1 for the 1986-1990 period. Improving health status of the elderly population might reduce, or at least postpone, trust fund outlays. On the other hand, assigning patients to DRGs is sometimes subject to uncertainty. In a case in which a patient might legitimately be classified in either of two DRGs, the hospital has an interest in selecting the higher-priced one. The extent to which the complexity of diagnoses has grown and might continue to grow would increase outlays, though by how much is difficult to estimate. Finally, forecasting changes in medical technology and their implications for spending is very difficult.

On the income side, revenues flow into the trust fund mainly through payroll taxes, which depend on wage rates--which in turn are strongly influenced by the extent of inflation--and on employment levels. While macroeconomic forecasting is always subject to great uncertainty, projections of balances in the trust fund are particularly sensitive to employment forecasts. This sensitivity occurs because employment only affects revenues, whereas a change in prices affects both revenues and outlays in the same direction.

CBO's last analysis of the long-term prospects for the HI trust fund assumed that the PPS rates would rise by the increase in the cost of the



market basket, plus one percentage point for 1987 and beyond. The analysis showed that the fund would remain financially viable until at least the mid-1990s. <sup>4/</sup> Since CBO's earlier analysis, added data suggest that the period of financial viability may be longer.

In 1984, for example, after rising each year since the inception of Medicare, hospital admissions of elderly patients fell (see Figure 1). <sup>5/</sup> Since Medicare's payments are based on admissions, future outlays will be reduced, provided that this drop in admission rates is not a short-run aberration, and that the complexity of admissions does not increase sufficiently to offset it. Prospects for the trust fund would thus improve.

It is not clear, however, that the drop in admissions is in any way attributable to the PPS, making its duration all the more uncertain. In 1983, most analysts predicted that the incentives under the PPS would stimulate admissions. Moreover, admissions of nonelderly patients began to drop in 1981, falling more than 7 percent--from 27 million to 25 million--by 1984 (also shown in Figure 1). Because this drop for the nonelderly began well in advance of the legislation that created the PPS, it--and therefore the decline for the elderly--may be largely caused by other forces affecting the hospital industry.

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4. Statement of Eric A. Hanushek, Deputy Director, Congressional Budget Office, before the House Committee on Ways and Means, Subcommittee on Health, September 13, 1984.
  5. All statistics in this section are based on data provided by the American Hospital Association from its panel survey of U.S. hospitals.

Figure 1. Hospital Admissions of Elderly and Nonelderly Patients, Fiscal Years 1967-1984

