CBO TESTIMONY

Statement of
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Mr. Chairman, thank you for the opportunity to appear before this Committee today to discuss the President's Comprehensive Health Reform Program. For several reasons, it is not possible to assess all the potential effects of this proposal. First, the operational details of many aspects of the proposal remain to be specified and the proposal's impact could be quite different depending on them. Second, the proposal does not include information about how the expansions of insurance coverage would be financed. A variety of methods could be used and the impact of this proposal on the federal budget and the economy would differ depending on the specific financing mechanisms chosen. Third, a complete analysis depends on estimates that the Joint Committee on Taxation is in the process of preparing. Several aspects of the President's plan, however, can be analyzed. The appendices to this testimony contain more detailed discussions of them.

Briefly, the Congressional Budget Office's (CBO's) analysis of the President's proposal for health reform suggests that it would significantly reduce the number of people without health insurance. In particular, virtually all low-income people who would be eligible for the full tax credit would become insured. The smaller subsidies and tax deductions for higher-income people, as well as changes in the health insurance market for small groups, would also result in some additional coverage.

In contrast to the substantial increase in access that would occur, the combined effect of the aspects of the President's proposal that are designed to control health care costs would probably not be large. Although a number of cost containment strategies are proposed, most of them would rely on voluntary responses to relatively small financial incentives that would probably not have much impact. A few of the cost control strategies put forth could actually raise costs. Nonetheless, even though each of the proposals for cost control would generate, at best, only small savings, in combination they could result in a modest one-time reduction in national health spending. These proposals, however, are unlikely to slow the rate of growth of health spending.

My testimony today will cover the following aspects of the President's proposal:

- Expanding access to health care;
- Controlling health care costs; and
- Modifying the Medicaid and Medicare programs.

EXPANDING ACCESS TO HEALTH CARE

Briefly, the President's Comprehensive Health Reform Program would expand access to health insurance through several mechanisms. Low-income people would be offered a tax credit for the costs of a health insurance policy worth up to $3,750, depending on household size and income. Individuals with incomes up to $50,000 and families with incomes up to $80,000 (depending on tax filing status) would be offered either a tax credit or a tax deduction for health insurance. Health insurance premiums for the self-employed would be fully deductible, up from the current 25 percent deductibility. Furthermore, changes in the market for health insurance would make policies available and more affordable for many small groups and individuals.

Tax Credits and Expanded Deductions

The President's proposal would allow all individuals and families with income below specified limits to claim tax credits or deductions on their individual income tax returns, unless they receive health care through federal programs, including Medicare and Medicaid. Families with income low enough to qualify for the maximum credit could receive vouchers to purchase health insurance.

Tax units with income below the tax-entry level--that is, the income below which a family would owe no taxes--would be eligible for the full refundable tax credit of $1,250 for an individual, $2,500 for a two-person family, and $3,750 for a family with three or more members. (These and other dollar values in the proposal would be indexed for general inflation.) In 1992, tax-entry levels are $5,900 for an individual, $9,850 for a head of household with one dependent, and $15,200 for a married couple with two children. Although these amounts exceed federal poverty guidelines for heads of household and married couples, the tax-entry level for a single individual is nearly $1,000 less than the projected 1992 poverty guideline. The definition of income used to determine eligibility for the tax subsidy, as well as its amount, is adjusted gross income plus the untaxed portion of Social Security and Railroad Retirement income and tax-exempt interest.

The credit would be less for tax units with income above the tax-entry level, phasing down to 10 percent of the full credit for tax units with income at or above 150 percent of the tax-entry point. All eligible tax units could choose either to take the minimum tax credit or to claim a deduction from taxable income. Both the tax credit and the deduction would be reduced by the amount of any health insurance premiums paid by employers.

