Health Care Reform Project

Phase I

Cost Containment
and
Incremental Reform

Committee for a Responsible Federal Budget

Technical Appendix by Lewin-VHI, Inc.

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COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET

The Committee for a Responsible Federal Budget is a bi-partisan non-profit educational organization committed to educating the public regarding the budget process and particular issues that have significant fiscal policy impact. The Committee sponsors, conducts, and distributes nonpartisan analyses and research. The Committee is supported by the contributions of corporations, foundations, and individuals. The Committee accepts no government funding.

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Health Care Reform Project

Phase I: Cost Containment and Incremental Reform

For twelve years, the Committee for a Responsible Federal Budget has worked to educate the public on the federal budget and related issues. Today, in the budget, all roads lead to health care spending.

- If government were to raise revenues and reduce non-health care spending enough to balance the budget next year, within a decade we once again would face $300 billion per year deficits, unless we did something to restrain the rate of growth in health expenditures.

- Health spending is growing more than twice as fast as the economy. Federal revenue growth only keeps pace with economic growth.

- ***We cannot solve the budget deficit problem anytime in the foreseeable future unless something is done substantially to restrain the general rate of growth in heath care spending and, specifically, the growth in the costs of Federal programs.*** This is true even assuming no new programs and no expansion of current benefits under existing programs.

As budget experts, not health care experts, our Committee undertook this study of health care reform to assess the likely cost and savings associated with frequently mentioned proposals. The Committee examined the inefficiencies and perverse incentives in the current system, identified incremental reforms proposed to mitigate or eliminate these factors, and estimated the budget savings that these measures would produce.

As budgeteers, we recognized that economic savings, health care savings, and budget savings are three different concepts. Furthermore, because "savings" in one sector are often costs to another, we looked at impacts across the economy. Our analysis highlights the three sectors affected by health care reform: individuals, large and small employers, and Federal, State and local governments.

As we debate how best to achieve the two main objectives of health care reform -- cost containment and improved access to health care -- we must remember that the two goals, while often conflicting, are inter-related. Attempting to increase access without meaningful cost containment will not prove to be a lasting solution.

The most important conclusion we reach in the first phase of our Health Care Reform Project is that there are ***no easy choices or quick fixes.***

- The illusion of easy solutions misdirects our efforts to accomplish meaningful reform.

  It exacerbates our tendency to underestimate the cost and overestimate savings associated with politically popular goals.

  We are concerned, for instance, that the politicians and the public could be tempted to rely on price controls to finance expanded health care benefits just as they have been tempted for so long to believe that we could solve the budget deficit problem if we only eliminate waste, fraud, and abuse in government. Similarly, we note that in the health care debate, various constituencies focus only on problems most apparent to them, argue for individual remedies, and ignore the potential cross-sectoral impact of proposed changes.

- The interaction of costs and savings across the Federal budget, national health, and the national economy -- as well as the interaction of the three economic sectors -- is not now well-understood by health care analysts, economists, politicians, and the American people.

  The thoughtful measurement of the *cumulative* effect of these interactions is essential if health care reform is to generate sustainable solutions to our health care cost and access problems.

- While it is seductive to say that health care costs are "societal" and to expect government to pay for what we want, in the end, health care consumers are individuals, and we must pay for what we consume, either as individual consumers or collectively as taxpayers.

- Historically, there has been a tendency to overestimate potential savings to be derived from changes in public policy.

  Government commits to new programs and increased spending, assuming that the increased outlays will be offset by projected savings.

  Too often, the projected savings do not materialize, government remains committed to higher spending, and the deficit goes up.

  In addition, it is difficult to measure accurately the impact of individual proposals. Each analysis requires a number of assumptions. The ability to develop good estimates is limited by available data and knowledge and the use of static, rather than dynamic, analytic techniques.

Using different assumptions can result in wide swings in projections. In their budgets, public policy makers must make allowances for major deviations.

Although we cannot afford to avoid any longer the tough decisions that have to be made, health care reform need not be an all or nothing proposition. Rising annual deficits projected by the President beginning in 1998 and continuing through the first decade of the 21st century are due largely to rising health care costs. Therefore, Federal government efforts must focus on cost containment. Expanded access may be financed gradually as savings are achieved.

- While we do not know how long it will take to forge a national consensus on system-wide reform, there are steps government might take immediately that could begin to expand access, achieve modest savings, and improve the prospects for more ambitious reform.

- The health care system should "self-finance" any expanded benefits with savings from incremental measures. Costs are already growing too fast. Adding more demand and new funding will only make this situation worse. It could be like throwing gasoline on a fire.

  Our experience shows that third-party payors have helped to eliminate traditional restraints on the demand for health care and have helped fuel rising costs. We must be careful not to further exacerbate this growth in cost. Therefore, expansion of coverage and benefits must be phased-in after we have demonstrated that we have replaced an uncontrollable system with one that has effective controls over costs.

  Fiscal discipline can help to focus the debate by making it more difficult to avoid the difficult choices necessary to make the health care system affordable.

  Absent effective fiscal constraints, adding to the demand for care could jeopardize the effort to achieve meaningful cost containment.

Incremental reforms can add to our knowledge base, reduce the risk of unacceptable outcomes, alleviate some of the access problems, and help prepare public opinion for the types of changes that will have to be made.

The following are examples of measures that can begin to control costs:

- Implementation of compatible electronic billing and claim processing systems;
- Medical malpractice reform;
- Outcomes research, enforcement of medical practice guidelines;
- Increased enrollment in effective managed care plans;
- Capping the tax deductibility of employer-paid health benefits; and
- Relaxing Federal Medicaid mandates and anti-trust provisions that impede State innovation.

The following are examples of measures that can help increase access to care:

- Small group market reform;
- Pre-emption of State-mandated benefits;
- Pre-emption of State legislative barriers to managed care; and
- Relaxing Federal Medicaid mandates and anti-trust provisions that impede State innovation.

In addition, the Federal government could provide leadership through example by reforming Federal health care programs (e.g., consolidating programs and closing underutilized facilities) and by converting the Federal Employee Health Benefit Program (FEHBP) to managed competition to test the approach.

In the longer term, effective reform will have to continue to target the two, often conflicting, but inter-related objectives:

- *Cost containment.* Meaningful reform must save money relative to the projected trend. Failure to do so will impede, if not prevent, the achievement of the second goal of universal access.

  Effective, long-term cost containment will require consumers to accept limits on what we demand and to pay more for what we get.

- *Access.* Assuring that all citizens have access to quality health care is a desirable social goal. Universal coverage may prove to be a precondition to long-term cost control and stability.

  Expanded access could easily go beyond providing those who need care, but cannot afford its cost. To some, expanding access means more and better benefits, lower out-of-pocket individual cost, broader coverage, even greater convenience. Any movement in this direction will require fiscal constraint until costs can be contained.

Solving the health care problem will require significant changes in the attitudes and behaviors of consumers, providers, and other players in the health care industry. For reform to be durable, all parties will have to commit themselves over the long term to making the necessary changes.

Executive Summary

This report represents the conclusion of the first phase of a two-part project by the Committee for a Responsible Federal Budget to identify and evaluate potential solutions to the growing cost of health care from a budget perspective.

This report covers incremental approaches to solving the cost growth problem. The second phase of this project will assess the cost containment potential of comprehensive health care reform proposals.

The net savings estimates for incremental proposals reviewed in this report clearly indicate that **they will do little to solve the overall problem of runaway health care cost growth.** These findings are illuminating in that they show how little of the overall problem appears to be resolved by addressing problems commonly believed to be major contributors to health care cost growth.

Nevertheless, health care reform is not an all or nothing proposition. Incremental reform measures may be worth pursuing.

- Although budget savings resulting from these proposals are small even under optimistic assumptions, they are sufficient to begin to alleviate some of the problems. Pursuing these savings begins to impose more fiscal discipline into the system. The resulting changes are largely compatible with larger reforms under consideration.

- Implementing these types of reforms will enable the debate to move on to the hard choices that must be made to address the health care problem.

- Proceeding with these types of reforms will allow us to test solutions and measure results on a more limited and controlled basis and to experiment and refine proposals before attempting to covert the entire health care system to new, untried approaches.

Conclusions

The root causes of the health care cost growth problem are not easily defined. Effective measures to achieve health care cost containment and broader access will not be easily implemented. As in the budget debate, we think there are easy solutions to the problem. But, there is no painless silver bullet, no magic pill that we can take. We will have to make hard choices about what we want from a health care system and how much we are willing to pay for what we want.

As a result of our analysis, we reach four major conclusions:

- ***Budgetary concerns must and will dominate the policy debate until we reach agreement on a politically and economically sustainable approach to controlling costs and financing care.***

  Out of necessity, we must focus on *specific measures to control costs and pay for what we want* as we consider what major changes should be made to the system.

  Separating health care policy objectives from the financing of those goals creates unsustainable expectations and allows us to ignore the difficult questions of how much we can afford.

- ***General economic benefits do not automatically translate into budget savings.***

  Unless proposals are properly structured to capture economic/societal benefits as budget savings -- that is, to actually reduce spending for health care -- the costs of new or expanded programs will not be offset by hoped for savings and will **increase** overall spending for health care far more than anticipated.

  Proposals to spend additional resources have definite budget consequences. We must be certain that "savings" proposed as sources of financing for new costs are as definite.

- ***As with all estimates, estimates of the cost or savings associated with proposals are only as good as the assumptions made and the data and analyses upon which the assumptions are based.*** The process of developing the budget estimates contained in this report illustrates the difficulty of the task of creating system-wide estimates for health care reform.

  Budget estimates for comprehensive health care reform proposals are even more uncertain. These estimates can best be interpreted as indicators of the general order of magnitude of a proposal's potential impact, not as guarantees of any outcome.

- ***It is very possible that unintended consequences may result from reform proposals or that measures simply will not work.*** We are not be able to correctly anticipate the direction and magnitude of behavioral changes.

  Until we have a better understanding of what works to control costs, we should be cautious about creating new or expanding existing benefits and programs. Otherwise, the addition of more resources to an unpredictable system may have an inflationary impact and actually increase annual rates of growth.

Health Care Reform: A Budgeteer's Perspective

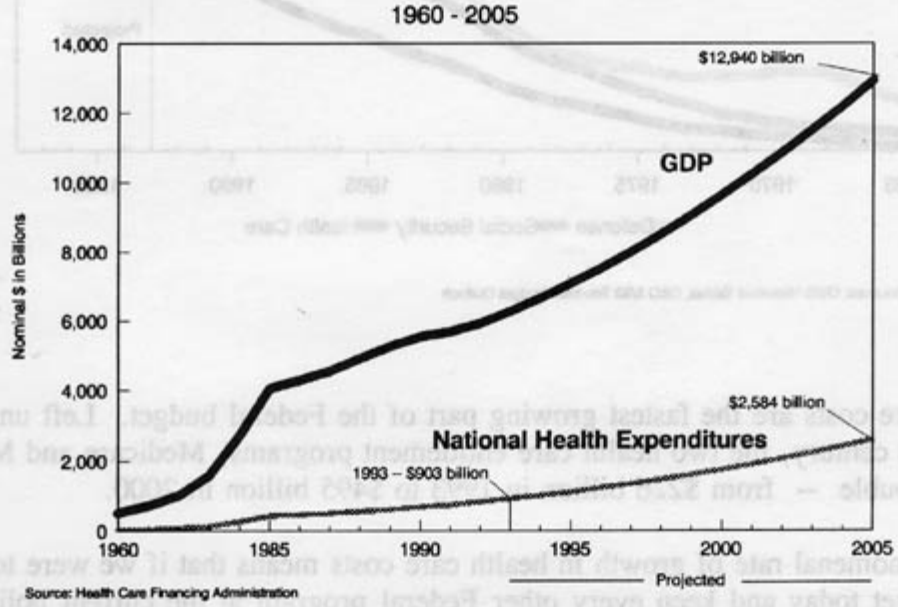
The health care reform debate greatly resembles the debate over the Federal deficit. We do not want to give anything up. We want more services and programs. But, we do not want to pay for what we get. More accurately stated, we want someone else to pay. In the case of health care, that somebody else is Federal, State, and local government through more subsidized programs; insurance companies through lower premiums and profits; employers through richer health care benefits; and doctors and hospitals in the form of less income. But, the fact of the matter is that we are the ones who pay, one way or the other, through higher taxes and lower incomes, for the Nation's health care bill.

This year, we as a Nation will spend an estimated $903 billion, or 14% of our gross domestic product (GDP), on health care (Chart 1).[1] This is almost $9,300 for every family or household or $3,500 for every individual.

Chart 1

National Health Expenditures and Gross Domestic Product

1960 - 2005



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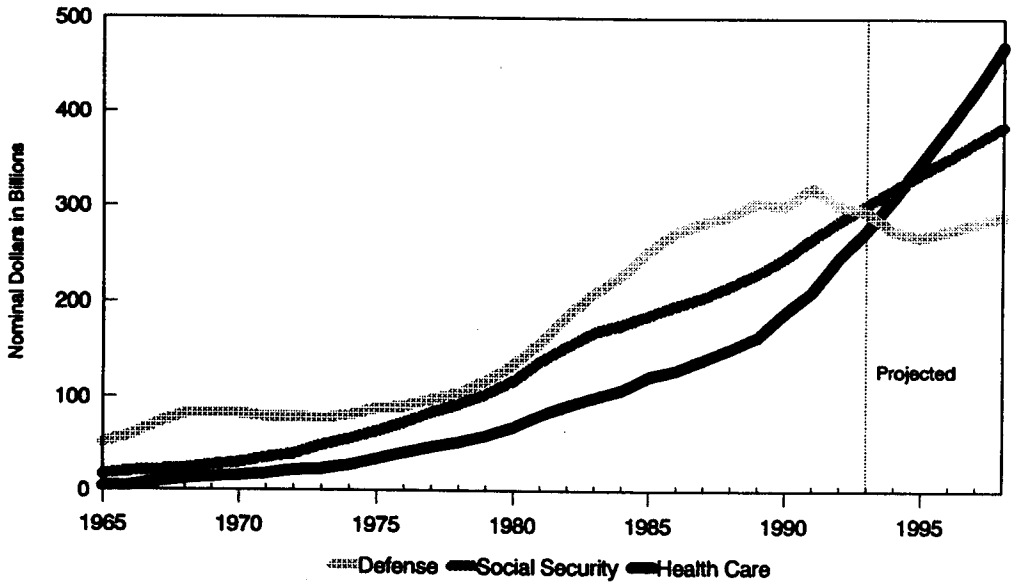
1 Throughout this paper, the national health expenditure projections and prior year date come from The Office of the Actuary, Health Care Financing Administration (HCFA), U.S. Department of Health and Human Service. For additional information on the methodolgy HCFA uses and a comparison with Congressional Budget Office projections, see Appendix 2 of this paper.

Currently, the Federal government spends more for health care (including Medicare, Medicaid, and civilian, military, and retiree health benefits) than for any other type of activity except defense and Social Security. By 1995, Federal spending for health care will exceed spending for every other type of spending (Chart 2).

Chart 2

Total Federal Health Care Expenditures

1965-1998



Sources: OMB Historical Tables; CBO 3/93 Ten-Year Budget Outlook

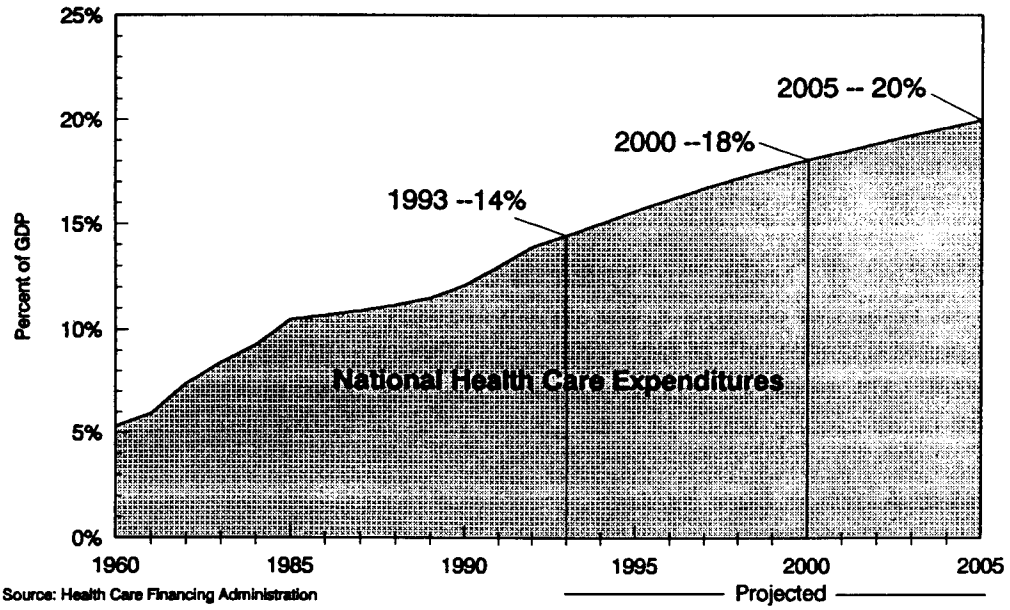
Federal health care costs are the fastest growing part of the Federal budget. Left unchecked, by the end of this century, the two health care entitlement programs, Medicare and Medicaid, will more than double -- from $226 billion in 1993 to $495 billion in 2000.

- The phenomenal rate of growth in health care costs means that if we were to balance the budget today and keep every other Federal program at the current policy level, within a decade, the growth in Medicare and Medicaid alone would produce deficits the same size ($300 billion) as we face today.

These projections assume no additional benefits or programs. If eligibility for Federal programs is broadened, or new programs are added, Federal spending for health care will grow even faster.

Chart 3

Health Care Expenditures are Projected to Grow as a Percent of GDP through the Year 2000 and Beyond



Health care costs are growing by over 10% per year -- roughly 4% faster than the economy as a whole, consuming an ever larger share of our resources. By the end of this century, health care costs are projected to be $1.7 trillion, over 18% of GDP (Chart 3). By 2030, even if we assume lower annual rates of cost growth than we are currently experiencing, health care will consume 32% of GDP. Clearly, we cannot afford to let this trend continue.

Despite this level of spending, it is estimated that over 36 million Americans, 15 percent of our population, do not have health insurance. Consequently, some may lack adequate access to health care. More Americans have limited coverage. Most Americans do not have any long term care coverage. Overall health indicators such as life expectancy and infant mortality do not show that we are better off than citizens of countries that spend significantly less per capita for health care. Efforts to improve access to and the quality of health care will add to the overall cost.

Concerns over both the growing cost of health care and insufficient access to health care for many of our citizens have prompted widespread interest in reforming the health care system. But, the debate over health care reform has yet to reach consensus on what is causing these problems, let alone what we should do to solve them and where the balance lies in addressing the cost containment and the access problems.

Public perception of the nature of the problem and the kinds of solutions that are required are not in accord with the policy experts' prescriptions. Polls indicate that the American people

think they are already paying too much for health care and are worried about getting too little. However, many of the reform measures under discussion are likely to result in higher visible costs for individuals and fewer individual choices of services and providers.

> While some of these measures are designed to bring the growth of health care costs under control, they are not likely to *reduce* the costs borne by all of us. Other measures under discussion are likely to *increase* overall costs. The net economic and budget impact of the changes under consideration is still far from clear.

When the interests of other significant players -- health care providers, health insurance companies, and manufacturers of medical products -- are added to the debate over what is in the public's best interest, deciding what to do and how becomes that much more complicated.

Furthermore, because the health care system is complex and so much depends upon human behavior, the net results of changes to the system are very difficult to predict. We know little about how proposed changes will in fact -- not just in theory -- affect the system. Adding to our demand for health care, either through expanded benefits or more publicly funded or subsidized programs, may inadvertently result in even greater rates of health care cost growth.

Budget Politics and Health Care Reform

The budgets of all sectors of the economy -- Federal, State and local governments, individuals and employers -- are being stretched by the rising costs of health care. It is therefore inevitable that the concern over the growing overall cost of health care has put the budget implications of reform in the center of the policy debate.

- Some policymakers have defined the Federal deficit problem as a health care problem -- solve the health care problem and the deficit problem goes away. While that over simplifies the nature of the overall Federal deficit problem, it is true that deficits will not be eliminated unless we limit spending or otherwise control the rate of growth in Federal spending for health care, or we raise revenues substantially.

- The cost-containment (or cost-increasing) potential of any reform proposal will weigh heavily in the assessment of the proposal's political viability. Proponents of any proposal are likely to emphasize potential savings and minimize potential costs. Critics will do the opposite. A "true" estimate does not exist because any estimate is only as good as its assumptions, the data upon which it is built, and the techniques used by analysts to estimate budget consequences.

Because the options under consideration would apply across the economy, it is important to keep a cross-sectoral perspective (Federal, State and local, and private). "Savings" to one sector are frequently offset by increased costs to another and do not result in net savings system-wide. For example, many measures to control the costs of Federal Medicare costs may result in cost shifting to private payors. Similarly, State efforts to reduce State Medicaid costs may increase Federal expenditures.

Putting Budget Estimates in Context

The Administration and the Congress are now embarking on an effort to remake an entire industry that in size approaches the economy of the United Kingdom. Major efforts are currently underway to determine the budget implications of proposed reforms economy-wide. While these efforts are necessary to identify and avoid the potential for cost-shifting to non-Federal sectors, it is important to recognize that budget estimates are different from estimates of economic or societal effects. Budget analysts are constrained by budget and accounting rules and techniques (budget scorekeeping) developed for the purposes of Federal budgeting.

The complexity of the task of estimating the budget impacts of overall health care reform sorely taxes Federal budget scorekeeping rules. These rules assume control (through the legislative process) can be exerted over spending, which is clearly not the case for the Nation's health care.

- Relying on existing federal budget scorekeeping rules to assess the savings potential for economy-wide reform proposals risks forcing the debate into familiar scorekeeping ground -- find a way to control resources and the proposal will achieve maximum scorable savings. In circumstances where control over resources is dispersed over a number of different players, as it is with health care, conventional budget scorekeeping rules are simply not up to the task.

- On the other hand, ignoring scorekeeping rules risks aggravating the Federal deficit by assuming and spending "savings" that fail to materialize or by creating uncontrollable Federal budgetary liabilities. Budget rules are intended to impose discipline into the estimating process in order to produce fair and comparable assessments of proposals.

Three important points should be emphasized about Federal budgeting and scorekeeping:

- There are only three ways to reduce Federal expenditures: increase revenues, cut spending, or both.

- To get "credit" under scorekeeping rules for savings, proposals must be made in statute, must be sufficiently specific to allow their impact to be estimated, and must be enforceable.

- Bill scorers assume that the proposal will work.

Scorekeeping rules and techniques attempt to measure the direct impact of legislation on the Federal budget. This is a static analysis that does not capture the complex interplay between and across sectors over time. Consequently, policymakers must recognize both the strengths and weaknesses of any budget estimate and, in their budgeting, make allowances for uncertainty.

Incremental Proposals to Contain Health Care Costs

The problems affecting our current health care system have been a long time in development. They will not be easy to fix. As the debate about the overall direction and nature of health care reform continues, the examination of incremental approaches to health care cost containment is useful.

- These proposals break the debate into more manageable and comprehensible pieces. Examining individual aspects of the problem and specific solutions to address them, permits us to understand better which problems are significant and which are not and which approaches are likely to be the most effective.

- The lack of consensus among policy experts, policymakers, the various components of the health care industry, and the public over a comprehensive solution is likely to preclude quick acceptance of any single proposal. Incremental proposals may serve as a basis for agreement and permit more immediate action while the larger debate continues.

In this phase of the project, a wide range of cost containment proposals were reviewed. These propose to remedy specific problem areas, leaving intact the overall financing and delivery system. Most, though not all, of these proposals would be compatible with versions of managed competition. Some of these incremental approaches would be compatible with single-payer national health insurance.

Basis of the Estimates

These budget estimates contained in this report are based upon estimates developed by Lewin-VHI, Inc. (see Appendix 1). Lewin-VHI analyzed illustrative proposals for their potential economic impacts (savings or costs) and allocated them across the economy by payer. Lewin-VHI's estimates do not discount the potential savings or costs for operational considerations.

The Committee has adjusted these Lewin-VHI estimates to represent our best judgment of the budgetary impact of the proposals. This approach takes into the account the feasibility of achieving reductions in actual spending.

Health Care Reform Proposals
Budget Estimates

Introduction

Options to contain health care costs require changes in behavior and in the way the system operates. Developing estimates of how much a particular proposal might save requires that we predict and quantify how behavior or system operations will be changed. Predicting the likely behavior of health care providers and consumers in response to changes in the system is clearly quite difficult. Therefore, any savings estimate should be viewed as helping to provide insight into the general order of magnitude of what might be attainable. Actually achieving the savings, or reducing costs from the projected *status quo* health care expenditure baseline, will require effort by those who pay for health care to implement the change and capture the savings

Potential savings may not be realizable for many reasons. There is a strong likelihood that discrete attempts to control costs in one segment of the system may fail to achieve expected savings because providers will shift costs to other payers and increase the volume of services provided to offset any savings that would reduce their incomes. Savings achieved by health care providers or insurers could be retained within the system, as profit, additional investment, or better quality of care or benefits rather than passed through as savings to purchasers of health care.