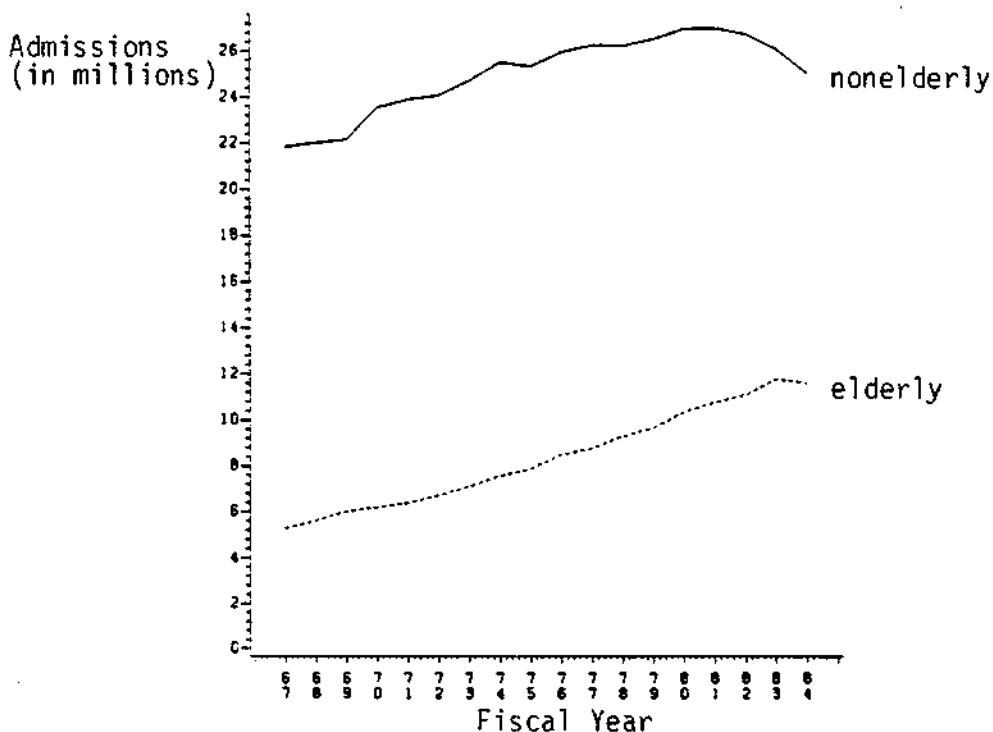
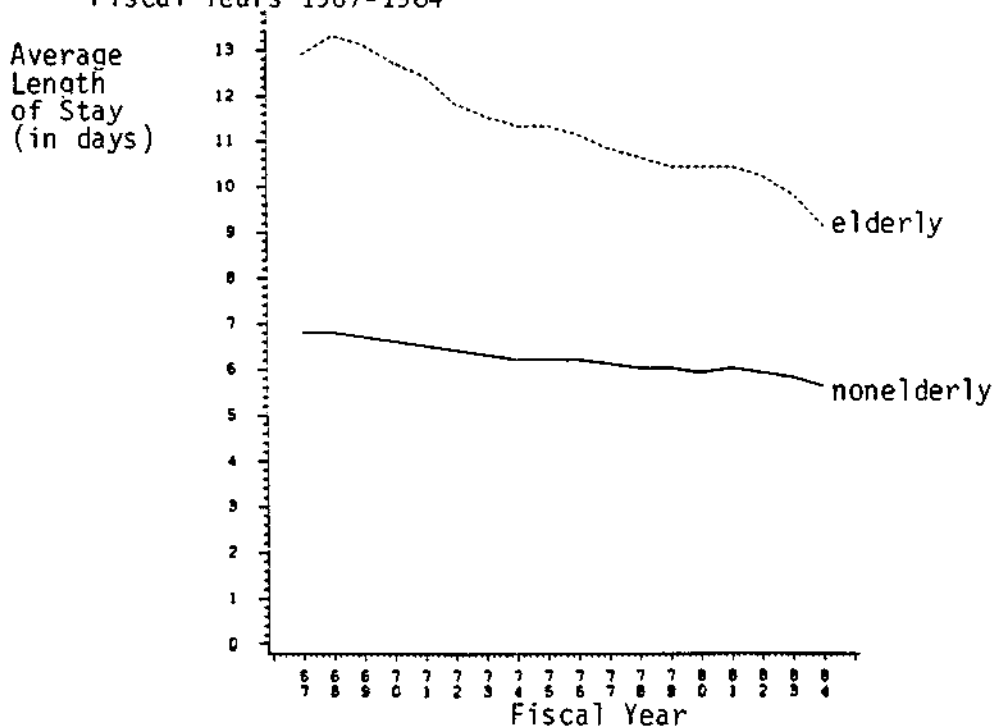


Figure 2. Average Length of Stay for Elderly and Nonelderly Patients, Fiscal Years 1967-1984



SOURCE: Congressional Budget Office from American Hospital Association Panel Survey.

In contrast, a longstanding trend toward declining lengths of hospital stays by elderly patients accelerated when the PPS began--falling from 9.8 days to 9.1 days between 1983 and 1984 (shown in Figure 2). The PPS carries strong incentives for cutting costs, including shorter stays. Again, however, no conclusions about cause and effect are possible because a corresponding acceleration of the trend toward shorter stays among the non-elderly began in 1981, with a fall from 6.0 days to 5.6 days over a three-year period.

Whatever its cause, the shortening of lengths of stays for the elderly has no immediate implication for Medicare outlays, because the PPS does not pay by the day. In the longer run, if shorter stays allowed hospitals to cut back on numbers of staff and beds, the opportunity for more budgetary savings might follow. To date, however, the aggregate data for all inpatient activities (not just Medicare) suggest that hospitals have not reduced their purchases of goods and services in proportion to the declines in use. For example, while total inpatient days fell by 8 percent between 1983 and 1984, and admissions by 3 percent, numbers of full-time equivalent staff fell by only 1.2 percent and numbers of beds by only 0.6 percent. As a result, the cost per admission rose by 8 percent for 1984, while the cost per day rose by 13 percent.

Despite the fall in hospital use and the rising cost per patient, hospital operating margins--that is, the percentage by which total expenses fall

below total revenues--did not decline in 1984. They stood at 5.7 percent for the industry as a whole, up from 5.3 percent in 1983, continuing a trend of rising margins since the early 1970s, when they were about 2 percent. This is not to say that some hospitals are not in financial distress, but--consistent with the original intent of the PPS--the industry as a whole appears to be in good financial health.

