CBO TESTIMONY

Statement of
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NOTICE

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Mr. Chairman, I appreciate the opportunity to appear before this Committee to discuss the problem of health care costs and the effectiveness of various strategies by which we might hope to achieve greater control over these costs.

Although the United States is a leader in medical research and has the capability to deliver the highest quality health care, criticisms of its health care system have been growing over the past decade. These criticisms have focused on two principal features of our system.

- Spending per person for health care in the United States is very high compared with other industrialized countries, and total national spending for health is increasing more rapidly than national income; and

- Many people in the United States lack financial access to health care-that is, they are uninsured and ineligible for existing public health care programs.

The United States spends much more per capita for health care than other industrialized countries. In 1987, the United States spent 11.2 percent of gross domestic product (GDP) on health care, compared with 8.8 percent in Canada, 8.1 percent in West Germany, 6.8 percent in Japan, and 6.1

percent in the United Kingdom. Moreover, the differential between the United States and other countries' spending on health care as a share of GDP has increased dramatically since 1965. This increase in health spending also has significant implications for the federal budget. In 1980, 11 percent of the federal budget went to health care. CBO projects that health spending will be nearly 20 percent of the budget by 1996.

THE HEALTH SECTOR

Many factors contribute to the high and rapidly rising costs of health care per capita, including an aging population and more effective and costly medical technologies that are being developed on a continuing basis. Many observers, however, suggest that a major reason for high and rapidly rising health costs is the failure of the normal discipline of the marketplace to limit the quantity of services supplied, resulting in part from the fact that consumers pay less than the full price of the services they purchase.

In the health services market, the conditions necessary for the existence of a fully competitive market are not met. In particular:

- Uncertainty with respect to the occurrence of illness has led to the development of extensive insurance of a type that encourages consumers to purchase more and higher quality services than they would in the absence of insurance;

- The complexity and rapid technological change in medical services and uncertainty about the efficacy of treatment have led consumers to delegate much decisionmaking to providers; and

- Entry by providers to the industry is severely regulated, knowledge about differences among providers is not commonplace, and in many cases there are few competing sellers.

The role of insurance in the health sector is critical to understanding the imperfections in the market for health services that contribute to high and rapidly rising costs. Thus, the characteristics of these two markets, and recent trends that affect their performance, provide background for the examination of the effectiveness of strategies for controlling costs.

The Market for Health Insurance

In 1990, about 70 percent of the population under the age of 65 had health insurance through some employment-based group. The growth in employment-based health insurance since the 1940s has been influenced by the lower premiums that can be charged for group health insurance compared with those for individual policies. These lower premiums are possible because risks are more predictable for larger groups and because administrative costs are lower as a share of benefits for groups. An additional factor in the growth of employment-based insurance is that employer-paid fringe benefits are excluded from the taxable income of employees. This exclusion will save individuals an estimated $56 billion to $58 billion in federal, state, and local taxes in 1991.

Although employment continues to be the principal source of health insurance, the availability of employment-based coverage has been reduced by changes in the private insurance market over the past decade. Many of these changes occurred in response to rapid increases in the costs of health care. A related impetus for change was the development of policies intended to control rising health care costs that encouraged competition among health insurers and increased choices of insurance arrangements available to consumers.

First, between 1980 and 1990, enrollment in health maintenance organizations (HMOs)--that is, combined insurance-service delivery systems--has risen nearly fourfold to 35 million people. HMOs offer a defined network of providers to their members, and are able to exert substantial control over the practice patterns of these providers. As a result, they have the potential to provide comprehensive health services for lower premiums than those of traditional insurers.

Second, traditional insurers have moved away from community rating, using experience rating instead. Under community rating, premiums are based upon the expected costs per person of providing insurance in a geographic area, averaged over the entire insured population. When experience rating is used, insurers base the premium for a given group on the average expected costs of insuring that group alone. Experience-rated premiums are lower-relative to community-rated premiums--for groups that are expected to have fewer health problems than the average in the community. The other side of the coin, however, is that premiums are higher for those that are expected to have more health problems than average, compared with community-rated premiums.

