Chapter Five

Other Considerations

The Administration has developed a comprehensive proposal that, if implemented as envisioned by its architects, could alleviate the problems it seeks to address: lack of insurance coverage, lack of access to health care, and rapidly rising health care costs. The proposal's scope is broad, and its attention to detail is extraordinary. It provides a blueprint for restructuring the entire health care system, complete in almost every particular of the design. In this respect it is unique.

As described in Chapter 1, the underlying principles of the proposal would be to establish a universal entitlement to a standard package of health benefits with a financing structure that would build on the existing employment-based system. The proposed system, however, would require all employers to make specified contributions to premiums on behalf of their employees, thereby ending the situation in which some employers in effect pay for the coverage of employees in other firms. All individuals and families, except Medicaid beneficiaries and others with very low income, would also be required to pay at least part of their premiums. Subsidies would be available to help employers and low-income families meet their premium obligations. The Medicaid program as it exists today would end, and Medicaid beneficiaries would enroll in "mainstream" health plans, which would receive the same premium payment for Medicaid beneficiaries as for any other enrollees.

People who had experienced difficulties obtaining health insurance coverage at a reasonable price, and those who feared losing coverage if they lost or changed their jobs, would find that those problems no longer existed. Families with no employed members and employees of small firms would not have to pay higher premiums than others in their community for the same coverage. Employed people would not lose their coverage when they left the labor force. High-risk people in particular would benefit since health status would no longer be a factor in determining the availability of insurance coverage or its price. Most people would have a choice of health plans available to them, which many do not today, and would be provided with information to help them to make informed choices.

To constrain the growth of health care costs, the proposal would establish mechanisms for limiting the rate of growth of premiums for the standard benefit package, and for setting the initial level of premiums in regional alliances. If they were implemented as intended, those mechanisms would be completely effective. The proposal would also attempt to limit federal obligations for subsidies. As discussed in Chapter 2, those limits might not be as effective.

In assessing the likelihood that the Administration's proposal would be able to achieve its goals and establish a stable system for financing health care, two important issues arise: whether it would be possible to implement the proposal fully in the time frame envisioned, and whether there might be unintended consequences that could affect the system's viability.

Policymakers and analysts can only speculate about such questions because of the magnitude of the institutional changes being proposed. The complexity and interrelated nature of the proposal's many components make it difficult to grasp all their possible interactions or to determine the extent of institutional change and development that would be necessary. Moreover, under the proposal an entirely new environment would evolve; the behavior and

expectations of consumers and providers would change in ways that one cannot fully anticipate today. Thus, the potential for unforeseen consequences--both favorable and unfavorable--would be significant.

The Congressional Budget Office's cost estimate, discussed in Chapter 2, assumes that the Administration's restructuring of the health care system would be implemented according to the schedule laid out in the proposal. That assumption may be questionable, however, especially as it relates to the capacity of the agencies that would carry out the program and to the data requirements of the system.

The cost estimate also assumes that the proposed methods for constraining the rate of growth of premiums for the standard health package would be completely effective. Such binding limits could, however, have unintended consequences for the health care system that would affect its overall acceptability and, hence, the sustainability of the limits.

This chapter explores these issues in more depth. The discussion is germane, however, not only to the Administration's proposal but also to any proposal that would involve a major restructuring of the health care system.

Institutional Capabilities and Resources

The organizational structure of the proposed system raises a basic question about its implementation: Would all the agencies involved have the capabilities, experience, and resources needed to undertake their assigned tasks in the time frame envisioned? Many of the critical tasks of setting up the system would be performed by the newly created National Health Board and by the regional alliances, which would be new and untried entities. State and federal agencies would also have major new roles.

The National Health Board would have considerable power and broad responsibilities for the functioning of the entire system, and a large, skilled professional staff would be essential. It would have many difficult tasks to perform--such as establishing a national program for managing the quality of care, developing a national information system for health care, establishing the initial target for the per capita premium for each regional alliance, determining the inflation factor for each regional alliance, estimating the market shares for each health plan in each regional alliance, developing risk-adjustment factors, and recommending modifications to the benefit package.

Moreover, those tasks frequently would have to be performed on extremely tight schedules dictated both by the effective start-up dates and the continuing needs of the proposed system. For example, the board would be required to establish a national program for quality management within one year of enactment and the information system within two years of enactment. On an ongoing basis, the board might have no more than a month in which to determine whether each regional alliance was in compliance with its target for the following year's premiums. After 1996, the board would also have to determine the annual inflation factor and the target for the per capita premium for each regional alliance by March 1 of the preceding year.

