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Under the First Concurrent Resolution on the Budget for 1983 (H. Con. Res. 352), passed by the House last week, significant reductions in spending for Medicare would be required in fiscal years 1983, 1984, and 1985. Since comparable reductions would also be required under the version passed by the Senate, this Committee soon will likely be considering program changes to meet a budget reduction target.

My testimony today will discuss some of the broad options the Committee has in meeting these targets. Its major point is that, given the magnitude of the savings called for, a reduction in the underlying growth in medical care costs is essential if substantial reductions are to be avoided in the degree of financial protection that Medicare provides to the aged and disabled.

BACKGROUND

The spending cuts called for in the budget resolutions respond to a bleak long-term budget outlook. Despite a projection of moderate economic recovery, the CBO forecasts increasing deficits if current policies are unchanged. By 1987, without changes in tax laws or spending programs, the deficit is projected to reach $250 billion, and could be much higher if the economy's performance is worse. With Medicare accounting for 9 percent of federal spending by that year, pressures to restrain growth in outlays in that program are likely to continue.

Even in the absence of general budget pressure to curb Medicare spending, declining balances in the Federal Hospital Insurance (HI) Trust

Fund later in this decade will focus attention on changes in Medicare. Under current policies, the HI Trust Fund is likely to become exhausted by the late 1980s. The basic problem is that spending for Medicare is growing much faster than the earnings that are taxed to pay for it.

Rapid increases projected for Medicare spending reflect two factors--the aging of the population and the rising costs of medical care. Not only is the proportion of the population aged 65 and over increasing, but the average age for this group is increasing as well, and medical costs for the elderly rise sharply with age.

Since Medicare pays for medical services that are purchased in the private sector, rising medical care costs increase Medicare outlays automatically. After adjusting for general inflation, per capita medical care spending among the general population increased by 124 percent between 1965 and 1980--or at an annual rate of 6 percent in real terms--and this trend is projected to continue.

Since the aging of the population cannot be changed, controlling growth in Medicare spending without cutting benefits substantially requires taking steps to control medical care cost increases. Two major options to contain costs are available--increased cost-sharing by beneficiaries, and changes in the manner in which hospitals and physicians are reimbursed for services by Medicare and other third-party payers.

INCREASED COST SHARING

Increased cost sharing--that is, an increase in the proportion of charges paid by Medicare beneficiaries--would tend to reduce the use of medical services and put downward pressure on prices. There would, of course, be some loss of financial protection against unavoidable medical expenses. Critics also contend that it would cause patients to forgo important medical services, especially patients with low incomes; however, varying the degree of cost sharing with recipients' incomes would mitigate such an effect.

Private Supplemental Insurance

If increased cost sharing is to be pursued as a cost containment policy, three issues must be addressed. The first concerns private supplemental coverage. Since over half of Medicare beneficiaries are covered by private supplemental plans (often referred to as "Medigap" policies) and another seventh receive Medicaid, effective cost sharing would require that some beneficiaries drop these policies.

One way to reduce reliance on these policies would be to reduce the current large implicit subsidy provided by Medicare to the purchasers of private supplemental plans. These plans reimburse their beneficiaries for Medicare's deductibles and coinsurance, and thus tend to increase the use of Medicare services. Since Medicare pays the bulk of the bills for these additional services, the supplemental coverage works to increase federal

outlays. Taxing the premiums of supplemental policies at a rate of about 35 percent would cause the policyholders to pay the full costs of their private coverage, and reduce fiscal year 1983 budget deficits by $2.5 billion.

Varying Cost Sharing By Provider

The second issue concerns giving people incentives through cost sharing to choose lower-cost hospitals. Under current law, Medicare requires the beneficiary to pay the same amount no matter which institution is used, so that there is no incentive to choose a lower-cost hospital. Having the deductible and coinsurance depend on a hospital's allowable costs per day, possibly adjusted for local wage rates and the hospital's case mix, would increase competition among hospitals to keep costs down, and result in more cost containment for a given amount of cost sharing.

