CBO TESTIMONY

Statement of
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NOTICE

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Mr. Chairman, I appreciate the opportunity to appear before this Committee. My testimony today will cover proposals for comprehensive health care reform, their potential to expand access to insurance coverage and control health care costs, and the Congressional Budget Office's (CBO's) methods for assessing the cost containment provisions in health legislation.

INSURANCE COVERAGE UNDER THE CURRENT SYSTEM

In March 1990, an estimated 33.4 million people--or 13.6 percent of the population--were without health insurance coverage. During the next year, the number of uninsured people grew by 1.3 million. About three out of five uninsured people are poor or near-poor, with incomes of less than 200 percent of the poverty threshold.

Moreover, estimates for 1987 indicate that the number who were uninsured at some time during that year was about 30 percent higher than the number who were uninsured during the first quarter of the year. If the same was true today, then about one in six people would have been uninsured at some time during the year.

The problem of inadequate insurance coverage is exacerbated by our inability to slow the growth in the cost of health care. Cost increases are raising premiums for health insurance faster than the growth in wages and

national income, thereby further eroding coverage. Since 1980, the proportion of the population under 65 without health insurance has increased by more than one-fourth. Moreover, there is considerable evidence that those who are uninsured use less health care and have worse outcomes when they do use the health care system.

APPROACHES TO ACHIEVING GREATER INSURANCE COVERAGE

Because of concern about the dual problem of the rising number of people without insurance and the increasing cost of health care, a substantial number of bills have been introduced that are intended to expand access and control spending. These proposals reflect a diverse set of approaches. Those, however, that could be characterized as comprehensive health care reform--in other words, changing the health care system to ensure that virtually everyone in the nation would have access to health insurance--can be grouped into three general approaches:

- Proposals that would offer tax subsidies to enable those who are uninsured to purchase private health insurance, combined with additional regulation of the health insurance market to ensure that insurance would be available and more affordable.

- Proposals that would require employers to offer health insurance to their employees or to pay a tax ("play or pay"). The tax revenues would be used to offset some of the cost of a public insurance plan. Additional tax revenues would be needed, however, to finance the shortfall for workers whose employers chose to "pay" and to subsidize coverage for low-income people without jobs who were not covered by Medicaid or Medicare. This approach would also involve additional regulation of the health insurance market to ensure that insurance policies would be available to employers who wanted to "play."

- Proposals that would replace the existing health care system with a single-payer public health plan covering everyone.

Any of these three general approaches would significantly expand access to health insurance. The third approach would, by definition, provide everyone with insurance. Continuity of health insurance coverage would also be improved under each of these alternatives. The approaches differ, though, in their potential impacts on national health spending, federal expenditures for health, the extent to which control over health care spending would be

improved, and the ability of consumers to choose their own health insurance coverage.

The impact of any health proposal on access, spending for health, and on the federal government's costs would depend on the details of the proposal. Such details would include the particular package of health benefits--namely, the services that would be covered as well as the deductible amounts and coinsurance payments that would be required--plus those provisions intended to contain costs, such as managed care and methods for setting reimbursement rates. The effects would also depend on many other details of the particular proposal under consideration. For example, if a tax subsidy were used, the effects would vary depending on tax rates, definitions of income, and configurations of filing units, as well as any complementary changes made in regulating the insurance market for small groups. Under a "play-or-pay" plan, those outcomes would be affected by such factors as the contribution rate required of employers and employees to participate in the public plan, the treatment of part-time workers, and new regulations of the small group insurance market. The effects of a single-payer public system would vary significantly depending on the extent to which private insurance was permitted to supplement the public plan and on the choice of administrative mechanisms used to operate the plan.

An overview of the effects of each approach, as illustrated by a specific proposal, is presented in Table 1. In each case, the estimated effects on national health expenditures in Table 1 take into account increases in spending resulting from new insurance coverage. Offsetting reductions in administrative costs and payment rates that would occur under a single-payer system are included only in that case. A detailed description of the characteristics of each of the illustrative proposals examined here is contained in the appendix.