The regional alliances--as the frontline agencies responsible for orchestrating the flow of funds through the health care system--would have an even broader, and possibly more demanding, set of responsibilities. They would combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems, and coordinators of the flow of information and money between themselves and other alliances. They would also have to implement the controls on premiums under the direction of the National Health Board. Any one of these functions could be a major undertaking for an existing agency with some experience, let alone for a new agency that would have to perform them all. Some regional alliances might succeed very well; others might be overwhelmed by these tasks, especially in their early years of operation.

States would also vary in their capability to assume their new responsibilities. Among other

things, they would be asked to develop standards for and certify health plans, establish guaranty funds, and ensure continued coverage for enrollees who had been in health plans that failed. Consequently, the responsibilities of state insurance regulators would probably expand considerably. But the states vary widely in the legal authority of their insurance departments and in the resources that they now devote to the regulation of health insurance. Whether all states would be prepared to undertake all these activities on schedule is therefore uncertain.[1] The three-year phase-in period, however, would give states the opportunity to increase the capacity of their insurance departments before 1998, if they needed to do so.

States would also play important roles in helping the regional alliances to perform their functions. In particular, they would be required to ensure that alliances received the premiums they were owed and help them to determine eligibility for subsidies for premiums and cost-sharing amounts. Since states would be financially liable for error rates above certain limits when determining eligibility for subsidies, they would have strong incentives to assist alliances with that task. Again, however, it is not clear that they would have the needed resources. The proposal would allow states access to information on tax returns from the Internal Revenue Service to assist them in determining eligibility, but many of the people likely to be eligible for subsidies would not be tax filers.

Interstate cooperation would be essential in order for states to meet their responsibilities effectively. Cooperation would be especially important for handling the complications that could arise in metropolitan areas that crossed state boundaries. The proposal recognizes this issue and includes provisions that would permit states to coordinate the activities of two or more regional alliances--including alliances in different states--in such areas as operating rules, enforcement procedures, fee schedules, and contracting with health plans. Setting up these types of arrangements could be difficult but would be important for the effective functioning of some health care markets.

Similar questions of capacity and resources arise with respect to the Department of Health and Human Services (HHS) and the Department of Labor (DOL)--the two federal agencies that would have major responsibilities under the proposed system. Given the reduction in federal employment that is under way, would HHS have the necessary resources to oversee the financial management of regional alliances and to take over the operation of states' systems if they were seriously out of compliance? Would DOL have the capabilities to oversee corporate alliances and to ensure that employers fulfilled their responsibilities in paying premiums and withholding employees' shares? Presumably, the funding necessary to carry out those functions and develop those capacities would be provided through the normal appropriation process. But in a world of limits on discretionary spending, increased resources for those purposes would mean reductions elsewhere.

Information Requirements

The Administration's proposal would depend critically on timely information, much of which has never been collected. Its data requirements fall into three broad categories: those related to the establishment of the parameters of the system that would determine the payments to health plans, those related to managing the quality of care, and those essential for the day-to-day administration and operation of the alliances and health plans. Notwithstanding the ongoing and rapid development of information technology in the health care industry, it is uncertain whether the data essential for decisionmaking would be available in a timely fashion. If they were not or if important information was of poor quality, the functioning of the system could be compromised.

The proposal recognizes the magnitude of these requirements. The National Health Board would be charged with developing and implementing a national health care information system, which

1. See General Accounting Office, *Health Insurance: How Health Care Reform May Affect State Regulation,* Testimony of Leslie G. Aronovitz before the Subcommittee on Health, House Committee on Ways and Means, November 5, 1993, GAO/T-HRD-94-55.

would function through an electronic data network based in regional centers. The information system would provide data to meet multiple requirements in such areas as quality assurance, information for consumers and providers, cost containment, and planning and policy development. Establishing even the framework for such an information system within the two-year time period envisioned by the proposal would be a challenge.

Requirements for Establishing Payment Parameters

The National Health Board would need extensive state and local data to develop the adjustment and inflation factors that it would use to determine the target for the per capita premium of each regional alliance. The data required to establish an effective mechanism for adjusting premiums for risk would also be considerable.