Varying Cost Sharing By Recipients' Incomes

The third issue is whether the degree of additional cost sharing in Medicare should vary with the recipients' incomes. If such variation were restricted to hospital services and a relatively crude test employed, administration would not be too difficult. For example, 10 percent coinsurance could be required for the second through thirtieth hospital days in an episode of illness, but persons with incomes below a certain level could apply to have this coinsurance waived. Some favor this approach as a way to make greater use of cost sharing without harming the needy, but others object to moving Medicare away from social insurance principles.

REIMBURSEMENT CHANGES

Another approach to containing costs would be to change the way Medicare reimburses hospitals and physicians so as to alter the incentives faced by these providers.

Hospital Reimbursement

Opportunities for cost containment are the greatest in hospital reimbursement because the existing system is so devoid of favorable incentives. Medicare reimburses hospitals on the basis of incurred costs, so that they automatically receive reimbursement increases whenever their costs increase. Another reason is that Medicare and Medicaid patients account for a particularly large proportion of hospital revenues.

Prospective Rates. Paying hospitals on the basis of prospective rates, where the payment is set in advance and not adjusted to reflect incurred costs, would change hospital incentives, inducing them to contain costs. Since those hospitals that are able to reduce their costs would not suffer financially, and indeed could gain from it, prospective payment offers the possibility of large savings in Medicare outlays over time. Prospective rates could reasonably be set to increase two percentage points per year more slowly than would Medicare reimbursements under current policies. In this case, savings would amount to $760 million in 1983, growing to $3 billion in 1985, and $6 billion in 1987. Prospective payment could increase federal outlays, however, if the rates were inadvertently set too high.

Prospective payment would involve some difficult technical issues, but a number of states and private organizations have pursued it and succeeded in containing costs. The principal difficulty stems from the need to set a different rate for each hospital, one that reflects the mix of patients treated and local factors that affect costs. Nevertheless, from 1976 to 1980, community hospital expenditures per capita in the six states with mature prospective reimbursement systems increased at an annual rate of 10 percent per year, compared with 14 percent in the rest of the country.

A negative aspect of prospective rates for some is that, even though it works through incentives, it is a regulatory system. The agency setting the rates could set them too high or too low, and the rates might inadequately reflect legitimate cost differences among hospitals. In addition, the conflict between the well-insured patient demanding the best possible care and the hospital under pressure from its payers to use services more judiciously could lead to some shifting of service delivery outside of the sector where rates are set prospectively.

Reimbursement Limits. A partial step in the direction of prospective payment is to place limits on reimbursements of incurred costs. For those hospitals whose reimbursements would have been higher than the limits, incentives to contain costs would be established. Medicare has some experience with reimbursement limits, in that it limits payments for routine costs under Section 223 of the 1972 amendments to the Social Security Act.

Reimbursement limits have the advantage of generating greater short-term savings because reimbursement reductions to some hospitals would not be partially offset by reimbursement increases to others. On the other hand, reimbursement limits would provide weaker incentives to contain costs than prospective rates, so their long-term potential for budget savings would be less. Prospective rates would change the incentives for all hospitals rather than only those expecting to exceed the limits, and rewards for cost reduction would not stop once the reimbursement limit was reached.

Setting the Rates or Limits. Whether prospective rates or reimbursement limits were pursued, the method of setting them must be chosen. Essentially, hospitals could be compared with their peers, as in the "Section 223" methodology used today, or rates could be set according to Medicare reimbursements during a base period, as in the recent proposal by the American Hospital Association, or the two methods could be combined.

The advantage of peer comparisons is that penalties are directed only at those hospitals judged to be relatively inefficient. A disadvantage is that our technical ability to make the peer comparisons might not yet be commensurate with the task, so that inequities among hospitals could result.

Moreover, when used to set reimbursement limits, peer comparisons tend to change the incentives of a smaller proportion of hospitals, thus limiting the potential for cost containment, compared with limits based on a

past period. For example, only 25 percent of hospitals will be affected in 1982 by the recently tightened Section 223 limits. The potential for large budget savings is also reduced by peer comparison, since only a minority of hospitals would get lower reimbursements. In contrast, limits or rates based on prior reimbursements would spread the burden more evenly among hospitals, so that larger savings could be obtained.