The following pages discuss cost containment measures that could be implemented without comprehensive system-wide reform. The list of options reviewed does not include all possible proposals. As this report was prepared, many cost containment proposals were deleted from our list because of the absence of sufficient data and analyses on which to develop estimates.[2]

- These estimates are **illustrative**. They provide an order of magnitude of the budgetary impact proposals could have given the assumptions used to develop the estimates. *Using different assumptions produces different results.*

- Many cost containment measures are more policy focused than operationally defined. Budget savings estimates require specific evidence that the proposal can be implemented and savings captured. In order to achieve budget savings, public and private payers will have to reduce payments to health care providers and pass the savings out of the health care sector of the economy. ***In other words, if the "savings" achieved do not result in reduced health insurance premiums or lower government outlays for health care relative to the current projections, overall spending for health care will not decrease and growth rates will remain unaffected.***

- Each measure is assumed to be implemented separately. If applied jointly, total savings could be either smaller or larger than the sum of the individual parts. When bundled

[2] For a summary of cost containment options considered, see Appendix 4.

together, it is possible that the savings will be smaller because the same expenditures are eliminated. Conversely, it is possible that the savings would be greater because the overall package of measures greatly increases the ability to effect cost containment.

All estimates presented in this report are based upon the analysis provided by Lewin-VHI, Inc. The Lewin-VHI estimates are based upon optimistic assumptions and represent estimates of potential savings that might be achieved by adopting the measures described. (See Appendix 1 for the full Lewin-VHI analyses.) Despite these optimistic assumptions, the Lewin analyses indicate that cost containment potential of the proposals included in this report is small relative to the level of national health expenditures.

The Committee goes beyond the Lewin-VHI analyses of the proposals' potential to reduce costs. The Committee findings represent our best judgment of the **budget** savings that these measures could produce. In general, the following steps must be taken in order to assure that these savings are achieved.

- All payers would need to conduct utilization reviews or other managed care measures to assure that savings are not eroded by increases in the volume of unnecessary care.

- In the case of Federal programs, reimbursement rates to health care providers would have to be adjusted to reflect anticipated reductions in costs.

- In the case of private payers, payment rates to providers would need to be reduced to reflect savings, and, in the case of private insurers, premiums would need to be reduced to reflect cost reductions. Businesses that self-insure would benefit from cost reductions to the extent that they are able to extract them from providers and their benefits administrators.

In this report, negative amounts represent savings from projected baseline expenditures. Positive amounts represents increases in costs relative to the baseline projections. This report uses as its baseline Health Care Financing Administration (HCFA) projections of national health expenditures.

Summary
Health Care Cost Containment Reform Options
($ in Billions)

(Negative amounts are savings from baseline expenditures.)

Options	TOTAL System-Wide Impact 5 Years	TOTAL System-Wide Impact 10 Years	PUBLIC SECTOR Federal 5 Years	PUBLIC SECTOR Federal 10 Years	PUBLIC SECTOR State 5 Years	PUBLIC SECTOR State 10 Years	PRIVATE SECTOR Employers 5 Years	PRIVATE SECTOR Employers 10 Years	PRIVATE SECTOR Individuals/Families 5 Years	PRIVATE SECTOR Individuals/Families 10 Years
Baseline National Health Expenditures	**5,904.50**	**15,158.90**	**1,914.40**	**5,069.60**	**869.20**	**2,262.50**	**1,971.40**	**4,967.50**	**1,149.50**	**2,859.30**
Prevention										
Expand Prenatal Care	-0.70	-2.30	3.20	8.00	-1.10	-0.90	-0.90	-2.30	-2.60	-6.90
Increase Childhood Immunizations	1.60	3.30	1.60	3.50	-0.02	-0.07	-0.03	-0.09	-0.02	-0.04
Administrative Savings										
Electronic Claims Processing	-2.40	-14.40	-0.02	-1.40	-0.10	-0.70	-1.10	-7.00	-0.90	-5.30
Smart Cards	-0.30	-2.00	-0.09	-0.60	-0.03	-0.20	-0.10	-0.70	-0.08	-0.50
Medical Malpractice Reform										
Malpractice Insurance	-4.00	-23.80	-1.20	-7.30	-0.50	-3.20	-1.30	-7.60	-1.00	-5.70
Defensive Medicine	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Anti-Trust Law Revision	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Managed Care										
Pre-empt State Legislative Barriers	-1.50	-4.40	0.00	0.00	-0.08	-0.23	-1.00	-2.90	-0.42	-1.27
Medicaid: Mandated Managed Care	-5.00	-15.70	-2.80	-8.80	-2.20	-6.90	0.00	0.00	0.00	0.00
Medicare Managed Care : Mandatory	-31.00	-98.80	-31.00	-98.80	0.00	0.00	0.00	0.00	0.00	0.00
Medicare Managed Care : Optional	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Invest in Outcomes Research	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Summary
Health Care Cost Containment Reform Options
($ in Billions)

(Negative amounts are savings from baseline expenditures.)

Options	TOTAL System-Wide Impact		PUBLIC SECTOR Federal		PUBLIC SECTOR State		PRIVATE SECTOR Employers		PRIVATE SECTOR Individuals/Families	
	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years
Baseline National Health Expenditures	**5,904.50**	**15,158.90**	**1,914.40**	**5,069.60**	**869.20**	**2,262.50**	**1,971.40**	**4,967.50**	**1,149.50**	**2,859.30**
Insurance Reforms										
Small Group Market Reforms	-25.20	-63.00	0.00	0.00	0.00	0.00	-21.40	-53.50	-3.80	-9.50
Pre-empt State Mandated Benefits	-7.50	-18.80	0.00	0.00	0.00	0.00	-6.40	-16.00	-1.10	-2.80
Medicare										
Gradually Eliminate Dispropor. Share Adjust	0.00	0.00	-9.50	-33.40	0.00	0.00	7.10	25.10	2.40	8.40
Reduce teaching adjustment from 7.7% to 3	0.00	0.00	-10.90	-30.00	0.00	0.00	8.10	22.50	2.80	7.50
Freeze PPS rates for 1 year	0.00	0.00	-15.20	-39.70	0.00	0.00	11.40	29.80	3.80	9.90
Subtotal: Provider Options	0.00	0.00	-35.60	-103.10	0.00	0.00	26.60	77.40	9.00	25.80
Incr. SMI coinsurance to 25%	0.00	0.00	-21.10	-56.10	0.00	0.00	0.00	0.00	21.10	56.10
Incr. SMI premiums to 30% for physician se	0.00	0.00	-30.10	-125.00	0.00	0.00	0.00	0.00	30.10	125.00
Incr. & index SMI deductibles for physician	0.00	0.00	-9.30	-37.50	0.00	0.00	0.00	0.00	9.30	37.50
Subtotal: Beneficiary Options	0.00	0.00	-60.50	-218.60	0.00	0.00	0.00	0.00	60.50	218.60
Taxation of Benefits										
Tax expenditure cap: Tax the insurance value of employer-paid health benefits										
Monthly premium greater than $165/indiv. & $400/family	-45.30	-164.40	-97.00	-352.30	-13.60	-49.30	-51.80	-187.90	117.10	425.10
Full amt. w/ tax credit for indiv. & some employer contribution	-94.50	-282.20	-221.40	-662.50	-31.00	-92.70	-94.00	-279.90	251.90	752.90
Tax Insurance Value of Medicare Benefits										
Tax those above income threshold	0.00	0.00	-30.50	-106.80	-4.30	-14.90	0.00	0.00	34.80	-121.70
Tax all beneficiaries	0.00	0.00	-54.60	-172.10	-7.60	-24.10	0.00	0.00	62.20	196.20

Prevention

Additional investments into prevention activities or wellness programs have been proposed as means to reduce health care costs. These activities and programs seek to reduce the incidence of illness, disease, or premature death. Prevention activities include immunizations, prenatal care, screening programs to detect disease earlier, and initiatives to discourage individuals from engaging in unhealthy behaviors (e.g., smoking, alcohol and drug abuse, unhealthy diets).

Evaluations of the cost effectiveness of these efforts generally portray the returns on investment of these types of activities as cost benefit ratios or in terms of the cost per year of life saved. Typical problems encountered in using these analyses to support budgetary analyses include:

- Benefit-cost analyses of the activities are based upon average costs and benefits of the program, not the marginal costs and benefits of expanding activities, coverage, or benefits.

- Benefits/savings estimates frequently include indirect savings -- averted costs of lost wages and other non-health care impacts (lost productivity) -- but do not include the costs of outreach or getting target populations to participate in programs.

- Benefits/savings accrue over lengthy periods. From a "cash flow" budget perspective, savings occurring sometime in the future do not offset current spending.

- Benefits/savings accrue to society in general. There is little certainty that savings will be recouped and not spent in some other way for health care.

- Analyses do not include additional health expenditures that may result from follow-up treatment and monitoring and from prolonged life.

- Analyses assume positive changes in behavior as a result of the effort. Few data are available to document the sustained effectiveness of various health education/awareness efforts.

To illustrate the potential impact of additional expenditures for prevention, expanded prenatal care and increased childhood immunizations are included in this report.

Expand Prenatal Care to All Uninsured Pregnant Women

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Total System-Wide	80	-200	-400	-700	-2,300
Public Sector					
Federal Government (Net)	600	700	1,100	3,200	8,000
States	-40	-100	-200	-400	-1,100
Private Sector					
Employers	-80	-200	-300	-900	-2,300
Individuals/Families Out-of-Pocket	-400	-600	-1,000	-2,600	-6,900

Finding

Using optimistic assumptions, a Federal program to provide prenatal care for all uninsured pregnant women will increase Federal costs for health care and, in return, provide only small savings for non-Federal budgets.

Assumptions: Analysis based upon Missouri Medicaid study.[3]

Cost-benefit studies generally indicate that prenatal care can help reduce the incidence of low birthweight babies and the high costs of care associated with the care of these infants. For this report, we analyzed the impact of extending prenatal care to all uninsured pregnant women. For simplicity, the analysis assumes that the Federal government would pay all of the costs of this effort. (If different financing assumptions are used, the cost of the program would be allocated differently in the above table and netted against the projected savings of each payer.)

- Savings from prenatal care result primarily from averted costs associated with the care of low birthweight babies in the first 60 days of life. Costs represent the additional costs of providing adequate prenatal care.

- Estimated savings from each additional dollar spent for prenatal care is $1.49.

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[3] Schramm, Wayne, "Weighing Costs and Benefits of Adequate Prenatal Care for 12,023 Live Births in Missouri's Medicaid Program, 1988", *Public Health Reports*, November-December, 1992. The Missouri study reflects actual experience in the Missouri program and is based upon more recent data than an alternative and widely reported benefit-cost estimate of $3.38 to $1.00, which comes from the 1985 Institute of Medicine report. The IOM results were derived through modelling. Savings were estimated by assuming that a targeted lower level of low birthweight babies (and accompanying savings) would be achieved as a result of prenatal care.

- Federal assistance displaces costs currently paid out-of-pocket and adds to Federal expenditures for health care. Uninsured pregnant women are already receiving about half of the prenatal care they would use if they had insurance.

- Savings from expanded care are allocated across payers in proportion to the share of low-income children's care currently covered by these payers. Full cost of providing care is allocated to the Federal government.

- No outreach costs are included in the estimate.

Discussion

While the Committee accepts general evidence that the cost of caring for low birthweight infants exceeds the cost of providing prenatal care and that women who receive prenatal care are less likely to have low and very-low birthweight babies, the Committee notes that the research has limitations. It does not include the cost of outreach. It is not based upon the cost of effective prenatal care. It is not certain that the results observed for a high risk population can be assumed for larger populations whose risk characteristics are different.

- The results of prenatal care in the Medicaid program may not be applicable to a non-Medicaid population of uninsured pregnant women. To the extent that women have less risky profiles (chiefly age, income, and education), they are not likely to show the same level of savings as a result of prenatal care.

- At least some of the savings attributed to Medicaid prenatal care appears to come from the diet-related factors and dietary assistance provided along with prenatal care. Because women with incomes exceeding the Medicaid cut-off may already have better diets, the same level of savings may not be achievable.

- Studies of the WIC (Women's, Infants' and Children's) program indicate average Medicaid savings for every WIC dollar spent ranging from $1.77-$3.13. However, estimated participation rates for WIC-eligible pregnant women and newborns are 85% and 90% respectively. CBO assumes that 85% constitutes a "full participation rate" since some eligible individuals will always choose not to participate. Additional investment, therefore, would be unlikely to increase national participation rates and produce the same level of returns.

Expand Childhood Immunizations for Vaccine Preventable Diseases

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Total System-Wide	280	320	380	1,570	3,300
Public Sector					
Federal Government (Net)	294	338	407	1,640	3,500
States	-5	-6	-10	-20	-70
Private Sector					
Employers	-6	-8	-10	-30	-90
Individuals/Families Out-of-Pocket	-3	-4	-7	-20	-40

Finding

A $300 million Federal program to provide childhood immunizations is not cost effective even under optimistic assumptions.

Assumptions:

- $300 million Federal program as proposed by President Clinton in his 1993 stimulus package. Program is assumed to continue in 1995-2003 at the inflation adjusted $300 million level. (Note: The President's 1994 budget, released after the completion of this analysis, indicates that this is a one-year proposal.)

- 39,000 annual cases of vaccine preventable disease.

- Direct medical costs and savings from published reports.[4]

Discussion

Committee findings are based on the following:

- The Centers for Disease Control report savings estimates for immunizations range from $10-$14 for each dollar invested. However, the analysis for Measles-Mumps-Rubella (14:1) is based upon *average* averted costs (discounted present value for up to 40 years) associated with treatment of the disease and resulting complications, lost wages from

[4] See C.C. White, J.P. Koplan, and Q.A. Orenstein, "Benefits, Risks, and Costs of Immunization for Measles, Mumps, Rubella," *American Journal of Public Health* (1985) and A.R. Hinman and J.P. Koplan, "Pertussis and Pertussis Vaccine: Reanalysis of Benefits, Risks, and Costs", *Journal of the American Medical Association* (1984).

missed work, and lifetime earnings lost due to retardation or death. In the research used for this report, the direct medical costs averted through immunization are only 37 percent of the total costs averted, while indirect costs make up 63 percent of costs averted.

- The Lewin-VHI analysis shows that because relatively few cases of preventable disease remain, present value of medical costs averted ($19 million) is small relative to the proposed new expenditure of $300 million for immunizations.

- The Lewin estimates probably overstate the budget benefits of vaccinations because they reflect the present value of future benefits. However, the Committee lacks the undiscounted annual data to estimate more precisely the budget impact of the proposal.

Administrative Savings

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Electronic Claims Processing					
Total System-Wide	0	-1,210	-2,940	-2,390	-14,400
Public Sector					
Federal Government (Net)	0	-120	-300	-240	-1,440
States	0	-60	-140	-110	-690
Private Sector					
Employers	0	-580	-1,400	-1,150	-6,930
Individuals/Families Out-of-Pocket	0	-450	-1,100	-890	-5,340
Smart Card System					
Total System-Wide	0	-170	-430	-310	-2,090
Public Sector					
Federal Government (Net)	0	-50	-130	-90	-630
States	0	-20	-40	-30	-210
Private Sector					
Employers	0	-60	-150	-110	-730
Individuals/Families Out-of-Pocket	0	-40	-110	-80	-520

In 1991, public and private insurance and billing costs were estimated to be $80 billion, 11 percent of total health care expenditures. Proposals to reduce administrative costs include standardization of insurance payment claims forms, extension of electronic billing and payment systems, computerization of patient medical records, electronic insurance eligibility (smart) cards, and streamlined medical review of claims. Electronic claims processing and smart card systems are included in this report.

Finding

Modest savings are possible from the implementation of electronic claims processing and insurance eligibility determinations.

The Federal government can recapture these savings by reducing Medicare and Medicaid fee schedules. Private insurers would also have to adjust payments to providers to reflect lower administrative costs. In addition, private insurers would realize savings from their own operations. Both sources of savings would need to be reflected in premiums charged in order for the purchasers of insurance (or benefits administration) to realize savings.

Electronic Billing and Computerized Claims Submission

Assumptions:

- Savings of $.50 per claim for insurers and $1.00 per claim for providers. One billion provider/patient claims filed.[5] Savings are net of amortized capital costs and annual system operating costs.

- Because some claims will always be filed by patients, a maximum of 85% of claims will ultimately be filed electronically.

- 65% of claims are already filed electronically for public programs. 20% of claims submitted to private payors are assumed to be currently filed electronically.

- Savings are phased in over 5 years beginning in 1996; and are allocated in proportion to payors' shares of health spending. This timing (which lags the Lewin-VHI estimates by two years) reflects industry/HCFA efforts through the Working Group for Electronic Data Interchange (WEDI) to reach agreement on standardized data elements and compatible systems.

Discussion

The large number of health care billing and payment transactions involving large numbers of providers and payers results in significant administrative costs. Some have suggested that switching to a single-payer system would save large amounts.[6] Under our current multi-payer system, savings from the administrative expenses of health care providers and payers are likely to be achievable. However, even under the most efficient systems, administrative expenses are likely to be significant simply because of the complexity and diversity of the services provided and the number of health care providers and payers involved.

Administrative savings derive from lower costs for claims processing, remittance, and payment and for insurance eligibility verification. Savings from enhanced electronic data transmission and handling would not apply evenly across all insured groups. For example, overhead costs for small groups have been found to be significantly higher than for large groups because of additional marketing and client servicing requirements and the additional risks associated with

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[5] The number of claims processed differs at the provider/patient and insurer levels. This estimate assumes one billion provider/patient claims filed. Each claim filed by a provider or patient is "unbundled" by the insurer when the claim is processed into an average of four separate claims. A total of 4 billion claims are estimated to be processed by insurers.

[6] GAO estimated paperwork savings of $67 to $100 billion and OMB estimated savings of $31 to $49 billion from switching to a Canadian-type single-payer national health insurance system.

small pools.

Since the bulk of Medicare claims are already filed electronically, most of the savings would accrue to the private sector.

In addition to administrative savings, the Bush Administration argued that clinical savings (reductions in diagnostic tests, lower hospital admissions, shorter hospital stays, and increased hospital staff efficiency) would result from electronic records systems. However, the Committee does not find sufficient data on which to base estimates of clinical savings.

Smart Cards

Assumptions:

- Illustrative assumption that smart cards would allow a 10% increase in efficiency of existing electronic claims processing technology.
- Additional savings (net of amortized capital investment and annual operating costs) of $.05 for insurers and $.10 for providers.
- 5-year phase-in period, beginning in 1996. (This represents a two-year lag of Lewin-VHI estimates for this proposal.)
- Savings allocated across payors in proportion to their share of health care expenditures.

Discussion

Smart cards are credit card-like insurance cards encrypted with individual insurance information. These could potentially reduce administrative costs by simplifying the verification of coverage. Eventually, these cards could include patient medical information. While this holds the promise of better information for providers, better outcomes data, and better care, a serious concern over individual privacy arises and would need to be resolved.

Medical Malpractice Reform

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Malpractice Premiums					
Total System-Wide	0	-2,090	-4,700	-4,000	-23,790
Public Sector					
Federal Government (Net)	0	-630	-1,410	-1,200	-7,140
States	0	-270	-610	-520	-3,090
Private Sector					
Employers	0	-690	-1,550	-1,320	-7,850
Individuals/Families Out-of-Pocket	0	-500	-1,130	-960	-5,710
Defensive Medicine					
Total System-Wide	0	0	0	0	0
Public Sector					
Federal Government (Net)	0	0	0	0	0
States	0	0	0	0	0
Private Sector					
Employers	0	0	0	0	0
Individuals/Families Out-of-Pocket	0	0	0	0	0

Proposals to reform medical malpractice liability seek to reduce the direct costs of malpractice claims and expenditures for defensive medicine, or care provided primarily because of a fear of malpractice litigation. Elements of these proposals include limiting awards for non-economic damages, promoting alternative dispute resolution, eliminating lump sum payments, and establishing standards of care guidelines to help physicians defend against malpractice claims.

Finding

Federal budget savings from reductions in malpractice premiums could be achieved if they are legislatively mandated for Federal programs. States and private sector payors could also achieve budget savings by reflecting savings in their payments to providers. The Committee does not assume savings from lower levels of defensive medicine.

Assumptions:

Malpractice premiums

- Based upon these reforms, which research shows to have the most impact on the volume of malpractice claims: capping the amount of non-economic damages that can be awarded; mandatory offset of collateral sources of recovery; and shorter statute of limitations for adult claims.

- 20% reduction in malpractice premiums as a result of reforms (a 25% potential reduction offset by 5% to reflect the fact that many states have already implemented some of these reforms) phased in between 1995-1998.

- No premium savings in 1993-1994 because of backlog of cases under pre-reform law.

Defensive medicine

- Lewin-VHI illustrative pricing uses $2.80 reduction in defensive medical costs for every $1.00 reduction in malpractice premiums. The Committee does not assume savings from lower levels of defensive medicine. There is insufficient evidence that the total amount of care provided by physicians and other health care providers will be reduced as a result of malpractice reform.

Discussion

Analyses show that malpractice reform has the potential to produce savings from two sources: reductions in malpractice insurance premiums; and reduced levels of defensive medicine. However, malpractice reform proposals generally do not include any mechanism to assure that savings from reductions in premiums and lower levels of defensive medicine will be recaptured from overall spending for health care. The major potential for savings from malpractice reform lies in lower levels of defensive medicine -- or care provided because of physicians' fear of litigation and large damage awards. Malpractice insurance premiums are estimated to add $10 billion a year to national health care spending. Defensive medicine costs are estimated to add up to $25 billion more.

Analysts differ in their assessment of the potential for malpractice reform to reduce health care spending.

- The Bush Administration argued that malpractice reform would enable physicians to be more conservative about the number of tests and treatments ordered.

- The Congressional Budget Office and other analysts argue that physicians are unlikely to alter their practice behavior as a result of malpractice reform alone. Fear of

malpractice is only one factor in a physician's decision-making process. As important are the practitioner's desire to make the patient well and to deliver the best possible care.

- In addition, because physicians are likely to make up for any reductions in volume related to malpractice reform with increases in the volume of other services in order to maintain their incomes, no net savings will be realized.

- Finally, some analysts fear that alternative dispute resolution procedures may actually add to malpractice claims by making it easier for patients to bring complaints against physicians.

Anti-Trust Law Revision

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yr.
Total System-Wide	0	0	0	0	0
Public Sector					
Federal Government (Net)	0	0	0	0	0
States	0	0	0	0	0
Private Sector					
Employers	0	0	0	0	0
Individuals/Families Out-of-Pocket	0	0	0	0	0

The clarification or revision of anti-trust laws is proposed to reduce obstacles to coordinated care arrangements involving both providers and insurers. Proposed measures would clarify antitrust standards that would apply to arrangements to share technology and services and provider pooling and managed care arrangements such as Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs).

Finding

The Committee attributes no savings to this proposal. Insufficient empirical data are available to determine that the proposal would produce budget savings.

Discussion

Proposals to reform antitrust law seek to permit providers to share expensive equipment and to encourage the formation of provider networks. Little data is available to help estimate the impact these proposals would have on overall health spending. For illustrative purposes, the Lewin-VHI analysis shows the potential savings if it is assumed that provider pooling and sharing of technology results in a 12-month lag in acquisition of new technology.

The Committee does not find sufficient evidence to support any budget savings as a result of changes in anti-trust law.

Managed Care

Increased use of managed care arrangements is proposed to correct the disincentives of retrospective fee-for-service payment systems. By integrating health care financing and delivery, managed care uses a number of different techniques to control costs and preserve quality including prepayment for care on a per capita basis, utilization review, case management, and "gatekeepers", which are all designed to prevent the delivery of unnecessary or inappropriate care. Because many managed care options rely on pre-negotiated compensation arrangements with specific care providers, they invariably limit consumer choice of service providers.

Analyses of managed care delivery relative to fee-for-service indicate a range of savings of 15-30% of personal health care expenditures. In addition to HMOs, managed care plans include Independent Practice Arrangements (IPAs), Preferred Provider Organizations (PPOs), and Point-of-Service plans, which uses a primary care physician as a gatekeeper to a network of specialists and hospitals. However, not all managed care approaches are equally effective. This report uses Lewin-VHI estimates of inpatient and outpatient utilization rates for HMOs and IPAs relative to fee-for-service arrangements.

Although some analysts believe that enrollees in HMOs may be younger and healthier, with correspondingly lower health costs than enrollees in other forms of coverage, research shows that HMOs can save costs when selection bias is controlled. It is not certain, however, that the same level of savings could be achieved if a significantly larger proportion of the population enrolled in HMOs. (Approximately 14 percent of the population is currently enrolled in HMOs.) Analyses show that while HMOs have lower per capita costs, annual cost increases in HMOs approximate the overall increase in health care costs, suggesting that other, more systemic changes may be required to slow the rate of growth of health care expenditures.

