Commentary

Prospective Payment: The Next Big Policy Disappointment?

by Henry J. Aaron

A revolutionary system of reimbursement under Medicare is now being implemented by the Health Care Financing Administration (HCFA). Instead of paying for the cost of all services rendered to Medicare patients, HCFA will pay hospitals a fixed sum based on each patient's diagnosis at admission. The new system of reimbursement according to diagnosis-related groups (DRGs) represents such an important conceptual change that many health experts in their enthusiasm over the new concept have overlooked the grave flaws of design in the proposed reimbursement scheme. An examination of these flaws and the perverse incentives they generate indicate why reimbursement according to DRGs is unlikely to achieve savings as large as were expected.

The Problem

The once-original observation that reimbursing hospitals and physicians for all services they choose to provide encourages rising costs has become a cliché. But even cliches may be true, and this one surely is. By assuring hospitals and physicians that they will be paid for whatever they do, the combination of fee-for-service reimbursement and heavy insurance protection removes virtually any incentive patients and providers might have for scrutinizing costs.

Against this background, the switch to fixed preset fee schedules applied to diagnoses determined at admission is remarkable. Under the DRG reimbursement system, payment will not depend on what services the patient receives, except in special circumstances. Patients who remain in the hospital for especially long stays or whose costs of treatment are extraordinarily high or who require certain costly procedures may trigger additional...

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payments, but only if the services are approved by specially constituted review boards. In addition, the DRG program is designed to reduce gradually the wide disparities among Medicare payment levels across regions and types of facilities.

Large savings are predicted for the DRG program. In 1982, Congress called for a reduction in Medicare expenditures through 1986 of more than $8 billion, although it did not specify exactly how all of these savings were to be achieved. Part of the savings were to be sought through a new method of reimbursement that the Department of Health and Human Services was to develop. DRGs were the result. According to congressional mandate, DRGs for the period through 1986 are to save no more and no less than Congress stipulated in the Tax Equity and Fiscal Responsibility Act of 1982. After 1986, additional savings are anticipated.

The perception is spreading that Americans could save a lot of money if we could find a way to stop providing hospital care that in some sense costs more than it is worth. The realization is also spreading that the key to such lies in methods of reimbursement. Some gains may be achieved by making consumers of health care more conscious of price, for example, by placing a limit on the value of employer-purchased health insurance that is excluded from the employee’s taxable income. But as long as patients are fully insured against the marginal cost of treatment at the time of illness, they will be encouraged to demand all treatment that provides any benefit whatsoever, regardless of cost, and hospitals and physicians will have every incentive to supply it. Hospital insurance comes close to providing such protection for most people in the United States. Many economists and a few elected officials would like to encourage the spread of cost sharing. The limitation on the exclusion from income tax of employer-purchased health insurance is one way to this end, but the prospects for such a change remain problematic.

That leaves reform of reimbursement as the best immediate hope for cost containment. And the DRG system is the reform of the day. Viewing DRGs marching off to fight rising hospital costs arouses admiration for the objective but chagrin at the choice of weapons.

To understand why DRGs are likely to save less than has been claimed for them and why they may distort the delivery of health care in medically undesirable directions, it helps to split the increase in hospital outlays into its components, The change in real hospital costs, $C$, equals the change in the number of admissions, $A$, multiplied by the change in the real cost per admission, $P_a$. The change in the real cost per admission, $P_a$, in turn, is equal to the change in the relative price of hospital inputs, $P_r$, multiplied by change in the quantity of inputs (labor, materials, and equipment) used per admission, $I$. The rate of increase of real hospital costs, therefore, is approximately equal to the sum of the rate of increase in admissions, inputs per admission, and inflation in the cost of hospital inputs beyond
the general rate of inflation, or $C = A + P_r + I$.

### The Problem With The Solution

The fundamental shortcoming of the DRG system is that it deals only with $I$, or change in the quantity of inputs per admission. DRGs establish the amount that hospitals will be paid for each diagnostic category. They can be used to discourage costly methods of treatment. The incentives to reduce $I$ may be important. For example, preliminary evidence suggests that lengths-of-stay have fallen sharply in those hospitals first brought under the DRG system. Although these savings may be offset by increased costs elsewhere, this result is encouraging. In addition, hospitals may be deterred from buying as much new equipment as in the past, as Anderson and Steinberg have pointed out.1 But any increase in hospital costs arising from further increases in the relative price of hospital inputs or, more importantly, in the number of admissions is outside the scope of the DRG system. The recent squabble over the amounts to be paid per diagnosis under Medicare should not be misread as direct control over $P_r$, the prices that hospitals pay for materials, equipment, and labor. At best, DRGs may indirectly slow the rise of these prices by holding down the ability of hospitals to pay increased prices.

The second problem is that the DRG system contains incentives to increase admissions. Marginal costs of hospital care are much below average costs in the short run. Studies differ on the size of the gap, but there is little doubt that the additional cost of adding one more patient is much lower than the average cost of treating patients of that type, provided the hospital is not congested. And as long as the reimbursement levels under the DRG system exceed marginal costs, which they must do unless non-Medicare patients are to bear all overhead costs, hospitals will have an incentive to admit additional patients. Such patients would include those formerly treated on an outpatient basis, a relatively inexpensive group to treat and from whom, therefore, the hospital could “make a profit.” This problem remains speculative as DRGs do not seem to have increased admissions so far, but the risk of future increases is serious.

