CBO TESTIMONY

Statement of
Robert D. Reischauer
Director
Congressional Budget Office

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NOTICE

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CONGRESSIONAL BUDGET OFFICE
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Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss the effectiveness of various strategies to control health care costs, as well as the Congressional Budget Office's (CBO's) methods for estimating the 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 essentially no control over the cost of that care. As a result, in 1989, we devoted 11.8 percent of our gross domestic product (GDP) to health care, 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. Further, the difference between the United States and other countries' spending on health care as a share of GDP has increased dramatically since 1965.

The extremely rapid growth in health spending also has significant implications for the federal budget. In 1980, 10.5 percent of the federal budget went to health care; CBO projects that this share will rise to nearly 20 percent by 1996.

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 their 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 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. In addition, the complexity and rapidly changing technology of medical services, as well as uncertainty about the efficacy of treatment, have 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.

As a result of the delegation of decisionmaking by consumers and their insensitivity to the cost of care, 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.

The experience under Medicare indicates that, when price increases have been held down, the volume of services has increased sufficiently to offset about half of the potential reduction in spending that would otherwise have resulted from the price limitations.

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 for harm to patients because of side effects or other complications associated with medical interventions.

Institutional aspects of the American health system are another source of rising health costs. For example, although medical malpractice premiums accounted for only about $5 billion--or 0.9 percent of all spending for health--in 1988, the malpractice climate may affect patterns of practice in ways that indirectly raise costs. There is particular concern that physicians may require an excessive number of tests in the face of potential liability lawsuits and in the absence of agreed-upon practice guidelines. 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 American providers may have incurred almost $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 desirable, however. 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. In addition, the current financing system permits new technologies to be introduced rapidly, 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

Many strategies for controlling health care costs have been developed and carried out during the past two decades, especially during the 1980s. The variety of approaches adopted reflects the complexity of controlling costs in a diverse and uncoordinated health system such as we have in the United States.

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 actually declined to below 24 percent of total costs by 1989. Even so, the United States remains significantly different from most other countries. For example, out-of-pocket costs were 7 percent in the former West Germany in 1985 and 3 percent in the United Kingdom in 1987.

Evidence from studies of the effect of cost sharing on spending for health services suggests that, if out-of-pocket costs were raised, use of services and total health spending would decline, although by a relatively small amount. Such a reduction in spending would probably have more impact on low-income people than on others.

Managed Care/Controls on Use

Because a substantial proportion of the health services provided to consumers are unnecessary or inappropriate--30 percent or more of certain procedures--managed care and other controls on use have been widely advocated in the United States since the early 1970s as a strategy for controlling costs. Managed care is provided through health maintenance organizations (HMOs) and preferred provider organizations, which combine both insurance and delivery systems. They review and intervene in decisions about health services in order to provide care more efficiently, and require or provide incentives for patients to use only their network of providers. In contrast, controls on use may be applied by traditional insurance plans without any limitations on the patient's choice of providers.

Both approaches have the potential to reduce health care spending, although their effectiveness varies depending on the strength of the controls employed. Moreover, the evidence on HMOs suggests that they achieve lower spending through a one-time reduction; the rate of increase in spending over time is apparently not affected.

Effective managed care or controls on use for one group of patients does not necessarily reduce total expenditures for all patients, however,

because our fragmented system of financing makes it possible for providers to expand services and raise prices for other groups of patients. The substantial administrative costs of managed care also offset some of the savings from using fewer services.

In contrast to the United States, many other industrialized countries monitor and review physicians, rather than individual patients and procedures. This process is applied uniformly and comprehensively to all physicians in order to identify those whose service patterns deviate from those of their peers. When indicators such as referral patterns, numbers of procedures and tests performed, and numbers of repeat visits deviate from the norm, committees that monitor regional health systems 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 experience with public programs suggests that more services are provided and billing practices change 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 may result in

higher prices being charged to other groups in the population; and, when prices are controlled for only some groups, they may have less access to care, as has been the case with Medicaid participants. Thus, unless price controls are extended to the entire health care system and 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.

Price controls have also been implemented through state all-payer hospital rate-setting programs, which have been used in Maryland, Massachusetts, New Jersey, and New York during various parts of the past two decades. Under these programs, the states established the reimbursement methodology and the actual rates that hospitals were paid. Payments to hospitals were then based on those rates, with all hospitals receiving uniform payments for specific services. Evaluations 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 without all-payer systems.

Competition

Competition among insurers and providers has increased over the past decade. The number of HMOs which directly compete with traditional

insurers 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 compared with 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.

