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NOTES

Unless otherwise indicated, all years referred to are fiscal years.

Numbers in the text and tables of this paper may not add to totals because of rounding.

PREFACE

This paper summarizes the methodology that the Congressional Budget Office (CBO) will use to estimate the effects of proposals to change the financing and delivery of health care. It does so by providing estimates for four major health reform bills that were introduced in the 102nd Congress. CBO has received many Congressional requests for estimates of the cost of these bills. The paper examines the effect of each bill on federal spending and receipts, the extent of health insurance coverage, and the amount of national health expenditures.

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CHAPTER I

INTRODUCTION AND SUMMARY

Reforming health care is currently high on the public policy agenda, in large part because of the continued rapid growth in national health expenditures. Health spending absorbed 14.0 percent of gross domestic product (GDP) in 1992, up from 5.9 percent in 1965. Deficit reduction, another focus of public policy, is also closely linked to health reform because the projected rise in federal health costs is the major reason for pessimism regarding the long-term budgetary outlook. The Congressional Budget Office (CBO) projects that, if current trends and policies continue, the federal deficit will climb to $456 billion, or 5.3 percent of GDP, by 2000. By contrast, if federal spending for the major health entitlements could be held to its current share of GDP, the deficit in 2000 would be half as large.

Another goal of health care reform is to extend health insurance coverage to many or all of the 35 million Americans who are now uninsured. Increasing coverage, however, will place further demands on the federal Treasury and exacerbate the difficulties of controlling costs. Greater control over health care spending is also likely to require significant changes in the health care system--changes that may limit desirable features such as freedom of choice of insurance plans and providers, rapid access to new technologies and treatments, and high levels of research and development.

The 103rd Congress will be considering a wide range of proposals that aim to expand access to health care and control costs, while maintaining quality. These proposals will be judged, in large part, by their estimated effects on the federal budget, the number of people with health insurance, and the total amount that the nation spends on health. This paper illustrates CBO's approach to preparing such estimates. It does so by examining four health reform bills introduced during the 102nd Congress:

- H.R. 1300, sponsored by Congressman Russo. The bill would establish a universal single-payer health insurance plan, modeled after the Canadian system, and limit spending through a national health budget.

- H.R. 5502, sponsored by Congressmen Stark and Gephardt, as ordered reported by the Subcommittee on Health of the House Committee on Ways and Means. Among other changes, the bill

would substantially expand Medicaid and Medicare benefits and establish overall limits on national health expenditures.

- H.R. 5919, introduced by the House Republican leadership and embodying much of President Bush's health reform program. The bill would make health insurance premiums for the self-employed tax deductible, regulate employment-based health insurance, promote the electronic transmission of health data, and reform the system of liability for medical malpractice.

- H.R. 5936, the Managed Competition Act of 1992, introduced by Congressman Cooper and other members of the Conservative Democratic Forum (CDF). The CDF bill would restructure the health insurance market by establishing regional health plan purchasing cooperatives and would create a federal program to subsidize the purchase of private insurance by low-income people.

These bills encompass a wide range of proposals--from the incremental to the comprehensive. Even the simplest one poses challenges to the estimator. Estimating the costs of these bills requires analysts to address most of the issues involved in estimating any health insurance legislation that is likely to be considered by the Congress. In fact, modified versions of these bills have been or are likely to be introduced in the 103rd Congress.

Each of these four bills aims to make health insurance coverage more widely available and reduce the rate of growth of spending for health. Some of the bills would make massive changes to the current system for financing and delivering health care. Estimates of the effects of such sweeping changes on overall health care spending, and its components, will necessarily be much less precise than estimates of incremental changes to existing federal programs.

Nonetheless, estimates of the effects of different approaches to health reform provide useful comparative information on the relative costliness of, or the potential savings to be gained from, alternative proposals. The estimates in this paper, although surrounded by considerable uncertainty, have been prepared on a consistent basis. This paper summarizes the underlying models and assumptions.

CBO has reviewed the extensive literature on health insurance, has prepared numerous papers and memorandums, and has assembled several panels of experts to evaluate its methodology. The assumptions used in this paper are considered to be reasonable by a wide range of health analysts. The

methodology and assumptions will be updated, however, as new information comes to light and in response to comments and suggestions that are received.

This introduction provides an overview of the major issues involved in estimating the effects of proposals to reform the financing and delivery of health care. First, it reviews issues involved in expanding access to health insurance and health care. Second, it examines the potential effects of provisions to control the growth of health care costs. Finally, it compares the effects of the four bills along three dimensions: the federal budget, the extent of health insurance coverage, and national health expenditures. Subsequent chapters provide detailed estimates for each of the bills.

