CBO TESTIMONY

Statement of
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before the
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NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Wednesday, October 9, 1991.

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Mr. Chairman, I appreciate the opportunity to appear before this Committee to discuss trends in the costs of health care, the implications of these trends for the economy, and the Congressional Budget Office's (CBO's) methods for assessing the potential savings associated with cost containment provisions in health legislation.

Unlike most other countries, which have chosen to control their health care sectors through stringent regulation, the United States has relied primarily on market forces. The result has been a system capable of delivering the highest quality medical care, but with few controls over the cost of that care.

In 1990, the United States spent $666.2 billion on health care--or $2,566 per person. Real per capita spending grew 4.6 percent between 1989 and 1990--a rate higher than the 4.4 percent annual growth between 1985 and 1989. The Health Care Financing Administration has projected that, by the year 2000, health care spending will total about $1.1 trillion (in 1990 dollars), or about $3,954 per person.

Moreover, the United States already spends much more on health than do other developed countries--11.8 percent of gross domestic product (GDP) in 1989, compared with 8.7 percent in Canada, 8.2 percent in the former West

Germany, 6.7 percent in Japan, and 5.8 percent in the United Kingdom (see Figure 1). In 1990, the share of GDP accounted for by health spending in the United States rose to 12.3 percent.

The rapid growth of national spending for health care, overall and per capita, has significant implications for the federal budget. In 1970, spending on health constituted 7.1 percent of the federal budget. By 1990, that share had grown to 13.4 percent. CBO projects that health care will account for over 20 percent of federal spending by 1996 (see Table 1).

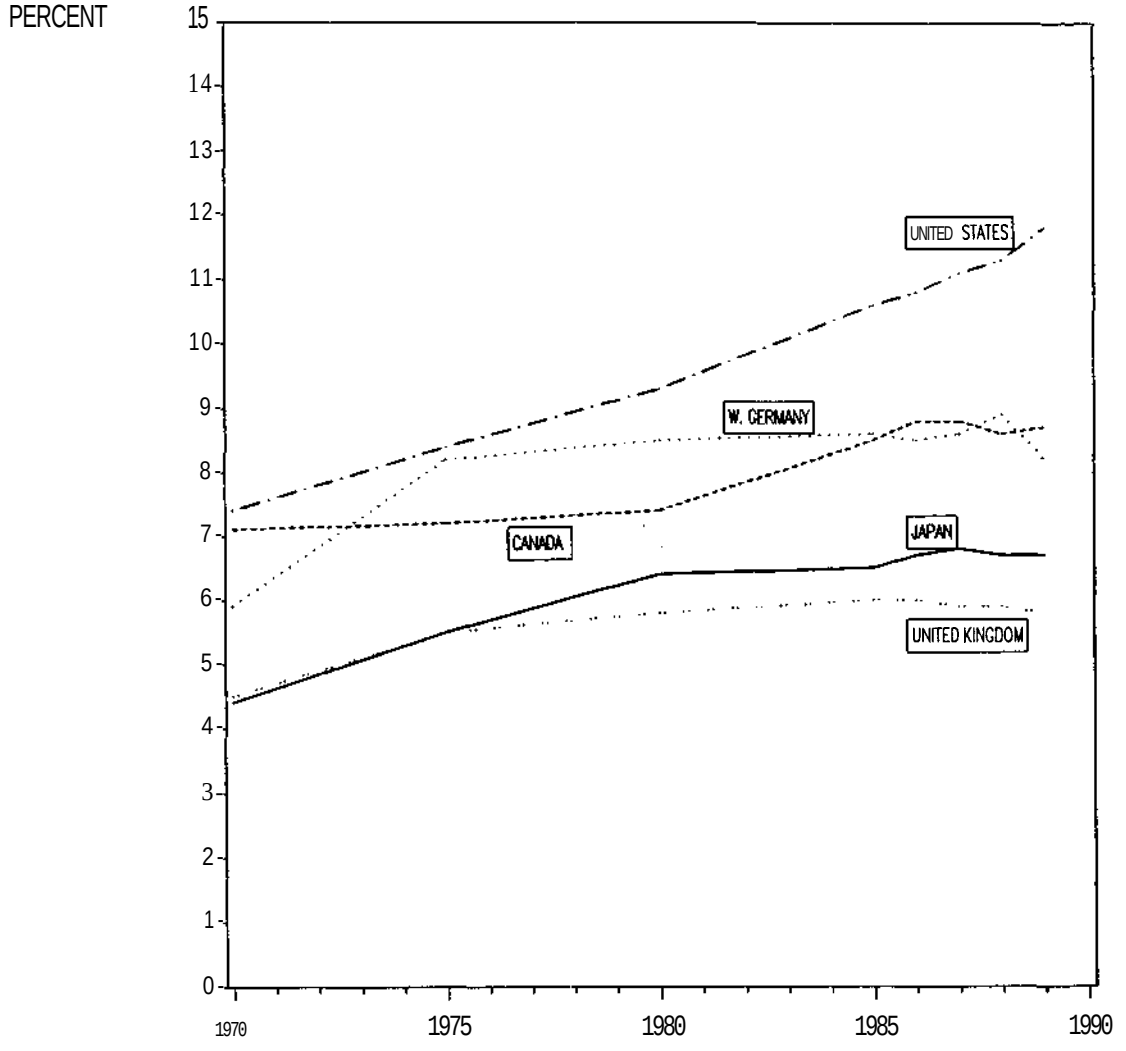
The consequences of continued growth in health care spending are obvious. Generally, the more the nation spends on health care, the less income--both private and public--is available to spend on other goods and services. Continuing increases in health care spending also make it more difficult to address the problems of the uninsured population, since most remedies would result in even higher private and public spending.