One element of managed care is utilization review, which is used both with fee-for-service and prospective pay plans. It requires precertification for hospital admissions, concurrent review of the care provided while hospitalized, and retrospective review after discharge. Although utilization review adds to provider and insurer administrative costs, effectively implemented, is estimated to save 1- 5 percent of personal health expenditures.

Pre-empt State Legislative Barriers to Managed Care

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yr.
Total System-Wide	-105	-400	-710	-1,500	-4,390
Public Sector					
Federal Government (Net)	0	0	0	0	0
States	-5	-20	-40	-80	-230
Private Sector					
Employers	-70	-270	-470	-1,000	-2,930
Individuals/Families Out-of-Pocket	-30	-110	-200	-420	-1,230

In some States, legislative barriers restrict the use of coordinated or managed care. Barriers include restrictions on reimbursement rates, contracting arrangements, and patient financial incentives. Proposals to pre-empt these barriers are intended to facilitate more managed care arrangements.

Finding

The Committee recognizes modest budget savings from this proposal.

This finding assumes that managed care providers will market their services in areas where barriers are removed and that their price advantage will attract new enrollees.

Assumptions:

- 10 percent increase in enrollment of privately insured individuals in HMOs.
- Savings based upon Lewin-VHI estimates of inpatient and outpatient utilization in HMOs relative to fee-for-service programs.

Discussion

Although it is uncertain how many individuals are prohibited from choosing HMOs because of State legislative barriers and would enroll in HMOs if the barriers were removed, given the price advantage of HMO coverage, a modest increase in HMOs appears reasonable.

Medicaid Managed Care

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Total System-Wide	-300	-1,600	-2,500	-5,000	-15,700
Public Sector					
Federal Government (Net)	-170	-900	-1,400	-2,800	-8,800
States	-130	-700	-1,100	-2,200	-6,900
Private Sector					
Employers	0	0	0	0	0
Individuals/Families Out-of-Pocket	0	0	0	0	0

Limited experience at the State level seems to indicate that Medicaid savings are possible through managed care arrangements. HHS estimates, for example, that the Arizona Health Care Cost Containment System achieves savings of 5.7 percent relative to traditional Medicaid fee-for-service.

Finding

Federal and State savings can be achieved by providing health care to Medicaid beneficiaries through effective managed care arrangements (HMOs).

Assumptions:

- Because 25% of the population lives in areas with no HMOs, 75% of Medicaid recipients assumed to be affected by this proposal.
- Savings phased-in over 4 years as capacity expands to meet requirements.
- Savings reflect Lewin-VHI estimates of utilization differences between HMOs and fee-for-service plans (11.7% fewer hospital days per 1,000 in population and 8.4% more physician visits per capita).

Discussion

This option assumes that the Federal government mandates use of managed care (HMO) plans and corresponding Federal matching payments to States are adjusted to reflect assumed savings. Savings are adjusted to reflect the absence of HMOs in some States.

Many Medicaid-eligible beneficiaries currently have difficulty finding physicians who will accept Medicaid payments. Because access problems could be solved by Medicaid HMOs, some analysts believe that HMOs would result in higher utilization of health care that would offset savings and potentially increase overall Medicaid costs.

Medicare Managed Care

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Mandatory HMOs					
Total System-Wide	-1,700	-10,100	-16,300	-31,000	-98,800
Public Sector					
Federal Government (Net)	-1,700	-10,100	-16,300	-31,000	-98,800
States	0	0	0	0	0
Private Sector					
Employers	0	0	0	0	0
Individuals/Families Out-of-Pocket	0	0	0	0	0
Voluntary HMOs					
Total System-Wide	0	0	0	0	0
Public Sector					
Federal Government (Net)	0	0	0	0	0
States	0	0	0	0	0
Private Sector					
Employers	0	0	0	0	0
Individuals/Families Out-of-Pocket	0	0	0	0	0

Based upon evidence that effective managed care (HMO) plans can achieve savings, the Federal government could seek to reduce Medicare costs by requiring/encouraging more beneficiaries to enroll in these types of plans.

Finding

If Medicare beneficiaries were required to enroll in effective managed care arrangements, Federal Medicare expenditures could be reduced. If managed care enrollment is optional, no savings are anticipated.

Assumptions:

- Because 25% of the population lives in areas with no HMOs, 75% of Medicare recipients assumed to be affected by this proposal.
- Savings phased-in over 4 years as capacity expands to meet requirements.

- Savings reflect Lewin-VHI estimates of utilization differences between HMOs and fee-for-service plans (11.7% fewer hospital days per 1,000 in population and 8.4% more physician visits per capita).

Discussion

Although HMOs have the potential to reduce costs, research shows that increased HMO use increases Medicare costs. Under a voluntary enrollment option, HMOs attract a disproportionate share of healthier beneficiaries. Under a capitated payment system reflecting the average actuarial cost for Medicare enrollees, payments to HMOs exceed payments that would have been made under traditional fee-for-service arrangements. Therefore, managed care savings are offset by the higher payments.

If, however, all Medicare beneficiaries were enrolled in managed care plans, savings reflecting the plans' lower costs could be achieved.

Rather than forcing Medicare beneficiaries into HMOs and IPAs, Federal Medicare benefits could be limited to the cost of an HMO plan, with the individual option to pay out-of-pocket for fee-for-service coverage. This would reduce the savings from this proposal, but would not eliminate them entirely as some beneficiaries would not want to, or be able to afford to, pay the additional costs.

Outcomes Research and Medical Practice Protocols

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Total System-Wide	0	0	0	0	0
Public Sector					
Federal Government (Net)	0	0	0	0	0
States	0	0	0	0	0
Private Sector					
Employers	0	0	0	0	0
Individuals/Families Out-of-Pocket	0	0	0	0	0

Outcomes research would increase the available knowledge of the qualitative results and cost-effectiveness of various treatment protocols. If providers were required to observe practice parameters developed on the basis of the research, some savings might result from the elimination of unnecessary care. Physicians would be able to make better judgments about the value of tests, procedures, and treatments before they prescribe them. Patients would be better able to make decisions about their own treatments. Payors would be better able to evaluate the appropriateness of the care provided.

Finding

The Committee does not attribute budget savings from outcomes research and the development of practice protocols. Although savings may eventually be possible, the Committee is skeptical about the prospects of recapturing them from overall expenditures.

Discussion

The Committee recognizes that outcomes research and the development of practice protocols have the potential both to reduce the incidence of unnecessary care and to improve the quality of care provided. However, the ability to achieve savings from these measures depends on several factors:

- Research on the effectiveness of procedures or treatments must be undertaken, completed, and reported to physicians before the procedure or treatment is superseded by new developments addressing the same condition or illness.

- Physicians must adjust their practice behavior in response to the research findings and the findings must be incorporated into the training of new physicians;

- Providers must not allowed to make up for lower utilization through other means (e.g., higher volume of other procedures and services);

- Public and private payers must refuse to reimburse providers for care delivered that is not in accord with the protocols and to pass the savings through to taxpayers and purchasers of insurance; and

- Consumers must have access to and use information on outcomes and provider practice patterns when making decisions about providers and medical treatment.

- For savings to be realized, the cost of treatments found to be effective must be lower than the cost of treatments that are found to be ineffective.

In other words, given the rapid pace at which medical treatment evolves and the length of time research requires, it is questionable that outcomes research and practice protocols will be able to achieve large savings.

Outcomes research would be greatly facilitated by broader electronic data collection and the computerization of patient records. This research would help demonstrate the effectiveness of procedures and help physicians to make more appropriate use of costly technologies. In addition, development and use of practice protocols could potentially assist in the determination of malpractice.

The Lewin-VHI analysis indicates that Medicare has already adopted a policy of investing in and enforcing practice parameters. Lewin-VHI assumes that the existing policy achieves one-third of the potential public sector savings. Any savings from this existing policy should be considered as already included in baseline projections. Consistent with the Committee's conservative approach to budgeting and to prevent double counting, we do not attribute additional savings to this proposal.

Insurance Market Reforms

Small Group Reform

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Total System-Wide	-4,000	-5,900	-8,800	-25,200	-63,000
Public Sector					
Federal Government (Net)	0	0	0	0	0
States	0	0	0	0	0
Private Sector					
Employers	-3,400	-5,000	-7,500	-21,400	-53,500
Individuals/Families Out-of-Pocket	-600	-900	-1,300	-3,800	-9,500

Small group market reform proposals seek to:

- Make insurance more affordable for small employers by reducing insurers' administrative costs for serving small employers; and
- Provide individuals better access to insurance through guaranteed issue and renewability, portability of insurance coverage, and community rating.

Finding

Administrative cost savings are possible though small group market reform.

Assumptions:

- Estimates based upon a standardized health plan provided to all groups (and individuals covered under the group purchasing arrangement) at a community rate.
- Insurer profits and marketing costs to small firms assumed to be roughly equivalent to cost of groups with 100-500 employees due to elimination of risk selection profits and reduced turnover in sources of insurance.
- Voluntary employer-paid health insurance benefits and no net change in the utilization of health care services. While some new groups will gain access to insurance at now affordable (lower) rates, others will drop coverage because their rates will increase as a result of community rating and pooling.

Discussion

This proposal assumes that the insurer administrative costs will be lower due to the elimination of medical underwriting, restricting pre-existing conditions limitations, and reducing the amount of premium variation, which contributes to frequent changes of coverage. In addition, the proposal assumes lower insurer risk-related profits and lower marketing costs due to more uniform plans and less frequent changes in coverage.

To achieve administrative savings, small group market reform requires the following minimum elements:

- Sufficient participation of groups to guard against adverse selection (participation by less healthy and more costly groups and non-participation by healthier less costly groups) and/or creation of health risk pools to protect insurers from adverse selection; and

- Minimum variation in plan benefits and premiums (premium bands).

To assure sufficient participation, some small group market reform proposals would mandate employer-paid benefits and would provide subsidies to help small businesses meet this responsibility. The availability of such subsidies would shift costs from individuals and employers to the public sector.

Under community rating, groups that previously had lower health care costs would see their premiums increase to help pay for groups with higher costs. If employer coverage is voluntary, as assumed in this report, no net increase in the utilization of health care is projected. Although some employers would be able to add coverage as a result of more affordable premiums, some employers will drop coverage as their rates rise. However, if employer-paid coverage is mandated, overall utilization of health care and health care expenditures would increase since businesses would not be able to drop coverage for their employees. (Utilization of health care would increase as a result of insurance. In general, previously uninsured individuals are estimated to increase their utilization of health care by 50% as a result of coverage.) Without sufficient provisions to guard against adverse selection, it is unlikely that small groups market reforms will be successful in the long term.

Pre-Emption of State Mandated Benefits

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Total System-Wide	1,200	-1,800	-2,600	-7,500	-18,800
Public Sector					
Federal Government (Net)	0	0	0	0	0
States	0	0	0	0	0
Private Sector					
Employers	-1,000	-1,500	-2,200	-6,400	-16,000
Individuals/Families Out-of-Pocket	-200	-300	-400	-1,100	-2,800

By requiring insurers to provide coverage for certain types of medical services, State mandates increase the overall cost of health insurance. State mandates range from maternity and newborn infant care, to invitro fertilization, chiropractic care, mental health, and substance abuse treatments.

Finding

Modest savings are estimated from pre-emption of State mandated benefits. The estimates assume Federal pre-emption of State mandates. Savings would be realized by private payors though reduced utilization of some services.

Assumptions:

- State mandated benefits assumed to add 15% to health insurance costs.
- One-half of employers (not including self-insured plans, which are exempt from State mandated benefit laws) assumed to eliminate coverage for benefits previously mandated by States.
- Utilization of services no longer covered by employer-provided insurance assumed to decline by 20%.

Discussion

To achieve system-wide savings, elimination of mandated benefits would need to be reflected in lower premiums. In addition, to the extent that providers increase the volume of other services increases to offset losses in incomes, savings would be reduced.

Studies show that 20% or more of insurance claims result from State mandated coverage requirements. Consistent with studies showing that utilization decreases by 0.2% for every 1% increase in price, withdrawal of insurance benefits for these services is estimated to decrease utilization by 20%.

Medicare Savings Options

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Hospital Payment Options[a]					
Total System-Wide	0	0	0	0	0
Public Sector					
Federal Government (Net)	-4,170	-10,000	-16,000	-35,600	-103,100
States	0	0	0	0	0
Private Sector					
Employers	3,130	7,500	12,000	26,600	77,350
Individuals/Families Out-of-Pocket	1,040	2,500	4,000	9,000	25,750
Beneficiary Cost Sharing Options[a]					
Total System-Wide	0	0	0	0	0
Public Sector					
Federal Government (Net)	-5,100	-19,370	-40,000	-60,500	-218,600
States	0	0	0	0	0
Private Sector					
Employers	0	0	0	0	0
Individuals/Families Out-of-Pocket	5,100	19,370	40,000	60,500	218,600

[a] See p. 17 for listing of individual options.

Cost containment proposals for Medicare are provided in the Congressional Budget Office (CBO) publication, *Reducing the Deficit: Spending and Revenue Options*, February 1993. Some proposals limit payments to hospitals and providers, while others increase cost-sharing requirements of beneficiaries.

Finding

Because of the ability of providers to shift costs to other payers, savings achieved through Federal cost containment efforts are assumed to be passed on to employers and individuals/families. System-wide, no savings are achieved.

Assumptions:

- No net change in utilization is assumed as a result of these proposals. The ability for

providers to shift costs to other payers offsets savings achieved on the Federal budget.

- Beneficiaries are assumed to absorb increases in premiums, coinsurance, and deductibles, either through out-of-pocket payments or through Medigap or Medicaid coverage.

Discussion

Estimates presented in the table above reflect the impact of the following reductions in payments to hospitals:

- Gradual elimination of the Medicare disproportionate share adjustment,
- Reduction of the payment to teaching hospitals, and
- A one-year freeze on prospect payment system (PPS) rates.

Options included to achieve Federal budget savings through increased beneficiary cost-sharing are:

- A 20% coinsurance requirement for Medicare Part B supplemental medical insurance (SMI) payments for home health care and skilled nursing facilities,
- An increase in SMI premiums for physician services from 25% to 30% of costs, and
- Increasing and indexing the SMI deductible for physician services (the current deductible of $100 per year would be increased to $150).

Although the estimates presented do not show any changes in utilization as a result of these proposals, changes affecting beneficiaries are likely to have impact on utilization of health care.

Financing Measures

Many proposals to change the financing of health care are designed to contain costs by making the cost of health care more visible to consumers. Some proposals would change how we pay for health care -- that is change the mix between tax-supported care and employment-based insurance and are not explicitly designed to control costs. This section reviews financing proposals that seek to contain costs by altering consumer incentives.

Caps on Federal Tax Expenditures

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Tax Excess Benefits					
Total System-Wide	-4,200	-13,500	-32,100	-45,300	-164,400
Public Sector					
Federal Government (Net)	-9,000	-29,200	-69,100	-97,000	-352,300
States	-1,300	-4.000	-9,700	-13,600	-49,300
Private Sector					
Employers	-4,800	-15,600	-36,900	-51,800	-187,900
Individuals/Families Out-of-Pocket	10,900	35,300	83,600	117,100	425,100
Full Taxation with Tax Credits					
Total System-Wide	-13,400	-24,600	-48,300	-94,500	-282,200
Public Sector					
Federal Government (Net)	-31,400	-57.700	-113,400	-221,400	-662,500
States	-4,400	-8,100	-15,900	-31,000	-92,700
Private Sector					
Employers	-13,300	-24,400	-47,900	-94,000	-279,900
Individuals/Families Out-of-Pocket	35,700	65,600	-128,900	251,900	752,900

Health insurance benefits are treated advantageously by the tax system (employer-paid benefits may be deducted from employer income and are excluded from employee income). Certain other health care expenditures also receive favorable tax treatment. A tax expenditure cap would eliminate the favorable tax treatment for health insurance above a specific threshold. This would reduce demand of "excess" health insurance and presumably reduce overall demand for health care.

Findings

Limits on the deductibility of health care benefits can reduce national health care expenditures.

Assumptions:

- Estimates based upon the Joint Tax Committee estimates contained in the CBO publication, *Reducing the Deficit, Spending and Revenue Options*, February 1993.
- Tax expenditure cap set at $165/month for individuals and $400/month for families. These amounts represent estimated average monthly premiums in 1992.
- Changes in the tax deductibility of health insurance assumed to change employee preferences for insurance relative to cash compensation.
- Each 1% increase in the effective price of insurance (due to the loss of tax deductibility) assumed to reduce demand for insurance by 0.4%.
- Lower insurance coverage associated with increased out-of-pocket expenditures and a reduction (0.2 % for each 1% increase in the price of services) in overall utilization.

Discussion

The favorable tax treatment accorded to employer-paid health insurance benefits and other health expenditures resulted in an estimated $53 billion in lost Federal tax revenues in 1992 (not including foregone FICA revenues). The favorable tax treatment of these health related expenditures lowers the effective cost of health insurance.

Tax expenditure caps would reduce government subsidization of health insurance. The caps could be designed to:

- Be progressive, that is impose a tax burden proportionate to income;
- Discourage overinsurance by taxing "excess" health insurance benefits above a level that would provide a standard level of coverage;
- Limit the ability of employers to provide "excess" health insurance by prohibiting the amount of per capita employer premium contributions.

Tax expenditure caps that seek to constrain the level of insurance to an absolute amount may be difficult to design. The cost of the same level of insurance coverage varies by region and, within regions, by individual characteristics, making equitable treatment under the cap a

problem. Because regional variations in incomes tend to reflect regional variations in the cost of living, a tax expenditure cap that is tied to median income could help adjust for cost differentials and help reduce inequities produced by an absolute cap.

Tax the Insurance Value of Medicare

($ in millions)

	1994	1998	2003	Total: 5 Yrs.	Total: 10 Yrs.
Tax Beneficiaries over Income Threshold					
Total System-Wide	0	0	0	0	0
Public Sector					
Federal Government (Net)	-2,000	-9,100	-20,600	-30,500	-106,800
States	-300	-1,300	-2,900	-4,300	-14,900
Private Sector					
Employers	0	0	0	0	0
Individuals/Families Out-of-Pocket	2,300	10,400	23,500	34,800	121,700
Tax All Beneficiaries					
Total System-Wide	0	0	0	0	0
Public Sector					
Federal Government (Net)	-3,000	-15,600	-30,000	-54,600	-172,100
States	-400	-2,200	-4,200	-7,600	-24,100
Private Sector					
Employers	0	0	0	0	0
Individuals/Families Out-of-Pocket	3,400	17,800	34,200	62,200	196,200

Benefits received under Medicare hospital insurance (Part A) and Supplemental Medical Insurance (SMI) programs are not taxed. Some or all of the insurance value of the programs (the actuarially determined value of the insurance, not the benefits actually received) could be subjected to income taxation. To prevent burdening the elderly with only low or moderate incomes, the proposal could be limited to individuals above a designated threshold income level.

Recommendation

No net change in the overall expenditures for health care is assumed from these proposals.

Assumptions:

- Estimates based upon the Joint Tax Committee estimates contained in the CBO publication, *Reducing the Deficit, Spending and Revenue Options*, February 1993.
- Because this proposal does not change in the cost of health care services to consumers,

no change in the utilization of health care is assumed.

Discussion

Payroll tax payments into the Medicare Hospital Insurance fund is shared by employers, who contribute 50 percent of the cost with pre-tax dollars, and by employees, who contribute 50 percent with after-tax dollars. Enrollees in Medicare's SMI program contribute 25 of the program costs through premiums. These proposals would tax half of the insurance value of the hospital insurance benefits and 75 percent of the insurance value of SMI. CBO estimates the following 5-year savings from this proposal:

- $51 billion if no income threshold is imposed;
- $31 billion with an income threshold. The tax would be applied to the amount the following exceed $25,000 for individuals and $32,000 for couples: adjusted gross income, plus 50 percent of Social Security benefits, plus 50 percent of the insurance value of Hospital Insurance, plus 75 percent of the insurance value of SMI.

Health Care Reform
Background Information

The Numbers

The health care industry is characterized by many players.

- An estimated 1,200 commercial insurance companies are in the health insurance business.
- Americans are enrolled in 1,350 Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPO).
- Care is provided by over 5,000 community hospitals (over 900,000 hospital beds) and 600,000 physicians and dentists, as well as other professionals and care facilities.
- Additionally, the industry includes manufacturers of pharmaceuticals, medical devices, supplies and equipment.
- Each State has its own set of rules and regulations affecting the financing and delivery of health care.
- Federal rules and programs further add to the complexity of the system.

Expenditures for health care are growing faster than the economy, rising from 6 percent of GDP in 1965, when Medicare was introduced, to 14 percent today. If current trends continue, national health expenditures will consume 18 percent of GDP by the year 2000. Unchecked, by the year 2030, national health expenditures will consume 32 percent of GDP, even with a projection methodolgy that "tamps down" the growth path with assumptions that a pure growth rate is clearly unsustainable.

Within the Federal budget, expenditures for health care in general and the health care entitlement programs Medicare and Medicaid in particular are the fastest growing components of spending.

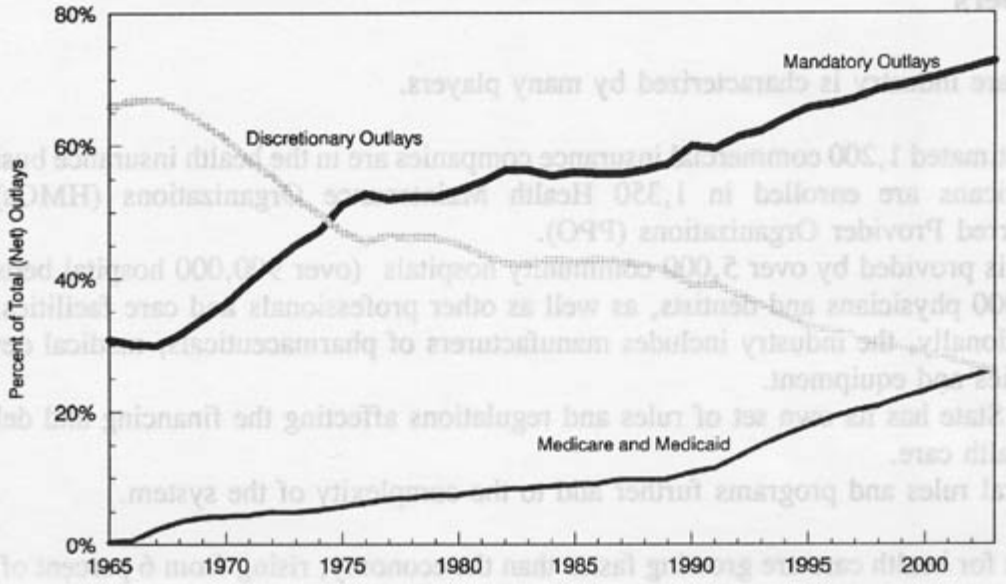
- In 1965, when Medicare was introduced, health care entitlements were $300 million, or 0.2 percent of Federal outlays (see Charts 4 and 5).
- Today, health care entitlements are almost 14 percent of Federal outlays.
- By the year 2000, these programs will cost almost $500 billion and consume 24 percent of total Federal outlays.
- Together, outlays for Medicare and Medicaid will surpass expenditures for Social Security by 1998.

This increase in health care spending is largely responsible for the increase in mandatory spending as a share of the Federal budget. In 1965, outlays were 66 percent discretionary and 34 percent mandatory (including net interest). By 1998, Federal outlays will be 30 percent discretionary and 70 percent mandatory (including net interest).

Chart 4

Composition of Federal Spending

Total Spending

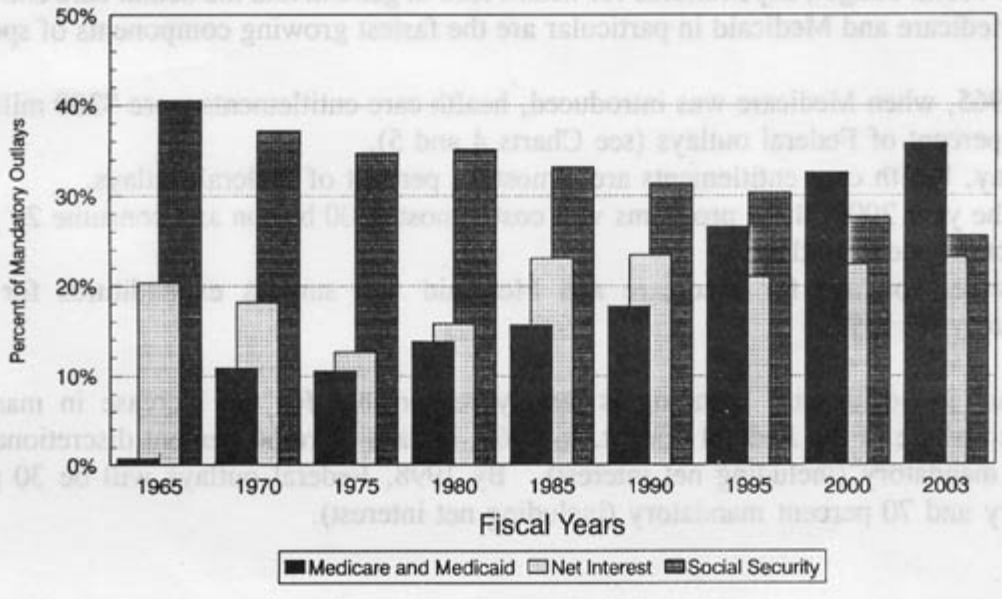


Sources: OMB Historical Tables, 1/93; CBO Economic and Budget Outlook: Fiscal Years 1994 - 1998.