Third, rapid increases in the cost of health care have also affected the level of premiums for health insurance. Between 1977 and 1987, the average

real premium paid by employers rose from $1,111 to $1,656 (in 1987 dollars), or by 49 percent. Because the costs of health insurance are a larger share of compensation for lower-wage workers, the dramatic rise in premiums has reduced employment-based coverage for them more than for higher-wage workers.

The Market for Health Services

Several characteristics of the market for health services are important in explaining the level and trends in health spending. One change that has affected the market is the increase in the supply of physicians relative to the population over the past two decades--from 1.6 per 1,000 population in 1970 to 2.4 per 1,000 in 1990. The availability of more physicians has improved access to health services in areas that were previously less well served and has made physicians more willing to participate in managed care arrangements and to negotiate discounts on prices.

Since physicians can influence the demand for medical services, however, the greater prevalence of negotiated discounts has not resulted in a decline in physicians' incomes. Instead, as prices have been constrained, the volume of services provided has risen. This increase may have resulted, in part, because consumers are likely to want more at the lower price, but it also

resulted because physicians can increase the number of services they provide or change the way in which their services are counted or billed. Evidence from the experience under Medicare indicates that, when prices decline, the volume of services increases sufficiently to offset about half of the potential reduction in spending that would otherwise have resulted from the price decrease.

In addition, some analysts believe that rapid technological change explains a significant portion of the increase in real health care spending per capita that has occurred over the past two decades. The present financing system for health care encourages the 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, with higher costs resulting and with potential for harm to patients because of side effects or other complications associated with medical interventions.

The market for health services has also been influenced by the continuous decline over time in the out-of-pocket costs for health services paid by consumers. Although consumers partially pay for their health services through insurance premiums, taxes, and lower direct wages, their decision to use a specific health service is influenced by the direct out-of-pocket cost for

that additional service. The decline in the proportion of costs paid out of pocket--from 46 percent in 1965 to 23 percent in 1980 and to 21 percent in 1989--has led to a rise in the quantity and quality of services consumers have purchased over the past decade, perhaps obscuring some of the effects of policies aimed at reducing the rate of increase in health spending over that period.

Finally, the medical malpractice environment has been cited as contributing to rising health costs. Although only about $5 billion--or 0.9 percent of all spending for health--was spent on medical malpractice premiums by all types of medical providers in 1988, the malpractice climate may also affect patterns of practice in ways that indirectly raise costs. For example, physicians may increase testing beyond the medically necessary level in the face of potential liability lawsuits and in the absence of agreed-upon practice guidelines.

Performance of the Health Sector

The characteristics of the markets for health insurance and health services combine to create a number of outcomes in the health care sector that are perceived to be problems. Three major problems are:

- The proportion of people without health insurance coverage has been growing over time--from 12.2 percent in 1978 to 15.7 percent in 1989--and the proportion of workers with insurance has been falling.

- Administrative costs associated with health care spending account for a high proportion of the costs of health care in the United States because of our multiple payer system, which requires tracking eligibility, marketing, risk assessment, monitoring of individual patient encounters, and a unique set of prices for each payer. In 1987, insurers' administrative costs 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.

- Despite the exceptionally high level of spending for health care in the United States, health outcomes such as infant mortality rates and life expectancy at birth are no better here than in other industrialized countries.

Although the United States spends more than other industrialized countries, some specific aspects of our system that contribute to these higher

per capita costs are perceived by many people to be desirable. For example, we value speed and accuracy of diagnosis and a short length of time between diagnosis and treatment. We also devote significant resources to basic medical research that yields improvements in diagnosis and treatment. Moreover, the current financing system permits rapid dissemination of new technologies, extending the benefits of research to the insured population with minimal waiting times.

POLICIES TO CONTROL HEALTH CARE COSTS

In response to concerns about rising health care spending and prices, many strategies for controlling health care costs have been developed and carried out during the past two decades, especially during the 1980s. Despite these efforts, spending on health has continued to rise at a dramatic rate. The variety of approaches adopted reflects the fact that controlling costs is a complex problem and that, in the United States, the market for health services is a diverse and uncoordinated system.