Effects on federal expenditures for health are presented in terms of both federal outlays for health and tax expenditures related to the exclusion of health insurance from taxable income and other deductions for health care. The estimates of tax expenditures reflect the impact those proposals would have on both income and payroll tax revenues. If federal outlays for health increased because of expanded insurance coverage through a public plan, and tax expenditures decreased because few people would continue to have employment-based insurance, then the increase in federal outlays would be offset in part by an increase in tax revenues. Conversely, an approach that expanded both employment-based coverage and public coverage would raise outlays and tax expenditures. Those estimates assume that the federal government would incur all of the increase in outlays for an expanded public plan. Those costs could, however, be shared between the federal and state

TABLE 1. COMPARISON OF ESTIMATED EFFECTS OF ILLUSTRATIVE WAYS TO INCREASE INSURANCE COVERAGE (In percent)

	Tax Subsidies and Market Reforms[a]	"Play or Pay" Employer Mandate and Market Reforms[b]	Single-Payer Public Plan[c]
Insurance Coverage			
Access	Improved	Improved	Assured
Percent Insured	93 to 95	97 to 99	100
Continuity	Improved	Improved	Assured
Initial Percentage Change in Spending for Health[d]			
Nationwide	2	3	Near 0
Federal Government			
Outlays	8[e]	17[f]	75[g]
Tax expenditures[h]	39	9	-95
Total Health Expenditures	15	15[f]	34[g]
Other Effects			
Potential for Cost Control	Improved only if other policies are adopted	Improved only if other policies are adopted	Improved
Choice of Coverage	Unchanged, or reduced if cost controls are adopted	Unchanged, or reduced if cost controls are adopted	Essentially eliminated

SOURCE: Congressional Budget Office.

NOTES: Currently, about 86 percent of the population is insured.

All three alternatives assume insurance plans typical of those available currently, with substantial copayment requirements and no coverage for long-term care. See appendix for full description of the alternatives.

a. Assumes tax credits equal to full value of insurance would be provided to half the uninsured and that new coverage would result for all members of this group. Some additional coverage would result from partial tax subsidies or from market reforms.
b. Assumes no change in overall or full-time employment would occur. Also assumes that all those eligible for free insurance under the public program would enroll but that only some among other eligible groups would enroll.
c. Assumes the single payer would use Medicare's rates, with hospital rates increased to cover costs. Spending would fall slightly if a relatively low increase in use occurred among the currently uninsured and if potential savings on administration were fully realized. Otherwise, spending would increase slightly.
d. Percentage changes are relative to current spending for health in each category shown--nationwide, federal outlays, federal tax expenditures, or total federal expenditures. Effects of financing provisions are not shown, nor are effects on individuals, firms, or state and local governments.
e. Represents the portion of the tax subsidy that is a refundable credit.
f. Includes the total cost of the public plan. More than 70 percent of the cost for employees in the public plan would be offset by tax collections from employers and employees.
g. Assumes federal government would pay all costs of the public plan, although costs could be divided between federal, state, and local governments in a variety of ways.
h. Includes effects on payroll taxes, although those are not usually counted as tax expenditures.

governments. If that were the case, then the effect on total federal health expenditures would be less than that shown in Table 1.

Tax Subsidies, Combined with
Additional Regulation of the Insurance Market

Under current law, the federal tax code provides a substantial subsidy for employment-based health insurance--nearly $60 billion in 1990, when the effect on both income tax and payroll tax revenues is considered. That subsidy arises from excluding qualified employer-paid health insurance premiums and certain other health costs from workers' incomes for tax purposes. In addition, low-income workers are eligible for a refundable tax credit on the purchase of health insurance that covers their children. This credit is for all premium costs, subject to a ceiling equal to 6 percent of qualified earnings. The maximum credit is now $451.

The current system of tax subsidies could be expanded to make the purchase of private health insurance less expensive for those who do not receive employment-based insurance. The President's Comprehensive Health Reform Program, for example, would offer a direct tax credit for the costs of a health insurance policy worth up to $3,750 to low-income people, depending on household size and income. Individuals with incomes up to $50,000 and

families with incomes up to $80,000 (depending on tax filing status) would be offered either a tax credit or a tax deduction for health insurance.

For such a system of tax subsidies to be effective, however, it would have to be combined with additional regulation of the insurance market to ensure that health insurance policies would be available and more affordable. The President's plan includes a variety of changes that would ensure that all groups could obtain health insurance, guarantee renewal of existing policies, and prohibit exclusions for preexisting conditions.