HEALTH SPENDING AND THE ECONOMY

Trends in and the performance of the health care system have important implications for the macroeconomy. Rising health care prices cut into wage

FIGURE 1.

HEALTH EXPENDITURES AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT IN THE UNITED STATES AND SELECTED COUNTRIES, 1970-1989



SOURCE: Congressional Budget Office calculations based on data from G. Schieber and J.-P. Poullier, "International Health Spending: Issues and Trends," *Health Affairs* (Spring 1991).

NOTE: Gross domestic product (GDP) is equal to gross national product less net property income from abroad. Use of GDP for international comparisons of health spending eliminates variations arising from differences in the role of foreign transactions in different economies.

TABLE 1. FEDERAL SPENDING ON HEALTH, FISCAL YEARS 1970-1996

	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995	19%
					In Billions of Dollars						
Total Federal Spending[a]	195.6	3323	590.9	9463	1,251.7	1337.1	1,503.7	1,501.2	1,533.5	1,533.5	1,604.8
Total Federal Health Spending[a]	13.9	29.5	61.8	108.9	168.0	187.7	216.5	239.5	265.0	293.9	328.4
Medicare[a,b]	6.2	12.9	32.1	65.8	98.1	104.5	117.6	129.1	142.5	158.0	176.6
Medicaid	2.7	6.8	14.0	22.7	41.1	52.0	61.7	70.7	81.1	92.4	1053
Veterans affairs[a]	1.8	3.7	6.5	9.5	12.1	12.5	13.9	14.4	153	16.0	16.9
Other[a,c]	3.2	6.1	9.2	10.9	16.6	18.7	233	253	26.1	27.5	29.6
					As a Percentage of Total Federal Spending						
Federal Health Spending	7.1	8.9	10.5	11.5	13.4	14.0	14.4	16.0	173	19.2	20.5
					As a Percentage of Federal Spending on Individual Health Programs[d]						
Federal Health Spending	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medicare[b]	44.6	43.7	51.9	60.4	58.4	55.7	543	53.9	53.8	53.8	53.8
Medicaid	19.4	23.1	22.7	20.8	24.5	27.7	28.5	29.5	30.6	31.4	32.1
Veterans affairs	12.9	12.5	10.5	8.7	7.2	6.7	6.4	6.0	5.8	5.4	5.1
Other[c]	23.0	20.7	14.9	10.0	9.9	10.0	10.8	10.6	9.8	9.4	9.0

SOURCE: Congressional Budget Office calculations and projections.