Our initial analysis of the President's proposal, based on 1989 data on income and health insurance coverage, indicates that just over half of all tax units would have qualified for either a credit or a deduction. Of the 19.6 million tax units without insurance in 1989, about two-thirds--or 12.5 million--would have been eligible for the full refundable tax credit, and virtually all other tax units without coverage would have been able to claim a reduced tax credit or take a tax deduction. Only about 300,000 of the 19.6 million currently uninsured tax units would not be offered any subsidy to purchase health insurance under the President's proposal. These 300,000 tax units had incomes of $40,000 or more.

In other words, the President's proposal would offer assistance to the vast majority of people who do not currently have health insurance, and this assistance would be targeted toward people with low and low-middle incomes. Although most people eligible to receive a full tax credit would probably use the voucher, thereby becoming insured, the response of those who would be eligible for smaller credits or tax deductions is more difficult to predict. Some of them would elect not to pay their required portion of the cost and remain uninsured. For example, an uninsured head of household with one dependent and an income of $25,000 who purchased a policy for $2,500 would have the choice of a $250 tax credit or a tax deduction of up to $2,500 for health insurance premiums. At an effective marginal tax rate of 15 percent, this

family would receive a greater subsidy--$375--by choosing the tax deduction, but would still have to pay the remaining $2,125 of the annual premium. Thus, it is likely that a substantial number of people would not elect to obtain insurance in response to the new subsidy.

Since the subsidy would decline as income rises, the program would create work disincentives for some families with income above tax-entry levels. Because the credit and deduction would be phased out over a broad income range, however, the work disincentives would be less than if the subsidy were abruptly cut off at a specific income level. Moreover, this approach would reduce the current work disincentive Medicaid recipients face; their health insurance would still be subsidized even if higher earnings ended their eligibility for Medicaid.

The President's proposal does not explicitly deal with some operational issues that would need to be addressed. For example, would people who got vouchers for the full tax credit because they expected to have low incomes have to repay the excess credit if their actual incomes exceeded the cutoff for the full credit? If so, some families might be reluctant to use the vouchers. If not, then equity issues would arise, since some families would receive a credit while other families with similar annual incomes would not.

The President's proposal would also ensure that appropriate insurance packages would be available so that people could take advantage of the tax credits and tax deductions. States would be required to develop a basic health insurance package equal to the value of the health insurance credit and ensure that at least two large insurers in the state offered this package. State risk pools would be established to cover those eligible for tax credits in order to protect insurers who attracted a less healthy group against the financial implications of adverse selection.

The level of the maximum tax credit appears to be substantially lower, however, than the amount needed to buy typical health plans that are available in today's market. Policies could be designed to sell for the amount of the credit, but they would be noticeably different from what is typical in most employment-based plans. Moreover, since per capita health care costs vary around the country, these packages would be considerably more generous in some geographic areas than in others.

Insurance Market Reforms

A series of regulatory changes in the health insurance market are proposed to make insurance available for both those who would be eligible for the new

subsidies and those who are employed in small firms that do not currently offer coverage to their employees. These regulatory changes would ensure that no group could be denied health insurance; renewal of existing policies would be guaranteed; exclusions for preexisting conditions would be prohibited except under very limited conditions; and college students would be able to obtain coverage through their college for six months following graduation.

Health Insurance Networks (HINs) would be established to enable small groups to obtain the lower administrative costs of health insurance associated with larger groups. If they were federally certified (rather than state certified), HINs would be exempted from state requirements to provide mandated benefits, premium taxes, and laws that would impede the development of managed care. States would be required to set up risk pools for small groups to protect insurers who attracted a disproportionate number of high-risk groups. Finally, over time, restrictions would be placed on the ability of insurers to impose risk-adjusted premiums, eventually eliminating all risk adjustments within the small group market.

The regulatory changes, combined with the requirement that states develop insurance packages for the value of the tax credit, would ensure that some type of health insurance package would be available to individuals

eligible for the credit and to all small groups. Regulating premium levels and eliminating experience rating would make insurance more affordable for many small groups, though the premiums charged to some other small groups with particularly healthy employees could increase.