CBO's preliminary analysis of the President's plan indicates that offering a $3,750 tax credit to all people with incomes below the specified limits would reduce the number without insurance by about 50 percent.[1] In addition, the smaller subsidies and tax deductions for higher-income people, as well as the proposed changes in the health insurance market, would expand coverage somewhat. We cannot, however, precisely assess the extent of that additional insurance. Although health insurance would be available and more affordable as a result of the insurance market proposals, it is uncertain how many of the uninsured with low or moderate incomes would choose to purchase insurance in response to the limited subsidy. For example, an uninsured head of household with one dependent and an income of $25,000

1. For a more complete discussion of CBO's analysis of the President's Comprehensive Health Reform Program, see Robert D. Reischauer's testimony of March 4, 1992, before the Committee on Ways and Means.

who purchased a policy for $2,500 would have the choice of a $250 tax credit or a tax deduction of up to $2,500 for health insurance premiums. At an effective marginal tax rate of 15 percent, this family would receive a greater subsidy--$375--by choosing the tax deduction but would still have to pay the remaining $2,125 of the annual premium.

Although it would not guarantee that everyone in the United States would have health insurance, the tax subsidy approach (combined with changes in the health insurance market) would improve access to health insurance. Further, the changes in the health insurance market would ensure continuity of health insurance coverage for those who wanted to change jobs.

The effect of this proposal on national health expenditures would depend on how much new insurance coverage would result, since the newly insured would use more health services than they had previously. If the percentage of people with insurance increased from 86 percent to 94 percent of the population, national health expenditures could rise by about 2 percent. In addition to the uninsured, a substantial number of currently insured people could be eligible to receive some subsidy under this approach, but their use of health services would not change much.

The effect on federal expenditures for health (both outlays and through tax expenditures) would depend on the number of people with new insurance and on those who had previously bought insurance that would entitle them to receive a subsidy. Providing the full refundable tax credit to half of the uninsured population would increase federal outlays about 8 percent. This estimate, however, does not take into account partial tax credits that would be provided to other people. Because of the partial tax subsidies available to many of those who already have insurance, federal tax expenditures would rise by 39 percent. The net effect would be a 15 percent increase in total federal expenditures for health. The impact of this increase in federal expenditures on households and businesses would depend on the specific financing methods used to increase revenues to cover these costs, which are not specified in the illustrative proposal.

A "Play-or-Pay" Employer Mandate, Assured Access to a Public Plan, and Additional Regulation of the Insurance Market

Another comprehensive approach would be to mandate that all employers either provide health insurance to their workers or pay a tax that would be used to help finance a public insurance program for people who were not covered. Employees would also be mandated to accept the offered coverage. Under this approach, additional regulation of the private insurance market

would also be necessary in order to ensure that all employers had access to affordable private health insurance policies, regardless of the health status of their work force.

Even though rates for group health insurance are generally substantially lower than rates charged to individual applicants, some employers do not offer insurance because their work force is primarily low-wage and their total compensation package could not easily be adjusted to accommodate the cost of health insurance. Other employers now face prohibitively high insurance premiums because of previously existing health conditions of some of their employees. Even with additional regulation of the insurance market, both types of firms would face significant costs under a mandate that they might not be able to transfer to workers in the short run.

To reduce or eliminate the resulting adverse effects--more part-time employment for low-wage workers or even bankruptcy of some small firms--the "play-or-pay" version would permit employers to choose between providing insurance directly or paying a payroll tax that would partially fund a public program. Uninsured people, whether or not they were employed, would then have the option to be insured under the public plan. Because additional regulation of the insurance market would limit the allowed variation in premium levels charged to firms with different compositions of employees,

some employers who do not now offer insurance to their employees would choose to "play" rather than "pay" the tax.

An illustrative employer mandate with a play-or-pay option could, for example, include a requirement that all employers provide insurance to their full-time (25 or more hours per week) workers or pay a payroll tax of 7.5 percent of payroll, with the employee contributing an additional 2.5 percent of wages.[2] Regulation of the insurance market could prohibit insurers from varying premiums charged to small groups based on group-specific risk, thereby ensuring that no group would face prohibitively high insurance premiums.

Under this illustrative option, coverage through the public plan would also be available to individuals and families who are not attached to the work force. Individuals and families with incomes below the poverty level would be offered coverage through the public plan at no cost to them. Individuals and families with incomes above the poverty level would have to contribute to the cost based on a sliding scale that would reach the full cost for those with incomes at or above 300 percent of poverty. Individuals and families with incomes above 300 percent of poverty would have to pay the full cost of health insurance coverage.

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2. For a discussion of an employer mandate without a play-or-pay option, see Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage* (July 1991).

Under this plan, access to health insurance would be significantly improved--approximately 23 million of the 33 million people without health insurance in 1990 would gain coverage through the workplace. Of these 23 million, about 10 million would have employment-based health insurance and 13 million would receive coverage through the public plan. The remaining people without insurance would not be included in the mandate, but they could choose to participate in the public plan by paying the required premium themselves.