ISSUES IN EXPANDING ACCESS TO HEALTH INSURANCE AND HEALTH CARE

Some of the bills under consideration aim to increase health insurance coverage by subsidizing the purchase of private health insurance or taking other measures to reduce its price. In estimating the costs and impacts of such bills, a critical assumption is the extent to which the purchase of insurance would rise with a fall in its price. Other bills would place more emphasis on expanding the coverage of public health insurance programs. In either case, the expansion of health insurance coverage would increase the demand for medical care by those who were previously uninsured. Changes in the scope of insurance or in cost-sharing arrangements would also affect the demand for care.

Demand for Health Insurance

The lower the effective price of health insurance, the more health insurance a consumer will purchase. Economic analysis argues that, in the long run, workers bear the full cost of employer-provided health insurance through lower cash compensation and other fringe benefits. This analysis is detailed in the CBO study *Economic Implications of Rising Health Care Costs* (October 1992). For estimating purposes, CBO assumes that an increase or decrease in employer spending for health insurance would be almost entirely offset by a decrease or increase in wages. Unlike wages, however, employer-provided health insurance is not subject to income or payroll taxation. Because of this tax advantage, the effective price of insurance for a person with employment-based coverage--in terms of forgone after-tax wages--is reduced by the employer's share of the premium times the employee's marginal income and payroll tax rate.

Many studies have attempted to measure the extent to which the purchase of insurance varies with its effective price. Based on a review of the literature available in early 1993, the estimates in this paper assume that a 10 percent decrease in the price of health insurance would, in the short run, lead to a 2 percent increase in the amount of health insurance purchased. In the jargon of economists, this represents a short-run elasticity of demand of -0.2. Over the longer run, the elasticity of demand could be as high as -0.6. A forthcoming CBO paper, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals," will describe CBO's estimating assumptions in more detail.

The amount of health insurance that people purchase can be viewed as the result of two separate decisions: whether to buy any health insurance at all and, if so, how much to buy. Similarly, in the case of employer-provided health insurance, the employer's decision to offer insurance can be distinguished from the employee's response to the offer. Little reliable information is available, however, about the effects of price changes on an individual's decision to purchase insurance or a firm's decision to offer it. For the present, CBO uses the same elasticities to estimate how much more or less coverage would be purchased and what proportion of a given group would obtain or give up insurance coverage in response to a change in its effective price. Changes in price might arise, for example, from increasing or limiting the tax deductibility of insurance (a feature of several bills), directly subsidizing its purchase (as in H.R. 5936), or reducing administrative costs.

For this paper, the estimated number of people falling in a given economic or demographic group is based on data from the 1991 Current Population Survey (CPS), conducted by the Bureau of the Census. For bills introduced during 1993, CBO's cost estimates will use the 1992 CPS.

Demand for Medical Care

People tend to use more medical care if they have insurance than if they lack insurance. Reductions in deductibles, coinsurance rates, or other forms of copayments also increase the demand for care. CBO's analyses and assumptions about the size of these effects are discussed in "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates" (April 1993) and "Behavioral Assumptions for Estimating the Effects of Health Care Proposals" (forthcoming).

CBO's estimates of the effect of extending insurance coverage on the demand for medical care are derived by comparing the use of medical services

for otherwise similar demographic groups who differ only in whether they had insurance during the year or not. The comparison uses data from the 1987 National Medical Expenditure Survey, conducted by the Department of Health and Human Services. The insured are defined as those under age 65 who were covered by an employment-based plan for the entire year and who had no public insurance benefits. Similarly, the uninsured are those under 65 who were without public or private insurance for the entire year. The results of this analysis suggest that, on average, the amount of services used by the uninsured would increase by 57 percent if they were covered by a typical employment-based plan and received no additional public benefits. The percentage increase in use would be greater for physician services than for hospital services.

CBO's estimates of the effects of changes in copayment requirements derive from the RAND health insurance experiment, which ran from 1974 to 1981. The experiment compared plans involving coinsurance rates of zero, 25 percent, 50 percent, and 95 percent. Copayment costs were capped at $1,000 per year or less, depending on a family's income. On average, the experiment found that covered medical expenditures were 23 percent higher with no coinsurance than with coinsurance of 25 percent. These estimates assume that, in total, covering uninsured people under a health insurance plan with nominal coinsurance would increase their use of health care service by 80 percent.

Reforms of the Insurance Market

Several bills would regulate the market for health insurance in ways designed to make insurance more widely available. Proposals in this category include assuring that no group or individual could be denied insurance (termed open enrollment), guaranteeing renewal of existing policies, prohibiting exclusion of preexisting health conditions, and requiring that an insurer charge all purchasers the same rates regardless of health status (community rating).

Such reforms would reduce the price of insurance for some individuals or groups but would increase the price of insurance for others. CBO therefore estimates that the reforms, by themselves, are likely to have little effect on the extent of private health insurance coverage, although the mix of people covered would shift toward higher-risk individuals. Some firms employing above-average risks would be encouraged to purchase insurance, but some firms with below-average risks might drop coverage. Private health expenditures would increase modestly because the newly insured high-risk people would demand additional health care.