The adjustment factors that would be used to establish the initial target for the per capita premium for each regional alliance are supposed to account for the variations in the health spending and insurance coverage of alliances as well as variations in the proportion of spending by academic health centers. Although data on per capita health expenditures would probably be available for states, whether that information would be available for regional alliances is uncertain. Moreover, reliable information on some of the proposed adjustment factors--such as the proportion of people whose insurance coverage was less generous than the standard benefit package--might not be available even for states.

Initially, calculating the inflation factors would require data on the relative changes in the demographic characteristics (age, sex, socioeconomic status, and health status) of the population of each regional alliance compared with those of the population as a whole. The sample sizes of existing national surveys (such as the Current Population Survey) are too small to produce reliable data of these types for all the regional alliances. Either the sample sizes of existing national surveys would have to be increased, or new regional and local surveys would have to be undertaken. Once the alliances were functioning, however, they would probably collect at least some of the demographic data as part of the enrollment process.

Under the proposed health care system, alliances would have to adjust the per capita payments to health plans to reflect the risk status of their enrollees. If that was not done or was not done well, plans that enrolled higher proportions of sicker or riskier individuals would be at a serious disadvantage competing in the new marketplace, and incentives would be strong for plans to engage in subtle forms of risk selection.

The proposal gives the National Health Board the responsibility for developing a methodology that alliances would use to adjust their per capita payments to health plans for risk. The feasibility of developing an effective risk-adjustment mechanism, however, is highly uncertain and depends on the answers to three questions.[2]

- Would it be possible to develop measures that could distinguish the high use of medical services that resulted because some enrollees were poor risks from the higher use that resulted because health plans were poorly managed?
- How precise would such measures have to be in order to keep risk-selection activities by health plans at minimal levels?
- If effective risk-adjustment measures could be developed, would the information needed to implement them be available to alliances and health plans?

The Administration's proposal recognizes the difficulties that could be encountered. For example, the board would be required to establish by April 1995 a method for adjusting payments to health plans prospectively to reflect the risk status of their enrollees, but the proposal contains an alternative should that task prove to be impossible. Specifi-

2. See, for example, Joseph P. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs*, vol. 13, no. 1 (forthcoming); and Testimony of Harold S. Luft, Acting Director, Institute for Health Policy Studies, University of California at San Francisco, before the Subcommittee on Health, House Committee on Ways and Means, November 9, 1993.

cally, the board could develop a mandatory reinsurance system for health plans that would remain in effect until a prospective risk-adjustment system was in place.

Requirements for Managing the Quality of Care

The National Health Board would be required to develop a program for managing the quality of care under the direction of a newly created National Quality Management Council. The council would develop national measures of performance relating to the provision of and access to health care services, the criteria for which the proposal specifies in considerable detail. The council would also conduct surveys on access to health care, use of health services, health outcomes, and patients' satisfaction. It would be responsible for providing an annual report to the Congress on the performance of each alliance and health plan and on trends in the quality of health care.

A fundamental precept of the Administration's proposal--one that is shared broadly by health policy experts--is that information on the performance of health plans and providers should be publicly available and in a standardized form that helps consumers to make informed choices. Accordingly, regional and corporate alliances would be required to provide annual reports on each health plan's performance using the standardized measures, including information about individual providers on some of the measures. Those reports would also include results of surveys of consumers on access, outcomes, and satisfaction.

The specifications in the proposal clearly indicate that tracking quality and performance would be a major undertaking for providers, health plans, alliances, and the board, and would greatly expand current reporting requirements. In addition, an inherent tension would exist between the consumers' need for information on which to base their choices and the demands that would be placed on plans and providers to report the required data.

Requirements for Administration and Operations

In order to carry out their basic functions, health alliances would need extensive management information systems and access to national information networks. They would also need the capabilities to conduct surveys and data analyses, or be able to contract for these services. One has only to review the functions that alliances would have to perform to realize that they would require collecting, maintaining, and updating large amounts of information on individuals, employers, and health plans. Examples include:

- Tracking enrollment and disenrollment in different health plans according to the risk characteristics of enrollees and whether they were receiving Aid to Families with Dependent Children or Supplemental Security Income;
- Determining the eligibility of employers and families for premium subsidies;
- Determining eligibility for reductions in cost-sharing amounts;
- Tracking the amounts of cost-sharing payments for low-income people enrolled in high-cost-sharing plans;
- Monitoring the premium amounts owed by families, taking into account their hours of qualified employment and any changes in their type of family that occurred during the year;
- Monitoring the premium amounts owed by employers; and
- Tracking individuals who were eligible to enroll in the regional alliance--such as students or members of two-worker families--but who enrolled in another alliance, and making appropriate payments to those other alliances on their behalf.