With most of the population covered by health insurance, national health expenditures would rise by at least 3 percent, reflecting the increased use of health services by this group. Federal expenditures for health would also rise for two reasons. First, more employment-based health insurance would increase the related tax expenditure. Second, the payroll tax imposed on firms that did not offer health insurance would not be sufficient to cover the costs of a public plan since, on average, these firms employ a lower-wage mix of workers. As a result, the public plan would require additional subsidies from general tax revenues. The effect of this increase in general tax revenues on households and businesses would depend on the specific financing mechanisms used. CBO estimates that, for the illustrative plan described above, total federal expenditures for health care would rise by 15 percent, taking into account the increases in both outlays and tax expenditures.

A Government-Run, Single-Payer System

Establishing a government-run, single-payer system would be another approach to comprehensive health care reform. Although the two previous alternatives would build on the existing multiple-payer system, thereby maintaining both private and public components, a single-payer public system would involve a complete restructuring of the current system for financing and delivering health care.

In the example discussed here, a new public insurance plan covering all legal residents would replace existing insurance for acute-care services.[3] The benefit package would be actuarially equivalent to the average benefits currently provided under private plans and Medicare. Medicare's current payment methods for hospitals and physician services would be extended to everyone in the public plan, though the actual rates might be adjusted to assure that the costs to providers would be covered. The program would be financed by broad-based federal and state taxes. Private health insurance would be permitted to offer coverage only for services not included in the public plan. Medicaid would continue to pay the required copayments under the public plan for low-income people and would provide coverage for long-term care services as it does now.

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3. For a more complete discussion of the single-payer approach, see Congressional Budget Office, *Universal Health Insurance Coverage Using Medicare's Payment Rates* (December 1991).

Under this plan, estimates for the initial change in national health spending would be near zero, as the result of several offsetting factors. Spending for acute-care health services would increase (at least before cost controls were put in place). The increase would take place because comprehensive insurance coverage and higher payment rates for some services previously paid by Medicaid and Medicare would be only partly offset by lower payment rates for services previously paid by private insurers. Additionally, administrative costs would fall because many payers in the current system would be replaced with a single payer.

Federal outlays would increase initially by 75 percent under this illustrative plan because most spending for acute-care services would be transferred to the public sector. These higher outlays could be assumed by the federal government alone, or could be shared among federal, state, and local governments. Private spending on insurance and health care would fall by about the same amount. The current tax subsidy to employment-based insurance would be eliminated under this approach and, consequently, tax expenditures related to health care would decrease by around 95 percent. Revenues to finance the increase in federal expenditures for health would, of course, increase taxes for households and businesses, and the effects of this increase would depend on the specific financing mechanisms used. The net effect on federal expenditures for health would be an increase of 34 percent.

The preceding analysis of alternative approaches to achieving comprehensive health insurance coverage assumed that cost controls were not included, with the exception of using Medicare's payment methodologies under the single-payer public plan. But effective cost containment could be incorporated into each of these approaches, thereby holding national and federal expenditures for health care below the levels indicated above. Control of health care costs would, however, imply changes from the current health care system that would affect the way in which health care was obtained because coordinated policies that combined uniform prices for all providers, controls over use of services, regulation of capital decisions and of the adoption and dissemination of new technology, and appropriate incentives for consumers would be required. As a result, some limitations would almost certainly have to be imposed on consumers' choices of health insurance coverage, providers, and alternative treatments. In addition, the development of new technologies would probably slow and waiting times to use them would probably lengthen.

Effective control over health care costs could be achieved most directly under a government-run, single-payer health care plan. This approach would require the most government involvement, with financing running through government budgets. As a result, it would put direct responsibility on the single financing authority--the government--for making decisions that would

largely determine total and government levels of health expenditures. In addition, there would almost assuredly be some reduction in health care spending under a single-payer system because of substantially lower administrative costs.

A single-payer system would not, however, guarantee effective control of health care expenditures. The extent to which spending was constrained would depend entirely on the decisions that were made about prices, use of services, cost-sharing by patients, and the amount and distribution of capital and technology.

Health care costs could also be controlled under other systems--including the existing multiple-payer, public/private one. Coordinated policies that applied to all payers, providers, and consumers could be put in place now or concurrently with a move to offer tax subsidies or with implementation of a play-or-pay mandate on employers to expand insurance coverage. In all three cases, national and federal health expenditures could be constrained to lower rates of growth than would occur otherwise.

