CBO TESTIMONY

Statement of
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Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee. My testimony today will cover the Congressional Budget Office's (CBO's) methods for examining the effects that cost containment provisions in health legislation would have on national health expenditures. These methods will be illustrated using two bills that were introduced in the last Congress.

THE EFFECTS OF COST CONTROL PROVISIONS ON HEALTH EXPENDITURES

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 of how at least some types of cost containment approaches affect health care spending.

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 expenditures that might be estimated for each proposal.

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 they would seek out providers who were more economical or charged less. In considering this strategy, however, it is worth noting that average cost sharing in this country is continuing to decline. Consumers paid 27 percent out-of-pocket for their health care in 1980, but only 22 percent in 1991.

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 benefit accounts to pay deductible amounts and coinsurance requirements.

As an example, if mandated cost sharing had been set at a level that increased out-of-pocket costs for the population with private fee-for-service health insurance by 40 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 can reduce inappropriate or unnecessary health care. Overall, however, the evidence of its effectiveness in reducing costs--other than through fully integrated health maintenance organizations (HMOs) with their own delivery systems--suggests that substantial savings could not be achieved by extending it 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 the incentives 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 could be as high or higher than the savings.

Another legislative approach would be to require that all consumers receive care through managed care organizations. For example, if everyone were required to enroll in a staff or group model HMO--the only type of managed care that has to date been demonstrated to achieve substantial savings--CBO estimates that national health expenditures could decline by as much as 10 percent. This is not an insignificant amount of savings; in 1991, national health expenditures were $752 billion, and a 10 percent drop would be $75 billion. Since there is no evidence, however, that even effective HMOs have been successful at reducing the rate of growth of health spending, and health care has been increasing recently at a 10 percent to 12 percent annual rate, we would still face the problem of higher health care costs in every subsequent year after these savings occurred.

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 physician services under the Medicare program were reduced 10 percent, CBO estimates that Medicare's spending for these services would drop 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 physician services by the non-Medicare population could also rise. As a result, although Medicare's spending for physician services would decline 5 percent, that reduction might not significantly affect the level of national health spending.

Stringent price controls may also affect access to care in some segments of the market. Access to care by Medicaid beneficiaries, for instance, has been adversely affected by the much lower prices that providers are offered in some states for serving this population.

Alternatively, government regulation could set maximum prices for physician services that all payers would have 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 could generate lower national health expenditures than would otherwise occur.

Price controls carried out through a single-payer system could also reduce reimbursements and sharply cut administrative costs for insurers and providers. In fact, the one-time drop in the cost of administration could have been around $30 billion to $35 billion in 1991, under the conservative assumption that only the administrative costs related to billing and processing 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 full amount only if prices paid to providers had been reduced to reflect the lower administrative costs that they would have incurred.

In both an all-payer and a single-payer system, legislation that included provisions for uniform monitoring of providers' patterns of care would have an

even greater impact than price controls alone. Such monitoring could reduce the magnitude of the response in volume and would allow the rate-setting process to take any volume increase into account in determining the next year's reimbursement rates.

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

In 1993, federal income and payroll tax revenues will be about $70 billion lower because health insurance received through employment and health care costs paid through flexible benefit accounts are not treated as taxable income. 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. Alternatively, consumers might join effective HMOs, with the same result.

One way to limit the exclusion would be to treat some tax-exempt employee health benefits as taxable income. In 1990, for example, employer contributions averaged about $110 a month for individual coverage and $270 for family coverage. If the tax exclusion had been capped at those levels, the implicit federal subsidy for health insurance would have been reduced by about

$10 billion in that calendar year. National health expenditures would also fall in response to the lower subsidy, but by less than the reduction in the subsidy.

If such limits were enacted, workers who currently have coverage above the limits 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 coverage above the limit in exchange for higher wages, thereby also raising their taxable incomes. (Most employers would probably 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 control health care costs. First, traditional insurance could be replaced with effective HMOs. 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, insurers could reduce the level of their reimbursement to providers, although this possibility would either limit the insured consumers' choice of providers or increase their out-of-pocket costs.