The potential impact of these proposals on insurance coverage of workers in small firms is difficult to assess, though the President's proposal suggests that premiums would drop and, in response to lower premiums, more people would obtain insurance. Over a period of time, the average premiums charged to small groups could be significantly reduced, particularly for the small groups that would be able to band together to purchase insurance through HINs. The magnitude of this reduction and the response of small employers and of employees of these firms are uncertain, however. Consequently, although it seems likely that the proportion of workers in small firms with employment-based group insurance would rise, CBO cannot predict the number of people who would be newly insured.

Overall Effects of Access Proposals

In summary, the aspects of the President's proposal that are intended to increase access to health insurance would quite likely result in a significant

reduction in the number of people without insurance. Assuming that insurance packages were made available for the amount of the tax credit, essentially everyone eligible for the full tax credit would probably take advantage of it.

The effect of the tax deduction on those with higher incomes is less clear, since these families would pay a substantial share of the premium. Those who are currently paying the full cost of their health insurance coverage would gain, but it is uncertain how many of those who are in this middle-income range and currently uninsured would be induced to purchase insurance. Creating new insurance packages and prohibiting most limitations on coverage of preexisting conditions, however, could make options that are more affordable available to this group and result in more coverage than is currently the case. Similarly, changing the insurance market for small groups would probably increase the number of people insured through employers. The net impact of all these changes would almost certainly be a significant expansion in coverage.

CONTROLLING HEALTH CARE COSTS

The President's proposal presents a number of strategies to control health costs, including encouraging enrollment in coordinated-care organizations, improving the level and quality of information available to purchasers of health insurance and services, encouraging healthy life-styles and preventive care, modifying the medical malpractice system, and reducing administrative and paperwork costs.

Coordinated Care

A major component of the proposal's cost containment strategy is to create incentives for greater participation in coordinated-care organizations. No specific proposal is put forth for the private sector, but the discussion suggests that coordinated-care organizations could provide more generous benefits for a fixed premium. Therefore, people who would purchase insurance because of the proposed tax credit and deductions would be attracted to coordinated-care organizations. To facilitate the ability of coordinated-care organizations to develop cost-effective benefit packages, the President's proposal would also prohibit states from imposing requirements on these plans that make them less competitive.

For the public sector, the President's proposal would require states that retained their current Medicaid programs--rather than elected to develop a new program that would cover everyone with incomes below poverty--to shift all nonelderly acute care Medicaid recipients into coordinated-care systems over a five-year period. Medicare beneficiaries would be offered a greater variety of coordinated-care arrangements, in addition to the health maintenance organizations that are currently available. These new types of coordinated care would, for the most part, be less restrictive than health maintenance organizations (HMOs) with respect to choice of provider and strength of controls over use of services. In addition, new incentives would be offered to HMOs to participate in the Medicare program, such as higher payments on behalf of Medicare enrollees and direct financial incentives for Medicare beneficiaries to join an HMO.

Evidence on the potential of managed care to reduce health care costs--whether in the private sector or in public programs--suggests that only staff and group model HMOs have been able to achieve significant reductions in costs per enrollee and that less structured coordinated-care organizations have little or no effect on health care spending. There is, however, insufficient information to permit estimates of the effectiveness of some of the newer forms of coordinated care--for example, point-of-service plans, which

permit insured consumers to choose managed care at the time they require service and which are mentioned prominently in the proposal.

The proportion of Medicare beneficiaries in coordinated-care arrangements could also expand, although if this resulted from the proposed higher payments to HMOs, the effect would probably be to increase costs overall rather than to decrease them. In fact, there is considerable evidence that HMOs currently receive more than Medicare would have spent on these enrollees in the fee-for-service sector.

The net impact on health care spending of any increase in the number of people in coordinated care cannot be assessed without more specificity about the types of coordinated care that would be offered. In the past, however, expanding coordinated care has not resulted in lower health care spending in the nation, even when particular organizations have been effective for their specific enrollees. When spending is constrained for one group in our multiple-payer system, spending for other groups appears to accelerate. These spending increases would at least partially offset the savings achieved by successful management of care by one payer in the system. If effective managed care were extended to cover everyone, however, some savings would be achieved.