Creating market incentives to increase the efficiency of the system has also been discussed, most frequently in the context of using tax subsidies to expand access to health insurance. This approach has been presented as an

alternative to the highly regulated one that would be implied either by a single-payer public plan or by government imposition of uniform policies encompassing prices, controls on use, and regulation of other aspects of the health market. The market approach to controlling costs would create incentives for consumers and other payers to choose insurance packages and providers that offered the most efficient and least expensive options for treatment.

There is great uncertainty about how effective a market incentive approach to controlling costs would be, either in the short run or in the long run. It would, however, offer the advantage that consumers and providers would probably retain more choice of insurance coverage and options for treatment than under the other approaches to control costs.

ESTIMATING THE EFFECTS OF COST CONTROL PROVISIONS ON NATIONAL EXPENDITURES FOR HEALTH

Over the past two decades, both public and private payers have made concerted efforts to apply many cost control strategies to the current health care system. As a result, there is evidence on the potential of at least some types of cost containment approaches to affect health care spending.

The Committee has asked me to discuss how successful various types of cost containment provisions are likely to be in restraining the growth in health care expenditures. To give you an understanding of CBO's estimating methods, let me describe several options for controlling health care costs and the issues that these options raise for cost estimating. Where possible, I will also indicate the magnitude of the potential reduction in national health care expenditures that might be estimated for each proposal.

This discussion is intended to be illustrative only, since the specific legislative language would have a considerable effect on the estimated savings. For CBO to include savings in its cost estimates, as a general rule the options must be specific and require explicit actions, rather than rely solely on encouraging voluntary efforts by the private sector. Also, estimates of proposals that would dramatically restructure the health care system are considerably more uncertain than estimates of policies that would require only modest adjustments to current arrangements. We usually find it much easier to estimate the budgetary effects of legislation that would change provisions of Medicare--a centrally controlled program with a single payer and a defined population--than to estimate the impact of legislation designed to lower the level or rate of growth of national health spending. In either case, our ability to analyze the impacts of legislation on health spending is greater the more specific the cost containment provisions are.

Increased Cost Sharing for Health Services

Strategies that would raise the out-of-pocket costs of health care for consumers are predicated on the assumption that consumers would become more cost-conscious if they paid more. In other words, they would be more likely to consider whether the value of an additional visit to the doctor was worth the extra cost or would seek out providers who were more economical or charged less.

Cost sharing for health services could be increased in a number of ways. One could mandate minimum cost-sharing requirements for private insurance, eliminate dual insurance coverage that offsets cost-sharing requirements of individual policies, or prohibit the use of flexible spending accounts to pay deductible amounts and coinsurance requirements. For example, if mandated cost sharing had been set at a level that increased out-of-pocket costs for the population with private indemnity health insurance from 25 percent to 35 percent in 1990, then national health expenditures would have been about 1 percent to 3 percent lower. This effect would be relatively small because consumers are not particularly sensitive to changes in their out-of-pocket costs. The reason is, in part, that they lack knowledge about alternative treatments, their costs, and their efficacy, and, therefore, they delegate decisionmaking to physicians and other providers.

Expanded Controls on the Use of Services

Managed care and controls on use can reduce inappropriate or unnecessary health care. Overall, however, the evidence of their effectiveness in reducing costs--other than through fully integrated HMOs with their own delivery systems--suggests that substantial savings could not be achieved by extending them to more people. Some reduction could occur, however, if expanded controls on the use of services were concentrated on populations with above-average hospital use.

One legislative approach might be to provide federal financial incentives to expand enrollment in HMOs. Incentives, however, would not necessarily elicit the desired increase in voluntary enrollment in HMOs unless they were very large. Further, because only some types of HMOs are effective at reducing use and expenditures, only a portion of any new enrollees would actually use fewer services. Finally, the federal costs of the financial incentives to expand enrollment in HMOs would offset some or all of the savings.

Price Controls

Price controls could be effective in reducing both the level and the rate of growth of spending, but their impact would be partially offset because providers would increase the volume of services (or change billing practices) to recover lost revenues. In addition, price controls applied to only one segment of the market would generally result in higher spending in other segments of the market.

For example, if the prices of physicians' services under the Medicare program were reduced 10 percent, CBO estimates that Medicare's spending for these services would be reduced 5 percent. This estimate reflects our assumption that physicians would offset about half of their potential revenue loss through increased Medicare volume. If providers attempted to keep their overall revenues constant, spending on physicians' services by the non-Medicare population could also rise. As a result, although Medicare's spending for physicians' services would decline 5 percent, that reduction might not significantly affect the level of national health spending.