The complexity of tracking the flow of people and dollars across alliances' boundaries highlights

the need for some type of national information system. Determining how much families would owe for their health insurance if they moved between alliances during the year would be particularly difficult. According to the proposal, the regional alliance in which a family was enrolled in December (termed the "final" alliance) would be responsible for collecting any amounts owed by the family, regardless of whether the family had lived in the alliance area for the entire year. All the other alliances in which the family had lived would be required to provide the final alliance with the information necessary to determine the family's total liability. Once the final alliance had collected the amount owed, it would have to distribute it equitably to all the alliances involved. Without an automated tracking system, that would be a monumental undertaking.

In addition to collecting and monitoring financial information on individuals and families, regional alliances would have to estimate the demographic characteristics of their eligible populations, including the number of families of each type, the number of extra workers in couples and two-parent families, the proportion of people enrolled in AFDC and SSI, and the number of people in different risk categories. They would also be responsible for estimating the distribution of enrollment across health plans, as well as the total amount of premiums that employers and families should pay and the expected shortfall in premium payments. Those estimates would be of critical importance to the alliance because they would affect the amounts owed by employers and families, the payments made to health plans, and the amount paid by the federal government for subsidies.

The Effects and Sustainability of Controls on the Rate of Growth of Premiums

Under the proposal, the rate of growth of premiums for the standard benefit package would be severely constrained for the 1996-2000 period, after which the rate of increase would be determined by the Congress or, if it failed to act, by a default procedure tied to real per capita economic growth and inflation in consumer prices.

Limiting the rate of growth of premiums would undoubtedly slow the growth of health spending. Thus, even though the proposal would provide universal health insurance coverage and include several new federal program initiatives, CBO estimates that national health expenditures would increase by 94 percent between 1995 and 2004, compared with a projected increase of 108 percent under the CBO baseline. That represents a reduction of $150 billion in 2004. The projected slower growth of spending would occur because of the restraints on premiums, reductions in the Medicare program, and other features of the proposal.

In preparing its cost analysis, the Congressional Budget Office has assumed that the controls on premiums in the Administration's proposal would be implemented as intended and that the mechanisms used to enforce those limits would effectively restrain spending on the services included in the standard benefit package. But what would be the consequences of that restraint, and could it be sustained?

Some experts believe that the targets for premiums could be largely met by increasing the efficiency of the health care system. According to this view, the system has plenty of "fat"--in the form of excess administrative costs and unnecessary use of services--that would be squeezed out by constraining the growth of premiums. Reductions in administrative costs might be achieved by such measures as standardizing claim forms and developing electronic information systems. The unnecessary use of services might be reduced by increasing enrollment in managed care plans and promoting clinically effective methods of treatment.

By contrast, others maintain that even if efficiency improved greatly, achieving the premium targets exclusively by those means would be extremely difficult and that tight constraints could have undesirable effects on the health care system and might prove to be politically untenable. Possible consequences might include reductions in payments to providers and less access to appropriate services for some consumers. The latter might take

the form of longer waiting times for nonemergency services--including visits to physicians, diagnostic tests, and elective surgeries--and reduced access to new high-cost medical technologies if health plans became more selective about the technologies they adopted. As a corollary, research and development in medical technology might slow, and its focus might shift.

At a general level, both views have merits and limitations. Opportunities undoubtedly exist for lowering administrative costs and reducing inappropriate use of services in the health care system, but trimming unnecessary spending might be difficult without increasing spending elsewhere. For example, although the proposal would streamline many aspects of the administration of health services, it also contains provisions that would entail new administrative costs, such as additional reporting requirements for health plans. Increasing enrollment in tightly managed health care plans--such as group- or staff-model health maintenance organizations--might indeed reduce health spending initially but might have little effect on the rate of growth of spending in the longer run. In addition, some of the methods for reducing the unnecessary use of services--such as promoting effective treatments through the use of guidelines for clinical practice--could also result in increasing the appropriate use of services. Although the effects of the use of guidelines on health spending are uncertain, shifting health care resources from less appropriate to more appropriate uses would almost certainly improve the overall quality of health care.