Many large firms that provide health benefits to their employees do not purchase health insurance from an outside carrier. Instead, the firms themselves bear the risk of paying for their employees' health expenses. These firms (called self-insured firms) employ about one-third of full-time employees with health care coverage. Excluding self-insured firms from any proposed reforms in the market for health insurance would diminish the effectiveness of those reforms. If self-insured firms were not included in a community rating plan, for example, they would continue to have an incentive to employ people with expected health costs that are below average.

Increases in Payment Rates

Some proposals aim to increase the access to health care for beneficiaries of Medicaid--the federal/state program of medical assistance to low-income people--by increasing the program's payment rates. At present, according to CBO's extrapolation of data from the Physician Payment Review Commission, Medicaid reimburses physicians at only about 65 percent of the rates in Medicare. As a result, it is argued, many physicians are unwilling to accept Medicaid beneficiaries as patients. According to data from the Prospective Payment Assessment Commission, however, the difference in payment rates for hospitals between Medicaid and Medicare is small.

ISSUES IN CONTROLLING HEALTH CARE COSTS

Several proposals are aimed primarily at controlling the costs of health care and health insurance. To the extent that any of these proposals succeeded in limiting the growth of costs, they would also increase access to health care by constraining the rise in insurance premiums and reducing out-of-pocket costs. Proposals in this category include achieving administrative savings through using common claims forms and expanding the electronic processing of claims, reforming laws governing medical malpractice, encouraging greater use of managed care, instituting a system of managed competition, and imposing price controls or global budgets on spending for health care.

Administrative Savings

Several bills attempt to reduce the administrative costs of health insurance by requiring electronic processing of claims; establishing a clearinghouse for processing claims; or standardizing insurance claims forms, electronic medical data, and procedures for reviewing utilization and reporting costs.

The CBO staff memorandum "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates" (April 1993) reviews the administrative savings that might ultimately be achieved under several alternative systems of health insurance. The greatest reduction in administrative costs could be achieved by a Canadian-style single-payer system, in which hospitals would be funded by global budgets, one insurer would pay other providers using a standard set of fees, and no copayments would be required of patients. Requiring copayments would reduce the use of health care services, but would also reduce the administrative savings because providers would have to bill the insurer or patient. Requiring providers to deal with the current number of insurers would erode the savings still further, even with uniform rates for all insurers (termed an all-payer system).

Except for H.R. 1300, the bills discussed in this paper do not go as far in standardizing administrative practices as does an all-payer system, because they would not establish uniform payment and copayment rates. In addition, the estimates in this paper attempt to reflect transition costs as well as potential savings. Although administrative costs could be reduced in a fully implemented system, it might be necessary to increase administrative costs in the short run to achieve savings later.

These bills also do not assure that the number of insurance claims handled electronically would rise above the baseline estimates. Both the Medicare and Medicaid programs are encouraging electronic claims processing, and the percentage of claims handled electronically is growing from year to year. Standardized claims forms are also being encouraged in the private sector. The American National Standards Institute recently approved a standard health insurance form that health insurance companies are expected to use.

Finally, many of the bills would impose additional requirements on insurers or health care providers or create additional administrative agencies. As a result, CBO estimates that incremental changes in administrative practices would not reduce either insurers' or providers' administrative costs. The single-payer plan established by H.R. 1300 would reduce administrative costs substantially, however, and the health plan purchasing cooperatives created by H.R. 5936 would reap some economies of scale in providing insurance to individuals and small groups.

Malpractice Reform

According to the available evidence, changes in the medical malpractice liability system could affect both total spending for malpractice premiums and the distribution of those premiums, but the impact on national health expenditures would be small. Malpractice premiums paid by all providers in 1990 totaled about $8 billion, or 1 percent of national health expenditures. Moreover, the development of practice guidelines and other efforts to standardize malpractice awards could result in more compensation for certain types or cases of malpractice as well as less compensation for others.

The existing evidence on the prevalence and costs of defensive medicine suggests that the potential to achieve savings is limited in this area, too. If the malpractice system were changed, much of the care that is perceived as defensive medicine would probably still be provided for other reasons, such as reducing diagnostic uncertainty. Therefore, the estimates in this paper assume no reduction in national health expenditures as a result of the proposed reforms in malpractice insurance.

Managed Care

Managed care comprises any type of intervention in the delivery and financing of health care that is intended to eliminate unnecessary and inappropriate care and thereby to reduce costs. Forms of managed care include several kinds of health maintenance organizations (HMOs), numerous forms of utilization review, and various arrangements that are based on specified networks of providers.

Fully integrated HMOs with their own delivery systems are the forms of managed care for which demonstrated cost savings are the greatest. CBO has estimated that staff- and group-model HMOs reduce personal health expenditures by 15 percent from their levels under traditional private health insurance with typical coinsurance. Some recent studies suggest that other types of HMOs, such as independent practice associations, may also reduce health care costs, but the evidence is less conclusive. There is little evidence, however, that even effective HMOs have succeeded in reducing the rate of growth of health spending.