Medicare's share of the health care market is sufficiently large that it could unilaterally set prices that are somewhat below private payers' prices, without affecting access to care for most Medicare beneficiaries. Access to

care by Medicaid beneficiaries, however, has been adversely affected by the much lower prices that providers are offered in some states for serving this population. In the private market, most insurers do not have sufficient market power to prevent providers from billing the patient for the balance if they limit prices. Thus, under competitive conditions, a private insurance company that limited its payments could lose some of its market share to insurers that paid higher prices and thereby reduced patients' out-of-pocket liability.

Alternatively, government regulation could set maximum prices for physicians' services that all payers had to follow. In other words, insurers would not be allowed to pay more, and physicians would not be allowed to bill patients for amounts above the regulated prices. Under such an all-payer system, providers could increase volume to offset some, but probably not all, of their lost revenue. Administrative costs would decline somewhat, since providers would not have to maintain and monitor many separate price schedules and claim forms. In addition, the authority that determined prices would also control their rate of increase. If the legislation included rules that would limit the growth in prices to less than the projected rate, then price controls in an all-payer system would generate lower national health expenditures than would otherwise occur.

For example, if the annual rate of growth in health care prices could be reduced by as much as 2 percentage points as a result of price regulation under an all-payer system, growth in national health expenditures would be cut by at least 1 percentage point a year. (This assumes that half the potential drop in spending that stemmed from the slowing of price increases would be offset by growth in the volume of services provided.) Over a five-year period under such a scenario, spending for health would be 4 percent to 5 percent less than it would otherwise have been.

Price controls carried out through a single-payer system could reduce reimbursements by the same amount and could also sharply cut administrative costs for insurers and providers. In fact, the one-time drop in the cost of administration could have been around $22 billion in 1990, under the conservative assumption that only the administrative costs related to billing of claims would be reduced if a single-payer system had been fully in place that year. National health expenditures would, however, have fallen by this amount only if prices paid to providers had been reduced to reflect the lower administrative costs that they would have incurred. Legislation including both price controls and provisions for uniform monitoring of providers' patterns of care would have an even greater impact than price controls alone, since monitoring would reduce the magnitude of the response in volume.

Limits on the Tax Exclusion for Employer-Paid Health Insurance Premiums

Limiting the tax exclusion for employer-paid health insurance coverage could reduce health spending by inducing employers and employees to change the provisions of their insurance policies. If the new policies incorporated higher cost-sharing by consumers, for example, the number of services used would fall. One way to limit the exclusion would be to include in an employee's taxable income any contributions by employers (including those in cafeteria plans and flexible spending accounts) that exceeded a certain level. For example, if employers' contributions that exceeded $250 a month for family coverage ($100 for individual coverage) had been treated as taxable income in 1990, about half of all insurance plans would have been affected and the federal tax subsidy to employment-based insurance would have been reduced by about $11 billion.

If such limits were enacted, workers who currently have high levels of coverage would have two choices. They could continue their current coverage and pay federal income and payroll taxes on the excess coverage. Alternatively, they could negotiate with their employers to cut back some, or all, of the excess coverage in exchange for higher wages, thereby also raising their taxable incomes. (Employers would be indifferent between continuing

current health benefits or substituting higher wages for them because both are tax-deductible business expenses.)

Lower amounts of coverage could be accomplished in several ways that would also help to reduce the growth in health care costs. First, traditional insurance could be replaced with HMOs and other effective managed care options. Second, higher copayments could be used to lower the cost of coverage. Third, coverage for some benefits (for example, chiropractic and dental care) might be dropped or scaled back. Finally, reimbursement to providers could be reduced, although this possibility would either limit the insured consumers' choice of providers or increase their out-of-pocket costs. In fact, all these ways of cutting back coverage would represent major departures from health insurance coverage as we know it today. Most people with employment-based insurance now have limited cost sharing and relatively unrestricted choice of providers, features that have been popular for decades. If workers chose to maintain their existing coverage, national health expenditures would not be affected much.

Limits on Expenditures

Legislation that provided for prospective budgets for hospitals, expenditure targets for physicians, and caps on overall national spending would involve major changes in the existing U.S. health care system, but it could result in substantial reductions in the rate of increase in health spending. The legislation would, however, have to include specific details of the mechanisms for setting, updating, and enforcing the limits.

