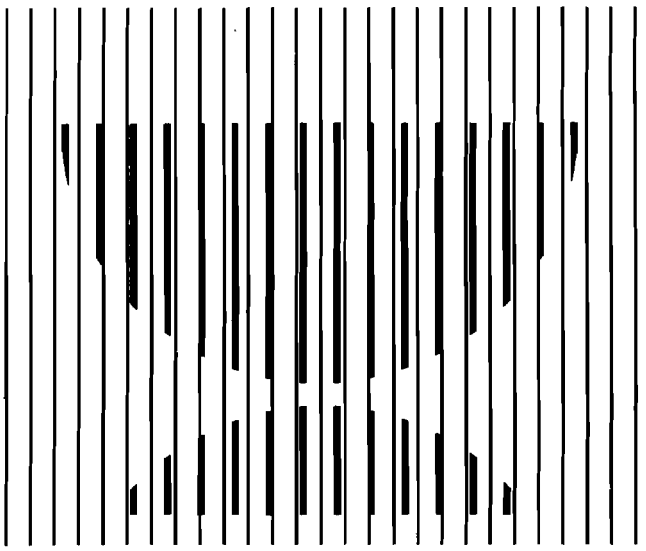
CBO STAFF MEMORANDUM

THE POTENTIAL OF DIRECT EXPENDITURE LIMITS TO CONTROL HEALTH CARE SPENDING

July 1992



CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

This Congressional Budget Office (CBO) Staff Memorandum describes various approaches to using expenditure limits to control health spending and identifies some of the operational issues that would be involved. A request from Representative Nancy Johnson, a member of the Subcommittee on Health of the House Committee on Ways and Means, provided the stimulus for the analysis. In keeping with CBO's mandate to provide objective and impartial analysis, this memorandum contains no recommendations.

The memorandum was prepared by Kathryn Langwell of CBO's Human Resources and Community Development Division, under the supervision of Nancy Gordon. Harriet Komisar contributed valuable comments on an earlier version. Roger M. Williams edited the text. Sharon Corbin-Jallow provided administrative assistance and prepared the final version of the manuscript.

CONTENTS

INTRODUCTION

Some policymakers have advocated direct control over health expenditures within a regulatory framework that specifies spending levels for a given time period. For example, the federal government could impose an annual limit on the growth of national health expenditures (NHEs). The potential impact of such a policy would depend on several factors besides the stringency of the limit relative to expected growth in NHEs. In particular, it would be necessary concurrently to introduce other cost control strategies and to specify mechanisms for enforcing the policy if the strategies were not successful. Moreover, the impact would depend on whether the expenditure limits were applied to the entire health care system or only to components. Finally, expenditure controls could affect the availability and quality of services.

Advocates of expenditure limits argue that they are an essential feature of an effective cost containment strategy. Advocates also claim that the use of expenditure limits to control costs would minimize the government's role in the health sector because the government would merely set the allowed amounts, while leaving consumers, providers, and payers with the independence and responsibility to make the changes in the health care market necessary to achieve the specified fiscal constraints.

Opponents of expenditure limits suggest that they would not control health spending and, in addition, would be accompanied by extensive government regulation of the health care market that could have undesirable effects. Critics believe expenditure limits would introduce new distortions into the market--for example, causing providers to avoid treating some patients, reducing the number of available providers, or shifting providers to geographic areas less likely to exceed the limit. In addition, expenditure limits could "lock in" existing inefficiencies in the health care system, which could punish efficient providers and offer inadequate incentives to inefficient ones. People who oppose expendi-ture limits also argue that stringent limits might be unsustainable over time.

DEFINITIONS OF EXPENDITURE CONTROLS

The term expenditure controls refers broadly to any regulatory strategy that sets limits on aggregate spending levels for specified health services. General approaches include global budgeting, expenditure targets, and expenditure caps.

Global Budgeting

Under global budgeting, operating budgets would be established for hospitals and other types of providers covered by the regulations. Within the overall budget limit, each provider would determine how to allocate funds and which services to provide. Providers exceeding their respective limits might be penalized--for example, with a reduced budget for the following year. Alternatively, the budget limits could be absolute. Global budgeting is usually viewed as a strategy suitable for hospitals or other large providers of health services.

