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Before the Subcommittee on Health and the Environment
Committee on Interstate and Foreign Commerce
U.S. House of Representatives

May 21, 1979

There should be no release
of this statement before
its delivery, scheduled for
2:15 p.m. (E.D.T), May 21, 1979

Expenditures on hospital care have grown rapidly during the last decade. From 1968 to 1978, expenditures grew at an average annual rate of 15 percent, about 4 percentage points higher than the average rate of increase for expenditures on all consumer services. In reaction to this trend, the Administration proposed legislation in 1977 to constrain hospital costs. Although this bill was not passed by the Congress, the hospital industry undertook a voluntary cost containment program in 1978. The Voluntary Effort has been effective in moderating cost increases, but total hospital expenditures are likely to increase by about 14 percent in 1979, far above the industry's 1979 goal of an 11.6 percent increase.

This year, in another attempt to restrain hospital cost increases, the Administration sent to the Congress the proposed Hospital Cost Containment Act of 1979 (H.R. 2626). The proposal would set guidelines for increases in hospital expenditures and would impose revenue controls on hospitals that fail to keep within them. The guidelines--which are based on the inflation rate for hospital purchases, population growth, and an intensity-of-service factor--would allow hospitals to increase their expenditures by about 11.3 percent in 1979. Revenue controls would take the form of caps on increases in inpatient revenues per

admission. Several kinds of hospitals--including small, rural hospitals and those in states with effective mandatory state hospital cost containment programs--would be exempt from the proposed program.

Mr. Chairman, at your request the CBO is preparing an analysis of hospital cost containment issues, including an assessment of the Administration's 1979 proposal. Today I would like to summarize our analysis of that proposal, outline several modifications that could affect its performance, and discuss some possible alternative approaches the Congress may wish to consider.

EFFECTS OF THE ADMINISTRATION'S PROPOSAL ON HOSPITAL REVENUES AND ON INFLATION

The Administration's proposal would reduce the growth in hospital costs and save purchasers of hospital care significant amounts of money. The rate of growth of hospital revenues over the next five years would slow down from a projected average annual rate of 13.6 percent to about 11.4 percent. As a result, total savings from 1980 to 1984 would amount to approximately $31.7 billion. Federal Medicare and Medicaid payments would be about $13.4 billion lower than they otherwise would have been.

Savings resulting from the Administration's proposal would increase over time. During the first year of revenue controls, savings would be relatively modest--about $1.4 billion in total,

of which some $0.6 billion would be reduced federal outlays. Savings from revenue controls would increase rapidly, thereafter. By 1984, savings are projected to be $12.0 billion, or 11 percent of what total hospital revenues would be if current policies were maintained.

These savings would reflect declines in revenue for many, but not all, community hospitals. We estimate that, because of their characteristics or their performance relative to the guidelines, about 70 percent of all community hospitals and 56 percent of all hospital expenditures would be exempt from revenue restrictions in 1980. By 1984, only one-half of all community hospitals and less than one-third of all hospital expenditures would be exempt from control.

The bill would also reduce overall inflation. Although the increase in the Consumer Price Index (CPI) through fiscal year 1980 would be largely unaffected, the cumulative increase through fiscal year 1981 would be reduced by about 0.1 percentage point, and the total cumulative increase through fiscal year 1984 would be reduced by about 0.4 percentage point.

EFFECTS OF THE PROPOSAL ON OTHER CRITERIA

The Administration's proposal would save substantial sums of money. Furthermore, it could affect quality of care, hospital

efficiency, access to care, and the quantity of "red tape." Whether or not the proposal would fairly treat different types of hospitals is also an issue.

Quality of Care. The Administration's proposal would probably not lower the average quality of hospital care from its 1978 level. Since the revenue caps would be based on increases in the prices hospitals pay for their purchases, hospitals would be able to buy the same goods and services in future years. Accordingly, the quality of care would not fall.

By limiting increases in the intensity of services delivered, the proposed program might impede future improvements in quality, but little is known about the relationship between intensity and quality. Since real revenue growth per admission (that is, increases in excess of those caused by inflation) would be substantially reduced by the proposal, hospitals would not be able to spend as much on new services as they have in the past, unless they reduce less valuable services that are currently provided.

Efficiency. The Administration's proposal would provide significant incentives for hospitals to cut waste and improve efficiency. In order to maintain their intensity of services and at the same time meet the revenue caps, hospitals would have to find areas in which to increase productivity. Furthermore, the

proposal attempts to compensate for differences in efficiency among hospitals by permitting low-cost hospitals to increase revenues more rapidly than high-cost hospitals. But unless efficiency adjustments could account for the diversity of cases among hospitals, high cost might mistakenly be interpreted as an indicator of inefficiency.

The mandatory controls would not necessarily be limited to high-cost, inefficient hospitals because the guidelines do not take into account the fact that a hospital's rate of increase in expenditures in a single year may not be related to its costs, let alone its efficiency.

Access to Care. In general, the Administration's proposal would not cause hospitals to limit access to care. It could, however, encourage hospitals to deny care to high-cost patients. If a hospital turned away a patient who required a relatively long stay or a large number of ancillary services, "dumping" that patient would reduce expenditures more than it would reduce allowed revenues, and thus would ease the constraint of the revenue controls. The bill could be modified to alter a hospital's revenue cap on the basis of changes in its patient mix. This would, however, increase the complexity of the proposal and the amount of red tape.

The effect of the proposal on access to hospital care would depend greatly on how the revenue caps were adjusted for additional admissions. The proposal leaves the form of the admissions adjustment to the discretion of the Secretary of Health, Education, and Welfare. An adjustment to the revenue caps is necessary because hospital costs normally rise or fall less than in proportion to the change in admissions. Without such an adjustment, controlled hospitals would have strong incentives to increase admissions, and thereby reduce savings. But an overly strict adjustment that would not allow hospitals the incremental costs of additional admissions would cause hospitals to restrict admissions.