#### **OPTIONS FOR CHANGING THE PPS**

The Congress is now considering changes to the PPS, reflecting either concerns about the system's design or perceived opportunities to realize additional budgetary savings. Some modifications are likely to be adopted this year, and others may be the subject of debate in the next several years. The remainder of my statement concentrates on possible changes in five areas:

- o The update factor;
- o The transition to national payment rates;
- o Payments to hospitals that serve disproportionately large numbers of low-income patients;
- o The indirect teaching adjustment; and
- o Expansion of the PPS to cover other hospital costs.

The notion underlying the PPS is that the national payment rate is adjusted only for unavoidable cost differences--those thought to be beyond any one hospital's direct control. The system now recognizes these differences by applying separate rates for urban and rural areas, by adjust-

ing the rates for local wage differences, and by adjusting rates for teaching hospitals to reflect their higher costs. Many of the options CBO has analyzed have been proposed in the belief that there are other unavoidable cost differences that are not now taken into account, or that current adjustments could be refined.

Important considerations in assessing these options are the effects on Medicare's aggregate payments to hospitals, the distribution of payments among types of hospitals, the incentives for hospitals and physicians, beneficiaries' access to care, and the quality of care available. The last issue--quality of care--is a particularly difficult effect to quantify.

Decisions about one dimension can interact with another. For example, whether an option is designed to increase, lower, or hold federal spending constant could affect the distribution of payments among hospitals. Raising payments to one type of hospital could be financed without increasing budgetary outlays, for instance, but only by lowering payments for some or all other hospitals. Similarly, decisions about the distribution of payments could affect the incentives facing hospitals. Changing payments related to some activities--for example, graduate medical education--would probably affect hospitals' decisions about size of residency programs and, indeed, about whether to undertake them at all. Finally, concern is widespread that, if aggregate payments are lowered sufficiently, hospitals would be discouraged from admitting Medicare patients or would change treatment courses in ways that would lower the quality of their care.

### The Update Factor

The Congress could legislate the PPS update factor annually, potentially leading to substantial budgetary savings relative to current projections. The CBO baseline projections incorporate the common assumption that PPS rates will rise each year by the growth in the cost of the hospital market basket plus one-fourth of a percentage point--about 5 percent for 1986. Depending on various factors, such as cost-reducing technological advances, the Congress could decide to set the update factor at a lower level. For fiscal year 1986, the House Committee on Ways and Means and the Senate Committee on Finance have proposed to overrule the Secretary's decision to freeze the PPS rates and, instead, to provide a small increase--1 percent and 0.5 percent, respectively. Though these actions would increase outlays relative to the Secretary's decisions, there would be substantial savings relative to the CBO baseline--\$5.2 billion to \$5.9 billion, respectively, during the next three years.

This approach has drawbacks, however. Consistently setting the update factor below the increase in the cost of the market basket might gradually reduce the quality of care Medicare beneficiaries receive. Hospitals in financial distress, or those that serve predominantly Medicare patients, might be forced to cut back services or even to close. Moreover, high-cost but beneficial advances in treatment might be less available to Medicare patients than to others with private insurance.

### The Transition to National Payment Rates

Another important issue for the PPS is whether the transition to national urban and rural rates should continue as now scheduled. In particular, many critics have questioned whether these rates are appropriate standards for all hospitals in the system. Individual hospitals' costs have varied considerably in past years, the variations being related to factors such as the size of the hospital, scope of services, region of the country, size of the city, cost of goods and services, and whether there is a teaching program.

Because of concern that current rates do not reflect all legitimate cost differences, proposals have been made to delay the transition for some period, such as one or two years, to allow time for the completion of current research and data collection. In this way, the system could be refined before being fully implemented. Alternatively, the PPS rates could be permanently based on a combination of hospital-specific, regional, and national rates. One proposal would use 50 percent regional rates and 50 percent national rates. Others would blend national and regional, or national and hospital-specific rates on a DRG-specific basis, with the exact proportions depending on the variability of costs within each DRG.

Just as the current transition poses risks, so would any of the alternatives. Delaying the transition, or allowing hospital-specific costs to affect PPS rates permanently, would allow some hospitals that had been less efficient in the past to receive more than those that had achieved lower

costs. Moreover, these approaches might diminish the incentives for hospitals to reduce costs. Finally, there is no evidence at present that regional rates would be superior to national rates. Although there are significant differences in average hospital costs among regions, these may derive from factors that the system was explicitly designed to ignore (such as the practice patterns of physicians) or from factors that are beyond hospitals' control but that might better be handled through specific adjustments to the PPS rates.