Some research suggests, however, that this greater competition has led to product differentiation and higher costs in the health care market, rather than to lower prices and greater efficiency. Increased competition appears to have made consumers better off by giving them more choices, but it has had little effect on spending.

Regulation of Capital Investment

The Health Planning and Resource Development Act of 1974 required that all states receiving federal health resources enact certificate-of-need (CON) laws that provided for state review and approval of capital investments planned by 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 advocate health planning and CON requirements suggest, however, that in most states CON was not applied in a systematic way that was 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.

Controls on Expenditure Levels

Another regulatory mechanism for controlling health care costs is to set prospective limits on spending. One way would be through global budgeting,

under which the government sets the operating budgets in advance for specific providers--most commonly hospitals. Another would be caps on expenditures, under which the government sets a fixed budget that absolutely controls spending levels. Or expenditure targets could trigger penalties if they were exceeded.

Medicare's "volume performance standards" for physicians, put into effect beginning in 1990, is the first attempt to use expenditure targets in the United States. Some other industrialized countries do more--they 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. This combined approach, global budgeting, and absolute caps have a greater potential to limit the level and rate of growth of health care spending than do other methods of controlling health care costs. Depending on how tightly the limits were set, however, they could adversely affect quality or access to care.

Potential to Control Health Spending

Achieving control over costs in the United States is more difficult than in other countries that have coordinated health care policies-applied to either a multiple-payer or single-payer system--or centralized health care systems.

Strategies to control health care costs carried out in the 1980s appear to have had little impact on 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.

Voluntary cost containment policies, policies that rely on incentives for this market to become more competitive, or policies that apply only to some--rather than all-consumers, providers, and payers in the market are unlikely to reduce overall spending on health care significantly. Greater control over health spending than has been observed to date would require that a combination of strategies be carried out concurrently and that policies be applied uniformly to all payers, consumers, and providers. Without a coordinated, uniform approach to cost containment, we are unlikely to be successful.

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

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 use in earlier stages of the legislative process. These estimates show how legislative proposals would affect federal spending over the next five years.

The Subcommittee 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. In order 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. When 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. As a general rule, the options must be specific and must require explicit actions, rather than relying solely on the encouragement of voluntary efforts by the private sector, for CBO to include savings in its cost estimates.

Increased Cost-Sharing for Health Sendees

Strategies that would raise consumers' out-of-pocket costs of health care 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 by mandating minimum cost-sharing requirements for private insurance, eliminating dual insurance coverage that offsets cost-sharing requirements of individual policies, and prohibiting the use of flexible spending accounts to pay deductible amounts and coinsurance requirements. For example, if the mandated cost-sharing was 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 personal health spending would have been reduced by about $9 billion in that year and national health expenditures would have been about 1 percent to 2 percent lower. This effect would be relatively small because consumers are not very sensitive to changes in their out-of-pocket costs, in part because they are not knowledgeable about alternative treatments

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 would be about 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 of 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 and, 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) in order 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, Medicare's spending for these services would be reduced 5 percent, under CBO's 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, while Medicare's spending for physicians' services would decline 5 percent, the level of national health spending might not be significantly affected.

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 loss of 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 rules were included in the legislation that would limit the growth in prices to less than the projected rate, then price controls in an all-payer system would probably 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. This impact on spending would have been even greater, but increases in volume would offset roughly 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 volume response.

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 our existing health care system, but it could result in substantial reductions in the rate of increase of 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 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, the impact on national health spending could be estimated 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 expenditure caps for various segments of the health care sector and specified the formulas to determine the annual rate of increase in the caps, then the savings could be estimated by comparing the caps with projected spending in their absence.

To illustrate the effect of an expenditure cap on national health spending, we could 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 $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 under the expenditure limits would exist, national health spending might not fall much.

CONCLUSION

The examples I have discussed today were selected to illustrate the type of problems that CBO faces in estimating the effects of legislative proposals that are intended to limit federal health spending or to constrain the rate of growth in national health spending. In general, 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, which is a centrally controlled program with a single payer and a defined population, than to estimate the impacts 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.

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 might be effective in reducing spending for that segment, but 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 behavior of providers, insurers, or consumers, and that do not include strong incentives or penalties, have little effect.

Some policies appear to have the potential to achieve greater control over health care costs. 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, thereby making it easier to address the other major problem of our health care system--notably, the lack of insurance for one-seventh of the population.

At the same time, however, some desirable elements of our current system would probably have to be changed. In particular, we would probably face increased constraints on our freedom to choose providers, health insurance coverage, and alternative treatments. We 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.