STATEMENT BY

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Mr. Chairman, I am pleased to be here to discuss the problem of the rising cost of hospital care. My testimony will analyze the reasons for the problem, the effectiveness of current efforts to control it, and several options for federal action.

BACKGROUND

Hospital costs, or more specifically total inpatient expenditures, have been increasing rapidly for many years. From 1970 to 1977, inpatient expenditures in community hospitals grew at an average annual rate of 14.6 percent. After a marked slowing in 1978 and 1979, growth accelerated rapidly and reached an annual rate of 18.5 percent for the first seven months of 1981 (see Table 1).

This rapid growth in hospital costs has led to substantial increases in federal spending for Medicare and Medicaid, of which roughly 60 percent is for hospital care. Federal outlays under these programs for hospital care totaled approximately $32 billion in fiscal 1981, an increase of $6.3 billion from 1980. For every 1 percent increase in total hospital costs, federal outlays increase by roughly $300 million.

Under current policies, rapidly rising hospital costs and increasing federal outlays are likely to continue. For example, adjusting for the cuts made in the Omnibus Budget Reconcilation

TABLE 1. ANNUAL PERCENTAGE INCREASES IN INPATIENT HOSPITAL EXPENSES, HOSPITAL INPUT PRICES, ADMISSIONS, AND SERVICE INTENSITY, 1970-1981[a]

Calendar Year	Inpatient Expenses	Input Prices	Admissions	Net Intensity[b]
1970	17.2	6.5	6.3	3.5
1971	10.6	5.2	0.4	4.7
1972	11.6	5.0	2.6	3.6
1973	11.3	5.7	3.5	1.7
1974	15.5	9.1	3.7	2.1
1975	16.8	11.0	0.3	4.9
1976	18.7	8.7	3.4	5.6
1977	15.2	8.0	2.5	4.1
1978	12.3	8.7	0.4	2.9
1979	13.3	9.4	2.7	0.8
1980	16.8	12.7	2.9	0.7
1981[a]	18.5	13.4	0.9	3.6
1970-1981[a] (Average annual increase)	14.8	8.6	2.5	3.2

SOURCES: Inpatient expenses, input prices, and admissions based on data from the American Hospital Association. Net intensity calculated as a residual.

a. Data for 1981 are annual rates based on the first seven months only.

b. A residual category of expenditures not accounted for by the input prices or admissions factors. Along with additional resources applied to patients' care, it may include productivity changes, changing patterns in use, errors in the measurement of input prices, and time lags between input price increases and expenditure increases.

Act of 1981 (P.L. 97-35), the Congressional Budget Office (CBO) projects that Medicare outlays for hospital care will rise at an average annual rate of 14 percent through 1986. It is expected that these projections will be even higher when adjustments for recent hospital cost increases are made. Besides increasing the size of the budget deficit, these rapidly increasing costs contribute to the dangerously low reserves anticipated in the combined Social Security trust funds by the mid-1980s. In addition, rising claims under the Medicaid program might lead states to cut back on eligibility and benefits even further.

Although the high rates of growth in hospital costs are due primarily to increases in prices faced by hospitals, inflation does not explain the most recent surge in hospital expenditures. In the past year, the cost of hospital care has increased more than the Hospital Market Basket, which measures changes in the prices of goods purchased by hospitals. This index increased by 12.7 percent in 1980 and 13.4 percent through July of this year, whereas inpatient expenditures increased by 16.8 percent and 18.5 percent in these respective periods.

Two factors explain why the costs of hospital care are growing faster than the prices of goods purchased by hospitals--the number of patients and the volume of services per patient.

The number of admissions increased at a rate of 2.5 percent per year during the 1970-1980 period. About half of this is explained by population growth and the aging of the population.

Increases in the volume of services per patient, frequently referred to as "intensity," also explain part of the real growth in hospital expenditures. Each year, the average patient receives a larger number of increasingly sophisticated diagnostic and therapeutic services during a hospital stay. For example, after adjusting for price changes, the average heart attack patient spent 86 percent more for ancillary services in 1971 than in 1964.[1]

Significant reductions in hospital costs would have to involve either reductions in admission rates or a slowdown in the growth of intensity. Although increases in efficiency--that is, the use of less labor, capital, or materials to produce a certain array of services--could contribute to reducing these costs, it seems likely that the savings to be gained would be much smaller than those associated with decreased admissions or slower growth in intensity.