Cost Sharing

Although cost sharing by consumers has often been discussed as a potentially effective strategy for controlling health care costs, out-of-pocket spending for health care declined from 23 percent of total costs in 1980 to 21 percent in 1989. Even so, the United States remains significantly different from most other countries. For example, out-of-pocket costs are 7 percent in West Germany and 3 percent in the United Kingdom.

Evidence from studies of the effect of cost sharing on spending for health services does, however, suggest that if the average coinsurance rate in 1989 had been increased from 21 percent to 31 percent, a decrease in spending of between 1 percent and 2 percent would have occurred--or about $6 billion to $12 billion in 1989. This reduction in spending would probably result from fewer initial visits to ambulatory providers and would have more impact on the poor than on other consumers.

Managed Care/Controls on Use

Because there is evidence that many of the health services provided to consumers are unnecessary or inappropriate, managed care has been widely advocated in the United States since the early 1970s as a strategy for

controlling costs. Managed care includes third-party payers' review and intervention in decisions about health services to be provided, and limitations on patients' choices of providers. Studies of its effectiveness suggest that managed care has a potential to reduce health care spending--although its effectiveness varies depending on the strength of the controls employed. The impact on health care spending is achieved through a one-time reduction in levels of use; managed care does not appear to affect the rate of increase in spending over time.

Effective managed care for one group of patients, however, does not necessarily slow the growth in total expenditures for all patients. Our fragmented system of financing makes it possible for providers to expand services and raise prices for other patients not getting managed care. The substantial administrative costs of managed care also offset some of the savings from using fewer services.

In contrast to the approaches to controlling use of services employed in the United States, several other industrialized countries monitor and review providers, rather than individual patients and procedures. This process is applied uniformly and comprehensively to all physicians, to identify those whose service patterns deviate from their peers. When indicators such as referral patterns, numbers of procedures and tests performed, and numbers

of repeat visits deviate from the norm, committees monitoring regional health systems then review these physicians and, if warranted, penalize them.

Price Controls

Price controls on medical care have been imposed several times in the United States. Overall, the evidence from the Medicare experience of the potential effect of price controls on health care costs suggests that more services are provided when prices are reduced across the board; price controls on one type of service create incentives for providers to substitute other services for the controlled one; price controls established for a specific population group (such as Medicaid enrollees) may result in higher prices charged to other population groups; and, when prices are controlled for only some groups, they may have less access to care. Thus, unless price controls are combined with systematic monitoring and review of all providers to prevent the volume of services from rising, their potential to solve the problem of health care costs is limited.

Competition

Competition among insurers and providers has increased over the past decade. The number of insuring organizations has grown, and many employees are offered a choice among several insurance packages--sometimes

with financial incentives to choose lower-cost, more efficient plans. The number of physicians relative to the population has grown, and physicians are now less able to control competition from other providers who perform services that overlap with those of physicians--and who generally charge lower prices than physicians for these services. Advertising by physicians, hospitals, dentists, and other providers--which was prohibited by medical ethics and state regulations in the past--has now become an accepted practice.

If competition were an effective strategy for controlling costs, health care costs--particularly in areas that have become much more competitive--should have risen more slowly over the past decade than they have. This outcome would not necessarily occur, however, if nonprice competition was the predominant response to changes in this market. Some research suggests that greater competition has led to product differentiation and higher costs in the health care market, rather than to lower prices and greater efficiency. The competition strategy, however, has not been fully put into place. Moreover, approaches to cost containment that rely on changing the conduct of markets may require substantial passage of time before the full effects are evident.

Regulation of the Market for Health Services

Because past efforts to control costs have had limited effect, some people have concluded that greater regulation of the market for health services is necessary. Regulatory strategies attempted in the United States include the federal health planning and certificate-of-need programs and the state all-payer rate-setting programs for hospitals. In addition, strategies used in other countries--global budgeting and expenditure targets--might be effective here.

Health Planning and Certificate-of-Need Programs. The Health Planning and Resource Development Act of 1974 required that all states receiving federal health resources enact certificate-of-need (CON) laws--providing for state review and approval of planned capital investments of health care institutions. By 1980, all states except Louisiana had enacted CON laws. Subsequent research on their effectiveness consistently found that they did not restrain hospital spending and, in 1986, CON requirements for states to receive federal funds were dropped. Those who support health planning and CON requirements suggest, however, that CON in most states was applied in an erratic and politically motivated way that was not consistent with cost-consciousness and the orderly adoption of new technologies.