Information for Purchasing Health Insurance and Health Care

If consumers do not have sufficient information available on the relative costs and benefits of competing health plans and on the effectiveness of alternative modes of care, they may make inefficient choices that result in spending that exceeds the value of the services received. Similarly, if providers are uncertain about the efficacy of treatments and diagnostic procedures, they may prescribe more services than are necessary or the wrong types of services.

The President's proposal seeks to increase information available to consumers and providers to help them make more efficient decisions. States would be required to make comparative information about average prices and costs of common health care services available to consumers within one year and to make information about the quality and outcomes of providers available to consumers within five years.

In theory, improved access to relevant information would lead to more efficient choices by consumers. They might make more cost-effective decisions about the appropriate insurance package to purchase. For example, some might choose insurance with a higher deductible but better catastrophic coverage. In response to the higher deductible, such consumers might then forgo a visit to the physician. The available evidence suggests, however, that

once a visit occurs, the provider largely determines which additional services will be used during the episode of care, without regard to the patient's out-of-pocket costs. Thus, although evidence does not exist to quantify how increased information for consumers would affect overall health spending, the effect would probably not be large.

To assist providers in making better decisions, federal funding for research on outcomes and for developing practice guidelines would be increased. The assumption is that, as more information on appropriate care became available, the amount of inappropriate and unnecessary care would be reduced.

Although practice guidelines could well increase the overall quality of care in the United States, it is unlikely that providing additional information, by itself, would significantly reduce national health expenditures or their growth. Providers are likely to substitute appropriate services for inappropriate ones--rather than just providing fewer services--both for therapeutic reasons and to avoid the drop in their incomes that would otherwise occur.

Preventive Health Care

The President's health reform program emphasizes the importance of health promotion and disease prevention for improving health and controlling health care costs. To support the goals of prevention and healthy life-styles, the President's budget proposes an average increase of about 11 percent over the 1992 level for preventive health programs in the Department of Health and Human Services, plus the Special Supplemental Food Program for Women, Infants, and Children in the Department of Agriculture. Funding for programs that would primarily affect maternal and child health would increase by 11 percent; other programs to improve access to primary care would grow by 16 percent. Although the percentage increases in spending are high relative to spending for other programs in the President's budget, they represent only small real increases, at least for services that are primarily medical, since inflation in medical prices is expected to continue to be substantially above general inflation in the economy.

The available evidence suggests that preventive programs to improve birth outcomes, reduce rates of unwanted pregnancy, and ensure that young children are immunized may reduce total health care costs. The costs of many other preventive and routine screening services applied to the entire population, however, would be likely to exceed potential savings. Similarly,

counseling to encourage healthy life-styles may be effective for only a small proportion of those who participate and, even for those who do change, potential savings may be small.

Thus, the aspects of the President's proposal that would affect maternal and child health, including immunization rates, could result in lower national health expenditures. The effects of other aspects of the President's proposal are difficult to assess because of the lack of specificity in some areas and because little information exists about the outcomes and impacts on health care costs of many prevention programs.

Malpractice Law

Changes in malpractice law also are a component of the President's proposals to control health care spending. Premiums for malpractice insurance contribute to health care costs. In addition, many people perceive "defensive medicine" to be a substantial contributor to the current level of health spending. Defensive medicine, which is designed to protect providers, is defined as changes in medical practice that result solely from the liability system and that involve costs in excess of any benefits to patients. In response, the President's proposal would promote improved quality of care in

order to reduce adverse outcomes that could result in malpractice suits, encourage other ways to resolve disputes, and impose limits on awards for successful malpractice suits.

The available evidence on the costs of malpractice insurance indicates that, while changes in the medical malpractice liability system could affect both total spending for malpractice premiums and the distribution of those premiums, the impact on national health expenditures would be small. Malpractice premiums paid by all providers in 1990 totaled only $5 billion, or 0.74 percent of national health expenditures.