NOTE: Federal health spending excludes spending for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program.

a. Total federal spending assumes compliance with discretionary spending limits for fiscal years 1991 through 1995. The discretionary spending limit in 19% is a CBO extrapolation. Individual program accounts are shown at baseline levels, because the Budget Enforcement Act specifies overall limits but not specific programmatic changes.

b. Medicare expenditures are shown net of premium income.

c. Includes federal employee and annuitant health benefits, as well as other health spending.

d. May not add to 100.0 because of rounding.

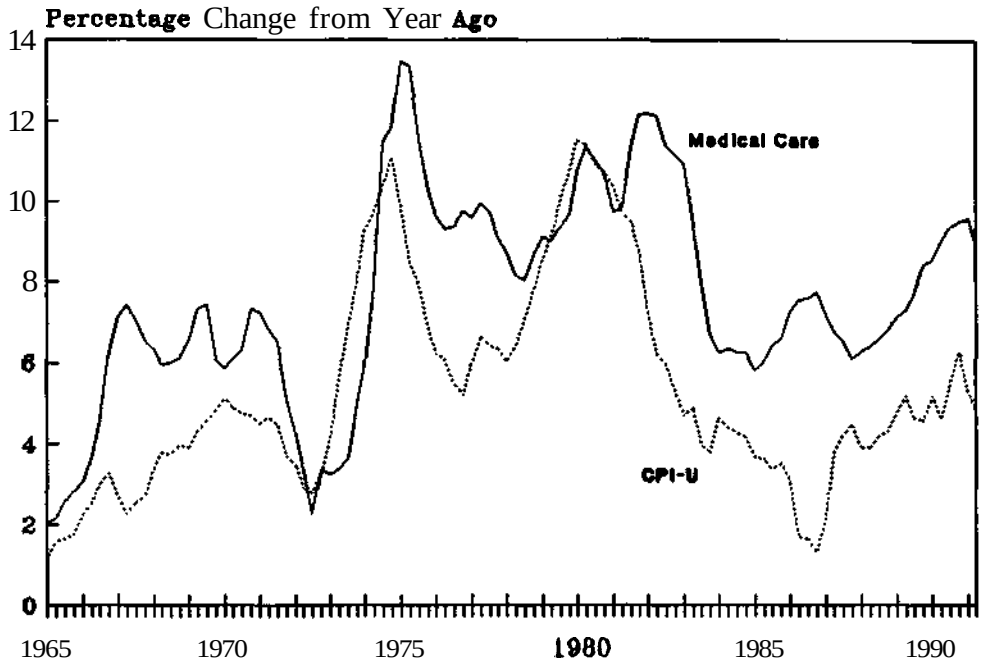
growth. Increases in health care costs, moreover, may disproportionately affect relatively low-paid workers. In the long run, the rapid increase in health care expenditures may retard economic growth, unless it is matched by a corresponding improvement in health.

Effects of Escalating Costs of Medical Care on Wages

Reported price increases for medical care have run ahead of general inflation for a long time. The divergence between the growth of the component for medical care in the consumer price index (CPI) and the overall growth of that measure of prices has if anything increased in recent years (see Figure 2). There is plenty of reason to doubt that the CPI medical component accurately measures price increases in medical care, because there is no good way to distinguish between rises in the price of medical services and improvements in medical technology. Both of these are reflected in the CPI medical care measure. Nevertheless, the reported medical price increases certainly reflect an increase in the cost of medical care.