The estimates in this paper assume that enrolling additional people in all types of HMOs will, on average, reduce their use of health care services by 7½ percent. Using an average figure allows the estimates to be consistent with a range of assumptions about the growth in various types of managed care

arrangements and the amount of savings associated with each one. More information on managed care may be found in a CBO staff memorandum, "The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures" (August 1992).

Managed Competition

Managed competition is the central feature of proposals to restructure the health care market in ways that would create incentives for consumers to be more cost-conscious in their decisions about insurance and health care. Increased cost-consciousness by consumers would give insurers and providers, in turn, the incentives to become more cost-conscious and efficient.

Many different proposals have been put forth under the "managed competition" umbrella. Some proposals of this kind could reduce health care costs, and others would have little effect. A recent CBO study, *Managed Competition and Its Potential for Reducing Health Expenditures* (May 1993), identifies features that would help maximize the savings in national health expenditures under that approach. These elements include:

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

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

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

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

- Universal insurance coverage arranged through the HIPCs;

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

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

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

Omitting some of these elements from a proposal for managed competition would significantly lessen its potential effectiveness. Moreover, even if a managed competition plan contained all these critical elements, the effects of restructuring the market for health insurance would occur over an extended period of time.

In the short run, however, managed competition could achieve savings in two ways. First, greater cost-consciousness could cause people to shift from fee-for-service medicine into health maintenance organizations. Second, limiting the tax-exempt amount of employee health benefits would encourage workers to choose insurance with more limited coverage and higher cost sharing, which would also tend to reduce their health expenditures.

CBO's estimate of the number of people who would join HMOs under a managed competition plan draws on the experience of California and Wisconsin--states whose health insurance programs for public employees bear some similarities to managed competition. These states offer each employee a choice of health insurance plans but pay only a fixed amount for coverage. If the employee wishes to choose a relatively expensive plan, the extra cost must be paid entirely out of the employee's own pocket. Choosing an indemnity insurance plan can cost an employee with a family an extra $200 or so a month. Not surprisingly, 74 percent of employees covered by the California plan and over 85 percent of Wisconsin's employees are enrolled in health maintenance organizations. Based on this experience, this paper assumes that, under the managed competition plan in H.R. 5936, three-quarters of the nonpoor urban population would ultimately choose HMOs.

Price Controls

Price controls could reduce both the level and the rate of growth of health care spending, but their impact would be partially offset because evidence suggests that providers would increase the volume of services or change billing practices to recover lost revenues. In addition, price controls that applied to only one segment of the market would generally result in higher spending in other segments of the market.

For example, if the prices of physician services under the Medicare program were reduced 10 percent, Medicare's spending for these services would drop 5 percent. This estimate reflects the assumption that physicians would offset about half of their potential revenue loss through increased Medicare volume. If providers attempted to keep their overall revenues constant, spending on physician services by the non-Medicare population could also rise, especially if physicians were able to raise fees outside Medicare. As a result, although Medicare's spending for physician services would decline 5 percent, that reduction might not significantly affect the level of national health spending.

For hospitals that would lose revenues from a change in Medicare, CBO's usual estimating assumption is that about 10 percent of the revenue loss would be offset by changes in billing practices. The estimates also assume that the volume of physician or hospital services does not decline in response to policy changes that increase revenues.

Limits on Expenditures

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

CBO's approach to estimating the potential impact of limits on expenditures in legislative proposals is to examine the proposal with respect to both the stringency of the limits and the specified enforcement mechanisms. Based on its best judgment, CBO then assigns a rating for effectiveness, with a fully effective limit receiving a 100 percent rating and a completely ineffective proposal receiving a rating of zero. Because the choice of an effectiveness rating is difficult and imprecise, the intermediate ratings used in this paper are limited to 75 percent, 50 percent, and 25 percent. The estimated savings for any expenditure limit equals the difference between the limit and the projected costs of the system without the limit, multiplied by the effectiveness rating.

Based on its assessment of the evidence of the effectiveness of limits on expenditures as they have been applied in the United States and in other countries, CBO believes that the likelihood of success increases with uniform payment levels and centralized claims processing, restrictions on the ability to purchase health care outside the regulated system, and global budgeting for

hospitals and other institutions. In addition, a continuously adjusting mechanism for paying physicians, as has been used in Germany and in some Canadian provinces, and budgeting or rate setting that applies to all providers and services would be most effective in enforcing the limits. A good data system with uniform reporting by all providers to allow quick feedback would also be an important component of an effective strategy for limiting health expenditures.