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1. Anne A. Scitovsky, "Changes in the Use of Ancillary Services for 'Common' Illness," in Stuart H. Altman and Robert Blendon, editors, Medical Technology; The Culprit Behind Health Care Cost? (U.S. Department of Health, Education and Welfare, 1979), p.41.

CURRENT EFFORTS TO CONTROL HOSPITAL COSTS

Concern with hospital costs in recent years has led to a variety of efforts to restrain their growth. The Carter Administration proposed the Hospital Cost Containment Act of 1979, which would have placed limits on hospital revenue increases. The proposal was defeated in the House of Representatives. On the basis of estimates prepared by the CBO during 1979, passage of the bill in that year would have led to 1981 federal savings of $920 million. Annual savings would have increased to $4.1 billion by 1984.

Three major cost containment programs are in place today:

- State-level cost control programs;
- Certificate-of-need review; and
- The Voluntary Effort.

State-level cost control programs have been quite successful in recent years in reducing growth in expenditures on hospital care. These programs vary significantly from one state to another, but in general they limit hospital revenue by setting in advance either maximum rates, total revenues, or revenues per unit of output. Only six states have mandatory state-run programs, but a number of other states have programs operated by private organizations such as Blue Cross plans or state hospital associations. The six states with mandatory cost control programs experienced a 48 percent increase in per capita community hospital

expenditures from 1976 to 1980, compared to a 68 percent increase for other states. The Medicaid provisions in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) are likely to encourage the six state-run programs to continue in their efforts to contain costs, but do not provide an incentive for additional states to adopt programs.

Certificate-of-need (CON) review addresses cost containment by attempting to prevent capital projects that would lead to excess capacity and result in excessive rates of hospital use. Under these programs, which are operated at the state level but required by the federal health planning program, state and local planning agencies review proposed hospital investments and approve those they decide are needed. Studies of state CON programs have not, however, offered encouraging results regarding cost containment.

The Voluntary Effort, which relies on appeals to hospitals to hold down Increases in their costs, appears to have been briefly successful. In 1979 and the first half of 1980, average quarterly increases in intensity were at an annual rate of about 0.5 percent, a rate considerably lower than the long-term average rate of 3.2 percent. But since mid-1980, the rate has averaged 2.6 percent.

This apparent weakening of the Voluntary Effort is not surprising. Voluntary approaches are unlikely to provide a long-term solution to the hospital cost problem. Their success requires physicians and hospital administrators to behave in ways contrary to their individual interests. The reduced threat of federal revenue controls has probably also weakened the ability of the Voluntary Effort to affect hospital behavior.

While the Voluntary Effort appears to be weakening, hospital costs are still probably lower than they would have been in the absence of the program. To the extent that the Voluntary Effort continues to weaken, a potential exists for more bad news about rising hospital costs.

OPTIONS TO CONTROL HOSPITAL COSTS

Additional options to slow the rise in hospital costs include:

- Increased reliance on market forces;
- Federal limits on hospital revenue or Medicare reimbursements; and
- Encouragement of more state-level cost containment efforts.

Increased Reliance on Market Forces

Increasing the impact of market forces on health care could lower hospital use and reduce intensity growth. For example, limiting the amount of employer contributions to health benefit plans that can be excluded from income and payroll taxes to $120

per month would induce many to economize on health insurance. Having to pay the last dollars of health insurance premiums out of after-tax income would cause employers to seek more cost sharing in health insurance policies and lead them to encourage increased enrollment in Health Maintenance Organizations (HMOs). Cost sharing has been shown to reduce rates of hospital use and to slow growth in intensity. Health Maintenance Organizations are able to achieve lower rates of hospital use.

While this option would contribute to slowing the rise of hospital costs in the long run, it would contribute less to solving the short-run problem. Indeed neither Congressman Gephardt's bill (H.R. 850) nor Senator Durenberger's bill (S. 433) would become effective until calendar year 1984. Many predict that changes in benefit packages reflecting the new incentives, and development of more efficient health care delivery systems, would take many years to accomplish. Moreover, the Medicare and Medicaid populations, which account for about 36 percent of hospital revenues, would not be greatly affected by most "pro-competition" proposals, at least initially. Thus, the problem of rapidly increasing Medicare and Medicaid outlays over the next few years would have to be dealt with in other ways.