The rise in medical care costs also widens the spread between the growth in cash wages workers receive and the growth in total employee compensation employers pay. This spread includes health insurance premium

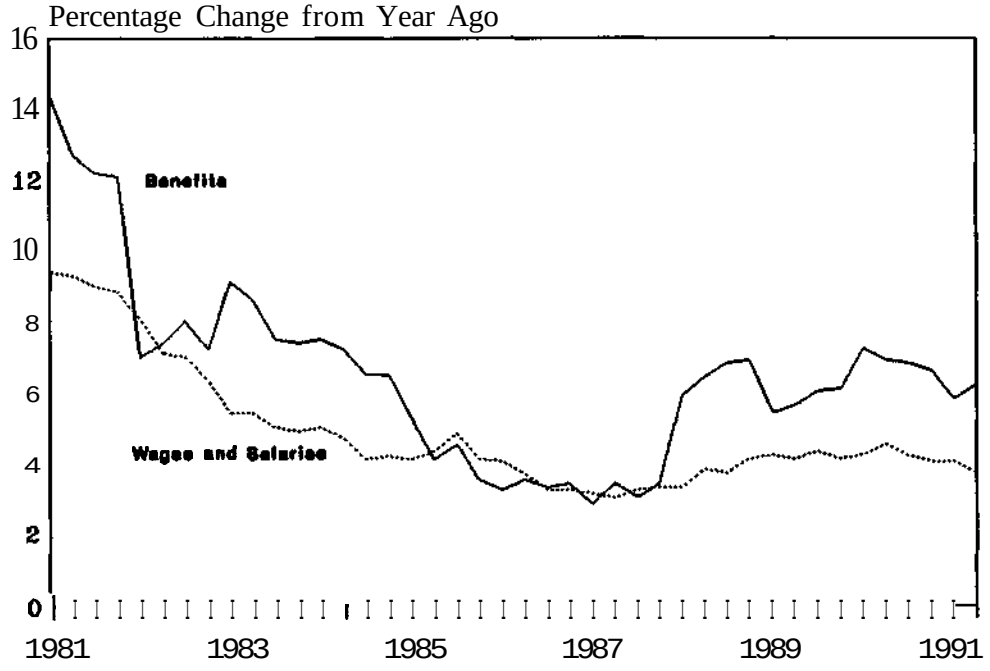
FIGURE 2. Medical Care Prices Have Far Outstripped General Inflation



SOURCE: Bureau of Labor Statistics and Congressional Budget Office.

NOTE: Before 1983, the CPI-U series is adjusted to incorporate a measure of homeownership conceptually similar to that of the current CPI-U.

FIGURE 3. Total Benefit Costs Have Risen Faster Than Wages and Salaries in Private Industry



SOURCE: Bureau of Labor Statistics and Congressional Budget Office.

employers pay, as well as costs of mandated benefits such as Social Security taxes and other fringe benefits. Figure 3 shows that total benefit costs have risen faster than wages and salaries almost every year in the 1980s. Sharply rising costs of health insurance were a major factor in these increases (see Table 2).

Most analysts agree that the bulk of medical insurance costs is paid ultimately not by employers, but by workers in the form of lower real cash wages. As the increase in insurance costs has been continuous over much of the postwar period, it was probably anticipated and incorporated into wage bargains. Thus by and large, the growth in medical care costs may not have added much to employers' total costs for compensation. But rising benefit costs most likely have cut into workers' cash wages and salaries, and help account for the weak growth of cash wages in the 1980s.