Expenditure Targets

Under an expenditure target approach, the regulatory authority would set targets for aggregate spending levels for specific health services--for example, physicians' services. Spending exceeding the targets would trigger certain penalties whose effects would be felt in the current period or in future ones. Expenditure targets could also be applied to other types of health services or to total health spending.

Expenditure Caps

An expenditure cap is similar to an expenditure target. But instead of establishing a target amount for a set of services, or for total spending, it would set an absolute spending limit that could not be exceeded during the specified period.

EXPENDITURE CONTROLS IN THE UNITED STATES AND OTHER COUNTRIES

The United States has little experience with expenditure limits as an approach to containing health care costs. Evidence on the potential effectiveness of limits comes from a demonstration of global budgeting for hospitals in one area of New York State and from the experience of the Medicare program with expenditure targets for physicians' services. Other countries, however, have used expenditure limits as one aspect of a comprehensive national health policy.

The Hospital Experimental Payment Program

The Hospital Experimental Payment (HEP) program, implemented in 1980 in two counties of the Rochester, New York, metropolitan area, set a

communitywide expenditure cap on hospital revenues for patient care for all nine hospitals in the area.[1] The hospitals had voluntarily agreed to operate under the constraints the cap imposed. Under HEP, Blue Cross--which provided health insurance for more than 70 percent of the Rochester market--Medicare, and Medicaid paid hospitals a set amount of money based on past expenses (updated for inflation). Hospitals whose costs exceeded the budget allocated to them lost money, and those whose costs remained below budget retained the surplus. Decisions about capital investment were made by the hospitals as a group and were paid for from a capital fund to which all nine hospitals contributed. HEP covered all the services--inpatient and outpatient--that hospitals offered; thus, the program provided incentives for them to use ambulatory care when appropriate and offered no incentives to attempt to fill empty beds.

Between 1980 and 1985, a number of measures of hospital market performance suggested that the global budgets under which the HEP hospitals operated were effective in controlling costs. Hospital expenses in the Rochester area increased 46 percent over this five-year period, compared with 52 percent for New York State (which during part of this period was operating under an all-payer system of setting rates) and 68 percent for the

1. See James A. Block and others, "A Community Hospital Payment Experiment Outperforms National Experience," *Journal of the American Medical Association*, vol. 257, no. 2 (January 9, 1987), pp. 193-197.

United States as a whole. In contrast, from 1972 through 1978, the rate of increase of Medicare's hospital spending per recipient in the Rochester area was comparable to the rates of increase for Boston and Minneapolis/St. Paul (two cities chosen for comparison in the study) and for the nation.

From the introduction of the HEP program through 1982, Rochester experienced an increase in Medicare's hospital spending per recipient that approximated the inflation rate, compared with sharply higher rates for those other two cities and for the nation overall. In addition, Rochester hospitals operated in the black throughout the initial five years of HEP, with operating margins of 2.6 percent compared with -15.8 percent for all hospitals in New York State.

The Rochester area is unusual, however, with Blue Cross and one large health maintenance organization (HMO) providing more than 80 percent of its private insurance coverage. This concentration of insurers could have been an important factor in achieving successful control of hospital spending. In addition, the ratio of hospital beds to population for the Rochester area was lower than for New York State, and the market penetration of HMOs was considerably higher in Rochester than in the nation. It is therefore unclear to what extent the results achieved, which reflect the conditions of the Rochester market area, could be replicated in other areas. It does appear,

however, that a critical element of the HEP was the willingness of the hospitals covered by the program to cooperate in making decisions that affected the performance of the hospital market.

Medicare's Volume Performance Standards

Under Medicare's system for controlling expenditures for physicians' services, annual target rates of increase--referred to as volume performance standards--have been set for Medicare expenditures for physicians' services since 1990. A target rate may be set by the Congress or determined by a default formula that combines growth in the number of beneficiaries, inflation, and a five-year average of past volume growth less a predetermined amount--1.5 percent in 1992 and 2.0 percent in subsequent years. If the actual rate of increase exceeds the target, physicians' fees under Medicare are lower in subsequent years.

In 1990, the target growth rate was 9.1 percent, but spending actually grew by 10.0 percent. As a result, physicians' fees under the Medicare program were lower in 1992 than would otherwise have been justified. In 1991, the target rate of growth of Medicare physicians' spending was 7.3 percent, but spending grew by 8.6 percent.