The governments of some other countries control the capital acquisitions of hospitals. In Canada and the former West Germany, for example, hospitals apply to the regional government for capital expenditures and the regional government provides funding only for approved investments. In Great Britain, the central government determines the national budget for capital costs, and decisions about capital acquisition are made at varying geographic levels depending on the type of expenditure. These restrictions on capital acquisition, which keep costs down but also tend to limit access to new technologies and treatments, appear to have led to a lower rate of technological diffusion than in the United States.

State All-payer Rate-setting Programs. During the past two decades, four states put in place statewide all-payer hospital rate regulation programs. Under these programs, the state establishes the reimbursement methodology under which hospitals in the state receive uniform payments for specific services from all third-party and direct payers. Results of nearly all of the studies of these systems find that they initially lowered costs by from 2 percent to 13 percent, and that they cut the rate of growth in hospital spending substantially below what would be expected in the absence of an all-payer system.

Controls on Expenditure Levels. Another regulatory mechanism for controlling health care costs is to set limits on spending prospectively. This can be done through global budgeting, under which the government sets the operating budget in advance for specific providers--most commonly hospitals. Or it can be done through caps on expenditures, under which the government sets either a fixed budget that absolutely controls spending levels or a target that triggers penalties if it is exceeded. While other countries have relied extensively on expenditure targets to influence physician spending, the Medicare volume performance standards for physicians put into effect in 1990 is the first such attempt in the United States. Some other industrialized countries combine expenditure targets for physicians' services with ongoing monitoring of the practice patterns of individual physicians, in order to reduce the potential for some physicians to increase their incomes at the expense of others.

If they are strictly applied, global budgeting and expenditure caps for overall spending or for types of services can limit the level and rate of growth of health care spending. Depending on how tightly they are set, however, they could adversely affect quality or access to care.

Control of health care costs--through either a one-time drop in spending or a lower rate of increase--is much more difficult to achieve in the United States than in countries that have chosen to develop a coordinated national health care policy or a national health system. In the United States, attempts to control health spending in one segment of the market or for specific groups of consumers may sometimes be successful for the part of the market affected. The impact on overall health spending in the nation may be much less, however, since providers may compensate for lower revenues from one segment of the market by increasing prices for, or the quantity of services provided to, other groups.

During the 1980s, a number of strategies to control health care costs were carried out. Although it is difficult to quantify the overall effect of each change separately, there appears to have been little impact on the growth in total health spending. The average annual rate of increase in real health spending per person was 4.3 percent between 1980 and 1985 and 4.6 percent between 1985 and 1989. In addition, the share of GDP devoted to health spending rose from 9.2 percent in 1980 to 11.7 percent in 1989.

Evidence from other countries, and from research, suggests that it may be possible to achieve greater control over health care spending in the United States than has been apparent over the past decade. It would be necessary, however, to make changes in the financing and delivery of health care. Several policies, used in combination, could substantially increase our ability to control health care spending. These policies include: elimination of first-dollar coverage under insurance policies; uniform utilization monitoring and review applied to all physicians rather than to individual patients and specific procedures; uniform payment levels that encompass all payers (including a prohibition against billing patients for any additional amounts); health planning that establishes capital and technology targets relative to population at national and regional levels, and that does not reimburse for services provided through unapproved purchases; and effective national and regional budgets for overall spending or expenditure targets for specific types of spending.

Without significant changes, the United States is unlikely to achieve much greater control over health care spending than it has in the 1980s. Moreover, the consequences of failure to obtain the benefits of effective cost containment will be many, including making it more difficult to address the other major failure of our health care system--the large and growing number of people in the United States without health insurance coverage.

To change the present system, however, we would have to make some concessions. Greater control over health care spending would probably mean less spending on research and development, longer waiting times for use of new technologies, and limitations on our existing choices of providers, health care coverage, and alternatives for treatment. Whether these trade-offs are desirable depends on the priority the nation places on controlling costs as against maintaining other characteristics of the current health care system.