A final alternative would be to continue the transition, but to expand the types of areas for which national rates are calculated. For example, a separate rate might be calculated for the largest Metropolitan Statistical Areas (MSAs), which consistently have had higher costs than either other urban areas or rural areas. Alternatively, separate rates might be calculated for central or inner cities that seem to have higher costs than suburban areas within the same MSA. This approach shares the drawback of using regional rates--namely, that some factors should be ignored and that others might better be handled through new or improved adjustments. Moreover, MSA and central city geographic definitions are rather arbitrary and do not necessarily correspond to the appropriate market area for hospitals.

#### Payments to Hospitals that Serve Disproportionately Large Shares of Low-Income Patients

Concern is widespread that hospitals serving disproportionately large shares of low-income patients (often called "disproportionate share" hospitals) are



placed at a disadvantage under the current PPS, which does not directly adjust for the potentially higher costs incurred in treating these patients. Preliminary evidence suggests, for instance, that low-income Medicare patients within a given DRG are more severely ill and more costly to treat than are higher-income beneficiaries. In addition, disproportionate share hospitals may incur extra operating and overhead costs in meeting the special needs of both elderly and nonelderly low-income patients. They may, for example, employ additional staff, such as nutritional technicians and language interpreters, or have special departments or facilities, such as social work services, that lead to higher average costs for Medicare patients.

The CBO has found that both a hospital's proportion of elderly patients who have low incomes, and its proportion of patients of all ages who have low incomes, are associated with significantly higher costs for treating Medicare beneficiaries. Moreover, these effects tend to occur beyond a threshold proportion of low-income patients, usually at about 15 percent of patients having low incomes, and are largest for urban hospitals with 100 beds or more. There is little or no increase in costs for small urban or for rural hospitals. 6/

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6. Statement of Nancy M. Gordon, Assistant Director for Human Resources and Community Development, Congressional Budget Office, before the Committee on Finance, Subcommittee on Health, United States Senate, July 29, 1985.

The cost of a disproportionate share adjustment could be financed in several ways. To avoid double payments, the indirect teaching adjustment could be reduced, since it already includes some allowance for the extra costs of treating low-income patients. Aggregate payments could then be allowed to expand to accommodate the remaining cost of the adjustment. Alternatively, the disproportionate share adjustment could be made without increasing budgetary outlays by reducing DRG payment rates for all hospitals or for particular groups of hospitals. For example, if urban hospitals only were eligible for the disproportionate share adjustment, then only urban rates might be lowered.

Both the House Committee on Ways and Means and the Senate Committee on Finance have proposed adjustments for disproportionate share hospitals. The Ways and Means Committee's plan would base the adjustment on the share of a hospital's patients who have low incomes and increase payments only for urban hospitals with 100 beds or more. The Finance Committee's plan would be based only on the share of elderly patients having low incomes, and it would be available to both urban and rural hospitals of 100 beds or more. In addition, the latter plan includes an adjustment for small hospitals with exceptionally large shares of low-income elderly patients.

#### The Indirect Teaching Adjustment

In the short run, the indirect teaching adjustment could be cut substantially while still serving its intended purposes of compensating hospitals for the

increased patient-care costs associated with teaching programs and with other factors not directly accounted for by the PPS. The CBO has estimated that an indirect adjustment of 8.4 percent (compared with the current adjustment of 11.59 percent) would be sufficient to take account of all cost factors not already considered in determining PPS rates. This technical correction would reduce payments by \$2.3 billion during fiscal years 1986-1988. If a specific disproportionate share adjustment were also legislated, a further reduction in teaching payments would be required to avoid double payment. Both the Ways and Means Committee's and the Finance Committee's bills would make further reductions--to 8.1 percent and 7.7 percent, respectively--which would be used to offset part of the cost of their disproportionate share proposals.

In the long run, especially if other changes to the DRG rates were enacted, the teaching adjustment might be reduced further. Findings from several ongoing research efforts to measure severity of illness might be used in conjunction with or in place of the DRG classifications.<sup>7/</sup> Moreover, other potential changes, such as separate PPS rates for large MSAs or central cities, would also affect the size of the teaching adjustment. To the extent that these and other changes improved the system's ability to account for systematic cost differences among hospitals, the teaching adjustment might be reduced to between 4 percent and 5 percent. The

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7. See, for example, the articles collected in the 1984 Annual Supplement of the Health Care Financing Review.

resulting savings could either be used to reduce the federal budget deficit or could be redistributed to all hospitals in the form of higher payment rates.