For many procedures, however, hospitals lack accurate information about true costs, marginal or average. The new need for accurate data under the DRG system may induce major improvements. But assignment of costs to particular procedures is inevitably somewhat arbitrary. As a result, charges for particular procedures may be only tenuously related to the costs actually associated with them. This means that reimbursement levels set initially for DRG categories are likely to vary from underlying costs in many cases. Some prices will be set too high and some too low. And the variation of costs incurred for treating particular diagnoses around the reimbursement levels set under the DRG system will be enormous. Alain
Enthoven and Roger Noll report that, DRG categories account for only 40 percent of the variance in the length-of-stay and 21 percent of the variation in hospital charges. They cite one study that found variations in hospital charges within one DRG (#206, disorders of the liver, excluding malignancy, cirrhosis, alcoholism, and hepatitis, age under seventy without complications or comorbidities) ranging from $1,171 to $114,515.2

Hospitals may try to find cases on which reimbursement exceeds cost and to direct those on which costs exceed reimbursement to other hospitals. Teaching and community hospitals are likely to end up with a disproportionate share of the cases where costs exceed reimbursements. Home health agencies are likely to find themselves saddled with responsibility for care formerly provided inside hospitals. But hospitals, as a group, will have an incentive to encourage admissions of cases where reimbursements exceed costs, including low-cost cases formerly handled on an outpatient basis.

A third problem with the DRG system arises from the imprecision of hospital accounting mentioned above. To the extent that hospitals find themselves pressed by reduced reimbursements per Medicare case, they will have incentives to reassign costs to procedures disproportionately performed on non-Medicare patients. Assigning costs to patients covered by other insurers will enable hospitals to increase revenues from private sources or from Medicaid. Resistance to such cost shifting is growing as all payers become increasingly sensitive to rising hospital costs. As such cost shifting occurs, however, Medicare savings will show up as increased expenditures somewhere else.

Extending the DRG principle to all payers along the lines proposed by Sen. Edward M. Kennedy and Rep. Richard Gephardt would reduce the problem of cost shifting. But it would not eliminate it entirely, as incentives would remain to shift routine examinations and tests from the hospital to preadmission screening and testing in physicians’ offices. Although some mention has been made of extending the DRG system to include physicians’ services, such an extension would cause serious administrative and political problems. Paying physicians a fixed, preset fee for each case, regardless of its complexity, would create divisive tensions between physicians and patients. Paying physicians for blocks of patients would be equivalent to reimbursing them on a capitation basis for a large part of their professional practice. Physician organizations have long opposed mandatory reimbursement on any basis other than fee for service.

A fourth problem with the DRG system is that hospitals are likely to find ways to manipulate it for their own advantage, although possibly in ways that reduce the efficiency of medical care or that increase cost. The greatest opportunities are likely to occur with respect to patients who have two or more problems. In that event, hospitals may be, tempted to discharge a patient after treating one problem and then to readmit the patient to treat another problem, thereby securing multiple reimbursement. They may be
tempted to encourage the provision of services that shift the patient from one DRG category to another with a higher reimbursement. They may even seek to treat marginal problems that otherwise would have been left alone because such problems are likely to cost less than average for that particular diagnostic category.

A fifth problem with the DRG system arises from that fact that even with 468 classifications many medical categories contain cases of widely varying complexity and call for disparate kinds of treatment. The heterogeneity within DRG categories was indicated above. Hospital administrators are certain to make the case for splitting existing categories or for adding measures of severity or complexity within categories to take account of heterogeneity. The list of 468 categories is likely to grow, and with such growth the complexity of the system and the opportunities for manipulation are bound to increase. Officials administering the DRG program will have to exercise great caution to prevent the growth in the number of categories from increasing costs, as hospital officials are unlikely to push hard for reclassifications that would reduce hospital revenues.

The Promise

Despite its flaws, the DRG system represents a major step in the reform of hospital reimbursement. It attempts to restore the reality of a budget limit on at least part of the operations of hospitals. It is one expression of a sudden realization by many that growth of hospital spending must be slowed. But it deals only with expenditures per admission, not with total outlays. As a result, it creates incentives adverse to its own objectives of cost control and the efficient delivery of medical services. Only if the total budget of each hospital is the object of control can such perverse incentives be minimized. Total budget limits would still have serious administrative problems, including notably the need to decide when hospitals would be granted special allowances for rapidly growing or changing caseloads. But the control mechanism itself would not create incentives to increase caseloads or to manipulate admissions.

The chance of reducing costs in a sustainable and rational manner through any regulatory approach will be increased if demand-side incentives are also changed. Limitation of the exclusion from taxable income of employer-purchased health insurance would promote cost consciousness by employees. It could increase interest in health maintenance organizations or preferred provider organizations able to provide care at reduced cost. For the foreseeable future, however, most hospital care is likely to be provided outside the framework of prepaid group practices. The problem of how to heighten awareness of costs among fee-for-service providers will not get easier to solve, and it is too big a job to be left to DRGs.
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