CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Peter R. Orszag, Director

June 6, 2008

Honorable Joe Barton
Ranking Member
Committee on Energy
and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

As you requested, I am providing additional information regarding CBO's estimate for a provision included in H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2008, as passed by the House of Representatives on March 5, 2008. That provision would modify the circumstances under which a physician can refer patients to a hospital in which the physician has a financial interest.

Under current law, physicians are prohibited from referring patients to a provider of health care services in which the physician has a financial interest. There are exceptions to that prohibition, however, for referrals to a hospital that serves predominantly rural populations or to a hospital in which the physician's financial interest is in the whole hospital (in contrast to an interest in some discrete component of the hospital).

Section 106 of H.R. 1424 would prohibit new physician-owned hospitals from participating in Medicare, beginning 18 months after the date of enactment. It also would require existing physician-owned hospitals to meet certain requirements to continue qualifying for an exception from the current prohibition. The new requirements would include specific limits on the percentage of the hospital that physicians may own and on the allocation of financial returns on those investments, and would have the effect of limiting the number and size of physician-owned specialty hospitals. H.R. 1424 also would limit increases in the number of operating rooms and beds at existing physician-owned hospitals.

CBO estimates those changes would reduce Medicare spending by reducing the number of hospital services provided to Medicare beneficiaries and by shifting the provision of some services to settings where payment rates are lower than for services furnished in hospitals.

We estimate that enacting section 106 would result in Medicare savings in the fee-for-service sector of $0.4 billion over the 2009-2013 period and $1.8 billion over the 2009-2018 period. Changes in spending in the fee-for-service sector affect payment rates for Medicare Advantage plans. As a result, the estimated budgetary impact is about 30 percent larger than the estimated change in fee-for-service spending. Thus, CBO estimates the provision would reduce Medicare spending by $2.4 billion over the 2009-2018 period.

This estimate is lower than an estimate CBO prepared last year for a similar provision of H.R. 1362. Since that previous estimate was prepared, we have obtained additional information about a number of factors that affect the estimated savings. Consequently, the current estimate reflects the following adjustments:

- We anticipate that fewer hospitals would be affected by the prohibition on the participation of new physician-owned hospitals in Medicare because the assumed effective date for the moratorium would be about one year later than that assumed in our estimate for H.R. 1362;

- Based on information provided by representatives of the physician-owned hospitals, we have concluded that such institutions provide few ancillary services and have therefore lowered our estimate of the savings from reduced use of ancillary services; and

- We have estimated savings that would result from a reduction in the number of "index events" (that is, procedures like spinal fusion or cardiac surgery that represent the primary reason someone would go to a hospital). Earlier research by the Medicare Payment Advisory Commission (MedPAC) had suggested that opening physician-owned specialty hospitals is associated with an increase in the number of index events.[1] Although we considered that MedPAC analysis in preparing last year's estimate, that estimate did not assume a change in the number of index events because we did not have sufficient empirical

1. Medicare Payment Advisory Commission, "*Physician-Owned Specialty Hospitals Revisited*," August 2006.

evidence to support such a judgment. However, more recent research has corroborated the finding that opening physician-owned specialty hospitals is associated with an increase in the number of index events.[2] Based on the accumulation of similar findings, we now expect that the reduction in the number of physician-owned specialty hospitals that would result from enacting this provision would decrease the number of index events by 20 percent in orthopedic or surgical specialty hospitals and by 6 percent in other hospitals (primarily cardiac hospitals).

CBO's projections of the number of physician-owned hospitals and the amount of Medicare payments to those hospitals were based on information reported in several studies by the Government Accountability Office, agencies of the Department of Health and Human Services, and RTI International.[3]

Under current law, CBO estimates that Medicare payments to hospitals that would not participate in Medicare as a result of the new requirements will total $17 billion over the 2009-2018 period. (That amount includes payments to existing hospitals for services that, under current law, will be furnished to patients who will be treated in beds or operating rooms that would not be added as a result of the legislation.) Orthopedic or surgical specialty hospitals account for about $6 billion of that total. Cardiac and other hospitals account for the remaining $11 billion.

CBO estimates that implementing the legislation would reduce Medicare payments by $1.1 billion over the 2009-2018 period for patients who will be

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2. See, for example, Nallamothu, Rogers, Chernew, et al., "*Opening of Specialty Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries*," JAMA, March 7, 2007, and Mitchell, "*Utilization Changes Following Market Entry by Physician-owned Specialty Hospitals*," Medical Care Research Review, August, 2007.

3. See the following studies by the Government Accountability Office: "*Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*," GAO-03-683R, April 18, 2003; "*Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*," GAO-04-167, October 2003; "*Specialty Hospitals: Information on Potential New Facilities*," GAO-05-647R, May 19, 2005. See also: Department of Health and Human Services, "*Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*," 2005; RTI International, "*Specialty Hospital Evaluation*," CMS Contract No. 500-00-0024, September, 2005; Centers for Medicare & Medicaid Services, "*DRA Report to Congress*" (the report and related documents are available at http://www.cms.hhs.gov/physicianselfreferral/06a_dra_reports.asp), August 8, 2006.

treated under current law at physician-owned orthopedic or surgical specialty hospitals. A reduction in the number of index events accounts for $0.4 billion of that total, reflecting CBO's estimate that there would be a 20 percent reduction in such events. Lower use of ancillary services for patients who would instead be treated in community hospitals accounts for less than $50 million of that total, while lower prices for outpatient surgical services that would be furnished in ambulatory surgical centers or other nonhospital settings account for nearly $0.7 billion in savings. (We estimate that the price differential would be about 20 percent.)

CBO estimates that implementing the legislation would reduce Medicare payments by $0.7 billion over the 2009-2018 period for patients who will be treated under current law at cardiac and other physician-owned hospitals. A reduction in the number of index events accounts for $0.6 billion of that total, reflecting CBO's estimate that there would be a 6 percent reduction in such events. Lower use of ancillary services for patients who would instead be treated in community hospitals accounts for the remaining $0.1 billion. We estimate that there would not be significant savings for outpatient services for cardiac patients who would be treated in ambulatory surgical centers or other nonhospital settings.

In summary, we estimate that savings over the 2009-2018 period would total:

- $1.0 billion from a reduction in the number of index events,

- $0.1 billion from lower use of ancillary services for patients who would be treated in community hospitals instead of physician-owned facilities, and

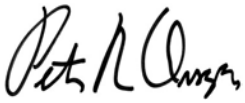
- $0.7 billion from lower prices for outpatient services that would instead be furnished in ambulatory surgical centers and other nonhospital settings.

I also would like to correct a statement in a letter we sent to Congressman Johnson on August 17, 2007, regarding CBO's estimate for the physician-owned hospital provision in H.R. 1362. In that letter, we stated that reductions in the use of outpatient services accounted for $2.3 billion of the $2.9 billion of estimated savings over the 2008-2012 period, and that changes in payment rates for services that would be furnished in ambulatory surgical centers

accounted for the remaining $0.6 billion. That explanation inadvertently reversed the impact of the two effects. In fact, the larger savings in our estimate last year ($2.3 billion) were from the lower payment rates that would apply to ambulatory service centers.

I hope this information is helpful to you. We would be happy to review the specific details of our estimate with you or your staff. The CBO staff contact for further information is Shinobu Suzuki.

Sincerely,



Peter R. Orszag
Director

cc: Honorable John D. Dingell
Chairman

Honorable Sam Johnson

Identical letters sent to the Honorable Jim McCrery, the Honorable Jon Kyl, the Honorable Mike Crapo, the Honorable Kay Bailey Hutchison, and the Honorable John Cornyn.