Even if Medicare's expenditure targets for physicians succeed in constraining the rate of increase in spending for their services, the impact on national spending for those services remains uncertain. The imposition of targets for Medicare alone, which accounts for about 30 percent of physicians' revenues, could lead to changes in physicians' practice patterns that result in the provision of more--or more costly--services to non-Medicare patients. Thus, Medicare may achieve savings at the expense of other third-party payers and individual consumers.

The Experiences of Other Countries

Some other industrialized nations have relied more extensively on various types of expenditure controls.[2] In Canada, global budgets for hospitals are negotiated annually between the provinces and the individual hospitals. Expenditures have not always been kept within the budget limits, however, and provincial governments have often paid cost overruns in the hospitals.

Several of the Canadian provinces have also established expenditure targets for physicians' services. Physicians are reimbursed on a fee-for-service

2. See Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991) for a more extensive discussion of other countries' approaches to controlling health care costs.

basis according to a schedule negotiated between the provinces and physicians' associations. If the expenditure targets are exceeded, fees are generally reduced in the subsequent round of negotiations. Quebec's system is particularly stringent: it sets a cap on aggregate income for physicians for each quarter and, if the cap is being exceeded, reduces payments for the rest of the quarter.

In addition, the Canadian federal government caps its contribution to national health spending. Until 1977, the federal government matched provincial spending dollar for dollar. Since then, per capita payments have been made to the provinces, regardless of the actual health care expenditures in each province. These per capita amounts have been determined under a formula based on growth in the gross national product. As a result, the provinces have borne an increasing share of the cost of health care because the federal contributions they receive have generally grown more slowly than their health expenditures.

In Germany, guidelines for limits on the overall growth rate of national health spending and on several types of services are set annually by an assembly consisting of providers, insurance carriers, labor unions, employers,

and state and local governments.[3] The system includes a negotiated expenditure cap for ambulatory services provided by physicians. If expenditures rise too fast, fees for physicians' services are reduced to keep total spending from exceeding the cap. Hospital reimbursement is also regulated, but global budgeting or other expenditure controls are not used. Instead, under the Statutory Health Insurance program, which covers about 90 percent of the population, the government reimburses hospitals by predetermined per diem amounts that are established through negotiations with each hospital.

In the United Kingdom, a combination of expenditure caps and global budgeting limits hospital spending. Total spending limits for hospital services in the country's National Health Service (NHS) are established by the national government within the framework of its entire budget. The regions receive annual funding based on a formula that accounts for population size and the mortality rate in each region. If a region overspends its allocation, it gets less money the following year. A hospital generally receives the same budget as the previous year--increased by an inflation factor--although hospitals can lobby for increased funding.

---

3. This paragraph describes the system in the former Federal Republic of Germany before its reunification with the German Democratic Republic.

Limits on expenditures for physicians' services are not a feature of the NHS. About half of physicians' incomes from the provision of ambulatory services come from capitated payments--in the form of a fixed amount per patient enrolled in each physician's practice. Patients who require inpatient care are referred to NHS specialists, most of whom are salaried employees of the regional health authority. Thus, while some fee-for-service payments exist under the NHS, the majority of physician services are funded through capitation or salary arrangements.

POTENTIAL TO CONTROL HEALTH SPENDING

When used in other countries, expenditure limits have been one component of a multifaceted, systemwide approach to controlling health care spending. In fact, to be effective, it appears that limits must be implemented in combination with other cost control measures and must be accompanied by enforcement mechanisms that ensure that the limits are not exceeded.

The potential effectiveness of expenditure limits would depend on the choice of cost control mechanisms that would also be introduced into the health care system. Those mechanisms could include price controls, utilization review and management, increased cost sharing for consumers,

changes in the tax treatment of employment-based health insurance, greater efficiency in the administration of public and private health insurance, and assessment of the value and appropriateness of new technologies before their adoption.

Considerable evidence about the potential effectiveness of alternative cost control strategies is available and has been assessed by the Congressional Budget Office.[4] If effective strategies were combined with expenditure limits, the interaction might make the strategies more effective than if they were adopted singly. Estimating the overall effect would be difficult, however.

The impact of expenditure limits on national health spending would also be determined by the enforcement mechanisms and the stringency of the penalties that would be imposed if spending exceeded the limits that had been established. To achieve the level of health spending specified by an expenditure cap or target would require that, if the goal were exceeded in one period, offsetting adjustments would be made in subsequent periods.