Distributional Consequences of Medical Cost Increases

Not all workers are equally affected by rising costs of health care. Because medical insurance premiums are a larger proportion of the overall compensation of those relatively low-paid workers that have health insurance,

TABLE 2. COMPONENTS OF EMPLOYER COSTS FOR EMPLOYEE COMPENSATION IN PRIVATE INDUSTRY, MARCH 1987 AND MARCH 1991

	As a Percentage of Total		Dollars per Hour
	March 1987	March 1991	(March 1991)
Wages and Salaries	73.2	72.3	11.14
Legally Required Benefits	8.4	9.1	1.40
Paid Leave	6.9	6.8	1.05
Insurance[a]	5.4	6.5	1.01
Retirement and Savings	3.6	2.9	.44
Supplemental Pay	2.4	2.3	.36
Total Compensation[b]	100.0	100.0	15.40

SOURCES: Bureau of Labor Statistics, Division of Employment Cost Trends; and Congressional Budget Office.

a. Primarily health insurance.

b. Totals may not add to 100 percent because of rounding and because of a small residual category, "other benefits."

their cash wages will have been reduced disproportionately relative to the those of higher-paid workers.

The increase in health costs may also affect workers differently depending on whom they work for. Small firms face higher medical insurance premiums, on average, than larger firms, both because their small payroll offers little opportunity for risk pooling and because the administrative costs of providing insurance to a small firm are higher. Thus, workers in these firms are particularly affected by the increase in medical costs. Moreover, some small firms have found that because they compete for workers with larger firms, they could not adjust cash wages by enough to account for their higher benefit costs: they have instead dropped medical insurance altogether, adding to the already large number of people with no medical insurance at all.

Rising costs of health care are, of course, even more serious for uncovered, low-paid workers and those who have no coverage because they do not work. With a growing share of GDP being devoted to health care, the poor access to care of these groups of the population may seem to be a growing injustice.

Long-Run Implications of Rising Medical Care Expenses

In addition to its impact on cash wages, spending on medical care can affect the growth of the economy. But the effects are hard to disentangle: growth could be increased or decreased, depending on what consumers get when they pay for medical care.

The share of health care expenditures in GDP has been rising relentlessly for decades, with no sign of a letup--and the United States spends a larger share of GDP on health than does any other industrial country. Some of the increase in medical costs is undoubtedly warranted: as people get richer, they probably want to spend more on their health. Moreover, advances in medical technology, while costly, have made it possible to save some people who just a few years ago would have been lost to injury or to disease.

Nevertheless, there are essentially no controls over the cost of health care, and in such circumstances, waste is likely to arise. Many examples are often cited: unnecessary procedures performed, too many hospital beds maintained, and too many pieces of expensive equipment purchased. In addition, incomes of physicians may bear little relation to, and sometimes may be much higher than, the true value of the services they perform. No one

knows how much of the growth in medical care costs is the result of waste and paying physicians too much. Yet, because citizens of other countries who pay far less for medical care do not seem notably less healthy, these factors probably play a role.

Waste in medical care diverts resources from other uses. In large part, the cost of such waste is that less is available for consumption of other goods and services. Some of the resources may, however, be diverted from saving and investment, leading to a longer-term reduction in productive capacity. If the inefficiencies grow, they will reduce the growth rate of the economy.

Growth in medical care costs also affects national saving, investment, and growth through its effect on the federal budget. Nearly half of the cost of medical care in the economy is paid for by all levels of government, through a variety of programs, the largest of which are the entitlements--Medicare and Medicaid. Entitlements are the hardest areas in the budget to control, so the escalation year after year in medical care costs puts upward pressure on the deficit that is hard to escape. Since the federal budget deficit preempts private saving, a larger deficit leads to lower investment and ultimately to a smaller productive capacity in the economy.

When increases in medical care costs are warranted--when, that is, they correspond to a real improvement in the health of the population--it may not matter much that saving and investment are reduced; the improvements in health may boost productivity and offset the loss of investment. In this sense, some portion of medical care spending is a kind of investment: indeed, economists call it investment in human capital. But when medical care costs increase because of waste or because prices are too high, no such offset occurs and in the long run the standard of living is reduced.

THE HEALTH SECTOR

The significant consequences of rising health care costs have led to many efforts to constrain this growth. Our ability to control these costs, however, has been limited by the characteristics of the health sector that uniformly exert upward pressures on spending.