Interactions Among Provisions

Although provisions designed to expand access to health care or to control its costs have been discussed separately, all of the proposed changes would interact with each other. For example, the choices made by consumers in restructured markets for insurance, the prices charged and the volume of services provided by physicians and hospitals in response to increased demand, and the response of providers to price controls or global budgets are interrelated in complex ways. CBO's estimates attempt to take account of these interrelationships, but such behavioral changes are difficult to predict when many aspects of the health insurance and health care systems are changing at once.

SUMMARY OF THE ESTIMATES

This section summarizes the effects of the four bills on the federal budget, health insurance coverage, and national health expenditures. The budgetary effects of the bills are shown as changes from CBO's baseline budget projections of March 1992, as described in the CBO study *An Analysis of the President's Budgetary Proposals for Fiscal Year 1993*. The baseline projections of national health expenditures and insurance coverage are detailed in the CBO study *Projections of National Health Expenditures* (October 1992). The baseline projections all assume a continuation of current policies and trends. Estimates for bills introduced during 1993 will reflect CBO's most recent budget baseline, including any new legislation, and updated projections of national health expenditures.

Estimated Budgetary Effects

By design, the four bills would affect federal spending in widely varying amounts (see Table 1).

TABLE 1. FEDERAL BUDGETARY EFFECTS OF HEALTH LEGISLATION
(By fiscal year, in billions of dollars)

	1994	1995	1996	1997	1998	1999	2000
H.R. 1300 (Russo)							
Outlays	0	406	618	649	676	702	727
Revenues	0	317	467	498	532	568	607
Deficit	0	89	151	151	144	134	120
H.R. 5502 (Stark-Gephardt)							
Outlays	0	-1	-3	8	13	11	20
Revenues	0	-1	-2	-1	a	a	1
Deficit	0	a	-1	9	13	11	19
H.R. 5919 (Michel)							
Outlays	a	a	a	a	a	a	a
Revenues	a	-1	-1	-2	-3	-3	-4
Deficit	a	1	1	2	3	3	3
H.R. 5936 (Cooper)							
Outlays	0	25	30	27	22	15	11
Revenues	6	11	8	10	10	11	11
Deficit	-6	14	22	17	12	5	-1

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

NOTE: The changes in outlays include changes in authorizations of appropriations for discretionary programs that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

a. Less than $500 million.

- H.R. 1300, by establishing a universal single-payer health insurance system, would channel about three-quarters of national health spending through the budget. By 2000, the bill would add about $725 billion to federal outlays. As with the other bills, the estimated changes in outlays include changes in discretionary programs that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

- H.R. 5502 would increase insurance coverage by expanding eligibility of low-income people for Medicaid, adding a prescription drug benefit to Medicare, and establishing a new governmental health insurance program for children. It also would curtail Medicare spending by establishing a cap on its rate of growth. On balance, the bill would raise outlays by about $20 billion in 2000.

- H.R. 5919 would make incremental changes in current programs of private insurance. It would reduce federal revenues by allowing self-employed people to deduct spending on health insurance from their taxable income and would have a negligible effect on federal outlays.

- H.R. 5936 would encourage the purchase of private health insurance by establishing health plan purchasing cooperatives and subsidizing the purchase of insurance by low-income people, but would limit the tax deductibility of health insurance premiums. It would increase federal spending in 2000 by roughly $10 billion.

As will be noted below, however, the effect of a bill on total national health expenditures--which includes private, state, and local government spending, as well as federal outlays--does not necessarily parallel its effect on the federal budget. That is, some proposals may increase federal government spending but reduce national health expenditures.

Ranking the bills in order of their effect on the federal deficit does not provide a meaningful comparison. Each of the bills, as introduced, fails to raise enough additional revenues in each year to pay for the new federal spending or tax expenditures that it would create. This result, however, is not inherent in any of the four approaches to health care reform. CBO cost estimates were not available at the time the bills were introduced, and their authors therefore did not know how much revenues would be required to pay for their proposals.

Any of the bills could be made deficit-neutral by adding additional taxes or reductions in spending.

Health Insurance Coverage

In 1992, 35 million Americans lacked public or private health insurance. CBO projects that the number of uninsured will rise to 39 million in 2000, assuming a continuation of current policies and trends (see Table 2). The four bills would have very different effects on health insurance coverage.

- The universal, national health insurance plan in H.R. 1300 would cover all 39 million uninsured in 2000.

- H.R. 5502 would increase enrollment in public programs--Medicaid and a new health insurance program for children--by 18 million in 2000. Of this number, 9 million would be newly insured. The number of newly insured people would reach 16 million in 2002, when the expansion of Medicaid is assumed to be fully phased in.

- The incremental changes in H.R. 5919 would expand private insurance coverage by fewer than 1 million people.

- The program of low-income assistance and tax subsidies in H.R. 5936 would lead 20 million of the uninsured in 2000 to purchase private health insurance coverage. Over 6 million people who would be eligible for Medicaid under current law, however, would have their health insurance only partly subsidized and would choose not to obtain coverage. The net increase in insurance coverage would be 14 million people.