The adjustments could be severe. It would not be sufficient, for example, to set penalties that would reduce future payments to providers in response to exceeding the previous year's targets unless the reduction in

4. See, for instance, the testimony of Robert D. Reischauer, Director of the Congressional Budget Office, before the Senate Finance Committee, May 6, 1992.

future payments would be sufficient to bring that year's spending to the level that would have been achieved had all previous years' targets been met. If the limit in one year were exceeded by more than the growth allowed for the next year, nominal spending would have to be cut. Moreover, unless the reductions were large enough to recover the excess spending in the previous year, total spending in successive years would exceed the desired amount.

Designing effective expenditure limits would involve a number of other basic decisions, as well as the resolution of a multitude of operational issues. For example, the method for establishing the allowed expenditure level, or rate of expenditure increase, would need to be determined. If the federal government set the level based on the expected rate of general inflation, population growth, and projected demographic changes, there would be essentially no allowance for changes in technology and medical practice that might lead to better outcomes or higher quality of care. Alternatively, a method that set an expenditure cap that was only slightly less than projected spending would probably not provide sufficient incentives to change the behavior of providers.

Other countries that have used expenditure limits as part of a national health policy have involved providers in the process of setting and monitoring expenditure caps. In Germany, for example, organizations of physicians

monitor performance under the caps and determine the payment-level adjustments necessary to stay within them. That approach might be more effective in achieving behavioral changes that would control costs than a policy that involved providers only minimally. In the United States, the HEP demonstration project in Rochester, New York, also involved the concurrence and cooperation of the hospitals that the program affected.

The capability to monitor performance under an expenditure limit seems essential to its success. If the available data system could not determine on a timely basis whether the allowed expenditure level was being achieved or exceeded, there would be less opportunity to provide the kind of feedback that would permit providers to make adjustments that would reduce health spending to the desired level in the relevant time period. One effective type of data system would produce profiles of providers' practices for individual providers, for groups of providers, and by region of the country.

Moreover, penalties for exceeding the allowed expenditure levels would need to address both the price and the quantity of services provided. If expenditure controls were applied only to some groups, rather than universally, providers could increase either prices or the volume of services for other groups in order to maintain revenues without triggering penalties. Similarly, if controls were applied only to spending for selected services,

changes in the mix of services provided could occur as uncontrolled services were substituted for controlled ones. In either case, savings would occur for the segment of the market the expenditure controls covered. But the provision of health care would be distorted, and overall health spending might not be reduced appreciably once providers had adjusted their behavior in response to the presence of the controls.

Thus, while direct controls over expenditure levels could be effective in reducing the level and rate of increase in health spending, their potential for achieving those objectives would depend on these variables: the method used to set the allowed levels and rates of increase; the choice of cost control strategies included in the policy and their impacts; the availability of timely data to monitor performance under the expenditure controls; and the nature of the penalties that would be applied if the allowed spending levels were exceeded.

CBO'S ASSUMPTIONS FOR ESTIMATING THE IMPACT OF EXPENDITURE LIMITS ON HEALTH SPENDING

Based on the preceding analysis, the Congressional Budget Office's assessment of the potential of expenditure limits to affect national health expenditures rests on the following assumptions:

- The impact of expenditure limits would be determined by the mechanisms selected to enforce the limit on spending. Expenditure limits that applied to all health care spending, if implemented with provisions for stringent enforcement, could result in lower national health expenditures than would occur in the absence of limits. The magnitude of the effect, however, would depend critically on the enforcement mechanisms.

- Limits applied to one segment of the market, one geographic area, or one type of health service could reduce spending for the affected group or service. But they would have less effect on national health expenditures because of substitutions among services and other compensating adjustments within the system.

- Effective expenditure controls that applied to only one segment of the population would reduce access to care and possibly lower the quality of care for that group relative to unconstrained groups.

In the absence of specific information about the mechanisms that would be used to enforce expenditure limits, it would not be possible to estimate the impact of the limits included in legislative proposals.

If expenditure limits were effective in controlling health care spending, however, the resulting changes in the U.S. health care system would adversely affect some features of the system that many people consider desirable. There would probably be longer waiting times for access to new technologies, less spending on research and development, and new limitations on our choice of providers, health insurance coverage, and treatment alternatives. Whether those are acceptable changes depends on the priority the nation places on controlling costs and on maintaining other characteristics of the current health care system.