Limits on Expenditures

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

For example, suppose legislation was passed that established prospective budgets for hospitals, with specific formulas for setting and updating them. Assume also that there was no leeway to increase the budget for a hospital when overruns occurred. In such a case, the impact on national health spending would be the difference between total spending for hospital services under the budgets and projected spending without the legislation. Similarly, if legislation set caps on expenditures for various segments of the health care sector, specified the formulas to determine the annual rate of increase in the caps, provided for monitoring performance under the caps in a timely way, and put in place enforcement mechanisms that would either make it impossible to exceed the cap or would make it possible to fully recover excess spending after it occurred, then one could estimate the savings by comparing the caps with projected spending in their absence.

Based on our assessment of the evidence on the effectiveness of limits on expenditures as they have been applied in the United States and in other countries, CBO believes the likelihood of success increases with a single payment mechanism or clearinghouse, restrictions on the ability to purchase health care outside the regulated system, and global budgeting for hospitals and other institutions. In addition, a continuously adjusting payback mechanism for physicians, as has been used in Germany and in some Canadian provinces, and budgeting or rate setting that applies to all providers and services would be effective in enforcing the limits. A good data system with uniform reporting by all providers to allow quick feedback would also be an important component of an effective strategy for limiting expenditures.

CBO's approach to estimating the potential impact of limits on expenditures in legislative proposals is to examine the proposal with respect to both the stringency of the limits and the specified enforcement mechanisms. Based on our best judgment, we then assign a rating for effectiveness, with a fully effective limit receiving a 100 percent rating and a completely ineffective proposal receiving a rating of zero. The estimated savings for any expenditure limit would equal the difference between the projected costs without the limit and the expenditure limit, multiplied by the effectiveness rating.

To illustrate the effect on national health spending of a fully effective cap, assume that legislation had been put in place beginning in 1986 that included a cap constraining the increase in national health expenditures to the rate of population growth (1 percent a year) plus 2 percentage points above the rate of general inflation. If such a cap were fully enforced, we estimate that national health expenditures would have been only $651 billion in 1991, or about 13 percent lower than the approximately $752 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 the market segment subject to the limits would realize savings, national health expenditures might not fall much.

Managed Competition

Managed competition is the central feature of proposals to restructure the health care market in ways that would create incentives for consumers to be more cost-conscious in their insurance and health care decisions. Increased

cost-consciousness by consumers would give insurers and providers, in turn, the incentives to become more cost-conscious and efficient.

Many different proposals have been put forth under the "managed competition" umbrella. Some proposals of this kind could reduce health care costs, and others would have little effect. CBO is currently preparing a paper on managed competition. It will identify features that would help maximize the savings in national health expenditures under that approach. These elements include:

- The creation of regional organizations (for example, health insurance purchasing cooperatives, or HIPCs) that would oversee and operate the restructured insurance market and help consumers make better-informed choices;

- Limitations on the tax-exempt amount of employee health benefits and a requirement that employers contribute no more than a fixed dollar amount toward their employees' health benefits;

- Standardized benefits and copayment rules, with a prohibition on supplemental insurance that would cover out-of-pocket costs under the standard package;

- The availability of uniform, reliable data on costs, outcomes, and quality;

- Universal insurance coverage;

- The requirement that all insurers offer open enrollment periods and base premiums on community rating;

- An accurate method to adjust for differences among insurers in the health status of their enrollees; and

- A significant reduction in the number of insurers and the creation of insuring organizations that would offer substantially nonoverlapping networks of affiliated providers.

In combination, these changes to the current system could result over time in a reduction in the rate of increase in national health spending. Omitting some of these elements from a proposal for managed competition would significantly

lessen its potential effectiveness. Even if all these elements were included, however, it would be extremely difficult for CBO to estimate the magnitude and the timing of the effects on national health spending, because of the complexities of analyzing a dramatic restructuring of the markets for health insurance and health services.

Two aspects of these proposals do provide some indication of the direction CBO's cost estimates will take. First, we have consistently taken the position that savings could be achieved by moving people from fee-for-service medicine into group or staff model HMOs. Thus, estimated savings would depend on the extent that a particular proposal would shift people into these types of managed care organizations. In addition, most proposals for managed competition would limit in some manner the tax-exempt amount of employee health benefits. Federal revenues would be increased to the extent that the limits are tightened. If employees then chose insurance with more limited benefits and higher cost sharing because there was less subsidy to health insurance, there could also be a further impact on national health expenditures.