National Health Expenditures

National health expenditures represent the total amount of spending in the economy on health-related services. This total may be subdivided into personal health spending, which consists of all direct spending for patient care (primarily hospital, physician, drug, and nursing home expenditures), and other health spending (including administrative, research, and investment costs). Alternatively, national health expenditures may be arrayed by source of funding--public (federal, state, or local governments) or private (primarily private health insurance benefits and out-of-pocket spending by consumers).

TABLE 2. HEALTH INSURANCE COVERAGE
(By calendar year, in millions of people)

Insurance Status	1994	1995	1996	1997	1998	1999	2000
Baseline							
Insured	219.8	221.5	223.1	224.7	226.2	227.9	229.4
Uninsured	36.2	36.8	37.3	37.9	38.4	38.8	39.2
Total	256.0	258.3	260.4	262.6	264.6	266.7	268.6
Increases from Baseline							
H.R. 1300 (Russo)							
Insured	0	36.8	37.3	37.9	38.4	38.8	39.2
H.R. 5502 (Stark-Gephardt)							
Insured	0	1.8	1.7	1.9	2.1	5.5	9.4
H.R. 5919 (Michel)							
Insured	a	0.1	0.1	0.2	0.2	0.2	0.2
H.R. 5936 (Cooper)							
Insured	0	8.9	10.1	11.1	12.3	13.6	13.9

SOURCE: Congressional Budget Office.

a. Less than 50,000.

National health expenditures totaled an estimated $832 billion in 1992. In CBO's October 1992 baseline projections, national health expenditures are projected to double in eight years, reaching $1.7 trillion in 2000. Of this total, $869 billion would be spent by private entities, $566 billion by the federal government, and $244 billion by state and local governments. Two programs, Medicare and Medicaid, would account for more than three-quarters of the public spending on health and almost 40 percent of national health expenditures in 2000.

CBO estimates that the two bills that place explicit limits on health expenditures, H.R. 1300 and H.R. 5502, would both reduce national health expenditures. H.R. 5936 would increase national health expenditures slightly, and H.R. 5919 would have an almost imperceptible effect (see Table 3).

Enactment of H.R. 1300 would raise national health expenditures at first, but would reduce spending about 9 percent in 2000. As the program was phased in, the administrative savings from switching to a single-payer system would offset much of the increased demand for health care services. Later, the cap on the growth of the national health budget would hold the rate of growth of spending below the baseline. The bill contains many of the elements that would make its limit on expenditures reasonably likely to succeed, including a single payment mechanism, uniform reporting by all providers, and global prospective budgets for hospitals and nursing homes. As a result, the estimate assumes that the expenditure limit would be 75 percent effective.

CBO estimates that under H.R. 5502, national health expenditures would fall about 4 percent below the level they would otherwise reach by the turn of the century. Experience with rate setting in Medicare indicates that expenditure limits could be reasonably but not totally effective in that program. The estimate therefore assumes that the limits on Medicare expenditures would be 75 percent effective. CBO is much less sanguine, however, about the effectiveness of the limits on other health spending, which are assumed to be only 25 percent effective. The savings from the limits on Medicare and other national health expenditures would be partially offset by provisions in H.R. 5502 that would expand both the covered population and the benefits of Medicare and Medicaid.

H.R. 5919 would increase national health expenditures by a negligible amount, primarily as a result of allowing the self-employed to deduct the cost of health insurance spending from their taxable income. The resulting expansion of insurance coverage would slightly increase the demand for health care services.

TABLE 3. PROJECTIONS OF NATIONAL HEALTH EXPENDITURES, BY SOURCE OF FUNDS (By calendar year, in billions of dollars)

Source of Funds	1994	1995	1996	1997	1998	1999	2000
Baseline							
Private	526	574	625	681	741	803	869
Public							
Federal	310	343	380	419	464	513	566
State and local	141	155	171	188	205	224	244
Total	977	1,072	1,176	1,288	1,409	1,540	1,679
Changes from Baseline							
H.R. 1300 (Russo)							
Private	0	-428	-469	-512	-560	-610	-663
Public							
Federal	0	494	529	553	576	598	618
State and local	0	-46	-56	-67	-79	-92	-105
Total	0	20	5	-27	-63	-104	-150
H.R. 5502 (Stark-Gephardt)							
Private	0	-5	-13	-22	-38	-57	-90
Public							
Federal	0	-2	a	11	16	14	23
State and local	0	a	-1	-1	-1	-1	-1
Total	0	-7	-13	-12	-23	-44	-67
H.R. 5919 (Michel)							
Private	a	a	2	2	3	3	4
Public							
Federal	a	a	a	a	a	a	a
State and local	a	-1	-1	-1	-2	-2	-2
Total	a	1	1	1	1	1	2
H.R. 5936 (Cooper)							
Private	0	45	45	47	51	56	56
Public							
Federal	0	30	29	25	20	13	10
State and local	0	-25	-29	-33	-37	-42	-47
Total	0	49	45	40	34	27	19

SOURCE: Congressional Budget Office.

a. Less than $500 million.