Chart 5

Composition of Federal Spending

Entitlement Programs and Net Interest



Sources: OMB Historical Tables, 1/93; CBO, The Economic and budget Outlook: Fiscal Years 1994 - 19998

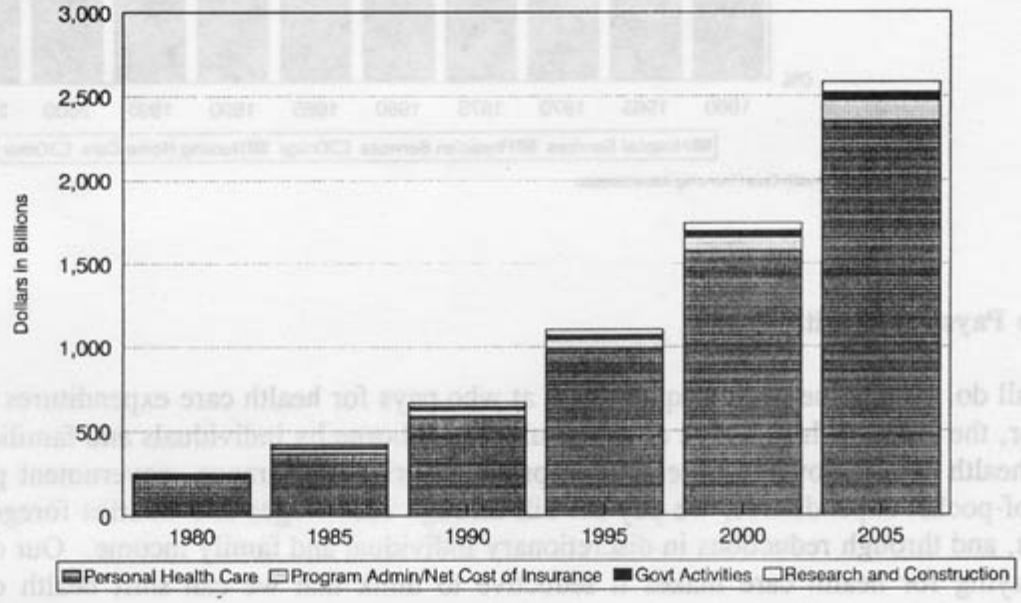
Components of Health Care Expenditures

Spending for personal health care constitutes the major portion of health care spending and includes expenditures for physician and hospital services, medical devices, drugs, and nursing home care (see Charts 6 and 7). Other major categories of expenditures include administration and the net cost of private insurance, government public health activities, and research and construction.

Chart 6

Components of National Health Expenditures

Personal Health Care Constitutes the Largest Share

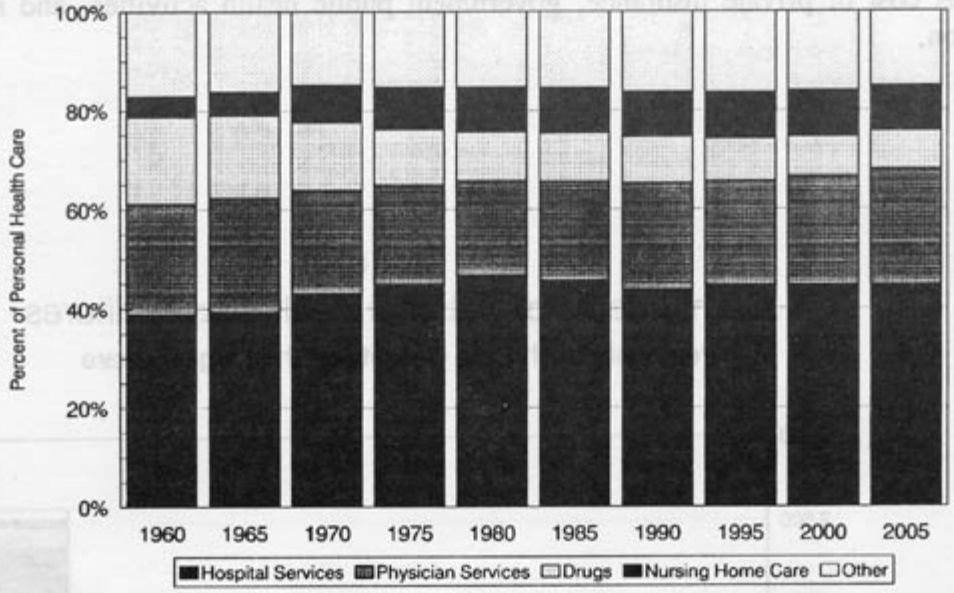


Source: Health Care Financing Administration

Chart 7

Composition of Personal Health Care Expenditures

Hospitals and Physicians Receive the Greatest Shares



Source: Health Care Financing Administration

Who Pays for Health Care?

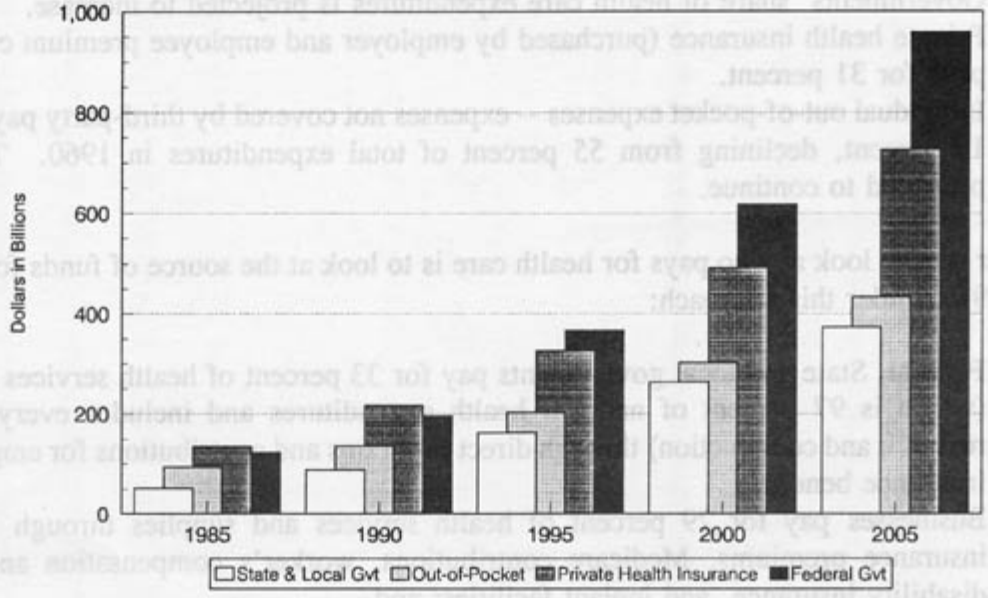
We all do. While the most frequent look at who pays for health care expenditures is by "final" payor, the Nation's health care costs are ultimately borne by individuals and families. Whether our health care is covered by employer-provided private insurance, government programs, or out-of-pocket expenditures, we pay the bill through cash wages and salaries foregone, through taxes, and through reductions in discretionary individual and family income. Our complex way of paying for health care makes it seductive to think that we can shift health care costs to someone else, but ultimately we pay the bill.

Charts 8 and 9 trace health care spending first by payer, then by source of funds. They show that individuals and families pay for health care -- not insurance companies, not businesses, not government.

Chart 8

National Health Expenditures By Payor

After 1992, the Federal Government Pays the Largest Share of Health Care Costs



Source: Health Care Financing Administration

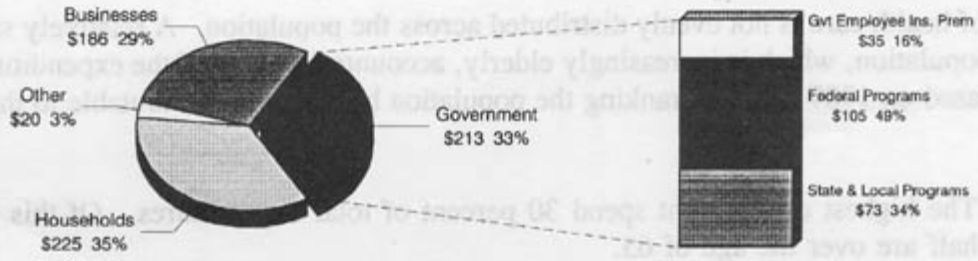
Chart 9

Health Services and Supplies

By Source of Funds

1990

($ in billions)



Total Expenditures for Health Services and Supplies: $643 B

Source: Health Care Financing Administration

Chart 8 shows the distribution of health care costs by payer. Under this approach:

- 46 percent of health care is paid for by government through direct health care programs. (Employee health insurance benefits paid by government employers are included under private health insurance.) The Federal government currently pays for almost 32 percent of national health expenditures. State and local programs contribute another 14 percent. Governments' share of health care expenditures is projected to increase.
- Private health insurance (purchased by employer and employee premium contributions) pays for 31 percent.
- Individual out-of-pocket expenses -- expenses not covered by third-party payors -- cover 19 percent, declining from 55 percent of total expenditures in 1960. This trend is projected to continue.

Another way to look at who pays for health care is to look at the source of funds for health care (Chart 9). Under this approach:

- Federal, State and local governments pay for 33 percent of health services and supplies (which is 97 percent of national health expenditures and includes everything except research and construction) through direct programs and contributions for employee health insurance benefits;
- Businesses pay for 29 percent of health services and supplies through payments of insurance premiums, Medicare contributions, worker's compensation and temporary disability insurance, and inplant facilities; and
- Households pay for 35 percent through out-of-pocket contributions, Medicare contributions, and employee or individual contributions to insurance premiums.

Businesses and households, through taxes, pay for government. Businesses are ultimately owned by individuals (through direct investments and through pension funds). Individuals support charitable and non-profit organizations. Therefore, individuals and families ultimately pay the Nation's health care bill.

Who Uses Health Care?

Usage of health care is not evenly distributed across the population. A relatively small minority of the population, which is increasingly elderly, accounts for most of the expenditures for health care. Based on 1987 data and ranking the population by spending attributable to them for health care:[7]

- The highest one percent spend 30 percent of total expenditures. Of this group almost half are over the age of 65.

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[7] Marc L. Berk and Alan C. Monheit, "The Concentration of Health Expenditures: An Update," *Health Affairs*, Winter 1992.

- The highest 10 percent of the population consumes 72 percent of total costs.
- The lowest 50 percent of health care users account for only 3 percent of the total dollars.

Between 1963 and 1970, the percentage of total expenditures used by the top 1 percent jumped from 17 percent of the total to 26 percent. This increase reflects expanding public and private insurance. Since 1970, health care spending has slowly become more concentrated. The proportion of health care used by the top 1 percent of users increased from 26 percent to 30 percent. Within this highest spending 1 percent, the percentage who were elderly grew from 32 percent to 48 percent between 1970 and 1987. In 1970, 10 percent of the population was over 65: in 1987, 12 percent was elderly.

Who Are the Uninsured?

In 1991, an estimated 36 million Americans lacked private health insurance and did not receive publicly financed insurance.[8] Of these:

- Almost 10 million (27 percent) were children;
- Almost 20 million (56 percent) were adults who worked either part- or full-time for at least some part of the year;
- Only 6 million (17 percent) were non-working adults.

Other characteristics of the uninsured:

- Together, uninsured working adults and their children made up 85 percent of the total uninsured population under the age of 65.
- Over 55 percent of the uninsured were in families making less than $20,000 in income, but approximately one quarter of the uninsured have incomes exceeding the median family income.
- Of those who worked, 14 percent were self-employed and 36 percent worked for businesses with fewer than 25 employees. Almost 24 percent worked for businesses with more than 500 employees.
- For adults, 48 percent of spells of uninsurance last 5 months or less, 16 percent last 6-9 months, 8 percent last 10-13 months, and 19 percent last more than 2 years.[9] Research shows that as the period of uninsurance lengthens, it becomes less likely that the individual will gain insurance.

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[8] Unless otherwise noted, all statistics about the uninsured from *Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1991 Current Population Survey*, Employee Benefit Research Institute, February 1992.

[9] Swartz, Katherine, John Marcotte, and Timothy McBride, "Spells without Health Insurance: The Distribution of Durations When Left-Censored Spells are Included," *Inquiry*, Vol. 320, No. 1, Spring 1993.

Why Are Health Care Costs Growing So Fast?

The short answer to the questions of why are health care costs growing so fast is that there is no easy answer and no silver bullet that will solve the problem. There are many explanations[10], but the major one is "market failure." Briefly, the components of market failure in health care are:

- Insufficiently informed consumers (patients), who lack adequate information about outcomes and price to be able to make sensible decisions about purchases of health care services and who delegate purchasing decisions to health care providers (physicians, hospitals);
- Provider-induced demand -- because incomes to physicians and hospitals are largely determined by price times volume, health care providers have little incentive to be cost-effective;
- Consumer price insensitivity, largely the result of private and public health insurance and tax policies providing favorable treatment to health expenditures, which mask the cost of health care services and may promote higher levels of demand for health care;
- Retrospective payment systems that pay for services after they are provided rather than prospective payment systems, which would force cost-effective decision making before a service is rendered;
- Physicians' lack of sufficient information about the efficacy and cost-effectiveness of procedures and technology;
- Expensive new technology and treatments -- less invasive and innovative procedures increase the demand for service and are paid for "invisibly" with health insurance, part of a vicious cycle where the availability of insurance increases the demand for new, expensive technology and treatments, that in turn increase the demand for insurance. The expanding use of new technology is often referred to as having increased "intensity" of care.

Other explanations of the growth in cost include the changing demographics and waste, fraud, and abuse.

- While the proportion of Americans over the age of 65 is increasing and their per capita consumption of health care is over three times the mean level of consumption of the general population, this change in demographics accounted for only .5 percent out of the total 10.4 percent increase in expenditures between 1990 and 1992. Growth in population contributed 1 percent out of a 10.4 percent increase during the same period.

- The Government Accounting Office has cited 10 percent of overall health expenditures ($80 billion based on 1992 expenditures) as an estimate for fraudulent or abusive

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[10] For a summary of likely contributing factors, see Appendix 3.

practices by health care providers. These practices include billing for tests, procedures, and treatments that were not performed, overcharging for treatment, and performing unnecessary tests and procedures. Other estimates of unnecessary or inappropriate care, which includes defensive medicine, are 10 percent of personal health expenditures ($70 billion based on 1992 expenditures) and 53 percent of hospital days.

Appendices

Appendix 1

Lewin-VHI, Inc.

Technical Appendix

with

Committee for a Responsible Federal Budget Supplement

COST SAVINGS UNDER ALTERNATIVE COST CONTAINMENT REFORMS

Prepared for:

THE COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET

Prepared by:

LEWIN-VHI, INC.

March 15, 1993

93LF0118

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COST SAVINGS UNDER ALTERNATIVE COST CONTAINMENT REFORMS

A. INTRODUCTION

In this analysis, we estimated the cost savings associated with several alternative cost containment initiatives. We present estimates of savings over 5-year and 10-year periods for the Federal government, state governments, employers, and households. These estimates are based upon available research on the effectiveness of similar cost-containment approaches where they have been attempted. In some instances, we rely upon estimates developed by government agencies and/or other analysts. The cost-containment reforms analyzed in this study include:

- Expanded preventive care
- Administrative simplifications
- Malpractice reform
- Anti-trust law revisions
- Efforts to promote managed care
- Expanded outcomes research
- Small group market reforms
- Preempting state mandated benefits
- Taxing expenditure caps
- Tax the insurance value of Medicare benefits
- Medicare cost controls including expanded HMO enrollment
- Medicaid reforms

Most of these reforms are intended to reduce overall health spending. However, some of these reforms, such as the Medicare cost controls, would only tend to shift costs to private payers with little change in overall health spending. The potential impact of these changes in the health care delivery system are very difficult to estimate. Throughout this analysis, we have tended to be optimistic in estimating cost savings to illustrate potential savings under these scenarios. In particular, we assume that providers will not respond to efforts to reduce health services utilization by attempting to increase the volume of other services provided.

Our estimates of the impact of these reforms on health spending are presented in Table 1. The methods used to develop these estimates are described below.

TABLE 1
SUMMARY HEALTH CARE COST CONTAINMENT REFORM OPTIONS
[In Billions]

Options	TOTAL System-Wide Impact		PUBLIC SECTOR Federal		PUBLIC SECTOR State		PRIVATE SECTOR Employers		PRIVATE SECTOR Individuals/Families	
	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years
National Health Spending*	$5,904.5	$15,158.9	$1,914.4	$5,069.6	$869.2	$2,262.5	$1,971.4	$4,967.5	$1,149.5	$2,859.3
Prevention										
Expanded Prenatal Care	(0.7)	(2.3)	3.2	8.0	(0.4)	(1.1)	(0.9)	(2.3)	(2.6)	(6.9)
Increase Childhood Immunizations	1.6	3.3	1.6	3.5	(0.02)	(0.07)	(0.03)	(0.09)	(0.02)	(0.04)
Administrative Savings										
Electronic Claims	(6.3)	(21.0)	(0.6)	(2.1)	(0.3)	(1.0)	(3.0)	(10.2)	(2.4)	(7.7)
"Smart Card" Systems	(0.9)	(3.1)	(0.3)	(0.9)	(0.1)	(0.3)	(0.3)	(1.1)	(0.2)	(0.8)
Malpractice Reform										
Malpractice Insurance	(4.0)	(23.8)	(1.2)	(7.3)	(0.5)	(3.2)	(1.3)	(7.6)	(1.0)	(5.7)
Defensive Medicine	(11.2)	(66.6)	(3.6)	(20.4)	(1.5)	(9.0)	(3.6)	(21.3)	(2.5)	(15.9)
Anti-Trust Revision	(1.9)	(7.3)	(0.6)	(2.2)	(0.2)	(0.9)	(0.7)	(2.5)	(0.4)	(1.7)
Promote Enrollment in Managed Care										
Preempt State Legislative Barriers	(1.5)	(4.4)	0.0	0.0	(0.08)	(0.23)	(1.0)	(2.9)	(0.42)	(1.27)
Expand Managed Care in Small Groups	(2.0)	(5.7)	0.0	0.0	0.0	0.0	(1.50)	(4.3)	(0.5)	(1.4)
Medicaid Managed Care	(5.0)	(15.7)	(2.8)	(8.8)	(2.2)	(6.9)	0.0	0.0	0.0	0.0
Mandatory Medicare Managed Care	(31.0)	(98.8)	(31.0)	(98.8)	0.0	0.0	0.0	0.0	0.0	0.0
Optional Medicare Managed Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Invest in Outcomes Research	(26.3)	(83.2)	(7.2)	(23.1)	0.0	0.0	(16.2)	(51.1)	(2.9)	(9.0)

TABLE 1 (continued)
SUMMARY HEALTH CARE COST CONTAINMENT REFORM OPTIONS
[In Billions]

Options	TOTAL System-Wide Impact		PUBLIC SECTOR Federal		PUBLIC SECTOR State		PRIVATE SECTOR Employers		PRIVATE SECTOR Individuals/Families	
	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years
Insurance Reforms										
Small Group Market Reforms	(25.2)	(63.0)	0.0	0.0	0.0	0.0	(21.4)	(53.5)	(3.8)	(9.5)
Preempt State Mandated Benefits	(7.5)	(18.8)	0.0	0.0	0.0	0.0	(6.4)	(16.0)	(1.1)	(2.8)
Medicare										
Eliminate Disproportionate Share Adjustment	0.0	0.0	(9.5)	(33.4)	0.0	0.0	7.1	25.1	2.4	8.4
Reduce Teaching Adjustment to 3 Percent	0.0	0.0	(10.9)	(30.0)	0.0	0.0	8.1	22.5	2.8	7.5
Freeze PPS Rates for One Year	0.0	0.0	(15.2)	(39.7)	0.0	0.0	11.4	29.8	3.8	9.9
Increase SMI Coinsurance for Home Health	0.0	0.0	(21.1)	(56.1)	0.0	0.0	0.0	0.0	21.1	56.1
Increase SMI Premiums	0.0	0.0	(30.1)	(125.0)	0.0	0.0	0.0	0.0	30.1	125.0
Increase and Index SMI Deductibles	0.0	0.0	(9.3)	(37.5)	0.0	0.0	0.0	0.0	9.3	37.5
Tax Employer Benefits										
Tax Benefits Over $165 per Month ($400 per family)	(45.3)	(164.4)	(97.0)	(352.3)	(13.6)	(49.3)	(51.8)	(187.9)	117.1	425.1
Tax Full Amount of Benefits with Tax Credit for Some	(94.5)	(282.2)	(221.4)	(662.5)	(31.0)	(92.7)	(94.0)	(279.9)	251.9	752.9
Tax Medicare Benefits										
All Beneficiaries over Income Threshold	0.0	0.0	(30.5)	(106.8)	(4.3)	(14.9)	0.0	0.0	34.8	121.7
All Beneficiaries	0.0	0.0	(54.6)	(172.1)	(7.6)	(24.1)	0.0	0.0	62.2	196.2

* "Projections of National health Expenditures", Congressional Budget Office, October 1992.
SOURCE: "Cost Savings under Alternative Cost Containment Reforms", Lewin-VHI, Washington, DC, February 26, 1993.

B. PREVENTION

Some forms of preventive care, such as immunizations and prenatal care, have been shown to be cost effective. That is, the cost of providing these preventive services is more than offset by reduced spending for preventable conditions such as low-birthweight children. However, increased Federal spending for prevention may not result in net Federal savings in cases where the cost of preventable conditions is now absorbed by non-Federal payers (employers, households, etc.). In these instances, Federal prevention programs may represent a net increase in Federal spending even though overall health spending is actually reduced by the program. In this analysis, we examined the impact of expanded prenatal care and immunizations.

1. Expanded Prenatal Care

To illustrate the impact of expanding prenatal care, we estimated the cost of covering all uninsured pregnant women for prenatal care services. Based upon a Lewin-VHI analysis of the 1987 National Medical Expenditures Survey (NMES) data, we estimate that there are about 303,000 pregnant women in the United States who are without health insurance.[1] These data also indicate that the cost of prenatal care services for pregnant women are about $2,260 per year (in 1994 dollars). Based upon these data, we estimate that it would cost about $685 million to cover all of these uninsured pregnant women for prenatal services.

Prenatal care is generally considered to be cost-effective. One study suggests that if proper prenatal care were extended to all high-risk populations, health spending for low-birthweight children would be reduced by $3.40 for every dollar spent on prenatal care. However, this estimate was based upon the questionable assumption that a program of comprehensive prenatal care would succeed in reducing the number of low-birthweight deliveries to the Surgeon General's target level. In fact, these high-risk population (e.g., drug abusers, teenagers, etc.) are often hard to reach, and it is often difficult to modify their behavior in ways which will actually

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[1] In our analysis, we updated the NMES data to reflect changes in Medicaid eligibility for pregnant women since 1987.

reduce low-birthweight deliveries.[2] Another empirical study comparing actual cost data for women with and without adequate prenatal care indicated that savings were only about $1.49 for each dollar spent on prenatal care.[3]

We used this latter study to estimate the reduction in health expenditures resulting from an expansion in coverage for prenatal care because it is based upon actual program experience. We assume that these savings phase-in over a period of two years. We assume that these savings are allocated across major payers for health care in proportion to the share of low-income children's care currently covered by these payers (Table 2).

2. Immunizations

About 98 percent of all school-age children in the United States are appropriately vaccinated, largely due to state requirements that all public school children be immunized prior to enrollment.[4] However, as much as 40 percent of the pre-school population in the United States has not been age-appropriately immunized.[5] President Clinton has introduced a $300 million program to expand vaccinations for pre-school children. In this analysis, we estimated the potential health care savings resulting from expanded immunizations under the President's proposal.

We estimated the potential impact of this program on national health spending based upon available data on the incidence and cost of vaccine-preventable diseases in the United States. The incidence of vaccine-preventable diseases was obtained from the Centers for Disease Control (CDC). These diseases include measles, mumps, rubella, pertussis, diphtheria, tetanus,

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[2] Institute of Medicine, "Preventing Low Birthweight", (Washington: National Academy Press, 1985), p. 27.

[3] Schramm, WF. "Weighing Costs and Benefits of Adequate Prenatal Care for 12,023 Births in Missouri's Medicaid Program, 1988", *Public Health Reports*, November 1991.

[4] Advance text of presentation by Walter A. Orenstein, M.D., Director, Division of Immunization, Centers for Disease Control. 26th National Immunization Conference, June 1-5, 1992; St. Louis, MO.