The existing evidence on the prevalence and costs of defensive medicine suggests that the potential to achieve savings is limited in this area, as well. The Office of Technology Assessment is conducting a study of this issue that may provide more information about the effect of defensive medicine on health care costs. At this time, however, there is little evidence to support an assumption that national health spending would be significantly reduced by modifying the medical malpractice system. If the system were changed, much of the care that is perceived as defensive medicine would possibly still be provided for other reasons, such as reducing diagnostic uncertainty as much as possible.

Thus, although changing the medical malpractice system could have some impact on health spending, that impact would probably be small relative to total national health expenditures in the near term. In time, changes in the malpractice environment could affect medical education and graduate training in ways that would lead new physicians to practice differently. What is unclear, however, is whether these different practice patterns would result in lower spending, even in the longer run.

Administrative and Paperwork Costs

Administrative costs of private health insurers, and of providers who must deal with the complexities of the existing public and private multiple-payer system, have been the subject of considerable discussion. There have been numerous suggestions for reducing these costs, either through mechanisms that would streamline administrative procedures within the current system or through a move to a universal, government-run health system.

The President's proposal provides several avenues for reducing administrative costs within the present health care system. They include encouraging electronic billing, which, it is suggested, could save $1 to $2 per claim; shifting from claim-by-claim review of the appropriateness of services

to monitoring profiles of providers' patterns of care; developing electronic cards for patients that could reduce the amount of time spent by providers in collecting information on insurance benefits and requirements; and computerizing medical records to ease transfer of information among providers.

In addition, the President's proposal for Health Insurance Networks would result in lower administrative costs for small group and individual insurance. Administrative costs of insurance for the smallest employer groups are now as high as 40 percent of the costs of benefits. HINs would permit these small groups to band together to form larger groups, which typically would require proportionately lower costs to administer.

The President's proposal estimates that administrative reforms to the present health care system--encouraging electronic billing, electronic cards, and so forth--could reduce costs by up to $4 billion annually. Estimates in the proposal also suggest that Health Insurance Networks have the potential to reduce administrative costs by as much as $9 billion annually. There is, however, considerable uncertainty about the speed with which these changes could be adopted and the form they might eventually take.

The President's proposal would also introduce new administrative costs. The administrative costs of insurers would rise as more people obtained private insurance. In addition, the administrative costs associated with determining and monitoring eligibility for the tax credit, at both the state and federal levels, could be significant. Thus, it is uncertain what the net effect of the President's proposal would be on the overall level of administrative costs.

Net Impact of Cost Control Proposals

Each of the elements of the cost control strategy presented in the President's proposal would have at best a modest effect on the level of national health spending and would probably have little or no effect on the rate of growth of health spending. It is important to realize, however, that taken together these proposals could have a significant impact on the level of national health expenditures, once they were fully in place. For example, the combined impact of these proposals on national health spending could be as much as $32 billion in 1997, if expanding coordinated care resulted in 1 percent lower national health expenditures, streamlining administrative systems saved another 1 percent, and the combined effect of all other cost control proposals reduced health spending by 0.5 percent. Similarly, savings could be as much

as $58 billion in 1997, if expanding coordinated care reduced national health expenditures by 2 percent, streamlining administrative systems saved 1.5 percent, and the combined effect of all other cost control proposals was 1 percent.

Although CBO does not yet have sufficient information to make reliable estimates of the effects of these proposals, individually or in combination--and we think their individual impacts would be small--they might result in measurable savings. These savings would, however, be offset by the increased spending for health care that would result from the expanded access to health insurance under the President's proposal. In addition, it is not possible to estimate the effect the President's proposal would have on the federal budget or the economy until the financing mechanisms are determined.

OTHER ASPECTS OF THE PRESIDENT'S PROPOSAL

In addition to provisions designed to expand access to health insurance and control health care costs, the President's proposal would significantly change

the nonelderly, acute-care portion of state Medicaid programs. It also suggests several changes in the Medicare program that, along with the Medicare provisions of the President's budget, would reduce the cost of the program.