Red Tape. Considering the magnitude of the task of controlling hospitals' total revenues, and considering the savings resulting from the Administration's proposal, the proposal would minimize federal intervention and red tape. The relatively lenient treatment of states that have their own hospital cost containment programs would help to minimize federal intervention in the economy. The Administration's approach would not require the government to dictate or review individual decisions about hospital spending. Hospitals would simply be subject to an overall revenue constraint, and they would be left to decide on their own how to meet it. This minimizes federal intervention and gives discretion to hospital administrators and medical staffs--those in the best position to make the choices about how to comply with the constraint.

Fairness. The Administration's proposal, as introduced, would result in different treatment for many similar hospitals. The principal reason for this uneven treatment is that the proposed plan is extremely sensitive to the year-to-year fluctuations in hospital expenditures. An individual hospital's expenditure increases vary a great deal from year to year, and the rate of increase during one year has little relationship to the rates in other years. Because of these erratic spending patterns, hospitals that met the guidelines one year would not necessarily be those with the lowest long-term growth rates in expenditures or those with more efficient, lower-cost practices. Furthermore, a one-year guideline would result in hospitals with similar long-term expenditure increases being treated quite differently. Two hospitals with similar expenditure growth over a period of years may have different expenditure increases in any one year, and the Administration's bill could result in one being placed under revenue controls but not the other. Once under controls, the one-year base period could also result in uneven treatment of similar hospitals. Because of the fluctuating expenditure patterns of hospitals, two hospitals that have similar revenues over a period of years may have a different level of revenues in any one year. Under controls, revenues allowed the hospital that had the lower revenues in the base year would be lower than those allowed the other hospital.

POSSIBLE MODIFICATIONS IN THE ADMINISTRATION'S PROPOSAL

The Administration's proposal could be modified to alter some of its effects on quality growth and to enhance its fairness. Such changes would, however, reduce savings. For example, to allow some real growth in hospital revenues, the revenue caps could be raised by one or two percentage points. Such an adjustment would allow service intensity to grow, but savings would fall. Allowing a one percentage point increase for intensity growth would reduce total 1980-1984 savings from approximately $31.7 billion to about $26.5 billion.

Lengthening the voluntary guideline period and the base period to two years would ensure more uniform treatment of similar hospitals. Such a change would also result in more accurate selection of hospitals with higher long-term rates of expenditure growth. But, because a two-year guideline in 1979 and 1980 would postpone implementation of the revenue controls until 1981, fiscal year 1980 savings would fall to near zero and overall five-year savings would fall by about $3 to $5 billion.

Another modification would be to use the same criterion--that is, revenues per admission--for both the voluntary guidelines and the mandatory caps. This modification would increase the uniformity with which hospitals are treated during both stages of the program without having a significant effect on savings.

MAJOR ALTERNATIVES TO THE ADMINISTRATION'S PROPOSAL

There are two major alternatives to the general approach of the Administration's proposed bill. The first would be to rely on voluntary efforts by hospitals and physicians to contain costs. The second would be to take steps to increase the competitiveness in the medical sector.

As I mentioned earlier, a voluntary effort to constrain cost increases was undertaken by the hospital industry at the end of 1977. Although there is substantial uncertainty about the effect of this effort, it appears that hospital costs were 1.5 percent lower in 1978 than they otherwise would have been. The voluntary approach depends on physicians and hospital administrators acting in ways that are in the interests of the medical care sector as a whole but against their individual interests. Although individual interests appear to have been partially put aside thus far, voluntary efforts are unlikely to be a long-term solution to the problem of rising medical costs.

Increasing the competitiveness in the hospital sector is another approach. In theory at least, stimulating competition can restrain cost increases and avoid the inevitable distortions and inefficiencies that accompany regulation. Two possible changes that would increase competition are:

- o Reducing the use of third-party (usually insurance company) payment, and
- o Substituting prepayment for fee-for-service modes of compensating health care providers.

Reducing the use of third-party payment could make hospitals more competitive by making the patient more conscious of hospital prices. This change could be accomplished without regulation by reducing current tax subsidies for the purchase of health insurance. One option would be to place a dollar limit on the amount of the premium that can be deducted from employers' and employees' income taxes.

Prepayment for medical services is another approach for reducing medical expenditures by fostering competition. The advantage of prepayment is that physicians have financial incentives to decrease rather than to increase services and to provide necessary services as inexpensively as possible. Admitting patients to less expensive hospitals is encouraged, and this causes hospitals to feel more competitive pressure. Prepayment also makes the comparative costs of medical care more apparent to consumers. One method of encouraging prepayment would be to require employers who offer their employees health insurance to offer a choice of plans with equal subsidies. This would expand the opportunities for prepaid health plans to compete with traditional insurers.

While competition is attractive as a solution, its potential impact is so far into the future and so uncertain that it is not now a viable alternative. Whatever the desirability of these options for increasing competition, it is unlikely that they would have much impact during the next five years. Reducing "first dollar" insurance coverage to any significant degree would take many years. Still more time would pass before hospitals would respond to the additional competitive pressures. Even further into the future is the potential that a large enough proportion of the population would be enrolled in prepaid plans to make a dent in hospital costs.

Consequently, the Administration's approach should be weighed according to its own merits, rather than as an alternative to competition. Indeed, adoption of the Administration's regulatory approach need not preclude setting in motion the forces that might increase competition in the future. A sunset provision might prompt an assessment of the state of competition in advance of any renewal of a regulatory approach.