Whether adverse consequences would result under a constrained system is also uncertain. Lower payments to providers and longer waiting times for some services would not necessarily have negative effects on health outcomes, although providers and some consumers would probably be less satisfied. Furthermore, shifting the focus of research on medical technology could yield positive benefits if manufacturers concentrated more on developing lower-cost substitutes for existing technologies and took the likely effects on costs into account when planning new research initiatives.

Ultimately, however, the effects of constraining the rate of growth of premiums would probably play out more at the alliance than the national level. The new system could encompass perhaps 100 to 200 different regional alliances or markets, each facing a target for its per capita premium. The restrictions on premiums might be more constraining in some markets than in others, because the existing degree of competition in those markets and the extent to which health plans and providers have already achieved greater efficiencies vary widely. The limits, therefore, might be much harder to meet in some areas than in others. Furthermore, the effects of the constraints on spending in any particular market would depend on the interrelated behavioral responses of health plans, employers, providers, and consumers in that market to the new incentives in the health care system.

In short, the full effects of limiting the rate of growth of premiums would be highly uncertain. In part, that uncertainty would arise because the restraint on premium growth would occur in a restructured health care system, operating under new incentives and with insurers and health plans facing new forms of restrictions as well as new opportunities. Uncertainty would also stem from the heterogeneity of the regional alliance markets and the probable variation in the ways their health care systems would adapt to restraints on spending.

The fact that limits on the rate of growth of premiums might begin to bite at different times and in different ways in each of the various alliances raises the issue of the political sustainability of those limits: Would the public and policymakers view them as an acceptable way to restrain health care spending? The situation would be particularly difficult because of the wide variation that currently exists in health spending across the country--at least some of which reflects differences in patterns of medical practice and competitive pressures in the marketplace.

On the one hand, to the extent that historical spending is used as the basis for determining the initial level of premiums in regional alliances, limits on the rate of growth of premiums will build in the inequalities in current spending. Some analysts argue that such an approach would be unfair to regions in which the health care system has already become "leaner" and more efficient, since those

regions would have a harder time meeting the growth targets (because they have less "fat" to trim). On the other hand, ignoring historical spending levels and instead establishing initial premium or spending levels according to some objective criteria reflecting need and differences in input prices could cause major disruptions within the health care system in some regions that currently have high rates of use.

The Administration's proposal has recognized both aspects of the problem. The National Health Board would attempt to adjust the regional alliances' targets for premiums to reflect current differences in health spending and insurance coverage. Although this approach would build on historical spending patterns, it would be modified by including the adjustment for insurance coverage. In other words, current spending patterns would be adjusted to account for low spending in an area that may reflect the population's lack of insurance coverage.

The per capita amounts for Medicaid, as well as states' maintenance-of-effort payments for current Medicaid beneficiaries who would no longer be eligible for the program, would also be based on historical spending. In the case of Medicaid, historical differences in per capita spending among regions may reflect differences in covered benefits and in reimbursement rates for providers, as well as variations in access to and use of services.

Under the proposal, the board would be required, by July 1995, to make recommendations to the Congress on:

- Eliminating, by 2002, the variation in regional alliances' targets for per capita premiums that resulted from variations in practice patterns; and

- Reducing, by 2002, the variation in the payments that states would make for beneficiaries receiving cash assistance and for maintenance of effort that resulted from differences in practice patterns, historical differences in the rates of reimbursement to providers, and the amount, duration, and scope of benefits covered by Medicaid.

The Congress would be required to conduct an expedited review of the board's recommendations, which would go into effect unless a joint resolution of disapproval was passed within 60 days. The board's recommendations would be of extreme interest to policymakers because they might have the effect of raising the allowed premium levels in some areas and lowering them in others. The board might also recommend that some states pay more than in the past for Medicaid beneficiaries and maintenance of effort and that others pay less.

CBO's analysis has assumed that the limits on the rate of growth of premiums would be sustained even though they are likely to create immense pressure and considerable tension. Such strains, however, would not be peculiar to the Administration's approach. Other methods of restraining the rapid growth of health care spending would be likely to generate similar stresses.

Conclusion

Fundamental reform of the nation's health care system will inevitably involve many uncertainties. New institutions will be required, and new responsibilities will be imposed on existing institutions. Their abilities to perform will be in doubt. The behavior of providers and consumers will change as incentives are altered. The magnitude and even the direction of these changes are difficult to foresee.