Proposals to Modify Medicaid

The Administration proposes to replace the federal share of Medicaid expenditures for acute care for the nonelderly population with a prospective per capita payment. The capitation amounts, which would vary by state, would be based on states' Medicaid expenditures for acute care in 1992, indexed for future years. The index would be based on the consumer price index, with an adjustment of 2 percent to 4 percent for inflation in medical costs that exceeded general inflation. The capitation amounts would also be adjusted as the age and sex composition of the eligible population changed.

The net fiscal impact of this proposal on the states would depend primarily on the relative magnitude of two factors. The capped federal payments for Medicaid would probably grow more slowly than health expenditures per Medicaid beneficiary. Although states would have considerable incentives to develop cost control strategies, these policies would

probably not be sufficiently effective to reduce the rate of growth in per capita spending to that for the federal contribution. In part, higher spending levels would probably occur because of legal decisions that require Medicaid payment rates to be increased. These higher payment rates could partially offset, or even exceed, savings achieved by states through effective cost control strategies. Operating in the opposite direction, states and localities would incur lower obligations for uncompensated care for the uninsured, since the proposed tax credits and deductions would significantly expand insurance coverage.

States would be required to assume the major responsibility for developing systems of health care for the poor, including Medicaid beneficiaries and other low-income people who would receive tax credits. States choosing to keep their Medicaid and tax credit programs separate would be required to certify eligibility and the amount of the tax credit for people wishing to obtain the credit prospectively, define a basic benefit package with an actuarial value equal to the tax credit amount, and assure that the basic plan was offered by at least two private health plans in the state. Moreover, basing the federal per capita amounts on actual 1992 expenditures by the states would lock in existing variations among the states in Medicaid reimbursement rates and coverage of services.

Alternatively, states could develop unified programs to provide coverage for all people with incomes below poverty. This approach would probably be administratively simpler than the first option and would provide states with the opportunity to develop coordinated systems of care for all low-income people. States that chose not to supplement the tax credit, however, might have to scale back their Medicaid benefit packages, since the tax credit alone might not be sufficient to pay for current Medicaid benefits.

Proposals to Modify Medicare

The President's proposal indicates that the disproportionate share adjustment for Medicare's payments to hospitals, which assists hospitals that treat disproportionate numbers of low-income patients, could be reduced since expanding health insurance coverage would result in less uncompensated care provided by hospitals. The proposal also suggests that reductions could be made in the indirect medical education adjustment to hospital payments and that Medicare's payments to hospitals for the direct costs of graduate medical education could be directed more specifically toward primary care programs and away from specialty training.

The impact of these proposals on hospitals would largely depend on how effective the President's health proposal was in increasing insurance coverage and, in turn, reducing the amount of uncompensated care the nation's hospitals provide. Overall, these and other proposed changes in Medicare, both in the President's health reform proposal and in the 1993 budget, could reduce Medicare costs by an average of about $7 billion per year over the 1993-1997 period.

CONCLUSION

The President's proposal would significantly reduce the number of people without health insurance coverage, particularly those who are in the lowest-income groups. In addition, it would make health insurance more available and affordable for employees of many small firms and for individuals purchasing their own coverage.

The provisions of the President's proposal that are intended to control the costs of health care, however, would at best have a modest effect on the level of national health expenditures, and any effect on the rate of growth in spending is unlikely. As a result, if the value of the tax credit and tax deduction were permitted to increase only at the rate of general inflation,

then the initial gains in access to health insurance that would result from this proposal would almost certainly be eroded over time. The alternative, to permit the value of the tax credit and tax deduction to increase at the same rate as national health expenditures, would impose substantially higher costs each year on the federal budget.

A large number of details remain to be resolved in the President's proposal, and the net impact of the proposal on insurance coverage and on health spending would be affected by these decisions. In addition, alternative mechanisms that could be chosen to finance the proposal would have differing effects on the federal budget and other aspects of the economy.