Market forces have been relatively ineffectual at controlling the costs of health care because most consumers are covered by either private or public health insurance and so have little incentive to limit the quantity or quality of their medical care. Although consumers partially pay for health services through insurance premiums, taxes, and lower wages, their decision to use a

specific health service is influenced by the direct out-of-pocket cost for that additional service. The proportion of personal health costs paid out of pocket has declined, however--from 39 percent in 1970 to about 24 percent in 1989--thus encouraging increased use of services.

The complexity and rapidly changing technology of medical services, as well as uncertainty about the efficacy of treatment, have also led consumers to delegate much decisionmaking to physicians. Physicians, in this role, may feel a social responsibility to provide the best possible care regardless of its cost, even when the benefits of specific treatments are marginal. Another result of consumers' delegating decisionmaking and their insensitivity to the cost of care is that physicians can strongly influence the amount of health care services that are used. Thus, when prices of medical services have been constrained, physicians have consciously or unconsciously been able to offset the potential reductions in their incomes by providing more services.

Technological change has also contributed to the increase in real health care spending that has occurred over the past two decades. The present financing system for health care encourages rapid dissemination of new technologies--access is available quickly for those with insurance or who can afford to pay directly--but excess capacity can easily develop. Excess capacity can then lead to overuse of these technologies, resulting in higher

costs and the potential to harm patients because of side effects or other complications associated with medical interventions.

Institutional aspects of the U.S. health system are another source of rising health costs. For example, although medical malpractice premiums accounted for only about $5 billion in 1988--or 0.9 percent of all spending for health--the malpractice climate may affect patterns of practice in ways that indirectly raise costs. One particular concern is that physicians may require an excessive number of tests in the face of potential liability lawsuits and without guidelines on agreed-upon practice. Also, administrative expenses account for a high and growing proportion of the costs of health care in the United States, because the multiple-payer system requires tracking eligibility, marketing, assessing risks, monitoring individual patient encounters, and using a different set of prices for each payer. In 1987, the administrative costs of private insurers and public programs were $23.9 billion, or 4.9 percent of spending in the United States, compared with 2.5 percent in Canada and 2.6 percent in the United Kingdom. Furthermore, estimates indicate that U.S. providers may have incurred an additional $100 billion for administration in that year.

Some specific aspects of the health system that contribute to higher per capita costs in the United States than in other industrialized countries are,

however, desirable. For example, most consumers in the United States are free to choose among providers, alternative treatments, and insurance packages. They also value speed and accuracy of diagnosis and a short length of time between diagnosis and treatment. In addition, significant resources are devoted to basic medical research to improve diagnosis and treatment, and the current financing system permits these advances to be introduced rapidly, thereby extending the benefits of research to the insured population quickly. Successfully controlling the rate of growth in health spending would, almost certainly, adversely affect some or all of these features of the health system.

CONTROLLING HEALTH CARE COSTS

Controlling costs in a diverse multiple-payer health system such as we have in the United States is extremely difficult. Moreover, the evidence suggests that while some attempts have been effective for subgroups of the population, they have had little or no impact on overall trends in national spending for health care.

Cost Sharing

Policymakers have frequently discussed--though not expanded--cost sharing as a means to increase control over health care costs. In fact, the proportion of expenditures on personal health that consumers paid out-of-pocket declined over the past decade, thereby actually contributing to the increase in health spending. Even so, cost sharing in the United States is significantly higher than in most other countries. For example, out-of-pocket costs were 7 percent in the former West Germany in 1985, 3 percent in the United Kingdom in 1987, and more than 20 percent in the United States, in both years.

Evidence from studies of the effect of cost sharing on spending for health services does suggest that, if out-of-pocket costs were raised, use of services and total spending on health would decline. Because consumers pay only a small proportion of the total costs of the health care they use, and because they delegate many of their decisions to physicians, a substantial increase in cost sharing would have only a modest effect on total health spending, however. In addition, the reduction in spending that occurred would probably have a greater impact on the use of services--both beneficial and unnecessary--by low-income people than by others.