[5] Hinman AR. "Immunizations in the United States", *Pediatrics* 1990; Supplement: 1064-1066.

TABLE 2

POTENTIAL SAVINGS RESULTING FROM EXTENDING PRENATAL CARE TO ALL UNINSURED PREGNANT WOMEN[a,b,c]
[In Millions]

	FEDERAL			INDIVIDUALS					
	PRENATAL CARE COST	FEDERAL SAVINGS	NET COST	EXISTING PRENATAL NOW PAID BY FEDERAL GOVERNMENT	REDUCED PREGNANCY COMPLICATIONS COSTS	NET IMPACT	STATE	EMPLOYER	CHANGE IN NATIONAL HEALTH SPENDING
1994	$684	$(81)	$603	$(342)	$(59)	$(401)	$(38)	$(81)	83
1995	747	(174)	573	(373)	(126)	(499)	(83)	(173)	(182)
1996	814	(190)	624	(407)	(138)	(545)	(90)	(188)	(199)
1997	887	(207)	680	(443)	(150)	(593)	(98)	(205)	(216)
1998	967	(226)	741	(483)	(164)	(647)	(107)	(223)	(236)
1999	1,054	(246)	808	(527)	(179)	(706)	(117)	(243)	(258)
2000	1,149	(264)	881	(574)	(195)	(769)	(127)	(265)	(280)
2001	1,252	(293)	959	(626)	(213)	(839)	(139)	(288)	(307)
2002	1,365	(319)	1,046	(682)	(232)	(914)	(152)	(313)	(333)
2003	$1,488)	$(348)	$1,140	$(744)	$(253)	$(997)	$(165)	$(342)	(364)

a There are 303,000 pregnant women without insurance. We estimated the cost of providing all of these women with prenatal care based upon the average cost of prenatal care and treatment ($2,260 per person in 1994 dollars) reported in the 1987 National medical Expenditures Survey (NMES) data. We projected program expenditures based on the rate of growth in health spending projected by CBO.

b Total health care cost savings resulting from prenatal care were estimated based upon research indicating the health care costs are reduced by $1.49 for every dollar spent on prenatal care.

c We assume that savings are distributed in proportion to spending by source of payment for children below 200 percent of poverty.

SOURCE: Lewin-VHI estimates.

TABLE 3
ESTIMATED COST OF VACCINE-PREVENTABLE DISEASES IN 1994

	HIGHEST NUMBER OF REPORTED CASES IN YEAR [1989-1991][a]	ESTIMATED COST PER CASE		AGGREGATE COST OF VACCINE-PREVENTABLE DISEASE	
		Direct Costs [Health Related]	Indirect Costs [Non-Health Related]	Direct Costs [Health Related]	Indirect Costs [Non-Health Related]
Measles	27,672	$138[b]	$436[b]	$3,763,392	$12,064,992
Mumps	5,712	10[b]	512[b]	57,120	2,924,544
Rubella	1,372	9[b]	320[b]	12,348	439,040
Congenital Rubella Syndrome	36	172,428[b]	47,306[b]	6,207,408	1,703,051
Pertussis	4,188	2,196[c]	756[d]	9,196,848	3,166,128
Diphtheria/Tetanus	64	2,196[e]	756[e]	140,544	48,384
Polio	0	NE	NE	NE	NE
Total	39,044	--	--	$19,377,660	$20,346,139

[a] For illustrative purposes, we assumed that the number of cases of vaccine-preventable diseases in 1994 will be equal to the highest number of reported cases per year for each disease during the 1989 through 1991 period. See: Division of Immunization, Centers for Disease Control, and Advance Text of Presentation by Walter A. Orenstein, M.D., at the 26th National Immunization Conference.

[b] Average cost per case derived from cost and incidence data reported in: Craig C. White, et al, "Benefits, Risks, and Costs of Immunization for Measles, Mumps, and Rubella", American Journal of Public Health, July 1985, Vol 75, No. 7.

[c] Average direct cost data reported in: Allan R. Hinman, M.D., Jeffrey P. Koplan, M.D., "Pertussis and Pertussis Vaccine", Journal of the American Medical Association, June 15, 1984, Vol. 251, No. 23.

[d] Data on the indirect cost of pertussis is unavailable. Estimated the overall average indirect cost per case based upon the average ratio of indirect to direct costs reported for rubella and congenital rubella syndrome.

[e] Cost effectiveness data were not available for diphtheria and tetanus. We assume that the average cost per case for diphtheria and tetanus is the same as for pertussis.

NE Not estimated.

SOURCE: Lewin-VHI estimates.

and polio. Information on the cost of these diseases was obtained from special studies of the cost-effectiveness of existing vaccination programs also developed by the CDC. The cost of these diseases include direct health care costs and indirect costs such as time lost from work and lifetime earnings lost due to retardation or death.

Extrapolating from these data, we estimate that there will be about 39,000 cases of vaccine-preventable diseases in 1994. The direct health care costs for these diseases will be about $19.3 million with an additional $20.3 million in indirect costs (Table 3). Thus, if the Clinton program were to eliminate all 39,000 cases of these diseases, the $300 million spent under the program will be offset by health care savings of $19.3 million, with an additional $20.3 million in non-health related savings. Health savings are assumed to be allocated across major payers for care (i.e., employers, governments, etc.) in proportion to the share of health spending for low-income persons currently paid by these sources (Table 4).

These results suggest that the cost of an expanded vaccination program would exceed the savings resulting from expanded immunizations. This seems to contradict other studies showing that childhood vaccines have been remarkably cost-effective, despite the growing cost of vaccines. For example, some studies indicate that the benefits of current expenditures for immunization programs are equal to as much as $14 for every dollar spent.[6, 7] The reason for this apparent discrepancy is that these studies measure the cost-effectiveness of existing programs while our estimates show the marginal benefit of additional expenditures. In fact, there is substantial evidence that there are diminishing returns to expansions of immunization levels.

For example, the CDC estimates that there would have been about 6.9 million cases of measles, mumps, and rubella in the absence of the existing immunization program. By comparison, they report only 35,000 cases of these diseases in 1991. These figures suggest that the existing program has eliminated 99.5 percent of the incidence of these diseases, even though immunization rates for some age groups are as low as 60 percent. While fully vaccinating the

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[6] White CC, Koplan JP, Orenstein QA. "Benefits, Risks, and Costs of Immunization for Measles, Mumps, Rubella", *American Journal of Public Health,* 1985: 739-744.

[7] Hinman AR, Koplan JP, "Pertussis and Pertussis Vaccine: Reanalysis of Benefits, Risks, and Costs", *Journal of the American Medical Association,* June 15, 1984, Vol. 251, No. 23.

TABLE 4
POTENTIAL SAVINGS RESULTING FROM EXPANDED IMMUNIZATIONS
[In Millions]

		HEALTH CARE SAVINGS BY PAYER[b]					
	COST OF IMMUNIZATIONS PROGRAM[a]	TOTAL SAVINGS	FEDERAL	STATE	EMPLOYER	INDIVIDUAL	NET FEDERAL COST
1994	$300	$19.4	$6.0	$4.5	$6.0	$2.9	$294.0
1995	312	21.0	6.5	4.8	6.4	3.3	305.5
1996	324	23.0	7.1	5.3	7.0	3.6	316.9
1997	337	25.1	7.8	5.8	7.7	3.8	329.2
1998	350	27.4	8.5	6.3	8.4	4.2	341.5
1999	365	29.8	9.2	6.8	9.1	4.7	355.8
2000	379	32.5	10.1	7.4	10.0	5.0	368.9
2001	395	35.4	11.0	8.1	10.9	5.4	384.0
2002	410	38.6	12.0	8.9	11.8	5.9	398.0
2003	$427	$42.1	$13.0	$9.7	$12.8	$6.6	$414.0

[a] The President has proposed a $300 million outreach program to expand vaccination of children, which we assume will be indexed over time at the rate of inflation.

[b] Includes health care savings only.

SOURCE: Lewin-VHI estimates.

population would eliminate the remainder of these cases, the cost of achieving this level of immunization is likely to exceed the cost savings associated with the remaining cases.

C. COST CONTAINMENT

There are several proposals specifically designed to eliminate unnecessary health expenditures and improve administrative efficiency. These include: standardized electronic claims transmission; medical malpractice reform; anti-trust law revisions; outcomes research; and efforts to promote enrollment in managed care.

Some of these proposals would reduce health spending for both public and private programs while others affect primarily privately-insured individuals. The methods used to estimate the impact of these initiatives are discussed below.

1. Administrative Simplifications

Administrative savings could be achieved by establishing uniform electronic claims processing standards and promoting the use of "smart card" systems for filing claims.

a. Electronic Claims Processing

Some proposals would set standards for electronic claims processing which would facilitate wide-scale submission of electronic claims. While actual data on the use of electronic claims filing systems are largely unavailable, industry analysts indicate that roughly one-third of all claims are now filed electronically. In fact, electronic claims filing is quite common in public programs such as Medicare and Medicaid. For example, HCFA estimates that roughly 60 percent of Medicare claims are already filed electronically. Electronic claims for private insurers is less common with perhaps 20 percent of claims filed through electronic means. More claims would be filed in this manner, but nearly all insurers require that the claims be submitted in their own unique electronic claims format. This proposal eliminates this obstacle by establishing uniform standards for electronic claims processing.

We estimated the impact of this standardization requirement based upon industry data indicating that insurer claims processing costs would be reduced by about $0.50 per claim.[8] We assumed that provider costs of filing claims would be reduced by about $1.00 per claim; these savings reflect the higher cost of compiling the information currently required in the forms. We also assumed that no more than 85 percent of all claims will ultimately be filed electronically reflecting the fact that many providers require patients to submit their own claims.[9] These savings were assumed to be phased in over the first five years of the program with savings of $3.0 billion per year by 2000 (Table 5).

TABLE 5
ADMINISTRATIVE SAVINGS
[In Billions]

	ADMINISTRATIVE SAVINGS			
	ELECTRONIC CLAIMS PROCESSING		SMART CARD SYSTEMS	
	Insurer	Provider	Insurer	Provider
1994	$0.1	$0.2	$0.015	$0.030
1995	0.3	0.6	0.032	0.064
1996	0.4	0.8	0.054	0.108
1997	0.6	1.2	0.087	0.174
1998	0.7	1.4	0.109	0.218
1999	0.8	1.6	0.121	0.242
2000	0.9	1.8	0.133	0.266
2001	1.0	2.0	0.146	0.292
2002	1.1	2.2	0.161	0.322
2003	$1.1	$2.2	$0.176	$0.352

SOURCE: Lewin-VHI estimates.

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[8] John F. Sheils and Gary J. Young, "National Health Spending Under a Single-Payor System: The Canadian Model", Staff Working Paper, January 8, 1992.

[9] Less than 100 percent participation is assumed because electronic claim filing would not be mandatory under most health reform proposals.

Most of these savings will accrue to private payers since the majority of claims for public programs are already filed electronically. Our estimates assume that the percentage of claims filed electronically in public programs will increase from 60 to 85 percent. The percentage of private sector claims filed electronically will increase from about 20 percent to 85 percent. Estimated savings were allocated across public and private payors accordingly. This implicitly assumes that private and public insurers adjust provider reimbursement levels downward to reflect the reduction in provider administrative costs. This adjustment is straightforward in the Medicare fee schedules where there is an explicit adjustment for administrative costs. However, it is less clear that these savings can be recovered for private insurance.

b. Smart Card System

The efficiency of electronic claims processing systems could be enhanced with the use of a "smart card" system. This would involve issuing a credit card-like insurance card to all individuals, which would be electronically imprinted with the individual's name and source of insurance. Patients would present this card to providers who would run the card through an electronic reader connected to central computers. These computers would be linked with the various insurers so that coverage information can be confirmed, patient cost-sharing requirements can be computed, and claims transactions can be initiated.

The smart card system has not been applied to health care in the United States. Some areas in Canada have experimented with the system, but there is little data at this time on its potential for reducing administrative costs. However, as compared with standard electronic claims processing systems, the administrative savings resulting from the smart card system are thought to be small.[10] For illustrative purposes, we assume that the net impact of smart cards, after allowing for amortization of capital investment costs, would be a 10 percent increase in the efficiency of existing electronic claims processing technology. Under this assumption, we estimate additional savings of 5 cents per claim for insurers and 10 cents per claim for providers. We assume that these savings will phase-in over a period of five years as the system is

[10] Interview with Michael Wolfson, Director, Social and Economic Systems, Statistics Canada.

established. Savings are assumed to be allocated across all payers in proportion to total health expenditures paid by each source.

Smart cards can also be used to record patient history information. These data can help providers improve patient outcomes with a long-term impact on quality of care and cost savings through the elimination of unnecessary or inappropriate procedures. In fact, this is one of the prime motivations behind the Canadian experiments with the program. These savings could materialize over time as the smart card system evolves. We assume in this analysis that any such savings would not occur until after the turn of the century.

2. Medical Malpractice Liability Reform

Several health reform plans include malpractice reforms designed to reduce medical liability costs. One survey indicated that physicians paid about $5.6 billion for medical malpractice insurance in 1989.[11] A General Accounting Office (GAO) study indicates that hospital malpractice insurance costs were $1.3 billion in 1985.[12] Based upon these data, we estimate that total malpractice insurance costs in 1993 would be about $10 billion. Other studies suggest that up to $25 billion in health spending is attributable to defensive medicine (i.e., services prescribed solely for the purpose of avoiding professional liability).[13] The tort reforms typically proposed include:[14]

- Capping the amount of allowable non-economic damages;
- Eliminating joint and several liability for non-economic damages;

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[11] Roger A. Reynolds, John A. Rizzo, and Martin L. Gonzalez, "The Cost of Medical Professional Liability", Journal of the American Medical Association, May 22/29, 1987, Vol. 257, No. 20.

[12] General Accounting Office, "Medical Malpractice Insurance Costs Increased, But Varied Among Physicians and Hospitals", U.S. House of Representatives, HRD-86-112.

[13] J.E. Moser and R.A. Musacchio, "The Costs of Medical Professional Liability in the 1980's", Medical Practice and Management, pp. 6-9, Summer 1991; R.A. Reynolds, J.A. Rizzo, and M.L. Gonzalez, "The Costs of Medical Professional Liability", Journal of the American Medical Association, Vol. 257, No. 20, pp. 2776-2781, 1987; General Accounting Office, "Medical Malpractice Insurance Costs Increased, But Varied Among Physicians and Hospitals", U.S. House of Representatives, HRD-86-112.

[14] "The President's Comprehensive Health Reform Program", February 6, 1992, pp. 50-51.

- Eliminating the collateral source rule that allows for double recovery;
- Requiring structured payments for malpractice awards, as opposed to lump sum payments;
- Promoting pretrial alternative dispute resolution, including mediation and pretrial screening panels, to encourage reasonable settlement; and
- Implementing procedures to enhance the quality of care.

If adopted nationwide, we estimate that these reforms would reduce malpractice insurance and defensive medical costs by $15.2 billion in 2000. These estimates may be optimistic, however, for several reasons. First, malpractice reforms, which rationalize the process of adjudicating claims, could make it easier to file a successful claim which could result in an increase in claims filed. Second, some of the savings achievable through malpractice reforms have already been realized in states that have already implemented some of these reforms. Third, reductions in defensive medicine will be difficult to achieve, since many providers often benefit financial from providing these unnecessary medical services. However, these estimates provide a useful illustration of the potential savings achievable through malpractice reforms.

The methods used to develop these estimates are described below.

d. Malpractice Insurance.

We estimated the impact of these reforms on provider liability premium costs based upon empirical research examining the effectiveness of malpractice liability reforms which have been implemented at the state level.[15, 16] Only a few of the set of proposed reforms described above show evidence of contributing to significant reductions in claims payments. Danzon found that a cap on the amount of damages that can be awarded reduced average claim severity by 23

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[15] P. Danzon, "New Evidence on Malpractice Claims" in Medical Malpractice: Can the Private Sector Find Relief?, Law and Contemporary Problems, Duke University School of Law, Vol. 49, No. 2, Spring 1986.

[16] R. Sloan and R. Bovbjerg, "Medical Malpractice: Crises, Response and Effects", HIAA Research Bulletin, May 1989.

percent.[17] The mandatory offset of collateral sources was found to reduce awards by between 11 and 25 percent. Measures affecting the statute of limitations for adult claims have been found to reduce the number of claims paid by six to seven percent. Although arbitration has been found to reduce the amount paid per claim, this approach is likely to be associated with an offsetting increase in claims. However, there was generally a lag of two or more years before these changes affected the number of claims due to a backlog of cases under pre-reform law.

These studies suggest reductions in malpractice claims of up to 25 percent associated with these measures. However, the impact of implementing these reforms nationwide is likely to be dampened by the fact that many states have already implemented some of these reforms. We assumed that these reforms would ultimately reduce malpractice premiums by 20 percent. However, we assumed no change in premiums during the first two years (1993 and 1994) due to a backlog of cases under pre-reform law. These premium savings were assumed to be phased in during the 1995 through 1998 period. Total malpractice premium savings were estimated to be $4.0 billion in 2000 (Table 6). We assume that these savings are allocated across payers in proportion to spending under current policy.

TABLE 6

ESTIMATED REDUCTIONS IN MALPRACTICE PREMIUMS AFTER ENACTMENT OF MEDICAL LIABILITY TORT REFORMS [In Billions]

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Current Malpractice Premium*	$11.2	$12.2	$13.3	$14.7	$15.9	$17.3	$18.8	$20.4	$22.2	$24.1
Premium Savings	0.0	0.0	0.6	1.3	2.1	3.2	3.6	4.0	4.3	4.7
Defensive Medicine Savings	$0.0	$0.0	$1.7	$3.6	$5.9	$8.9	$10.1	$11.2	$12.0	$13.2

* Medical malpractice insurance premiums are assumed to grow at the rate of growth in health expenditures over this period.

SOURCE: Lewin-VHI estimates.

[17] Elimination of the relatively small number of claims with very high damages would clearly be expected to have this effect on the average.

b. Defensive Medicine

Little evidence is available on how changes in malpractice liability will affect medical practice. The only empirical research on the costs of professional liability indicate that each dollar in malpractice insurance premium payments is associated with about $2.80 in other professional liability costs, most of which is additional utilization of health services.[18] We assumed that defensive medical costs would be reduced by about $2.80 for every dollar reduction in malpractice insurance payments resulting from the President's reforms. Using this assumption, we estimate that these malpractice reforms would reduce defensive medical costs by $11.2 billion in 2000 (Table 7).[19]

This probably represents a high-range estimate of potential savings in defensive medicine. There are many other factors besides liability avoidance that have shaped medical practice such as medical training, financial incentives, and patient expectations. Physicians are likely to continue to practice defensive medicine to avoid the psychic costs and lost income associated with preparing for trial.[20] Moreover, experience with Medicare payment reforms and managed care initiatives has demonstrated that aggressive interventions are typically required to affect significant changes in medical practice. Thus, it is unclear that changes in premium payments would in themselves result in substantial changes in physician practice. The effectiveness of these reforms could be enhanced by incorporating the use of medical practice parameters into the process of adjudicating claims.

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[18] Rodger Reynolds, "The Cost of Medical Professional Liability in the 1980s", Center for Health Policy Research, American Medical Association, Chicago, Illinois, September 1900.

[19] This estimate falls within the range of potential savings in defensive medicine estimated in: Lewin-VHI, "Estimating the Costs of Defensive Medicine", September 1992.

[20] Testimony by Robert D. Reischauer, Director, Congressional Budget Office, before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.

3. Anti-Trust Law Revisions

One of the major causes of increased health spending is the growth in health care technology. In many areas, competition among providers has resulted in costly duplication of technologies and services. Much of this duplication in technology could be avoided if providers were to cooperate in the acquisition and shared use of new equipment. However, concerns over antitrust liability pose an obstacle to increased cooperation in the acquisition of new technology. Antitrust liability has also been a concern in the development of professional peer review practices due to fear of charges that the process would be used to unfairly limit competition in the profession. For these reasons, it has been suggested that antitrust legislation be clarified to permit cooperation in the acquisition of new technology.

There is little evidence on the likely impact of antitrust reforms on the proliferation of new technologies. However, it is likely that these changes will make it easier for providers to form networks and that communities will be better able to cooperate on capital investment resulting in a reduction in the proliferation of new technology. For illustrative purposes we have assumed that this program induces a 12-month lag in the adoption of new technologies in large urban centers where duplication of technology is believed to be most prevalent. We estimated the impact of this assumption by imposing a 12-month lag in the portion of health care inflation attributed to service intensity. (It is estimated that about 25 percent of health care inflation is attributed to a growth in service intensity.[21]) We assume that these savings will phase-in over a five-year period (Table 7). We assume that these savings will be allocated across payers in proportion to total health expenditures.

4. Expanded Use of Managed Care

There are several ways in which the Federal government can expand the use of managed care programs such as health maintenance organizations (HMOs). These include: preemption of state legislative barriers to managed care, making managed care plans available to small

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[21] Based upon Lewin-VHI analysis of HCFA data on the components of health price inflation.

businesses through small group insurance market reforms, and expanded use of managed care in public programs. These cost containment efforts are discussed below.

TABLE 7
SAVINGS FROM ANTITRUST REFORMS
[In Millions]

	SAVINGS
1994	$80
1995	190
1996	337
1997	531
1998	777
1999	847
2000	923
2001	1,098
2002	1,197
2003	$1,305

SOURCE: Lewin-VHI estimates.

a. Preempt State Legislative Barriers to Managed Care

Some proposals would preempt all state legislation restricting the use of coordinated care programs. These legislative barriers include restrictions on reimbursement rates and selective contracting, restrictions on patient financial incentives, and restrictions on utilization review.

Unfortunately, there is little data on the number of persons affected by these barriers. For illustrative purposes, we assume that eliminating these barriers will result in a 10 percent increase

in the number of privately-insured persons enrolled in HMOs.[22] We estimate that this will reduce health spending for persons who are newly enrolled in HMOs to levels reported by persons currently enrolled in these programs. This estimate is based upon a Lewin-VHI analysis of inpatient and outpatient utilization in HMO and fee-for-service programs (Table 8). These savings were assumed to phase in over the first three years of the program reaching $0.5 billion by 2000 (Table 9). We assume that these savings are allocated across employers, individuals, and state workers' compensation programs in proportion to total health spending for these individuals.

TABLE 8
SELECTED AGE AND SEX-ADJUSTED UTILIZATION MEASURES AMONG THE NON-ELDERLY FOR ALTERNATIVE INSURED ARRANGEMENTS

		IPA MODEL HMO		GROUP MODEL HMO		ALL HMOs	
	Fee for Service	Amount	Percent Difference	Amount	Percent Difference	Amount	Percent Difference
Hospital Days [per 1,000]	419	390	(6.9%)	338	(19.1%)	370	(11.7%)
Physician Visits [per capita]	3.35	3.68	9.9%	3.57	6.6%	3.63	8.4%

SOURCE: Lewin-VHI analysis of the 1989 National Health Interview Survey Health Insurance Supplement data.

b. Expand Managed Care in Small Groups

Managed care plans typically avoid covering small groups due to adverse selection. Under most proposals to reform the insurance market, HMOs will be required to accept all applicants on an open-enrollment basis. This will make HMO coverage more widely available to persons in small groups. We assume that the percentage of workers in small firms enrolled in HMOs would increase to the level reported among larger firms. Savings for these individuals were estimated assuming that savings in these plans will be the same as for the average HMO

[22] About 15 percent of all workers are in a health maintenance organization. See: GHAA's National Directory of HMOs, 1990 Edition.

TABLE 9
COST SAVINGS UNDER SELECTED PROGRAMS TO EXPAND MANAGED CARE[a]
[In Billions]

Managed Care	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Preempt State Legislative Barriers	$(0.1)	$(0.2)	$(0.4)	$(0.4)	$(0.4)	$(0.5)	$(0.5)	$(0.6)	$(0.6)	$(0.7)
Expand managed Care in Small Groups	(0.1)	(0.3)	(0.5)	(0.5)	(0.6)	(0.6)	(0.7)	(0.7)	(0.8)	(0.9)
Medicaid Managed Care	(0.3)	(0.6)	(1.0)	(1.5)	(1.6)	(1.8)	(2.0)	(2.1)	(2.3)	(2.5)
Mandatory Medicare Managed Care	(1.7)	(3.8)	(6.2)	(9.2)	(10.1)	(11.1)	(12.2)	(13.4)	(14.8)	(16.3)
Optional Medicare Managed Care	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0

Managed care savings under these initiatives are assumed to grow with the rate of growth in health expenditures as projected by CBO once the program is fully phased-in.