For example, suppose legislation was passed that established prospective budgets for hospitals, with specific formulas for setting and updating them, and there was no leeway to increase the budget for a hospital when overruns occurred. In that case, one could estimate the impact on national health spending as the difference between total spending under the budgets and projected total spending for hospital services in the nation without the legislation. Similarly, if legislation included provisions for setting caps on expenditures for various segments of the health care sector and specified the formulas to determine the annual rate of increase in the caps, then one could estimate the savings by comparing the caps with projected spending in their absence.

To illustrate the effect of an expenditure cap on national health spending, assume that legislation had been put in place beginning in 1985 that included a cap that constrained the increase in total health spending to the rate of population growth (1 percent a year) plus 2 percentage points above the rate of general inflation. If enforced, national health spending would have been only $589 billion in 1990, or about 12 percent lower than the approximately $666 billion that was actually spent that year.

If, however, limits on expenditures were applied selectively to some groups and not others, then providers could increase prices and the volume of services for other groups in order to maintain revenues, without incurring penalties for exceeding the limits for the covered population. Although savings to the segment of the market subject to the limits on expenditures would exist, national health spending might not fall much.

Summary of Cost Control Assumptions

When considering various approaches to cost containment, one needs to keep several factors in mind:

- Providers can increase volume in order to recover revenues lost because of restrictions on price, regardless of whether the price controls are imposed on all or part of the system.

- Providers can increase prices in order to recover revenues lost because of more stringent monitoring of use, regardless of whether the monitoring is imposed on all or part of the system.

- Policies that affect only one segment of the market may be effective in reducing spending for that segment but still not lower overall spending much. Policies that extend to all consumers, payers, and providers generally produce a greater impact on national health spending.

- Proposals that encourage, rather than require, changes in the behavior of providers, insurers, or consumers, and that do not include strong incentives or penalties, have little effect.

As a result, some policies have the potential to achieve greater control over health care costs than others. Examples are uniform pricing under either an all-payer or a single-payer system, reviewing the treatment practices of

physicians, and enforcing limits on expenditures. If put in place concurrently, these policies could noticeably slow the rate of growth in health spending.

CONCLUSIONS

Each of the three approaches to expanding health insurance coverage could significantly reduce the number of uninsured people in this country, and would assure that everyone below the poverty level would have financial access to insurance. In addition, each approach could be combined with effective controls over health care costs. While cost containment could be accomplished most directly through a single-payer public plan, the same outcome would be possible under either a tax subsidy approach or a play-or-pay employer mandate.

Control over costs, however, would probably require extensive government involvement in the private health care market to ensure that there would be uniform policies covering prices and quantities of services, capital investment, and adoption of new technologies. Moreover, these uniform policies would adversely affect some aspects of the current system that many people view as desirable. In particular, consumers would probably face increased constraints on their freedom to choose providers, health

insurance coverage, and alternative treatments. They might also face greater delays in obtaining treatment, and technological progress in health care would probably occur more slowly. The magnitude of these changes would vary directly with the stringency of the controls on costs.

APPENDIX

DESCRIPTION OF ILLUSTRATIVE PLANS

This appendix describes in more detail the assumptions made about the three illustrative plans that are compared in Table 1 of the testimony. For all three plans, the insurance benefit package was assumed to cover only acute-care services, not long-term care. Further, substantial copayment requirements would be imposed on patients under these plans.

Tax Subsidies and Market Reforms

The analysis of the tax subsidies and health insurance market reform approach to comprehensive health care reform draws from the Congressional Budget Office's (CBO's) March 4, 1992, testimony before the Committee on Ways and Means of the House of Representatives on the effects of the President's Comprehensive Health Reform Program on access to health insurance. The President's plan has four basic features that would expand access to health insurance:

- Tax units with income below the tax entry level--that is, the income below which a family would owe no taxes--would be

eligible for a full refundable tax credit of $1,250 for an individual, $2,500 for a two-person family, and $3,750 for a family with three or more members. In 1992, tax entry levels are $5,900 for an individual, $9,850 for a head of household with one dependent, and $15,200 for a married couple with two children. The tax credit would be in the form of a voucher that could be used by low-income families to purchase health insurance.

- The maximum tax credit would phase down to 10 percent of the full credit for tax units between the tax entry point and 150 percent of the tax entry point.

- Individuals with incomes up to $50,000 and families with incomes up to $80,000 (depending on tax filing status) would be offered either a tax credit of 10 percent or a tax deduction for health insurance.

- Health insurance premiums for the self-employed would be fully deductible, up from the current 25 percent deductibility.