In CBO's estimation, H.R. 5936 would add about 1 percent to national health expenditures in 2000. Initially, national health expenditures would increase by a greater amount because a comprehensive set of benefits would become available to a larger group than health insurance currently covers. The growth in expenditures would gradually slow, however, as competition among insurers encouraged more people to enroll in health maintenance organizations. After several years, these savings would offset some of the increased health care costs resulting from extending access to those who currently lack insurance.

CONCLUSION

This paper has used four bills introduced in the 102nd Congress to illustrate the issues involved in estimating the effects of plans to reform the health care system. These estimates, however, relate to specific bills and not to generic proposals. For example, the estimate for H.R. 1300 would not be applicable to all single-payer proposals, nor would the estimate for H.R. 5936 apply to all bills featuring managed competition. In the months to come, CBO will use the approaches and assumptions outlined in this paper to prepare estimates of health reform proposals that the 103rd Congress will be considering.

CHAPTER II

H.R. 1300, UNIVERSAL HEALTH CARE ACT OF 1991

H.R. 1300 would establish a universal, government-run health insurance program to replace all other public and private coverage. The bill was introduced by then-Congressman Martin Russo early in 1991 and received 70 cosponsors. The estimate assumes that the bill would be enacted in 1993 and that the benefits and tax increases would begin in 1995.

SUMMARY OF THE BILL

The Russo bill would create a single-payer program of national health insurance modeled after the Canadian system. All legal residents would be eligible for comprehensive health benefits with no out-of-pocket payments. People would pick their own health care providers, and providers accepting payments from the federal program would be prohibited from billing patients for covered services. Total spending would be limited by a national health budget, which would grow no more rapidly than the economy. The program would be financed primarily by increases in income and payroll taxes and partly by contributions from state governments.

Benefits

The benefits provided by the program would include payment for hospital care, physician and other professional services, nursing home care, home health services, hospice care, prescription drugs, preventive health services, home and community-based services to assist people unable to perform two or more activities of daily living, and any other health services that the Secretary of Health and Human Services deems appropriate. This estimate assumes that the Secretary would not cover over-the-counter drugs or most dental care, eyeglasses, or other durable medical equipment. The bill generally limits mental health benefits to 45 days per year for inpatient care and 20 visits per year for outpatient services.

The new program would replace existing public and private health insurance programs. Medicare, Medicaid, Federal Employees Health Benefits, and benefits under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) would be terminated. Health benefits for veterans and

Native Americans would be terminated if they duplicated benefits provided under the national health insurance program.

Administration and Cost Control

The national health insurance program would be administered by the federal Health Care Financing Administration. States could choose to administer the program if they met all the federal requirements. The federal government or the states could contract with private entities to process claims for payments, but each state could have no more than one processor.

The Secretary of Health and Human Services would establish annual state and national budgets for spending under the national health insurance program. The budgets would include separate amounts for capital spending by hospitals and nursing homes and for direct medical education. The total national health budget would be allowed to grow by no more than the increase in the gross national product for the previous year.

Hospitals and nursing homes would receive periodic payments based on annual operating budgets, approved by the federal government or the state, and not on the volume or type of services provided. Payment for home health services, hospice care, and facility-based outpatient services could be based on an annual budget, a fee schedule, or an alternative prospective payment method. Physicians and other professionals would be reimbursed using a fee schedule similar to Medicare's resource-based relative value scale. Payments for other items and services, including prescription drugs, would also be made on the basis of fee schedules established by the Secretary. The Secretary would collect the necessary data by establishing a uniform reporting system for health care providers.

Financing

The program of national health insurance would be financed by increases in payroll and income taxes, contributions by state governments, and income-related premiums paid by elderly people.

The limit on earnings subject to the payroll tax for Medicare's Hospital Insurance would be eliminated. The tax rate for employers would be increased to 7.5 percent, but the rate for employees would remain at 1.45 percent. The tax would also be imposed on state and local government workers not now covered.

Personal income tax rates would be increased for those at or above the current 28 percent marginal tax bracket; a new 38 percent bracket would be added for individuals with income over $120,000 and couples with income over $200,000. The portion of Social Security benefits subject to income taxation would be increased from 50 percent to 85 percent. And the tax rate on corporate income over $75,000 would be increased from 34 percent to 38 percent.

States would be required to make maintenance-of-effort payments equal to $85 per year per resident, plus 85 percent of the state's Medicaid payments in 1993, increased by subsequent growth in the gross national product. People age 65 or over with income above 120 percent of the poverty level would be required to pay a premium of $55 per month for long-term care. Both the state per capita payments and the premium are fixed in the bill and are not indexed.