The ramifications and consequences of even incremental approaches to reform are not easy to predict. The complexity of the existing system and the intense interest all Americans have in health care issues make it difficult to anticipate the outcome of even modest changes in existing programs. For example, most policymakers badly misjudged the political response to the Medicare Catastrophic Care Act, and analysts seriously underestimated the fiscal consequences of recent changes in the Medicaid program.

As the Congress considers the Administration's proposal and other alternatives for systemic and incremental reform, the inherent uncertainties of change must be weighed against the detrimental consequences that flow from the current system--increasing numbers of people who lack the security of insurance coverage for health care and the rapidly rising costs of that care.

Appendix

Summaries of Recent Health Care Analyses by the Congressional Budget Office

The Congressional Budget Office (CBO) publications listed below are available to Congressional staff and the general public. To obtain copies, call CBO's Publications Office at (202) 226-2809.

Evaluating the Costs of Expanding the CHAMPUS Reform Initiative into Washington and Oregon (CBO Paper, November 1993, 46 pp.)

In 1988, the Department of Defense (DoD) began the CHAMPUS Reform Initiative (CRI) as a test of managed care in the military. In August 1993, DoD proposed extending a revised version of CRI to Washington and Oregon, certifying to the Congress that CRI would be the most efficient method of providing health care to the two states. As required by law, this paper reviews DoD's analysis. CBO's findings suggest that the revised CRI benefit is likely to cost more than DoD has estimated.

Behavioral Assumptions for Estimating the Effects of Health Care Proposals (CBO Memorandum, November 1993, 37 pp.)

To estimate the effects of proposals to change the health care system, CBO must make assumptions about the behavioral responses that might occur as a result of new policies. This memorandum draws on the best available research to develop a set of guidelines on which to base CBO's estimates. These guidelines will be revised as new evidence appears.

Projections of National Health Expenditures: 1993 Update (CBO Memorandum, October 1993, 22 pp.)

This memorandum provides projections of national health expenditures through 2003. It updates the tables and figures in CBO's study *Projections of National Health Expenditures* (October 1992) based on the methods described in that study and consistent with CBO's September 1993 economic assumptions and baseline budget projections.

Controlling the Rate of Growth of Private Health Insurance Premiums (CBO Memorandum, September 1993, 27 pp.)

This memorandum analyzes two illustrative policy options that are intended to highlight some of the key issues surrounding the regulation of health insurance premiums. The first option is a "stand-alone" measure to limit the rate of increase in private health insurance premiums. The second option incorporates additional policy measures that could mitigate some of the potential adverse effects of a stand-alone policy. (The two options are not based on any specific legislative proposal.)

Estimates of Health Care Proposals from the 102nd Congress (CBO Paper, July 1993, 57 pp.)

The 103rd Congress will be considering a wide range of proposals to expand access to health care and control costs while maintaining quality, and

CBO will have to estimate the effects of these proposals on the federal budget. This paper illustrates CBO's approach to preparing such estimates by examining four health reform bills introduced during the 102nd Congress: H.R. 1300, sponsored by Congressman Russo, establishing a single-payer system; H.R. 5502, sponsored by Congressmen Stark and Gephardt, expanding Medicaid and Medicare and setting overall limits on national health expenditures; H.R. 5919, introduced by the House Republican leadership, embodying much of President Bush's health reform program; and H.R. 5936, introduced by Congressman Cooper and other members of the Conservative Democratic Forum, establishing regional purchasing cooperatives for health insurance and a federal program to subsidize the purchase of private insurance by low-income people.

Trends in Health Spending: An Update (CBO Study, June 1993, 91 pp.)

Since the early 1960s, national health expenditures have risen rapidly despite many attempts to control their growth. This study examines trends in the market for health services since 1960 to provide background information and a context for assessing proposals to change the U.S. health care system. The report focuses on increases in the costs of hospital services, physician services, and drugs and other medical nondurable items. It also compares trends in health spending by the nation with trends in Medicare spending.

Managed Competition and Its Potential to Reduce Health Spending (CBO Study, May 1993, 58 pp.)

This study looks at whether managed competition could constrain spending on health care by motivating consumers, insurers, and providers to be more cost-conscious. The report identifies eight features that are critical for achieving the full savings that managed competition could potentially deliver, including health insurance purchasing cooperatives, caps on contributions by employers, and standardized benefits.

Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals "Cost Shift"? (CBO Paper, May 1993, 45 pp.)

During the 1980s, the revenues that hospitals received for treating Medicare and Medicaid patients declined, on average, relative to what it cost hospitals to treat those patients. CBO looks at the extent to which hospitals were able to cover their costs of uncompensated care and their unreimbursed costs of treating Medicare and Medicaid patients during the 1980s with subsidies from state and local governments; sources other than patient care, such as revenues from hospitals' parking facilities and donations; and revenues from private patients.

Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates (CBO Memorandum, April 1993, 60 pp.)

The United States is a leader in medical research and has the ability to deliver health care of the highest quality, but critics find fault with two aspects of the system: a substantial number of people lack health insurance coverage, and health care costs are high compared with countries where coverage is universal. CBO examines two approaches by which both universal health insurance coverage and greater control over health care costs might be achieved. The first approach is a single-payer system in which all covered health care services are insured and paid for by a single insurer, and the second is an all-payer system in which services are covered and paid for by multiple insurers but all payers adopt the same payment methods and rates.

Projections of National Health Expenditures (CBO Study, October 1992, 70 pp.)

The rapid growth of spending on health care will not decrease in the 1990s unless the present health care financing and delivery system is changed. This CBO study reviews the growth in national health spending since 1965, describes CBO's methodology for projecting national health expenditures, and ana-

lyzes trends in spending by type of spending and source of funds.

Economic Implications of Rising Health Care Costs (CBO Study, October 1992, 70 pp.)

This study, a companion to the one above, analyzes how rising health care costs significantly affect the economy by squeezing household and government budgets, distorting the labor market, and diverting resources from other priorities. Because the current health delivery system lacks a mechanism to match benefits with costs, spending on health may not reflect the preferences of either consumers or society. Instead, many factors--detailed in this study--seem to encourage excessive health spending. CBO finds that workers have borne most of the costs of employer-provided insurance in the form of lower real wages and reduced nonmedical benefits. Over the 1973-1989 period, these health costs have gobbled up more than half of the real gains in workers' compensation.

The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures (CBO Memorandum, August 1992, 31 pp.)

This memorandum looks at what might happen to national health expenditures and to spending under Medicare, Medicaid, and private health insurance if all acute care services now funded through insurance arrangements were provided through delivery systems incorporating two specific forms of managed care. One is staff-model and group-model health maintenance organizations. The other is "effective" forms of utilization review, which CBO interprets to mean utilization review that incorporates precertification and concurrent review of inpatient care.

The Potential of Direct Expenditure Limits to Control Health Care Spending (CBO Memorandum, July 1992, 17 pp.)

This memorandum describes various approaches to using expenditure limits to control health spending and identifies some of the operational issues that would be involved.

The Effects of Managed Care on Use and Costs of Health Services (CBO Memorandum, June 1992, 32 pp.)

This memorandum assesses the evidence about the effect of managed care organizations and interventions on the use and costs of health services--both for the affected populations and for the entire health care system--focusing on managed care for acute care services.

Selected Options for Expanding Health Insurance Coverage (CBO Study, July 1991, 100 pp.)

About one in seven Americans lacks health insurance. This study explores three options to expand health insurance coverage for the uninsured: mandating job-based coverage, expanding the Medicaid program, and combining the two. Each of these options could substantially reduce the ranks of the uninsured and keep most existing insurance arrangements intact, the study finds, but spending on health care could rise considerably.

Rising Health Care Costs: Causes, Implications, and Strategies (CBO Study, April 1991, 110 pp.)

This study describes the economic factors that contribute to the growth in health spending and examines what is known about the effectiveness of different strategies for achieving greater control over costs. The five strategies examined by the study are cost sharing by consumers; managed care that limits the freedom of health care providers and consumers; price controls; efforts to increase competition among insurers and providers; and regulation of the market for health services, including controls on capital and uniform payment systems that encompass all payers.

Updated Estimates of Medicare's Catastrophic Drug Insurance Program (CBO Study, October 1989, 73 pp.)

This study estimates the cost to Medicare of covering outpatient prescription drugs as required by the Medicare Catastrophic Coverage Act of 1988. The methodology described in this report remains applicable to estimates of proposals to provide a prescription drug benefit under Medicare.

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