To assure that health insurance would be available and more affordable to those who wanted to purchase it, the President's plan also includes requirements on states and new regulation of the health insurance market:

- States would be required to work with health insurers to develop basic health insurance benefit packages that would cost the amounts of the tax credits.

- States would be prohibited from requiring health insurers to include specified benefits or coverage provisions.

- Health insurance networks would be established to enable small businesses to obtain insurance with lower administrative costs than are currently incurred.

- Health insurers would be required to insure all groups that wanted to buy health insurance. Coverage would be guaranteed and renewable. Preexisting condition clauses that limit coverage under employment-based policies would generally be prohibited.

- Limits would be placed on the ability of insurers to set premiums based on variations in risk among similar blocks of business, and mechanisms to spread risks across insurers would be developed.

"Play-or-Pay" Employer Mandate and Market Reforms

Under this illustrative option, all employers including the government would have the following choice:

- Either offer at least a minimum insurance plan to employees who worked 25 hours or more per week; or

- Pay a payroll tax of 10 percent of payroll--7.5 percent assessed on the employer and 2.5 percent assessed on the employee.

Nonworking spouses would have to be covered by the plan. Dependents, other than spouses, would have to be covered through age 18 (age 23 for full-time students). Children might be covered by either spouse's plan at the employees' discretion, but would have to be covered by at least one of them.

Employers would have to provide benefits that were actuarially equivalent to a minimum plan: a single annual deductible of $250 per person, a coinsurance rate of 20 percent, and a catastrophic limit of $875. The premium for family coverage under such a plan is estimated to be about $2,645 in 1990. (Roughly 90 percent of workers have coverage that is at least this generous.) To be excused from the payroll tax, the employer would have to contribute 75 percent of the cost of this minimum plan.

Employers who chose to pay the tax rather than offer a minimum health plan would be allowed to offer supplemental coverage to their employees--commonly known as a "wrap-around" policy. For example, if the current health insurance plan covered dental care, employees would be worse off under the public plan. In this case, an employer might choose to drop its health plan, pay the voluntary tax, and offer a dental insurance plan that would supplement the public plan. In this example, the employees would retain their current level of benefits and the employer would have lower costs if the sum of the tax and the costs of the dental insurance were lower than the costs of the current private insurance policy.

All individuals and families whose incomes were below 100 percent of poverty would be eligible for Medicaid coverage (without cost). Individuals and families whose incomes were above the poverty level could "buy in" to

Medicaid based on a sliding scale of contributions. Specifically, the contribution or "premium" would be the smallest of the following:

- Five percent of family income above poverty for each covered family member;

- Ten percent of family income above poverty; or,

- The total cost of Medicaid coverage for an average family of this size.

Single-Payer Public Plan

Under this alternative, the government would be the sole insurer for basic acute-care services. There would be only one comprehensive benefit package, which would be actuarially equivalent to the average benefits that private insurance plans and Medicare currently provide. This universal public plan would cover the services typically included in private insurance plans now and would require copayments by patients up to an annual cap.

The universal plan would cover all legal U.S. residents, financed from broad-based taxes. Private insurers would not be permitted to offer competitive or supplementary insurance (such as the medigap coverage now sold to Medicare enrollees) for services provided under the public plan, but they could cover other services. A residual Medicaid program would supplement the universal plan for low-income people, covering their copayments and some services (primarily long-term care) excluded from the universal plan.

Payment rates for hospital and physician services covered under the universal plan would be set using Medicare's current payment methodologies. For physician services, Medicare's rates would be applied to all services without adjustment, thereby reducing rates now paid by private insurers and increasing rates now paid by Medicaid. For hospital services, two adjustments would be required. First, rates now paid for Medicare enrollees would be increased by about 10 percent because Medicare's payments now cover only about 90 percent of hospitals' costs for treating Medicare patients. Second, for some diagnoses, the rates appropriate for Medicare patients would be modified to reflect the different (generally lower) costs of treating younger people. Hence, both Medicaid and Medicare rates for hospital services would increase, while average rates paid by private insurers would fall. The net result of these payment rate changes, together with the extension of insurance

to those who are now uninsured, would be to increase payments for health care services by up to $17 billion for 1990.

The results shown in Table 1 assume that the public insurer's administrative costs would resemble Medicare's, equal to about 2 percent of the total cost of covered services or 2.3 percent of benefit payments. The results also assume that the billing costs of providers might fall by as much as one-half compared with the current system of multiple insurers. As a result, if payment rates for providers were reduced to reflect their lower administrative costs, administrative costs--for insurers and providers combined--might have been lower by about $22 billion had a single-payer system been in place for 1990.