Limiting Revenue or Reimbursements

The second option would constrain hospital costs through the supply side rather than the demand side. Each hospital would face a ceiling, set in advance, either on total inpatient revenues or on revenues per admission. In response to having its revenues limited, a hospital would have to lower its expenses or find its net revenue reduced. While this option is clearly regulatory, it involves much less detailed management of institutions by government than most examples of regulation.

This approach has the potential of getting faster results then demand-side approaches such as competition. Rather then waiting for patients to balk at higher prices, hospitals would get an immediate signal from revenue limits. Unless they expected the limits to be short-lived, hospitals would react to a revenue limit by taking actions to reduce expenses.

Achieving fair treatment among hospitals could be difficult, however, under such an option. Hospitals produce a highly heterogeneous series of services appropriate to a wide range of medical problems, so that limits would have to vary according to diagnostic mix and other factors. While New Jersey is experimenting with this particular approach, most proposals have avoided such

complexity by limiting the percentage increase in revenues per patient from a base period. But this leads to a different set of problems--such as a tendency to put relatively efficient hospitals at a disadvantage.

Some have suggested a variant to this option that would limit only reimbursements from Medicare and Medicaid. The main appeal of this variant is that it could achieve large federal savings with what many consider to be less intrusive regulation of the private sector. It has been seen by many as a policy of prudent federal purchasing, rather than one of regulation.

Medicare and Medicaid reimbursement limits have two serious disadvantages, however. First, hospitals would be able to offset at least some of the reduced federal reimbursements by increasing their charges to private patients and, ultimately, to employers who pay most of the private insurance premiums. To the extent that hospitals could shift these reimbursement reductions, the problem of rising hospital costs would not be solved but instead shifted from the federal budget to the private sector. Indeed, one proposal currently receiving consideration within the Administration, to reimburse only 98 percent of allowable costs, holds no prospect of solving the cost problem since hospitals would not be able to avoid the reimbursement reduction by reducing their costs.

The second disadvantage of setting limits to reimbursement is that it could potentially reduce access to hospital care by Medicare and Medicaid patients. As reimbursements for the care of these patients were reduced, they would become less attractive to hospitals. While few hospitals refuse to treat Medicare and Medicaid patients today, the seeds of a long-run problem are becoming visible. Hospitals with large proportions of Medicare and Medicaid patients appear to be having problems in raising capital. Lenders see these hospitals as being poorer risks, and are less willing to fund their capital projects; they tend to favor the hospitals serving predominantly privately-insured patients. Reimbursement reductions could exacerbate this phenomenon.

Encouraging State-Level Cost Containment

The third approach--encouraging state-level programs--would contribute to slowing the rise in spending for hospital care. It could be implemented with either carrots or sticks. The carrot approach would involve sharing with states the savings realized by the Medicare and Medicaid programs from state efforts. Currently, states receive only 12 cents for every dollar of reduction in Medicare and Medicare reimbursements that their cost control programs achieve. If states were given a higher proportion of the savings, more of them might establish effective programs.

Alternatively, hospitals in states with high rates of increase in per capita hospital expenditures could be made subject to new federal revenue limits. States could be given the flexibility to use either mandatory revenue controls, private-sector review programs, or the Voluntary Effort, but would have to meet specific targets in order to have their hospitals excused from federal regulation.

Limiting revenues at the state rather than federal level would have the advantages of being adaptable to local conditions and philosophies and making possible a variety of approaches in different states. A drawback is that it would be unlikely to work in states where the political commitment was lacking.

CONCLUSION

The problem of rising hospital costs is a serious one, and it is likely to continue unless additional measures are taken. A solution will not be easy, since it will involve reducing rates of use and slowing the growth in service intensity. The range of available options is wide, however, including both the encouragement of competition and the use of regulation--at either the federal or the state level--to limit revenues. It will probably be necessary to use more than one of these options, especially if the Congress is concerned with mounting federal deficits in coming years. I do not see any serious incompatibilities between the competitive approach and the use of regulation.