Assessing the full effect of restructuring the entire health insurance market, however, is much more difficult. Little information from either the United States or abroad is available on the time that it would take for all the changes to occur or on the magnitude of the impacts of these changes once

they were fully implemented and all behavioral responses had occurred. We are convinced, however, that even if a managed competition approach with all the critical elements described above were carried out, its effects would occur over an extended period of time. Significant savings in national health expenditures would probably not occur within the usual five-year time horizon of CBO cost estimates.

A PRELIMINARY ASSESSMENT OF THE COSTS OF TWO LEGISLATIVE PROPOSALS

Estimating the potential costs or savings of health reform proposals is one of the most difficult tasks CBO has attempted. First, health expenditures are currently about 14 percent of gross domestic product and are projected to rise to at least 18 percent by the year 2000. The effects of changes in this large a system must be uncertain. It is often difficult even to forecast spending in current federal health care programs, as CBO has found in recent years when Medicaid spending increased by 19 percent in 1990, 28 percent in 1991, and 29 percent in 1992, far exceeding projections. Moreover, many of the health reform proposals under consideration include provisions for which there is no actual experience and no solid evidence to be used as the basis for our estimates.

The task of estimating costs becomes even more complex since five years--the usual time frame for cost estimates--is not a long enough period for forecasting the impact of some health reform proposals. Some of them might require longer than five years to be fully carried out, and cost estimates that stop at five years would not provide the information that is needed to assess all their effects.

In addition, CBO is being asked not just to estimate the impact of these proposals on the federal government's budget, but also to examine their effect on national health expenditures and on the number of people with health insurance. National health reform involves important interactions between the private sector and the federal budget, but analyzing these interactions and their impacts is extremely difficult. As a result, estimating the costs and savings associated with health reform proposals requires more thought, more coordination and consultation with other federal offices such as the Joint Committee on Taxation, and more time than most cost estimates.

To illustrate the estimating issues and principles, CBO is providing a preliminary assessment of two health reform bills introduced in the 102nd Congress: H.R. 5936, the Managed Competition Act of 1992, and H.R. 5502, the Health Care Cost Containment Act of 1992. Although they are not current bills, the proposals represent different approaches to health reform and

illustrate the complexity of making cost estimates in this area. CBO has not yet completed year-by-year estimates for the two bills, but it is possible to give you an outline of their probable effects on national health expenditures.

Our analysis reflects H.R. 5936 as introduced and H.R. 5502 as reported by this subcommittee. For both bills, we have delayed the implementation dates by one year to reflect possible enactment in late 1993. The Congressional Budget Office and the Joint Tax Committee have worked together in examining the effects of changes in the tax law.

The Managed Competition Act of 1992

H.R. 5936 would attempt to control costs and expand access to health insurance by restructuring the way health insurance is provided. The bill would establish a National Health Board to define a standard health plan; to establish standards for reporting prices, health outcomes, and measures of consumer satisfaction; and to provide information to consumers on the quality of care. Plans that met board standards would be defined as Accountable Health Plans (AHPs).

Changes in the tax code would encourage the use of AHPs, because employers paying more than the cost of the lowest priced AHP in the area would be required to pay a 34 percent excise tax on the costs above this amount. The self-employed would be allowed to deduct 100 percent of the costs of the lowest priced AHP. In each state, Health Plan Purchasing Cooperatives (HPPCs) would be established, and all individuals except those working for businesses with more than 1,000 employees (up to 10,000 employees at each state's option) would be required to purchase their health insurance through the HPPC to receive the favorable tax treatment. Individual contributions for health insurance could be deducted for tax purposes only up to the cost of the lowest priced AHP.

Finally, H.R. 5936 would replace the Medicaid program with a new federal program that would help purchase health insurance coverage through HPPCs for low-income individuals. Individuals and families with incomes below the poverty level would be eligible to join AHPs with no premium and only nominal copayments. Individuals and families with incomes between 100 percent and 200 percent of poverty would be responsible for paying a portion of premiums, based on a sliding scale.

CBO's preliminary assessment is that, after a few years, H.R. 5936 would leave national health expenditures at approximately the same level they

would reach otherwise. Initially, however, national health expenditures would increase. This result stems in large measure from the assumption that the National Health Board would select a comprehensive set of benefits for its AHP. Because these benefits would be available to a larger group than is currently covered by health insurance, national health expenditures would be higher in the first few years.