Combining the two methods is feasible and has some advantages. For example, the Congress might extend the current Section 223 limits from their current coverage of routine costs to coverage of all operating costs. This would extend incentives to contain costs to ancillary services, where much of the recent increase in costs has taken place. But since techniques for adjusting for diagnostic mix are controversial and relatively untested at this point, expanded Section 223 limits might be set relatively high initially. The remainder of any budget savings goal could be achieved by either a prospective rate or a limit based on 1981 or 1982 reimbursements. As techniques to adjust for case mix differences improve with experience, more emphasis could be placed on peer comparisons.

Which Payers Should Be Included? Perhaps the most important issue to be faced by the Congress when it considers changes in hospital reimbursement is whether to limit them to Medicare (and indirectly Medicaid), or to apply them to all payers.[1] A Medicare-only system certainly intrudes less

1. Under current law, Medicaid hospital reimbursements cannot exceed Medicare's, so in those states which have not implemented an alternative reimbursement method, Medicaid reimbursements would be affected by changes in Medicare.

into the private sector, reflecting only prudent purchasing on behalf of the government, and is simpler administratively. On the other hand, it would result in less cost containment and pose risks to beneficiaries' access to hospital care.

Less cost containment would be achieved by a Medicare-only system because of the ability of hospitals to make up some of the reimbursement reduction by raising charges to private patients, most of whom are well insured. Such "cost shifting" would be limited, however, because the large proportion of hospital revenues accounted for by Medicare and Medicaid patients--about 45 percent over all community hospitals--would preclude the shifting of all of the reimbursement reduction and thus leave some incentives to reduce costs. Within a Medicare-only system, prospective rates would probably result in less cost shifting than reimbursement limits, because they would offer hospitals greater rewards for containing costs.

Reimbursement reductions applying only to Medicare and Medicaid could reduce beneficiaries' access in two ways. First, some hospitals might turn away public patients because private patients would be willing to pay more. Second, some hospitals with predominantly Medicare and Medicaid caseloads would lose out in the competition for capital financing to hospitals with relatively more favorable financial prospects.

Physician Reimbursement

Reforms in physician reimbursement could yield significant budget savings, but an important part would come at the expense of beneficiaries rather than physicians. Spending by the Supplementary Medical Insurance (SMI) trust fund, much of which is for physician services, totalled $16.8 billion in fiscal year 1981, and has been growing rapidly. Since physicians are permitted to collect from patients the amounts of fees that exceed what Medicare judges to be reasonable--which they do for roughly half of claims--further reductions in reimbursement might often be passed on to the beneficiaries. Requiring physicians to accept Medicare reasonable charges as payment in full might be a prerequisite for using reimbursement policy to control the costs of physicians' services, although some are concerned about the reduction in access to care that might result.

One possible direction for changing physician reimbursement policy would involve concentrating any reductions on services for which reimbursement is relatively generous. Some studies have indicated that physician time spent performing surgery and diagnostic procedures is much more highly remunerated than time spent examining and counseling patients. Similarly, time spent with patients in the hospital is reimbursed at higher rates than time spent in the office. Such differences in relative fees, which are automatically reflected in Medicare's reimbursement system, probably influence the mix of services and the setting in which they are performed. Concentrating reimbursement reductions on those services compensated most highly might do more to reduce total costs than a uniform reduction.

CONCLUSION

Making long-term reductions in Medicare outlays without cutting substantially into in benefits will require control of the growth in overall medical care costs. If cost sharing is to be used to contain costs, public policy toward private supplemental coverage will have to be reconsidered. In addition, changes in hospital reimbursement policies, particularly the use of prospective rates, could potentially reduce costs significantly. A key issue here is whether to extend the policy changes to payers other than Medicare and Medicaid.

In considering options for fiscal year 1983, an important criterion might be whether they would make it easier to pursue cost containment in the future. For example, expanded Section 223 limits, while not capable of affecting many hospitals' incentives initially, might make a sophisticated prospective payment system (or an indemnity benefit system, for that matter) more feasible in the future.