SOURCE: Lewin-VHI estimates.

based upon the utilization data shown in Table 8. We assume that these savings will be allocated across employers and employees in small groups in proportion to the share of the premium paid by employers and employees under the plan.

c. Medicaid Managed Care

One alternative is to require all states to use managed care plans. However, HMOs are also likely to be impractical in rural areas where about 25 percent of the population now lives. We assume that under such a program, 75 percent of all Medicaid recipients would be enrolled in an HMO. We estimated savings based upon the average change in utilization under all HMOs (including IPA and group) as summarized in Table 8. Savings are assumed to be phased-in over the first four years of the program as capacity is expanded. Savings are assumed to be distributed across the state and Federal government in proportion to the Federal match.

d. Medicare Managed Care

Mandatory enrollment of Medicare beneficiaries in HMOs could also result in substantial savings. As discussed above, however, we assume that mandatory HMO enrollment would be achievable for only about 75 percent of the population. We estimated savings based upon the average change in utilization under all HMOs (including IPA and group) as summarized in Table 8. We also assumed that savings will phase-in over a period of five years as HMO capacity is expanded to serve the Medicare population.

Rather than adopting a mandatory HMO program, efforts could be taken to increase optional enrollment in HMOs. We assume, however, that this will have no net impact on Medicare spending. This is because a recent study indicates that the use of HMOs in Medicare has actually increased Medicare spending for those enrolled by about 5.7 percent.[23] The study showed that HMOs have tended to attract a disproportionate share of healthier Medicare enrollees. Thus, the Medicare capitated payment, which is based upon the average actuarial cost

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[23] "The Impact of the Medicare Risk Program ont he Use of Services and Cost to Medicare". Jerrold Hill, Randall Brown, Dexter Chu, and Jeanette Gergeron. Princeton, NJ: Mathematica Policy research, Inc., December 1992.

per enrollee under Medicare, is on average greater than what would have been paid in benefits for these persons under conventional Medicare coverage. Therefore, we assume that there will be no managed care savings unless enrollment in HMOs is mandatory among all Medicare beneficiaries.

5. Medical Practice Parameters

Many health reform proposals would expand upon the development of medical practice parameters research. The impact of developing these parameters may be minimal, however, unless efforts are taken to require their use in insurer plans. In this analysis, we estimated the impact of requiring all insurers to use these parameters. A growing body of research exists on medical practice parameters which would be implemented under the program. We estimate that total savings due to medical practice parameter will be $83.2 billion over the 1994 through 2003 period (Table 10). This estimate assumes that in private insurance, these savings are passed on to consumers in the form of lower profits. The methods to estimate the savings from practice parameters are:

a. Public Programs

It is estimated that research performed to date on 20 major procedures has produced practice guidelines which, if fully implemented, would result in potential savings to Medicare of up to $2.5 billion.[24] We assume that the savings from these practice guidelines will phase in over a four-year period beginning in 1994. Medicare savings from ongoing medical guidelines research is assumed to increase by one percent per year starting in 1998.

Some portion of the savings to Medicare under practice parameters research should be considered as part of the baseline. That is, the existing investment in practice parameter will be incorporated into the Medicare program under current policy. We assume that about one-third of the potential savings under this program will be realized under current policy. We assume that

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[24] Unpublished data provided by Karen Davis of Johns Hopkins University.

TABLE 10
SAVINGS ATTRIBUTED TO
EXPANDED DEVELOPMENT AND PROMULGATION OF
MEDICAL PRACTICE PARAMETERS RESEARCH
[In Billions]

	MEDICARE	PRIVATE PLANS
1994	$0.4	$1.0
1995	0.9	2.3
1996	1.5	3.9
1997	2.1	5.8
1998	2.3	6.1
1999	2.5	6.7
2000	2.8	7.3
2001	3.2	8.1
2002	3.5	9.0
2003	$3.9	$9.9

SOURCE: Lewin-VHI estimates.

the remainder of these potential savings will be realized through aggressive efforts to enforce these parameters through utilization review programs.

b. Private Sector

It is estimated that existing practice guidelines data could reduce premium costs in employer-based plans by as much as three percent.[25] We assume that these savings will occur primarily among persons not already enrolled in HMO plans and half of private-sector plans will ultimately incorporate these parameters into their utilization review program. We assume that these savings will phase in over a four-year period. Potential savings are assumed to increase by one percent per year beginning in 1998 as new research becomes available.

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[25] Presentation by Mark Chasim to the Florida Task Force on Private Sector Health Care Responsibility.

D. FEDERAL PROGRAM REFORMS

There are several ways in which Medicare expenditures can be reduced. Many of these options have been analyzed by the Congressional Budget Office (CBO) in their annual deficit reduction analysis.[26] Some of the options considered include:

- Gradually eliminating the disproportionate share adjustment;
- Reduce teaching adjustment from 7.7 percent to 3.3 percent;
- Freeze PPS rates for one year;
- Increase SMI coinsurance to 20 percent for home health care;
- Increase SMI premiums to 30 percent for physicians services;
- Increase and index SMI deductibles for physician services;

The CBO estimates of potential savings to the Federal government under these policies are shown in Table 11. (We extrapolated the CBO projections through 2003.) Our estimates of the impact that these changes will have on health spending for other payers is described below.

1. Hospital Payments

Medicare payments to hospitals could be reduced by lowering adjustments for disproportionate share and teaching hospitals and/or by freezing PPS payment rates. While these changes would reduce Federal spending, there is evidence that hospitals will raise charges to other providers to recoup these losses. This cost-shifting implies that these reimbursement reductions will be passed on to employers and households with no net change in national health spending. In this analysis, we assume that the full amount of these reimbursement reductions is passed on to employers and individuals in proportion to the share of total private health insurance costs paid by these two groups.

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[26] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options", Washington, D.C., February 1993.

2. Medicare Cost-Sharing

The net Federal cost of the Medicare program can also be reduced by increasing SMI deductibles and coinsurance and by increasing SMI premium payments. These changes will shift a substantial portion of the cost of health care to beneficiaries who will pay the higher patient cost-sharing as either increased out-of-pocket payments or increased Medigap insurance payments. This shifting will result in little net impact on aggregate health spending. This assumption is reflected in the estimates presented above in Table 11.

E. INSURANCE MARKET REFORMS

Several health reform proposals would regulate the insurance markets so that all individuals will be able to obtain insurance regardless of their health status at a group rate. These plans often eliminate costly state minimum-benefit requirements as well.

1. Small Group Market Reforms

Many health reform plans include several insurance reforms which would substantially alter the way in which insurance is marketed and thereby both improve access and reduce administrative costs. These reforms include:

- All employer health plans and individual plans which are purchased with health insurance tax credits or deductions would have to be guaranteed issue and guaranteed renewable. Health status would not be a permissible consideration in determining whether to cover an individual.

- Coverage would be portable, allowing workers to change jobs without loss of coverage due to pre-existing condition exclusions.

- Premium variations by health status would be restricted through premium bands and the creation of health risk pools.

TABLE 11
SAVINGS UNDER SELECTED FEDERAL PROGRAM REFORMS
[In Millions]

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Medicare										
Gradually Eliminate Disproportionate Share Adjustment	$470	$1,100	$1,800	$2,600	$3,500	$3,850	$4,273	$4,743	$5,265	$5,844
Reduce Teaching Adjustment to 3 Percent	1,650	2,000	2,200	2,350	2,750	3,052	3,388	3,761	4,175	4,634
Freeze PPS Rates for One Year	2,050	2,850	3,150	3,450	3,750	4,087	4,455	4,856	5,293	5,770
Increase SMI Coinsurance for Home Health	2,300	3,860	4,520	5,010	5,450	5,940	6,475	7,058	7,093	8,386
Increase SMI Premiums	2,090	3,330	5,530	8,180	11,010	13,900	16,709	19,282	21,509	23,444
Increase and Index SMI Deductibles	$710	$1,410	$1,880	$2,360	$2,910	$3,579	$4,402	$5,415	$6,660	$8,192

SOURCE: CBO estimates for 1994 through 1998 and projected to 2003.

These provisions would reduce small group insurer administrative costs substantially. Insurer administrative costs in small firms are currently equal to as much as 40 percent of benefit payments (Table 12). By comparison, administrative costs for large firms are typically equal to only about five percent of claims. These reforms would reduce administrative costs by: 1) reducing the practice of medical underwriting; 2) restricting pre-existing condition limitations; 2) restricting pre-existing condition limitations; and 3) reducing large premium variations across insurers that often lead to frequent changes in coverage. These measures would reduce the administrative costs associated with establishing an insurance policy and reduce claims processing costs by eliminating the need to cross-check with pre-existing condition data.[27] These reforms would also reduce the frequency of changes in sources of coverage, resulting in lower marketing costs and substantially-reduced profits derived from risk selection.

We estimated the impact of these changes on insurer administrative costs based upon a study of the impact of mandatory pooling arrangements for small businesses conducted by Hay/Huggins for the Congressional Research Service.[28] This study estimated the change in claims processing and general administrative costs resulting from the adoption of a standardized health plan provided to all groups at a uniform community rate. We further assumed that, under these reforms, insurer profits and marketing costs in small firms would be roughly the same as for groups with between 100 and 500 employees due to the elimination of risk selection profits and reduced turnover in sources of insurance. Using these assumptions, we estimate that administrative savings would be $7.5 billion in 2000. These savings (shown in Table 13) are assumed to be distributed across employers and employees in proportion to the share of the premium paid by these groups.

It is likely that insurance market reforms will result in some shifts in coverage which will ultimately affect the level of health services utilization. For example, limits on premium variations will tend to reduce premiums for higher-risk individuals while increasing premiums for low-risk

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[27] Lewin-VHI, "Projecting the Changing Employer Health Insurance Environment: 1987-1994", prepared for the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, June 1990.

[28] Congressional research Service, "Costs and Effects of Extending Health Insurance Coverage", Library of Congress, October 1988.

TABLE 12

INSURANCE COMPANY ADMINISTRATIVE EXPENSE BREAKDOWN AS A PERCENT OF INSURANCE CLAIMS UNDER CURRENT POLICY AND THE BUSH REFORM OPTION PLAN

	Claims Administration		General Administration		Risk and Profit		Commissions		Other		TOTAL	
Number of Employees	Current Policy	Bush Reform	Current Policy	Bush Reform	Current Policy	Bush Reform	Current Policy	Bush Reform	Current Policy	Bush Reform	Current Policy	Bush Reform
1 to 4	9.3%	5.0%	12.5%	6.0%	8.5%	5.5%	8.4%	1.6%	1.3%	0.8%	40.0%	18.9%
5 to 9	8.6	5.0	11.2	6.0	8.0	5.5	6.0	1.6	1.2	0.8	35.0	18.9
10 to 19	7.2	5.0	9.2	5.5	7.5	5.5	5.0	1.6	1.1	0.8	30.0	18.4
20 to 49	6.3	4.5	7.6	5.0	6.8	5.5	3.3	1.6	1.0	0.8	25.0	17.4
50 to 99	4.3	4.0	4.8	4.8	6.0	5.5	2.0	1.6	0.9	0.7	18.0	16.6
100 to 499	4.1	4.0	4.0	4.0	5.5	5.5	1.6	1.6	0.8	0.7	16.0	15.8
500 to 2,499	3.9	3.9	3.2	3.2	3.5	3.5	0.7	0.7	0.7	0.7	12.0	12.0
2,500 to 9,999	3.8	3.8	1.4	1.4	1.8	1.8	0.3	0.3	0.7	0.7	8.0	8.0
10,000 or more	3.0%	3.0%	0.7%	0.7%	1.1%	1.1%	0.1%	0.1%	0.6%	0.6%	5.5%	5.5%

SOURCE: Lewin-VHI estimates derived from Hay/Huggins data as it appeared in: Congressional Research Service, "Cost and Effects of Extending Health Insurance Coverage," Library of Congress, October 1988.

individuals who currently benefit from lower premiums. This "leveling" of premiums could result in increased coverage for high-risk groups who currently cannot obtain and/or afford coverage. However, this is likely to be offset by a reduction in coverage for lower-risk individuals who would now pay a higher premium. Although the net impact on coverage and/or health services utilization is difficult to predict, we assume in this analysis that expansions in coverage for high-risk groups will be roughly offset by reductions in coverage for low-risk groups with no net impact on health services utilization.

TABLE 13
SAVINGS UNDER SMALL GROUP INSURANCE REFORM AND PREEMPTION OF STATE MINIMUM BENEFITS LAWS
[in billions]

	SMALL GROUP ADMINISTRATIVE SAVINGS	PREEMPTION OF STATE MINIMUM BENEFITS
1994	$4.0	$1.2
1995	4.7	1.4
1996	5.1	1.5
1997	5.5	1.6
1998	5.9	1.8
1999	6.5	1.9
2000	6.9	2.1
2001	7.5	2.3
2002	8.1	2.4
2003	$8.8	$2.6

SOURCE: Lewin-VHI estimates.

2. Preemption of State Minimum Benefits Laws

Many health reform plans would preempt state mandated benefits laws. State mandates include: newborn care (46 states), psychiatric care (37 states), chiropractors (35 states), dental care (27 states), and other services. State-mandated benefits have been estimated to add about 15 percent to the cost of health insurance.[29]

We assumed that half of all employers who now purchase insurance would eliminate coverage for these state-mandated benefits (i.e., some may wish to retain dental coverage, etc.). Utilization of these services for persons in plans that discontinue these benefits was assumed to decline by about 20 percent.[30] These potential savings do not apply to self-insured plans because they are already exempt from state-benefit mandates under the Employee Retirement Income Security Act of 1974. These savings (shown in Table 13) are assumed to be distributed across employers and employees in proportion to the share of the total premium paid by these groups.

F. FINANCING

The Federal deficit could also be reduced by imposing various types of taxes on health benefits. These include:

- Tax the insurance value of employer-paid health benefits in excess of $165 per individual per month ($400 per family).

- Tax the full amount of employer-provided benefits, but provide a tax credit for individuals and some employers.

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[29] John Gabel and Gail Jensen, "The Price of Mandated Benefits", Inquiry 26: 419-431 (Winter 1989).

[30] The Rand health insurance experiment data indicates that a one percent change in the price of health services to the individual would be associated with a 0.2 percent reduction in utilization of these services. This estimate is derived from: Willard G. Manning, et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment", The American Economic Review, Volume 77, Number 3, June 1987.

- Tax the insurance value of Medicare benefits for persons with incomes over a specified threshold.

- Tax the insurance value of Medicare benefits for all beneficiaries.

Estimates of Federal tax revenues under these options are provided by the Congressional Budget Office (CBO). State income tax payments would also increase by including the value of employer health benefits in taxable income. We estimated these tax increases using the tax module of the Lewin-VHI Health Benefits Simulation Model.

1. Taxation of Employer Health Benefits

These CBO estimates assume that employers do not reduce the level of insurance coverage in response to these taxes. In fact, these taxes will effectively raise the price of insurance to workers which may result in a shift to less comprehensive health coverage. Unfortunately, there is little data on how workers and employers will respond to this policy. There is some evidence on the impact of price on the demand for insurance. These studies suggest that for each one percent increase in the cost of insurance, there is a reduction in the number of employers who purchase insurance of between 0.2 and 0.6 percent.[31,32,33,34,35]

It could be argued that these data estimate the elasticity of demand for insurance for employees rather than for employers. This is because employer insurance is merely a portion

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[31] Charles E. Phelps, Demand for Health Insurance: A Theoretical and Empirical Investigation, Rand Corp., Santa Monica, 1973.

[32] J.F. Long and F.A. Scott, "The Income Tax and Nonwage Compensation", Review of Economics and Statistics, 64(2) 1982:211-219.

[33] A. Taylor and G. Wilensky, "The Effect of Tax Policies on Expenditures for Private Insurance", in Jack Meyer (ed) Market Reforms in Health Care, Washington, DC, AEI 1983: 163-184.

[34] M. Holmer, "Tax Policy and the Demand for Health Insurance", Journal of Health Economics, 3 (3) 1984:203-221.

[35] F. Sloan and K. Adamche, "Taxation and the Growth of Nonwage Compensation", Public Finance Quarterly, 14 (2) April 1986:115-137.

of total employee compensation paid as an in-kind benefit in lieu of wages. In that sense, the employer is largely indifferent between paying compensation in the form of insurance versus wages. Thus, employer insurance purchases implicitly reflect worker preferences for the consumption of health insurance services. In this analysis, we assume that each percent change in the effective price of insurance is associated with a reduction in the demand for insurance of 0.4 percent (i.e., the mean of the elasticities estimated in the literature). This reduction in insurance coverage was used to adjust aggregate employer health insurance expenditures and the CBO estimate of tax revenues under the policy to the levels shown in Tables 14 and 15.

This lower level of coverage will be associated with both an increase in out-of-pocket health spending and a reduction in health services utilization. The Rand data indicates that utilization of health services is reduced by about 0.2 percent for each 1.0 percent increase in the price of services at the point of service. We estimated the change in health services utilization on the basis of this estimate using the health benefits simulation model (HBSM).

2. Tax Insurance Value of Medicare

One approach to raising revenues is to tax the insurance value of Medicare. Benefits could be taxed for all beneficiaries or for only those with a threshold. CBO estimates of Federal tax revenues under these policies are presented in Table 16. These changes will have no impact on the cost of services to consumers, so we assume no change in utilization and aggregate health spending.

TABLE 14
ESTIMATION OF CHANGE IN HEALTH SPENDING UNDER AN EMPLOYER HEALTH BENEFITS TAX ASSUMING FULL IMPLEMENTATION IN 1994*
[In Billions]

		TAX BENEFITS OVER $165 PER MONTH		TAX FULL AMOUNT OF BENEFITS WITH TAX CREDIT FOR SOME	
	CURRENT POLICY	WITHOUT BEHAVIORAL RESPONSE	WITH BEHAVIORAL RESPONSE	WITHOUT BEHAVIORAL RESPONSE	WITH BEHAVIORAL RESPONSE
Employer Insurance Premiums[a]	$255.4	$255.4	$250.6[d]	$255.6	$240.2[D]
Federal Tax Revenue[b]	0.0	10.5	9.0	33.4	31.4
State Tax Revenue[c]	$0.0	$1.5	$1.3	$4.7	$4.3
Health Spending by Persons with Employer Insurance [excludes administration]					
Out-of-pocket[a]	$67.8	$67.8	$68.4	$67.8	$69.6
Insured[a]	231.1	231.1	226.3	231.1	215.9
TOTAL	$298.9	$298.9	$294.7[e]	$298.9	$285.5[e]
Change in Health Spending					
Employer	--	--	$(4.8)	--	$(13.4)
Individual [includes tax payments]	--	12.0	10.9	38.1	37.5
Federal	--	(10.5)	(9.0)	(33.4)	(31.4)
State	--	(1.5)	(1.3)	(4.7)	(4.3)
TOTAL	--	--	$(4.2)	--	$(13.4)

[a] Lewin-VHI estimates based upon the 1987 NMES data adjusted to 1994, based upon CBO projections of health spending.

[b] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options", Washington, DC, February 1993.

[c] We assume that state income tax expenditures for health benefits are reduced in proportion to the Federal tax expenditure. The state income tax expenditure was estimated by Lewin-VHI using the Health Benefits Simulation Model (HBSM).

[d] Assumes a price elasticity of 0.4 for the purchase of insurance.

[e] Assumes a price elasticity of 0.2 for use of health services.

* Estimates assume that behavioral responses occur immediately upon implementation of the program.

SOURCE: Lewin-VHI estimates.

TABLE 15

IMPACT OF REDUCING TAX EXCLUSION FOR EMPLOYER BENEFITS ON FEDERAL TAX REVENUES [In Billions]

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Tax Benefits Over $165										
Without Utilization Response[a]	$10.5	$17.9	$22.6	$28.0	$34.2	$41.3	$49.4	$58.6	$69.1	$81.0
With Utilization Response[b]	9.0	15.3	19.7	23.8	29.2	35.3	42.1	49.9	58.9	69.1
Tax Full Amount of Benefits with Credit for Some										
Without Utilization Response[a]	33.4	40.4	46.7	53.6	61.4	70.3	80.5	92.2	105.5	120.7
With Utilization Response[b]	$31.4	$38.0	$43.9	$50.4	$57.7	$66.1	$75.7	$86.7	$99.2	$113.4

[a] CBO estimates for 1994 through 1998 extrapolated through 2003.

[b] CBO estimates adjusted for behavioral response estimated by Lewin-VHI.

SOURCE: Lewin-VHI estimates.

TABLE 16
TAX REVENUES UNDER ALTERNATIVE TAXES OF MEDICARE HEALTH BENEFITS
[In Billions]

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Tax Insurance Value of Medicare										
All Beneficiaries over Income Threshold	2.0	5.3	6.4	7.7	9.1	10.7	12.7	14.8	17.5	20.6
All Beneficiaries	3.0	10.5	11.9	13.6	15.6	17.8	20.3	23.1	26.3	30.0
Change in National Health Spending (Both Tax Options)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

SOURCE: Estimates provided by the Joint Committee on taxation updated to the 1994 through 2003 period.

G. CAVEATS

The potential impact of changes in health care delivery systems and administrative procedures are very difficult to estimate. Many of these programs have never before been attempted, so it is extremely difficult to predict their outcomes. Wherever possible, the estimates presented here are based upon the best available data on the potential savings associated with various cost containment models. As such, these estimates represent our best estimates for comparative purposes. Still, data on the likely impact of these provisions is often unavailable or inconclusive. Moreover, where data do not exist, estimates have been developed based upon analytic judgment to illustrate potential savings. Therefore, these estimates should be considered illustrative of potential impacts rather than definitive projections of cost savings.

The difficulty in estimating the cost impacts of these plans is compounded by a lack of detail on these reforms. Many of these reforms are not now specified in enough detail that they could be implemented. In fact, the cost estimates may change substantially as these details emerge. Despite these reservations, we feel that this analysis provides useful insights into the relative impacts of the various reform plans. In developing these estimates, we assumed that these programs are enacted in 1993 and implemented beginning in 1994. Where appropriate, our estimates reflect assumed lags in the implementation of cost containment initiatives. However, delays in implementation could substantially reduce potential savings.

This analysis does not consider many of the important second order effects of the proposals. For example, it does not consider the potential hidden costs associated with slowing the growth in health spending on technological developments and quality of care. Nor does it consider the impact of the proposals on employment or wage levels. These effects deserve careful consideration in evaluating health care reforms; unfortunately, the lack of details for both programs makes it difficult to assess the impact of these second order effects.

19-Apr-93

Supplement to the Lewin-VHI, Inc. Analyses

Health Care Cost Containment Options

($ in billions)

(Negative amounts are savings from Baseline expenditures.)