The growth in per capita health expenditures would gradually slow, however. Because group model or staff model HMOs can provide health care more efficiently than other organizational forms, they would probably be the lowest priced bidders in many HPPC areas. Based on past performance, we expect their prices would be 10 percent to 15 percent below the price of similar fee-for-service plans, and the cost of enrolling in these HMOs would be fully tax-deductible. Thus, enrollment in them would probably rise more rapidly under managed competition than under current law, thereby slowing the growth in national health expenditures. After a number of years, these savings could offset the increased health care costs resulting from extending access to those who currently lack health insurance.

The Health Care Cost Containment Act of 1992

H.R. 5502, the Health Care Cost Containment Act of 1992, would attempt to control health costs by establishing limits on national health expenditures. Separate limits would be applied to Medicare spending and to national health expenditures. Limits would be enforced through rate setting, although states with approved programs and federally qualified HMOs would be exempt from the maximum rates. Access would be extended by expanding Medicaid coverage for pregnant women and children with family incomes below 200 percent of poverty and for all nonaged individuals with incomes below 100 percent of poverty. Medicaid payment rates would also be increased, and a new federal health insurance program for children would be started. Finally, Medicare would expand its coverage of certain prevention benefits and add a new prescription drug benefit.

CBO estimates that H.R. 5502 would reduce national health expenditures about 5 percent by the year 2000. Our preliminary assessment is that the Medicare expenditure limits would be 75 percent effective. We have a great deal of experience with rate setting and potential volume offsets in the Medicare program, which indicates that expenditure limits could be reasonably effective in controlling Medicare spending. At the same time, we are much less sanguine about the effectiveness of limits on other health spending. States

would be permitted to operate their own systems as long as the growth in health care spending did not exceed what it would have been under the maximum rates. This calculation would be very difficult to make, and specific data on states would not exist in usable form for several years. Finally, the bill exempts federally qualified HMOs from rate setting. Federally qualified HMOs are more broadly defined than group or staff model HMOs and include organizational forms that have not been shown to be cost-effective. Because of these and other potential sources of leakage, we have assumed that the limits on expenditures for non-Medicare spending would be only 25 percent effective. It is our understanding that H.R. 200, the Health Care Containment Act of 1993, would limit the HMO exemption to group or staff model HMOs. While we have not completed an assessment of H.R. 200, we expect that its expenditure limits will be more effective than those in H.R. 5502.

The savings from the limits on Medicare and national health expenditures would be partially offset by provisions in H.R. 5502 that would expand insurance benefits and extend the population covered by health insurance. Overall, however, we estimate that H.R. 5502 would result in national health expenditures falling about 5 percent below the level they would otherwise reach by the turn of the century.

CONCLUSION

In the past, most health care legislation changed payment methods or levels in relatively small, discrete ways or expanded eligibility for existing programs. Thus, CBO has considerable experience estimating the impact on costs of such changes to Medicare and Medicaid. In general, reasonably good data and research studies permit us to develop well-founded estimates.

The task we are facing today, however, is a much more difficult one. Reform of the health care system is likely to involve massive changes in current health care financing and delivery systems and perhaps comprehensive restructuring of the markets for health insurance and health services. Estimates of the effects of such sweeping changes on overall health care spending, as well as on individual components such as federal health spending, will be much less precise than estimates of changes in Medicare and Medicaid. For one thing, past experience does not encompass changes of this magnitude. Although there is some evidence from other countries, these findings must be used cautiously, because the substantial differences in cultures, politics, and economic systems mean that the responses of citizens, providers, and insurers in other nations may have only limited relevance to the United States.

In addition, it is likely that any health reform policy would require a number of years of development and would be phased in over a period of time. Moreover, it might take a few more years before it would be possible to discern the behavioral responses of all the participants in the health care and health insurance markets who would be affected. At the same time, of course, many other things will be changing, including overall economic conditions, the introduction of new technologies for diagnosis and treatment of illness, and--as our experience with AIDS and the recurrence of tuberculosis in recent years has shown--even the health status of the population. Thus, considerable uncertainty surrounds any estimates of the longer-term effects of health reform proposals on national health expenditures and on the federal budget. Nonetheless, estimates of the effects of different health reform approaches will provide useful comparative information on the relative costliness of, or the potential savings to be gained from, alternative proposals.