Managed Care

Managed care attempts to reduce inappropriate and unnecessary care by reviewing decisions on how to treat specific individuals and, in some cases, limiting the patient's choice of providers. During the 1980s, the proportion of the population in managed care grew dramatically. In 1988, over 60 million people (about half of those with traditional insurance) had some degree of managed care as part of their insurance package, 35 million were in health maintenance organizations (HMOs), and 18 million were in preferred provider organizations (PPOs).

As for the impact of managed care, evidence indicates that only staff and group model HMOs--in which the doctors are part of the HMO and have no independent practice--are clearly effective in reducing use and costs. Most people are in much more loosely structured managed-care arrangements, which have not consistently had a significant effect on spending. In addition, although the health care of nearly half of the privately insured population is now subject to some type of review, its expansion appears to have had little or no effect on the overall level of spending on health. Furthermore, the administrative costs of monitoring individual patients and decisions about treatment can be high. Other countries do not monitor individual patients and procedures, but instead monitor and review providers, using data systems

that include all patients. This process makes it possible to identify physicians who routinely stray from standard practices.

Price Controls

Price controls are another method for controlling health costs. They have been used over the past decade, particularly by Medicare and Medicaid. When price controls are imposed, however, the volume of services rises. Controls may also adversely affect access to care if they are imposed for only one group, because providers can obtain higher prices for serving other groups. If price controls were applied uniformly to the whole health care system, they would have greater potential to control health care costs, although responses in volume would still occur unless controls on use were also imposed on providers.

Another approach to controlling prices is the all-payer hospital rate-setting strategy that Maryland, Massachusetts, New Jersey, and New York have tried for various periods. These states set the payment levels that hospitals received for providing services and required that all payers in the state--both private and public--use those rates. Studies of all-payer systems have shown that they generated a significant one-time drop in hospital

spending of between 2 percent and 13 percent and also lowered the rates of growth in spending. Whether similar savings would be achieved if rate setting was adopted in other states with different health system characteristics is uncertain. In addition, it is not known what effect hospital rate setting had on total spending for health services in these all-payer states. Lower spending for hospital care was possibly offset, to some extent, by higher spending for other services.

Competition

Another strategy for controlling health care costs that has been widely advocated is increased competition. Competition did increase among insurers and providers during the 1980s, but costs have not been reduced. Because consumers directly pay only a fraction of the full cost of their health insurance premiums and of the health services they use, most competition is apparently on the basis of generosity of benefits, amenities, and quality rather than on price. Increased competition appears to have made consumers better-off by giving them more choices, but it has had little effect on spending.

Regulatory Policies

A substantial amount of the growth in spending for health care--as much as 10 percent to 15 percent-appears to be associated with new technologies. Indeed, some experts have suggested that, if health care costs are to be controlled, limiting the growth of technology is essential. The health planning and certificate-of-need programs that the federal government required of the states in the late 1970s and 1980s, however, were ineffective in controlling growth in capital and new technologies, perhaps because they were applied in a nonsystematic way in most states. In contrast, other countries impose limits on capital and new technologies that seem to be effective. In 1987, the former West Germany had 1.9 magnetic resonance imaging (MRI) units for every 2 million people, compared with 7.4 MRIs for every 2 million people in the United States. More recent data for Canada indicate that country had only 0.9 MRIs for every 2 million people in 1989.

Imposing limits on expenditures is another strategy that has been used in other countries (and by Medicare) to control spending on physicians' services. Limits could be established in several ways:

- Global budgeting for hospitals could set hospital budgets prospectively, so hospitals would not gain from admitting more people or from doing more than necessary.

- Targets for spending on physicians' services could be combined with penalties for exceeding them, usually in the form of lower fees in the future.