Proposals	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	5-Yr Total	10-YrTotal
Baselines												
Total: National Health Expenditures	**996.70**	**1101.86**	**1215.19**	**1335.25**	**1462.29**	**1596.68**	**1757.80**	**1889.06**	**2049.15**	**2215.66**	**6111.28**	**15619.63**
Federal	325.75	366.06	410.89	458.78	508.39	561.22	617.45	676.71	740.39	807.89	2069.88	5473.55
State	146.09	162.76	181.74	202.06	222.00	242.20	262.43	282.76	303.89	325.70	914.65	2331.63
All Private	297.33	325.36	354.25	384.14	417.28	452.91	491.80	532.83	578.16	623.87	1778.37	4457.93
Individual Out-of-Pocket	185.73	203.14	221.47	240.22	260.24	280.90	320.72	325.51	350.10	376.01	1110.79	2764.02
Other Private	41.80	44.54	46.83	50.05	54.37	59.45	65.40	71.26	76.62	82.20	237.60	592.51
Cost Containment Options												
I Prevention												
A Increase prenatal care	**0.08**	**-0.18**	**-0.20**	**-0.22**	**-0.24**	**-0.26**	**-0.28**	**-0.31**	**-0.33**	**-0.36**	**-0.75**	**-2.29**
Federal	0.60	0.57	0.62	0.68	0.74	0.81	0.88	0.96	1.05	1.14	3.22	8.06
State	-0.04	-0.06	-0.09	-0.10	-0.11	-0.12	-0.13	-0.14	-0.15	-0.17	-0.42	-1.12
Employers	-0.08	-0.17	-0.19	-0.21	-0.22	-0.24	-0.27	-0.29	-0.31	-0.34	-0.87	-2.32
Individual Out-of-Pocket	-0.40	-0.50	-0.55	-0.59	-0.65	-0.71	-0.77	-0.84	-0.91	-1.00	-2.69	-6.91
B Increase childhood immunizations	**0.28**	**0.29**	**0.30**	**0.31**	**0.32**	**0.34**	**0.35**	**0.36**	**0.37**	**0.38**	**1.51**	**3.30**
Federal	0.29	0.31	0.32	0.33	0.34	0.36	0.37	0.38	0.40	0.41	1.59	3.51
State	-0.00	-0.00	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.03	-0.07
Employers	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.04	-0.09
Individual Out-of-Pocket	-0.00	-0.00	-0.00	-0.00	-0.00	-0.00	-0.01	-0.01	-0.01	-0.01	-0.02	-0.05
II Administrative Savings												
A Electronic billing/claims processing	**-0.30**	**-0.90**	**-1.20**	**-1.80**	**-2.10**	**-2.40**	**-2.70**	**-3.00**	**-3.30**	**-3.30**	**-6.30**	**-21.00**
Federal	-0.03	-0.09	-0.12	-0.18	-0.21	-0.24	-0.27	-0.30	-0.33	-0.33	-0.63	-2.10
State	-0.01	-0.04	-0.06	-0.09	-0.10	-0.11	-0.13	-0.14	-0.16	-0.16	-0.30	-1.00
Employers	-0.14	-0.43	-0.58	-0.87	-1.01	-1.16	-1.30	-1.44	-1.59	-1.59	-3.03	-10.11
Individual Out-of-Pocket	-0.11	-0.33	-0.45	-0.67	-0.78	-0.89	-1.00	-1.11	-1.22	-1.22	-2.34	-7.79
B Electronic patient Smart Cards	**-0.05**	**-0.10**	**-0.16**	**-0.26**	**-0.33**	**-0.36**	**-0.40**	**-0.44**	**-0.48**	**-0.53**	**-0.89**	**-3.10**
Federal	-0.01	-0.03	-0.05	-0.08	-0.10	-0.11	-0.12	-0.13	-0.14	-0.16	-0.27	-0.93
State	-0.00	-0.01	-0.02	-0.03	-0.03	-0.04	-0.04	-0.04	-0.05	-0.05	-0.09	-0.31
Employers	-0.02	-0.03	-0.06	-0.09	-0.11	-0.13	-0.14	-0.15	-0.17	-0.18	-0.31	-1.09
Individual Out-of-Pocket	-0.01	-0.02	-0.04	-0.07	-0.08	-0.09	-0.10	-0.11	-0.12	-0.13	-0.22	-0.78
III Medical Malpractice Reform												
A Malpractice Premiums	**0.00**	**0.00**	**-0.60**	**-1.30**	**-2.10**	**-3.20**	**-3.60**	**-4.00**	**-4.30**	**-4.70**	**-4.00**	**-23.80**
Federal	0.00	0.00	-0.18	-0.39	-0.63	-0.96	-1.08	-1.20	-1.29	-1.41	-1.20	-7.14
State	0.00	0.00	-0.08	-0.17	-0.27	-0.42	-0.47	-0.52	-0.56	-0.61	-0.52	-3.09
Employers	0.00	0.00	-0.20	-0.43	-0.69	-1.06	-1.19	-1.32	-1.42	-1.55	-1.32	-7.85
Individual Out-of-Pocket	0.00	0.00	-0.14	-0.31	-0.50	-0.77	-0.86	-0.96	-1.03	-1.13	-0.96	-5.71
B Defensive Medicine	**0.00**	**0.00**	**-1.70**	**-3.60**	**-5.90**	**-8.90**	**-10.10**	**-11.20**	**-12.00**	**-13.20**	**-11.20**	**-66.60**
Federal	0.00	0.00	-0.51	-1.08	-1.77	-2.67	-3.03	-3.36	-3.60	-3.96	-3.36	-19.98
State	0.00	0.00	-0.21	-0.45	-0.74	-1.11	-1.26	-1.40	-1.50	-1.65	-1.40	-8.33
Employers	0.00	0.00	-0.57	-1.21	-1.98	-2.98	-3.38	-3.75	-4.02	-4.42	-3.75	-22.31
Individual Out-of-Pocket	0.00	0.00	-0.41	-0.86	-1.42	-2.14	-2.42	-2.69	-2.88	-3.17	-2.69	-16.98

Annual allocations by payor derived by Committee for a Responsible Federal Budget from totals contained in Lewin-VHI anaylsis.

19-Apr-93

Supplement to the Lewin-VHI, Inc. Analyses

Health Care Cost Containment Options

($ in billions)

(Negative amounts are savings from Baseline expenditures.)

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Baselines												
Total: National Health Expenditures	**996.70**	**1101.86**	**1215.19**	**1335.25**	**1462.29**	**1596.68**	**1757.80**	**1889.06**	**2049.15**	**2215.66**	**6111.28**	**15619.63**
Federal	325.75	366.06	410.89	458.78	508.39	561.22	617.45	676.71	740.39	807.89	2069.88	5473.55
State	146.09	162.76	181.74	202.06	222.00	242.20	262.43	282.76	303.89	325.70	914.65	2331.63
All Private	297.33	325.36	354.25	384.14	417.28	452.91	491.80	532.83	578.16	623.87	1778.37	4457.93
Individual Out-of-Pocket	185.73	203.14	221.47	240.22	260.24	280.90	320.72	325.51	350.10	376.01	1110.79	2764.02
Other Private	41.80	44.54	46.83	50.05	54.37	59.45	65.40	71.26	76.62	82.20	237.60	592.51
Cost Containment Options												
I Prevention												
A Increase prenatal care	**0.08**	**-0.18**	**-0.20**	**-0.22**	**-0.24**	**-0.26**	**-0.28**	**-0.31**	**-0.33**	**-0.36**	**-0.75**	**-2.29**
Federal	0.60	0.57	0.62	0.68	0.74	0.81	0.88	0.96	1.05	1.14	3.22	8.06
State	-0.04	-0.08	-0.09	-0.10	-0.11	-0.12	-0.13	-0.14	-0.15	-0.17	-0.42	-1.12
Employers	-0.08	-0.17	-0.19	-0.21	-0.22	-0.24	-0.27	-0.29	-0.31	-0.34	-0.87	-2.32
Individual Out-of-Pocket	-0.40	-0.50	-0.55	-0.59	-0.65	-0.71	-0.77	-0.84	-0.91	-1.00	-2.69	-6.91
B Increase childhood immunizations	**0.28**	**0.29**	**0.30**	**0.31**	**0.32**	**0.34**	**0.35**	**0.36**	**0.37**	**0.38**	**1.51**	**3.30**
Federal	0.29	0.31	0.32	0.33	0.34	0.36	0.37	0.38	0.40	0.41	1.59	3.51
State	-0.00	-0.00	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.03	-0.07
Employers	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.01	-0.04	-0.09
Individual Out-of-Pocket	-0.00	-0.00	-0.00	-0.00	-0.00	-0.00	-0.01	-0.01	-0.01	-0.01	-0.02	-0.05
II Administrative Savings												
A Electronic billing/claims processing	**-0.30**	**-0.90**	**-1.20**	**-1.80**	**-2.10**	**-2.40**	**-2.70**	**-3.00**	**-3.30**	**-3.30**	**-6.30**	**-21.00**
Federal	-0.03	-0.09	-0.12	-0.18	-0.21	-0.24	-0.27	-0.30	-0.33	-0.33	-0.63	-2.10
State	-0.01	-0.04	-0.06	-0.09	-0.10	-0.11	-0.13	-0.14	-0.16	-0.16	-0.30	-1.00
Employers	-0.14	-0.43	-0.58	-0.87	-1.01	-1.16	-1.30	-1.44	-1.59	-1.59	-3.03	-10.11
Individual Out-of-Pocket	-0.11	-0.33	-0.45	-0.67	-0.78	-0.89	-1.00	-1.11	-1.22	-1.22	-2.34	-7.79
B Electronic patient Smart Cards	**-0.05**	**-0.10**	**-0.16**	**-0.26**	**-0.33**	**-0.36**	**-0.40**	**-0.44**	**-0.48**	**-0.53**	**-0.89**	**-3.10**
Federal	-0.01	-0.03	-0.05	-0.08	-0.10	-0.11	-0.12	-0.13	-0.14	-0.16	-0.27	-0.93
State	-0.00	-0.01	-0.02	-0.03	-0.03	-0.04	-0.04	-0.04	-0.05	-0.05	-0.09	-0.31
Employers	-0.02	-0.03	-0.06	-0.09	-0.11	-0.13	-0.14	-0.15	-0.17	-0.18	-0.31	-1.09
Individual Out-of-Pocket	-0.01	-0.02	-0.04	-0.07	-0.08	-0.09	-0.10	-0.11	-0.12	-0.13	-0.22	-0.78
III Medical Malpractice Reform												
A Malpractice Premiums	**0.00**	**0.00**	**-0.60**	**-1.30**	**-2.10**	**-3.20**	**-3.60**	**-4.00**	**-4.30**	**-4.70**	**-4.00**	**-23.80**
Federal	0.00	0.00	-0.18	-0.39	-0.63	-0.96	-1.08	-1.20	-1.29	-1.41	-1.20	-7.14
State	0.00	0.00	-0.08	-0.17	-0.27	-0.42	-0.47	-0.52	-0.56	-0.61	-0.52	-3.09
Employers	0.00	0.00	-0.20	-0.43	-0.69	-1.06	-1.19	-1.32	-1.42	-1.55	-1.32	-7.85
Individual Out-of-Pocket	0.00	0.00	-0.14	-0.31	-0.50	-0.77	-0.86	-0.96	-1.03	-1.13	-0.96	-5.71
B Defensive Medicine	**0.00**	**0.00**	**-1.70**	**-3.60**	**-5.90**	**-8.90**	**-10.10**	**-11.20**	**-12.00**	**-13.20**	**-11.20**	**-66.60**
Federal	0.00	0.00	-0.51	-1.08	-1.77	-2.67	-3.03	-3.36	-3.60	-3.96	-3.36	-19.98
State	0.00	0.00	-0.21	-0.45	-0.74	-1.11	-1.26	-1.40	-1.50	-1.65	-1.40	-8.33
Employers	0.00	0.00	-0.57	-1.21	-1.98	-2.98	-3.38	-3.75	-4.02	-4.42	-3.75	-22.31
Individual Out-of-Pocket	0.00	0.00	-0.41	-0.86	-1.42	-2.14	-2.42	-2.69	-2.88	-3.17	-2.69	-15.98

Annual allocations by payor derived by Committee for a Responsible Federal Budget from totals contained in Lewin-VHI anaylsis.

19-Apr-93

Supplement to the Lewin-VHI, Inc. Analyses

Health Care Cost Containment Options

($ in billions)

(Negative amounts are savings from Baseline expenditures.)

Proposals	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	5-Yr Total	10-YrTotal
Baselines												
Total: National Health Expenditures	**996.70**	**1101.86**	**1215.19**	**1335.25**	**1462.29**	**1596.68**	**1757.80**	**1889.06**	**2049.15**	**2215.66**	**6111.28**	**15619.63**
Federal	325.75	366.06	410.89	458.78	508.39	561.22	617.45	676.71	740.39	807.89	2069.88	5473.55
State	146.09	162.76	181.74	202.06	222.00	242.20	262.43	282.76	303.89	325.70	914.65	2331.63
All Private	297.33	325.36	354.25	384.14	417.28	452.91	491.80	532.83	578.16	623.87	1778.37	4457.93
Individual Out-of-Pocket	185.73	203.14	221.47	240.22	260.24	280.90	320.72	325.51	350.10	376.01	1110.79	2764.02
Other Private	41.80	44.54	46.83	50.05	54.37	59.45	65.40	71.26	76.62	82.20	237.60	592.51
Cost Containment Options												
E Increase SMI Premiums to 30%	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Federal	-2.09	-3.33	-5.53	-8.18	-11.01	-13.90	-16.71	-19.28	-21.51	-23.44	-30.14	-124.98
State	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Employers	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Individual Out-of-Pocket	2.09	3.33	5.53	8.18	11.01	13.90	16.71	19.28	21.51	23.44	30.14	124.98
F Increase and Index SMI Deductibles	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Federal	-0.71	-1.41	-1.88	-2.36	-2.91	-3.58	-4.40	-5.42	-6.66	-8.19	-9.27	-37.52
State	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Employers	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Individual Out-of-Pocket	0.71	1.41	1.88	2.36	2.91	3.58	4.40	5.42	6.66	8.19	9.27	37.52
IX Taxation of Employer Health Benefits												
A Tax benefits > $165/mo ($400/mo family)												
Without utilization response	**-4.87**	**-8.31**	**-10.49**	**-12.99**	**-15.87**	**-19.16**	**-22.92**	**-27.19**	**-32.06**	**-37.58**	**-52.52**	**-191.45**
Federal	-10.50	-17.90	-22.60	-28.00	-34.20	-41.30	-49.40	-58.60	-69.10	-81.00	-113.20	-412.60
State	-1.47	-2.51	-3.16	-3.92	-4.79	-5.78	-6.92	-8.20	-9.67	-11.34	-15.85	-57.76
Employers	-5.61	-9.56	-12.07	-14.95	-18.26	-22.05	-26.38	-31.29	-36.90	-43.25	-60.45	-220.33
Individual Out-of-Pocket	12.71	21.66	27.35	33.88	41.38	49.97	59.77	70.91	83.61	98.01	136.97	499.25
With utilization response	**-4.18**	**-7.10**	**-9.14**	**-11.04**	**-13.55**	**-16.38**	**-19.53**	**-23.15**	**-27.33**	**-32.06**	**-45.01**	**-163.47**
Federal	-9.00	-15.30	-19.70	-23.80	-29.20	-35.30	-42.10	-49.90	-58.90	-69.10	-97.00	-352.30
State	-1.26	-2.14	-2.76	-3.33	-4.09	-4.94	-5.89	-6.99	-8.25	-9.67	-13.58	-49.32
Employers	-4.81	-8.17	-10.52	-12.71	-15.59	-18.85	-22.48	-26.65	-31.45	-36.90	-51.80	-188.13
Individual Out-of-Pocket	10.89	18.51	23.84	28.80	35.33	42.71	50.94	60.38	71.27	83.61	117.37	426.28
B Tax full amt of benefits w/ tax credit												
Without utilization response	**-14.21**	**-17.19**	**-19.87**	**-22.81**	**-26.13**	**-29.91**	**-34.25**	**-39.23**	**-44.89**	**-51.36**	**-100.21**	**-299.85**
Federal	-33.40	-40.40	-46.70	-53.60	-61.40	-70.30	-80.50	-92.20	-105.50	-120.70	-235.50	-704.70
State	-4.68	-5.66	-6.54	-7.50	-8.60	-9.84	-11.27	-12.91	-14.77	-16.90	-32.97	-98.66
Employers	-14.11	-17.07	-19.73	-22.65	-25.94	-29.70	-34.01	-38.95	-44.57	-51.00	-99.50	-297.74
Individual Out-of-Pocket	37.98	45.93	53.10	60.94	69.81	79.93	91.53	104.83	119.95	137.24	267.76	801.24
With utilization response	**-13.36**	**-16.17**	**-18.68**	**-21.45**	**-24.55**	**-28.13**	**-32.21**	**-36.89**	**-42.21**	**-48.25**	**-94.21**	**-281.89**
Federal	-31.40	-38.00	-43.90	-50.40	-57.70	-66.10	-75.70	-86.70	-99.20	-113.40	-221.40	-662.50
State	-4.40	-5.32	-6.15	-7.06	-8.08	-9.25	-10.60	-12.14	-13.89	-15.88	-31.00	-92.75
Employers	-13.27	-16.06	-18.55	-21.29	-24.38	-27.93	-31.98	-36.63	-41.91	-47.91	-93.54	-279.91
Individual Out-of-Pocket	35.70	43.21	49.91	57.30	65.60	75.16	86.07	98.58	112.79	128.94	251.73	753.26

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19-Apr-93

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Other Private	41.80	44.54	46.83	50.05	54.37	59.45	65.40	71.26	76.62	82.20	237.60	592.51
Cost Containment Options												
VI Outcomes Research/Practice Parameters	**-1.40**	**-3.20**	**-5.40**	**-7.90**	**-8.40**	**-9.20**	**-10.10**	**-11.30**	**-12.50**	**-13.80**	**-26.30**	**-83.20**
Federal	-0.39	-0.88	-1.49	-2.17	-2.31	-2.53	-2.78	-3.11	-3.44	-3.80	-7.23	-22.88
State	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Employers	-0.86	-1.97	-3.32	-4.86	-5.17	-5.66	-6.21	-6.95	-7.69	-8.49	-16.17	-51.17
Individual Out-of-Pocket	-0.15	-0.35	-0.59	-0.87	-0.92	-1.01	-1.11	-1.24	-1.38	-1.52	-2.89	-9.15
VII Small Group Market Reform												
A Small Group Administrative Savings	**-4.00**	**-4.70**	**-5.10**	**-5.50**	**-5.90**	**-6.50**	**-6.90**	**-7.50**	**-8.10**	**-8.80**	**-25.20**	**-63.00**
Federal	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
State	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Employers	-3.40	-4.00	-4.34	-4.68	-5.02	-5.53	-5.87	-6.38	-6.89	-7.48	-21.42	-53.55
Individual Out-of-Pocket	-0.60	-0.71	-0.77	-0.83	-0.89	-0.98	-1.04	-1.13	-1.22	-1.32	-3.78	-9.45
B Pre-emption of State Mandated Benefits	**-1.20**	**-1.40**	**-1.50**	**-1.60**	**-1.80**	**-1.90**	**-2.10**	**-2.30**	**-2.40**	**-2.60**	**-7.50**	**-18.80**
Federal	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
State	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Employers	-1.02	-1.19	-1.28	-1.36	-1.53	-1.62	-1.79	-1.96	-2.04	-2.21	-6.38	-15.98
Individual Out-of-Pocket	-0.18	-0.21	-0.23	-0.24	-0.27	-0.29	-0.32	-0.35	-0.36	-0.39	-1.13	-2.82
VIII Medicare Program Reforms												
A Grad. Elim. Disp. Share Adjustment	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Federal	-0.47	-1.10	-1.80	-2.60	-3.50	-3.85	-4.27	-4.74	-5.27	-5.84	-9.47	-33.45
State	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Employers	0.35	0.83	1.35	1.95	2.63	2.89	3.20	3.56	3.95	4.38	7.10	25.08
Individual Out-of-Pocket	0.12	0.28	0.45	0.65	0.88	0.96	1.07	1.19	1.32	1.46	2.37	8.36
B Reduce Teaching Adjustment to 3%	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Federal	-1.65	-2.00	-2.20	-2.35	-2.75	-3.05	-3.39	-3.76	-4.18	-4.36	-10.95	-29.69
State	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Employers	1.24	1.50	1.65	1.76	2.06	2.29	2.54	2.82	3.13	3.27	8.21	22.27
Individual Out-of-Pocket	0.41	0.50	0.55	0.59	0.69	0.76	0.85	0.94	1.04	1.09	2.74	7.42
C Freeze PPS Rates 1 year	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Federal	-2.05	-2.85	-3.15	-3.45	-3.75	-4.09	-4.46	-4.86	-5.29	-5.77	-15.25	-39.71
State	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Employers	1.54	2.14	2.36	2.59	2.81	3.07	3.34	3.64	3.97	4.33	11.44	29.78
Individual Out-of-Pocket	0.51	0.71	0.79	0.86	0.94	1.02	1.11	1.21	1.32	1.44	3.81	9.93
D Increase SMI Coinsurance for Home Health	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Federal	-2.30	-3.85	-4.52	-5.01	-5.45	-5.94	-6.48	-7.06	-7.09	-8.39	-21.13	-56.08
State	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Employers	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Individual Out-of-Pocket	2.30	3.85	4.52	5.01	5.45	5.94	6.48	7.06	7.09	8.39	21.13	56.08

Annual allocations by payor derived by Committee for a Responsible Federal Budget from totals contained in Lewin-VHI anaylsis.

19-Apr-93

Supplement to the Lewin-VHI, Inc. Analyses

Health Care Cost Containment Options

($ in billions)

(Negative amounts are savings from Baseline expenditures.)

Proposals	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	5-Yr Total	10-YrTotal
Baselines												
Total: National Health Expenditures	**996.70**	**1101.86**	**1215.19**	**1335.25**	**1462.29**	**1596.68**	**1757.80**	**1889.06**	**2049.15**	**2215.66**	**6111.28**	**15619.63**
Federal	325.75	366.06	410.89	458.78	508.39	561.22	617.45	676.71	740.39	807.89	2069.88	5473.55
State	146.09	162.76	181.74	202.06	222.00	242.20	262.43	282.76	303.89	325.70	914.65	2331.63
All Private	297.33	325.36	354.25	384.14	417.28	452.91	491.80	532.83	578.16	623.87	1778.37	4457.93
Individual Out-of-Pocket	185.73	203.14	221.47	240.22	260.24	280.90	320.72	325.51	350.10	376.01	1110.79	2764.02
Other Private	41.80	44.54	46.83	50.05	54.37	59.45	65.40	71.26	76.62	82.20	237.60	592.51
Cost Containment Options												
X **Taxation of Medicare Benefits**												
A **Tax beneficiaries over income threshold**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Federal	-2.00	-5.30	-6.40	-7.70	-9.10	-10.70	-12.70	-14.80	-17.50	-20.60	-30.50	-106.80
State	-0.28	-0.74	-0.90	-1.08	-1.28	-1.50	-1.78	-2.07	-2.45	-2.89	-4.28	-14.97
Employers	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Individual Out-of-Pocket	2.28	6.04	7.30	8.78	10.38	12.20	14.48	16.87	19.95	23.49	34.78	121.77
B **Tax all beneficiaries**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Federal	-3.00	-10.50	-11.90	-13.60	-15.60	-17.80	-20.30	-23.10	-26.30	-30.00	-54.60	-172.10
State	-0.42	-1.47	-1.67	-1.91	-2.19	-2.50	-2.85	-3.24	-3.69	-4.21	-7.65	-24.13
Employers	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Individual Out-of-Pocket	3.42	11.97	13.57	15.51	17.79	20.30	23.15	26.34	29.99	34.21	62.25	196.23

Annual allocations by payor derived by Committee for a Responsible Federal Budget from totals contained in Lewin-VHI anaylsis.

Appendix 2
National Health Expenditures

Appendix 3
Factors Contributing to Rising Health Care Costs

Appendix 4
Health Care Cost Containment Options

Appendix 5
Preliminary Comparison of Major Health Care Reform Options

Appendix 2
National Health Expenditures

The model to project national health expenditures (NHE) was developed by the Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. The Congressional Budget Office (CBO) uses the same model, but uses CBO economic and technical estimating assumptions.

The HCFA model uses seven factors:

- Gross Domestic Product (GDP) deflator (as contained in the Administration's economic assumptions) to measure general inflation
- HCFA's health price proxy divided by GDP to get a relative price measure
- Population growth based upon Social Security Administration projections
- Change in age composition of the population
- Change in sex composition of the population
- Per capita use (e.g. inpatient days per capita adjusted for changes in population factors)
- "Intensity", the residual that cannot be explained by the first six factors as well as any errors.

CBO's projections are based upon January 1992 CBO economic assumptions and CBO baseline assumptions for Federal programs (Medicare, Medicaid, administrative and overhead costs, Federal research, etc.).

A comparison of the HCFA[1] and CBO[2] projections for selected years follows:

	1993		1995		2000	
	$ billions	NHE/GDP	$ billions	NHE/GDP	$ billions	NHE/GDP
HCFA	903	14.4%	1,102	15.6%	1,740	18.1%
CBO	889	14.0%	1,072	15.1%	1,679	18.0%

[1] Bruner, Sally T., Daniel R. Waldo, and David R. McKusick, "National Health Expenditures Projections through 2030," *Health Care Financing Review*, Fall 1992, Vol.14, No.1.

[2] Congressional Budget Office, *Projections of National Health Expenditures*, October 1992.

Appendix 3

Factors Contributing to Rising Health Care Expenditures

Factor	Description	Comment
General and Demographic Factors		
Normative Societal Values	High quality health care seen as a "right." Availability should not be restricted by ability to pay.	Public opinion supports guaranteed access to health care (EBRI, 1992).[1] 88% of respondents to an EBRI/Gallup Poll survey agreed or strongly agreed that everyone should be entitled to the same level of health care irrespective of ability to pay for care. 75% of respondents indicated that they would be willing to pay 5% of their income or less for a system that would provide insurance for the entire population (including themselves).

[1] Employee Benefit Research Institute, *Health Care Reform: Tradeoffs and Implications*, Number 125, April 1992.

Factor	Description	Comment
Aging Population	Proportion of the population over the age of 65 has increased from 8% in 1950 to 12% in 1987. Mean per capita spending for health care for the over 65 is 2-5 times greater than younger age categories.	Real per capita health care expenditures grew by 500% between 1950 and 1987. Proportion of elderly accounts for only 15% out of the total 500% increase. (Newhouse, J. 1992)[2] Aging population accounted for 3% of the increase in spending for personal health care between 1965-1983, 4.6% of the increase between 1983-1987, 4% of the increase between 1987-1990, and 4.8% of the increase between 1990-1992. (CBOa, 1992)[3] In 2020, aging population will boost per capita health care spending by 12% relative to 1990 spending and 23% in 2040.[4] Between 1990 and 2020, total health care spending per capita is projected to increase over 900%.[5]

[2] Newhouse, Joseph P., "Medical Care Costs: How Much Welfare Loss?", *Journal of Economic Perspectives*, Volume 6, Number 3, Summer 1992.

[3] Congressional Budget Office, *Projections of National Health Expenditures*, October 1992, p.17.

[4] Aaron, Henry J., Serious and Unstable Condition, Financing America's Health Care, The Brookings Institution, 1991.

[5] Bruner, Sally T., Daniel R. Waldo, and David McKusick, "National Health Expenditures Projections through 2030," *Health Care Financing Review*, Vol. 14, Number 1, Fall 1992. Population projections from Bureau of the Census, *Current Population Reports, Population Projections of the United States, by Age, Sex, Race, and Hispanic Origin: 1992-2050*, November 1992.