#### Expansion of the PPS to Cover Other Costs

The two major types of inpatient hospital costs not currently covered under the PPS are those for capital and for expenditures on medical education programs.

Capital. Though the Social Security Amendments of 1983 set up a system of prospective reimbursement for hospitals' operating costs, it did not change the method for reimbursing capital-related costs. Medicare's share of such costs as interest, rent, and depreciation expenses are still paid retrospectively, based on the proportion of costs attributable to Medicare patients in each hospital. These reimbursements for capital expenses account for about 6 percent to 7 percent of Medicare's payments to hospitals--roughly \$3 billion to \$4 billion in fiscal year 1986. Because of concern that too much has been spent on hospital facilities and equipment, and that the combination of prospective reimbursement for operating costs and retrospective payments for capital expenses provides even greater incentives for investment, the Congress made clear that it intended to consider ways of making capital reimbursement policy conform to the PPS.

One alternative would be to include all capital costs in the DRG rates by increasing each rate by a uniform percentage--based on a national

average for the percent of hospital expenditures attributable to capital. The major drawback to this approach is that, for any one hospital, expenses are "lumpy"--that is, large projects and expenditures occur infrequently. Therefore, immediate implementation of the uniform add-on would disadvantage those hospitals that have recently made large expenditures. Another approach would be to include only some capital costs in the DRG rates--such as those for equipment--but continue to pay retrospectively for the costs of constructing and renovating facilities. Although this method would alleviate the problems caused by varying liabilities for past projects, it would not provide incentives to limit future spending on large projects. Finally, capital expenditures could be rationed by establishing statewide limits for such spending, perhaps at a percentage of Medicare's payments to hospitals in a given state. This approach might improve targeting of funds to where the need is greatest, but many critics would oppose the expanded role of government in allocating capital.

Direct Medical Education. Also excluded from PPS since its inception are the direct costs incurred by hospitals for medical education--for example, residents' stipends, faculty salaries, and classroom costs. <sup>8/</sup> Interest in modifying the current reimbursement scheme stems from three concerns. First, retrospective cost reimbursement of any function provides

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8. More than 70 percent of direct medical education expenses reimbursed by Medicare is for graduate training of physicians. The remainder is for training in nursing and the allied health professions.

no incentive to economize. Second, the growing supply of physicians might call into question federal payments that support adding more to their numbers. Finally, up to half of direct medical education costs consists of items that are shared in common with other activities, so hospitals might increase their revenues by attributing more of the common costs to the education function.

One way to control Medicare's payments for direct medical education involves either continuing "reasonable cost" reimbursement, but subject to limits or freezes, or moving to a prospectively established total for each hospital's medical education payment or to a prospective rate per-resident. These options would accrue savings relatively slowly, because they could only lower the rate of increase on about 3 percent, or about \$1.5 billion, of Medicare's payments to hospitals.

Other approaches would deny or significantly reduce payments for particular groups of residents. These options, having somewhat greater savings potential, could be enacted either separately or in addition to the former type of option. For example, Medicare could pay differentially for residents in various specialties (for example, primary care versus other specialties), at various stages of training (for example, before versus after board certification), or of different backgrounds (for example, graduates of American versus foreign medical schools). In contrast to controls on reimbursements for all residents, however, the effects of the differential payment options on

particular groups of residents or hospitals would be correspondingly greater. Finally, if costs for training particular categories of residents were no longer reimbursed, budgetary savings could be increased further by dropping these groups from the intern and resident count on which the indirect teaching adjustment is based.

#### Other Issues

There are many other issues related to prospective payment that the Congress might address. Examples are inclusion of the hospitals currently exempted from the PPS, and control of costs in outpatient settings and skilled nursing facilities. There is not time to discuss these issues today, however.

#### **CONCLUSION**

Medicare's PPS represents a major step toward developing the mechanisms for controlling hospital costs and encouraging efficiency, but it is an extremely complicated system. As we learn more about the factors influencing hospitals' costs, the Congress is refining the system and seems likely to continue these efforts for some years hence. Moreover, the rapid pace of change in the health-care system and the aging of the population, to name only two of many influences, suggest that federal health policy will remain an important budgetary issue for the future.