- Caps on expenditures could place absolute limits on spending.

All of these strategies could control some or all components of spending, but their effectiveness would depend on how the limits were set and how stringently they were enforced.

Potential to Control Health Spending

Controlling costs in the United States is more difficult than in other countries that have coordinated health care policies or centralized health care systems. But one could achieve greater control over costs through a combined strategy that might include eliminating first-dollar insurance coverage; setting uniform payment rates for providers; monitoring medical care by examining each

provider's entire practice; controlling the growth of capital and technology, with goals set at a national or regional level; and establishing effective limits on national and regional expenditures.

Without significant changes, the United States is unlikely to achieve greater control over health care spending in the 1990s than it did between 1980 and 1990, when real spending per person increased at an average annual rate of 4.4 percent. Also, without cost containment it will be more difficult to address the other major problem of the health care system--the large and growing number of people in the United States without health insurance coverage. Effective control over costs would, however, require that some desirable features of the current system be scaled back.

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

The Congressional Budget Office has responsibility for preparing cost estimates for bills reported by Congressional committees. We also prepare cost estimates, at the request of committees, for them to use in earlier stages of the legislative process. These estimates show how legislative proposals would affect federal spending over the next five years.

The Committee has asked me to discuss the types of cost containment provisions that CBO would judge to be successful in restraining the growth in health care expenditures and would, therefore, score as generating savings in its cost estimates. To give you an understanding of CBO's 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 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 must 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.

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 the 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 1989, then national health expenditures would have been about 1 percent to 2 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 Use of Services

Managed care and controls on use can reduce inappropriate or unnecessary health care. Overall, however, the evidence on their effectiveness--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.

For example, if all private insurers were required to include specific controls on use in their policies, national health spending could be as much as 1 percent to 2 percent lower. The exact impact would depend on the stringency of the required controls and on the previous level of hospital use by the affected population.

A different legislative approach might provide federal financial incentives to expand enrollment in HMOs. Encouraging behavior, however, would not necessarily elicit the desired growth. 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 substantially 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 would estimate 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.

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 an all-payer system, with regulated prices that were constrained to grow only at the rate of general inflation, had been put in place in 1985, personal health spending in 1989 would have been about $40

billion lower, and national health spending would have been reduced by nearly 7 percent. The impact on spending would have been even greater, except that our estimates are based on an assumption that increases in volume would offset half of the maximum potential savings.

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 as large as $50 billion in 1989, if a single-payer system had been fully in place that year and 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.

Expenditure Limits

Legislation that provided for global prospective budgets for hospitals, expenditure targets for physicians, and caps on overall spending within the system 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, in the absence of 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 was put in place beginning in 1985 that included a cap that constrained the increase in total health spending to the rate of general inflation. If enforced, national health spending would have been only $463 billion in 1989, or about 23 percent lower than the approximately $604 billion that was actually spent that year. If, instead, the

cap constrained the rate of increase to 8 percent a year, national health spending would have been $569 billion in 1989--nearly 6 percent lower.

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. While savings to the segment of the market subject to the limits on expenditures would exist, national health spending might not fall much.

CONCLUSION

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

Without significant changes in the structure of the health care system, the United States is unlikely to be able to achieve much greater control over

health care spending in the 1990s than was evident in the 1980s. The consequences of failure to obtain the benefits from effective cost containment are many. Spending on health care will increase as a share of national income. Workers will receive a greater share of compensation as health insurance coverage, and less in the form of direct wages and salaries. As health care costs continue to rise at a rate that exceeds the rate of increase in wages and salaries, fewer workers--particularly lower-wage workers-will have employment-based group insurance. Governments, both federal and state, will spend a larger amount to maintain current health programs, exerting pressure on government budgets and potentially crowding out funds for other programs.

At the same time, however, if effective controls on health spending were put in place, some desirable aspects of the current system would probably have to be scaled back. 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.