Factor	Description	Comment
Insurance and Price Insensitivity of Patients (Consumers)		
Tax Treatment of Health Insurance Benefits	Favorable tax treatment of employer-paid premiums reduces the effective price of insurance and provides a hidden subsidy causing higher levels of spending for health care.	The tax subsidy given to health insurance coverage and health care expenditure is "unwarranted." It distorts the cost of health insurance and health care, leading to demand pressures on the system to boost prices. (Warshawsky, 1991)[6]
Expansion of Insurance	In 1940, fewer than 10% of the population had any health care insurance. In 1988, 87% had some insurance. In 1991, 84% of the non-elderly and 99% of those over the age of 65 were insured.	The spread of insurance does not account for much of the increase in expenditures except to the degree than it has induced technological change. (Newhouse, 1992) Insurance against the expenditure for health care increases consumption of those services unless demand is completely price inelastic. Providers raise their fees and provide more sophisticated services in response to the expansion of health insurance, setting off demand for more insurance. (Feldstein, 1973)[7]
Cost-Based Insurance (Retrospective Payment)	Retrospective payment provides no incentives limit cost or control volume. Growth in real expenditures for health care led, by the 1970s, to concerns about retrospective payment arrangements, introduction of prospective pay systems in Medicare and HMOs. HMO enrollment has grown from 9 million in 1980 to over 35 million.	Retrospective pricing can be allocatively efficient when there is little insurance and prices are determined under competitive markets. Discipline on patient and provider behavior (consumption of services) gives way to growing price insensitivity with the expansion of insurance. (Weisbrod, 1991)[8]

[6] Warshawsky, Mark J., "Projections of Health Care Expenditures as a Share of GNP: Actuarial and Economic Approaches," *Finance and Economics Discussion Series 170,* Board of Governors of the Federal Reserve System, November 1991.

[7] Feldstein, Martin S., "The Welfare Loss of Excess Health Insurance," *Journal of Political Economy,* March/April 1973.

Factor	Description	Comment
Retrospective Payments and R&D	Insurance coverage that provides retrospective (cost-based) reimbursement provides no incentives to develop cost-effective technologies. Because providers will adopt latest technology, regardless of price, researchers focus on improving quality without consideration of cost. Availability of high cost technology drives up the demand for insurance. The availability of more insurance coverage leads to the development of more costly technology.	Given the 10-15 year research, development, and testing timeframe of new technology, work on many costly new innovations may have begun before cost containment concerns. Although long-term impacts of cost containment on R&D are uncertain, some impacts are evident. With switch in Medicare to DRGs (diagnosis related groups) and increased enrollments in HMOs, development of some costly new technology has been slowed (e.g., positron emission tomography -- PET). Use of less costly forms of treatment (pharmaceuticals over surgery) has increased the profitability of research into them. (Weisbrod, 1991)
Price Insensitivity of Patients (Consumers)	Expansion of insurance coverage has reduced price sensitivity of patients (consumers) and increased demand for health care. Between 1960 and 1990, out-of-pocket expenditures for personal health care dropped from over 55% to 20%. Between 1950 and 1980, average coinsurance rate dropped from 67% to 27%.	Employers offering a choice of insurance plans do not reward employees choosing lower cost options with higher wage. This discourages price comparisons and reduces incentives for efficient insurers to lower prices. A 10% decrease in price is estimated to boost health care expenditures by 1-2% (Manning, 1988).[9]

[8] Weisbrod, Burton A., "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment," *Journal of Economic Literature*, Vol. XXIX, June 1991.

[9] Manning, William *et.al.*, *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, Rand Corporation, 1988.

Factor	Description	Comment
Patients (Consumers)		
Income Growth	As incomes grow, patients (consumers) may choose to spend more on health care. As national incomes rise, people may choose to purchase health services that improve the quality of life.	From 1940 to 1990, income growth accounted for a 35-70% increase in health care expenditures (assuming income elasticity of demand of 0.2-0.4), compared to a total increase of 780%. If income elasticity of demand is assumed to be 1.0, which is consistent with other developed nations, income growth would account for 25% of the overall increase. (Newhouse, 1992)
Patients' Lack of Sufficient Information	Patients (consumers) lack sufficient information about the efficacy and price of providers and procedures. Without sufficient information about outcomes, even if prices information is not available, consumers cannot make necessary evaluations. Given lack of sufficient ability to evaluate outcomes, consumers overvalue visible features (e.g., high tech equipment, amount of contact with physician) and may equate price with quality.	If changes in quality resulting form cost constraint are hard to monitor, cost shaving will occur in those areas as opposed to areas when changes are more visible. (Weisbrod, 1991)
Physician-Induced Demand		
Physicians' Income Incentives	As the number of physicians increases, physicians increase prices and volume to protect their incomes.	There is no correlation between the growth in the number of physicians (1940-1990) and the growth in health care spending. (Newhouse, 1992)

Factor	Description	Comment
Defensive Medicine	Fear of malpractice claims leads to multiple procedures and tests to minimize chances of a successful suit.	Although amount of defensive medicine is uncertain, most widely cited amount is 1% of 1984 expenditures. Even if defensive medicine were 0 in 1940, its growth cannot account for much of the increase in overall expenditures. (Newhouse, 1992) Defensive medicine accounted for an estimated 17.6% of expenditures for physician services in 1989 (American Medical Association, 1992).[10] Malpractice insurance costs contributed .2 percent to average annual hospital cost growth during the 1983-86 period, when malpractice expenses rose 20 percent per year. The impact of the fear of malpractice (defensive medicine) is difficult to quantify and no estimate provided. (GAO, 1992)[11]
Physicians' Lack of Sufficient Information	Physicians lack adequate information on the efficacy of procedures and technology. If the use of the treatment is not likely to harm the patient and has the potential to help (particularly if the patient is insured), the physician has no incentives not to try it.	
Low productivity	If productivity gains for health care services lag behind productivity of the rest of the economy, expenditures will rise.	Measurement problems with the CPI-Medical index do not permit analysis. (Newhouse, 1992)

[10] American Medical Association, "Medical Professional Liability Costs and the Savings from Tort Reform," *Policy Research Perspectives*, September 1992.

[11] Government Accounting Office, *Hospital Costs: Adoption of New Technologies Drives Cost Growth*, GAO/HRD 91-120, September 1992.

Factor	Description	Comment
Technology		
Introduction of Costly Technology	Expensive new capital and procedures have increased the cost of treatment. Because many new procedures are less invasive, patients are more willing to undertake them. Providers have no incentives to evaluate the marginal benefits and marginal costs of new technologies under the retrospective pay system.	Changes in technology are common across fee-for-service and HMO systems. Changes in technology are also common across different medical systems of developed countries, which are all experiencing similar rates of expenditure growth (though lower per capita spending than the US). (Newhouse, 1992) Because of insurance, little market discipline exists to assure the cost of new technology is justified by its benefits. Higher costs lead to higher insurance and less sensitivity to the cost of new technologies. (CBOb, 1992)[12] In addition to acquiring new technology (the cost of which hospitals largely pass on to third-party payers), hospitals must increase the skill level of their personnel. (GAO, 1992)
Broadening Definition of Health Care	As new procedures and capabilities are developed, consumers demand their inclusion in benefits packages. This added demand for insurance increases expenditures.	Coverage is not limited to technology available at any period of time. Technological advances not only expand the capability to prolong life and enhance health care, but also provide opportunities to address problems not conventionally (or currently) considered as "illness" treatable by "health care." (Weisbrod, 1991)

[12] Congressional Budget Office, *Economic Implications of Rising Health Care Costs*, October 1992.

Appendix 4

Health Care Cost Containment Options

Proposal	Range of Savings Estimates	Comments
Prevention		
Increase Prenatal Care for high risk women/provide nutritional assistance for nutritionally high risk pregnant women	$1 invested yields $3.38 in savings -- Institute of Medicine (1985); $1 invested yields $1.49 in savings -- Missouri Medicaid (1988) $1 invested yields $3 in Medicaid treatment cost savings for high risk women -- WIC $1 spent on nutritionally high risk pregnant women reduces Medicaid cost by $1.92 to $4.21 in first 60 days after birth. -- Bush Administration	"Savings" in part represent average medical costs averted for treating problems associated with low-birthweight infants. The Food and Nutrition Service (FNS) estimates that 85% of eligible pregnant women are receiving WIC assistance -- a full participation rate assuming that some individuals will not use the program. Further investments unlikely to yield the same returns.
Childhood Immunizations	Returns of $10 (polio) - $14 (measles, mumps rubella) per $1 spent -- Center for Disease Control (CDC)	97- 98% of children entering school have been immunized, but percentages may be as low as 50% for inner city preschoolers. "Savings" are averted treatment costs and other non-medical costs realized up to 40 years following immunization.
Smoking cessation for pregnant women	$5-6 in savings (averted neonatal intensive care and extended care for low birthweight infants) for each $1 invested-- Bush Administration	Behavioral change that is hard to achieve. Evidence of high relapse rates among former smokers.
Reduce substance abuse	N/A	N/A
Cholesterol Screening		Office of Technology Assessment (OTA) found little evidence of cost effectiveness for middle-age adults; no evidence that screenings reduce morbidity and mortality in elderly populations.

Proposal	Range of Savings Estimates	Comments
Increase access to primary health care (expanding community health services)	N/A	N/A
Administrative Savings		
Paperwork savings from single-payer (Canadian-type) system	$22 billion/year (CBO) $31-49 billion/year (Bush Administration) $67-100 billion/year (GAO)	Savings estimates are gross -- do not net out potential increases in costs resulting from increased access to health care by the previously uninsured.
Electronic claims processing	$6 billion/ year by the year 2000 (HHS) $3 billion/year by the year 2000 (Lewin/VHI) $4-10 billion/year min. (WEDI)	HHS and Lewin/VHI base savings on $.50/claim. Workgroup for Electronic Data Exchange (WEDI) estimate is conservative due to lack of data. (Savings per claim depends on whether "claims" defined as forms submitted by patients/providers or as claims process by insurers. Each form may be processed as several "claims.)
Computerized medical records	$20 billion/year by year 2000 (Bush Administration)	Savings from elimination of unnecessary treatment and reduced administrative costs.
Managed/Coordinated Care		
Increase enrollment in HMOs	$51-64 billion (CBO)	Savings of 15% of personal health expenditures (7.5% for Medicaid). Note: Bush Administration estimates savings of 25-30% relative to fee for service.
Increase enrollment in PPOs		CBO attributes no savings to PPOs due to lack of supporting data.
Increase utilization review	$3-7 billion (CBO)	Savings of 1-4% of personal health expenditures. (.5-2% for Medicaid). Estimates of inappropriate care range from 10-20% of total expenditures for personal health care.

Proposal	Range of Savings Estimates	Comments
Malpractice Reform		
Reduce defensive medicine costs	$0 (CBO) $21 billion/ year (Bush Administration) $4 billion/year in premium savings and 11 billion/year in reduced defensive medicine in year 2000 (Lewin-ICF)	CBO -- physician behavior would not change. Bush Administration -- Savings of up to $21 billion -- estimated amount spent on defensive medicine. Lewin -- $2.80 in savings for every $1 in malpractice insurance premium reductions Neither GAO nor EBRI assume significant savings from malpractice reform.
Insurance and Health Care Market Changes		
Institute system-wide price controls		CBO estimates that under multi-payer system, half the savings from price controls would be offset by increased volume.
Increase small group purchasing power through pooled purchasing	$9 billion/ year (Bush Administration)	Savings from efficiencies of scale for administration of small group plans. Overhead charges for small groups may be reduced to around half of current levels, but will still exceed levels of large single-employer plans.
Increase availability of consumer information about insurance options	N/A	N/A
Develop practice guidelines and undertake outcomes research to increase availability of consumer information.	$0 (CBO)	CBO does not assume behavioral changes and a reduction of unnecessary care as a result of increased information alone.

Proposal	Range of Savings Estimates	Comments
Federal Program Reforms		
Medicare		
Increase use of managed care	$31 billion/5 years (Lewin)	Assumes mandatory HMOs where available.
Increase the SMI coinsurance rate from 20 to 25%	$20.5 billion/5 years (CBO)	Federal budget savings.
Tax 50% of insurance value of benefits	$54.6 billion/5 years -- no income threshold (CBO) $30.6 billion/5 years -- w/ income threshold (CBO)	Federal budget savings.
Increase SMI premiums for higher income beneficiaries	$18.5 billion/5 years -- premiums cover 50% of costs with $60K individual and $80K couple threshold. (CBO) $17.5 billion/5 years -- premiums cover 100% of costs with $125K individual and $150K couple threshold (CBO)	Federal budget savings.
Reduce current 7.7% payment for indirect teaching costs	$3.9 billion/5 years if reduced to 6% (CBO) $10.9 billion/5 years if reduced to 3% (CBO)	Federal budget savings.
Eliminate disproportionate share adjustment	$9.4 billion/5 years if phased in over 5 year (CBO) $15.3 billion/5 years if eliminated immediately (CBO)	Federal budget savings.
Medicaid		
Increase use of managed care	5.7 percent relative to fee for service in Arizona (HHS)	Based upon Arizona Health Cost Containment System, which only provides acute care and not mental health, long-term or home health care.
	$5.0 billion/5 years (Lewin)	Lewin -- assumes mandatory HMOs where available.
Institute prospective pay system		34 States (1989) already use prospective pay, 3 used retrospective.
Reduce annual rate of growth for disproportionate share payments to 12%	$4.9 billion/5 years (CBO)	Federal budget savings.

Proposal	Range of Savings Estimates	Comments
Prohibit provider tax and donation programs	$12 billion/ 5 years (OMB)	Based upon 1991 SWAT team findings.
Demedicalize custodial care		HUD frail elderly demonstration costs Federal government $8,000/yr/capita for housing vouchers and services. Beneficiaries pay 30% of adjusted income.
Civilian and Military Health Benefits		
Change hospital reimbursement rates to prospective arrangement for Federal Employee Health Benefit Program (FEHBP)	$6.7 billion/5 years (CBO)	Federal budget savings.
Increase employee contributions for health insurance benefits	N/A	N/A
Other Federal Health Care Programs		
Consolidate VA, IHS, and DOD health facilities	N/A	N/A
Close or convert inefficient/underused VA hospitals	$1.1 billion/5 years (CBO)	Federal budget savings.
Financing		
Tax employer paid health insurance premiums in excess of $400/mo. for family and $165/mo. for individual coverage	$113.2 billion/5 years (CBO) in income tax revenue	These thresholds represent average premiums in 1992.
Tax all employer paid health insurance premiums, but allow a 20% tax credit for premiums up to $400/mo. for family and $165/mo. for individual coverage	$235.4 billion/5 years (CBO) in income tax revenue	Net of $230 billion in new income tax revenues and $190 billion in new tax credits.

Appendix 5

Preliminary Comparison of Major Health Care Reform Options

Plan Feature	1. Managed Competition[a]	2. Managed Competition with Global Budget Cap[b]	3. Single Payer National Health Insurance
Access:			
• Coverage	Near universal: Private employer-based, small employer, and phased-in public plan to cover low-income in private Accountable Health Plans/Partnerships (AHPs).	Near universal, through private employer or public plans.	Universal: public plan. Everyone covered.
• Portability of coverage	Yes.	Yes.	Yes.
• Community or experience based rating	Community.	Community.	Community.
• Small group reform	Health Insurance Purchasing Cooperative (HIPCs) -- one per region to provide pooled purchasing power to small employers and the self-employed.	Same as #1.	Not applicable.

[a] Based upon Paul Ellwood and Lynn Etheredge, Jackson Hole Group, *The 21st Century Health Care System* (9/91).
[b] Based upon Paul Starr and Walter Zelman, "A Bridge to Compromise", *Health Affairs*, Supplement 1993.

Plan Feature	1. Managed Competition[a]	2. Managed Competition with Global Budget Cap[b]	3. Single Payer National Health Insurance
Benefits:			
• Coverage	Uniform Effective Health Benefits for all necessary care.	Standard Comprehensive Benefit package.	Comprehensive: all necessary care.
Cost Containment:			
• Global budget	No.	Yes: capitated payments to health plans. Regional budget set in one of following ways: (1) benchmark premium times number of enrollees; (2) total premiums paid to all plans; (3) total spending on covered benefits for eligible individuals; (4) total spending for covered and uncovered services.	Yes.
• Physician rate setting	No: Capitated payments and rates negotiated by individual plans with participating providers.	No, but available as a backup: payment rates negotiated with individual providers by individual plans.	Yes: Fee schedules.
• Hospital and other health care facilities budgets	No: Individual plans negotiate reimbursement.	No, but available as a backup: payment rates negotiated with providers by individual plans.	Yes: operating and capital budgets.
• Price regulation for other medical services or goods	No: Prices negotiated by individual plans and market driven.	No, but regulatory authority available as backup.	Yes: Prices of durable and non-durable goods controlled.

Plan Feature	1. Managed Competition[a]	2. Managed Competition with Global Budget Cap[b]	3. Single Payer National Health Insurance
• Managed care	Yes, providers required to form/join accountable health plans/partnerships (AHPs) in order to preserve tax-deductibility of their patients' health care benefits. Lowest cost (regional) plan ceiling for tax deductibility provides strong incentives for managed care.	Encouraged -- existing plans may compete for HIPC business. HIPCs can encourage development of managed care plans. One fee-for-service plan allowed per HIPC region.	Permitted.
• Administrative savings/costs	Savings from capitated payment (instead of fee-for-service) payment system and reduced overheard for small groups and self-employed. Cost increases from managed care (pre-authorizations, utilization review, etc.). (Assume implementation of electronic billing and single claim form under any system.)	Same as #1.	Elimination of multiple payers simplifies provider and physician administrative requirements (enrollment, eligibility verification, billing, collection, etc.) and reduces costs. Administrative costs of private insurers eliminated, partially offset by cost increases from development of national administration to support the new system. (Assume implementation of electronic billing and single claim form under any system.)
Financing:			
• Tax expenditure cap	Set at level of lowest cost acceptable plan (AHPs) . Limit can be placed on employer and/or employee.	Could use cap to partially offset additional Federal costs.	Not applicable.

Plan Feature	1. Managed Competition[a]	2. Managed Competition with Global Budget Cap[b]	3. Single Payer National Health Insurance
• Employer-paid premiums	Premiums in excess of lowest cost plan ceiling may lose tax deductibility.	Employers required to pay fixed percentage of premium (e.g. 75%) capped at some percentage of payroll (e.g., 7%). Federal subsidies make up the difference up to cost of benchmark plan.	No, but employer taxes would increase to cover Federal costs.
• Individual cost-sharing: (premiums deductibles and co-pays)	Important component. Conditions are plan specific and reflect competitive conditions.	Employees contribute premium share up to fixed percentage of family income (e.g., 2%). Self-employed, part time employees and unemployed with incomes above poverty pay up to a fixed percentage of the difference between their income and the poverty level (e.g. 9%). Federal subsidies make up difference. Those below poverty pay nothing.	Can be built in, standardized for all covered and individual taxes would increase to cover Federal costs.
• Federal financial contribution	Yes, direct funding for means-tested subsidies individuals to purchase insurance, to small employers to offer insurance, and to create risk-pools.	Same as #1.	Yes, Federally financed.
• Additional revenue	Provider taxes, cigarette taxes, general revenues.	Provider taxes, cigarette taxes, general revenues.	Provider taxes, cigarette taxes, general revenues.
• State financial contribution	Maintain current contribution to support public plan and/or to assume responsibility for long term care.		Maintain current contributions.

Plan Feature	1. Managed Competition[a]	2. Managed Competition with Global Budget Cap[b]	3. Single Payer National Health Insurance
Administration:			
• National oversight responsibility	National Health Standards Board (Appointed independent Federal Agency) and Congress.	National Health Board.	HCFA or Other Designated Federal Agency and Congress.
• Rate/reimbursement setting	Not applicable: market driven.	National Board and States.	HCFA or Other Designated Federal Agency and States.
• Eligibility of insurers	Accountable Health Plans/Partnerships certified by National Board. (Certification required for tax-advantaged treatment of premiums.)	HIPCs and States.	Not applicable.
• Eligibility of HIPCs	Certified by National Board.	Same as #1.	Not applicable.
• Provider/Plan reporting requirements	Established by National Board.		Established by HCFA or Other Designated Federal Agency.
• Definition of standard/uniform effective health benefits	Established by National Board.	Same as #1.	Established by HCFA or Other Designated Federal Agency.

Plan Feature	1. Managed Competition[a]	2. Managed Competition with Global Budget Cap[b]	3. Single Payer National Health Insurance
Federal Budget Impact:			
• Cost of access/individual coverage	Direct subsidies (tax credits) for low-income unemployed individuals and low-wage workers and their families; tax subsidies for small employers to provide benefits.	Same as #1.	All costs of covered services come on-budget. Additional cost of universal access offset at least partially by reduced administrative costs.
• Medicare/Medicaid	Medicaid costs transferred to subsidies for primary and acute care provided through AHPs. Medicare may or may not be folded in.	Medicaid absorbed into HIPCs plans with individual Federal subsidies. Medicare left outside of system with beneficiaries free to choose HIPC plans (some incentive like drug benefit offered to encourage voluntary change).	Not applicable. All individuals covered through national plan.
• Other costs	Start-up subsidies for HIPCs plus direct administrative costs.	Same as #1.	Direct administrative costs. (Billing/payment activities may be contracted to fiscal intermediaries.)
• Savings	Tax expenditure reduction (increased revenues). Savings from cost containment.	Savings from global cap and from cost containment.	Tax expenditure eliminated (revenues increase). Assume higher revenues from increased taxation to pay for increased on-budget costs.

Plan Feature	1. Managed Competition[a]	2. Managed Competition with Global Budget Cap[b]	3. Single Payer National Health Insurance
Financial Impact on Employers:			
• Employee benefits	Generally, limits on deductibility of health care benefits could reduce benefit costs if benefits currently provided exceed cap. Over long-term, cap should help constrain growth in costs. While some smaller employers would experience premium decreases as a result of community rating, some would experience premium increases. Increased benefit costs for employers newly offering coverage.	Employee benefit costs capped at some percentage of payroll and the required contribution towards premium (not to exceed benchmark premium). While some smaller employers would experience premium decreases as a result of community rating, some would experience premium increases. Increased benefit costs for employers newly offering coverage.	Health benefits no longer provided by employer.
• Employee wages	Employees may demand higher wages to compensate for loss in the value of benefits, increased co-pays and deductible, and to allow them to purchase (with after-tax dollars) additional coverage.	Employees may demand higher wages to compensate for required contribution to insurance.	Employees may demand higher wages to compensate for loss of tax-free benefit and to pay the additional individual taxes required for national plan.
• Taxes	Increase because of limit on deductibility of health care benefits and need to pay incremental costs of universal access and accompanying subsidies.		Increase to help pay for national plan.

Plan Feature	1. Managed Competition[a]	2. Managed Competition with Global Budget Cap[b]	3. Single Payer National Health Insurance
Financial Impact on Individuals:			
• Employee benefits	Limited by cap on tax deductibility. Employees would experience some loss of benefits if current plan coverage exceeds offerings of new AHPs. Employees of some small employers would gain coverage.	Some employees gain health insurance benefits. Employees of large employers would have choice of employer plan or benchmark plan. Some employees could lose benefits if current plan has richer benefits than new offerings with capped employer contributions.	Employer-provided health care benefits eliminated. All individuals would be covered under national plan.
• Employee wages	May increase if employers pass on premium savings in form of cash wages. Increases would offset higher co-pay and deductibles. May decrease (or not increase) to offset new health insurance benefits.	Same as #1.	Increase to compensate for loss of tax-free benefit and to cover additional taxes required for national plan.
• Taxes	Increase because of limit on deductibility of health care benefits and need to pay incremental costs of expanded access and accompanying subsidies.	Increase to pay incremental cost of expanded access and accompanying subsidies.	Increase to help pay for national plan.

Plan Feature	1. Managed Competition[a]	2. Managed Competition with Global Budget Cap[b]	3. Single Payer National Health Insurance
Impact on State Budgets:			
• Savings	Savings from coverage of previously uninsured workers receiving coverage under private plans. Potential Medicaid administrative and program savings if Federal program assumes all costs of low-income subsidies. Savings, if any, from cost containment.	Same as #1.	At least the same level of contribution likely to be required as a cost-share for national plan.
• Costs	Additional costs may be incurred if States are expected to finance long-term care or to pay more for expanded access.	Additional costs may be incurred if States are expected to finance long-term care or to pay more for expanded access. Overall costs would be capped under the global budget.	At least the same level of contribution likely to be required as a cost-share for national plan.
• Revenues	Increase if State taxes tied to Federal tax rules (due to the limits on deductibility of employer-provided health care benefits). Increases required to offset additional costs of expanded access.		Increase if State taxes tied to Federal tax rules (due to elimination of the deductibility of employer-provided health care benefits). Increases required to offset additional costs of universal access.

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