ESTIMATED FEDERAL COSTS

H.R. 1300 would place three-quarters of national health expenditures on the federal budget. Part of the costs of the new national health insurance program would be offset by repealing Medicare, Medicaid, and other existing federal health programs. To avoid increasing the deficit, the remaining costs would have to be covered by additional taxes and payments by states or beneficiaries. Table 4 summarizes the effects of the bill on outlays, revenues, and the federal deficit.

Cost of the National Health Insurance Program

CBO estimated the cost of the national health insurance program in the following three steps:

- Estimate the amount of covered health services in 1994, the year before the new program would take effect.
- Add the estimated amount of additional health services that would be demanded under the new program in the absence of a limit on total health spending, and subtract the estimated administrative savings.
- Estimate total spending for 1995 through 2000 based on the expenditure limit set in the bill and its likely effectiveness.

TABLE 4. ESTIMATED BUDGETARY EFFECTS OF H.R. 1300
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000
Outlays						
National Health Insurance Program	627	947	1,016	1,085	1,158	1,234
Repeal Medicare[a]	-119	-178	-199	-222	-248	-276
Repeal Medicaid	-75	-113	-126	-142	-160	-179
Repeal Federal Retiree Health Benefits	-4	-5	-6	-7	-8	-9
Authorizations of Appropriations[b]	-23	-33	-35	-38	-40	-43
Total, Outlays	406	618	649	676	702	727
Revenues						
Increase Hospital Insurance Tax	135	199	210	221	232	244
Income and Payroll Taxes on Additional Income[c]	81	124	139	154	172	191
Payments by States	63	87	91	95	99	104
Increase Individual Income Tax Rates[d]	17	26	27	28	29	31
Increase Taxation of Social Security Benefits	5	7	8	9	10	11
Increase Corporate Income Tax Rates	6	11	11	11	12	12
Long-Term Care Premium	9	13	13	13	13	14
Total, Revenues	317	467	498	532	568	607
Deficit						
Total Effect of H.R. 1300	89	151	151	144	134	120

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

a. Includes Medicare premiums and administrative costs.
b. Includes repeal of federal employee health benefits, benefits under the Civilian Health and Medical Program of the Uniformed Services, and most health benefits for veterans and Native Americans. These changes would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.
c. Includes effect of interactions with other provisions.
d. Includes effect of increased tax rates on estates and trusts.

Covered Services. The national health insurance program would cover virtually all spending on services enumerated in the bill, including hospital care, physician and other professional services, nursing home care, and home health services. For these items, the estimate excludes only other private funding (largely philanthropic contributions) and 20 percent of current out-of-pocket spending (representing services that the new program would not cover). All spending on prescription drugs is assumed to be covered.

The bill does not include dental care, vision care, or durable medical equipment in its list of covered services. The estimate assumes that the Secretary would choose to cover the portion of these services currently paid by government or private health insurance.

Additional Demand for Services. Under H.R. 1300, spending on health care would no longer be limited by a person's income, wealth, or insurance coverage. Providing health insurance to people who currently lack insurance and eliminating copayments for those who have insurance would increase the demand for health services. Expanding the coverage of health care to include home and community-based services for the disabled would also greatly increase their use.

The estimated additional demand for health services under the bill is generally based on the methodology detailed in CBO's April 1993 staff memorandum, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates." Under those assumptions, hospital utilization would grow by 12 percent over three years if not constrained by the national health budget. The unconstrained demand for physician and other professional services would increase by 30 percent, and spending on prescription drugs would increase by 35 percent, over three years. And the demand for nursing home and home health care would grow by 50 percent over five years. These figures are weighted averages of the estimated increases in demand on the part of the currently uninsured, Medicare beneficiaries, Medicaid recipients, and people with private health insurance coverage. The estimates of unconstrained demand also assume that spending would increase in proportion to the growth in the use of health care services.

Administrative Savings. Replacing a variety of private insurers, government programs, and individual out-of-pocket payments with a single payer would reduce the costs of administering the health care system. The national health expenditure accounts, developed by the Health Care Financing Administration, record administrative expenses in several places. The category labeled "administration" includes the direct costs of administering government programs as well as profits, overhead costs, and additions to the reserves of

private health insurers. The costs of billing for services, filing claims forms, complying with utilization review, and other administrative requirements are included in hospital and physician expenditures and other specific categories of personal health spending.

The estimate assumes that the national health insurance program would operate with direct administrative costs equal to 5 percent of covered services in 1995, 4 percent in 1996, 3.5 percent in 1997 and 1998, and 3 percent thereafter. In comparison, direct administrative costs are projected to be about 7 percent of covered services in 1994 under current law. Medicare's administrative cost rate is about 2 percent, and the administrative cost of Canada's single-payer system is less than 2 percent of services. Although the administrative costs of the national health insurance program might eventually fall to the Canadian level, the estimate assumes that this level would not be reached within the first six years.

The estimate also assumes that hospitals, nursing homes, physicians, home health agencies, and other health care professionals could save about 6 percent of their costs by dealing with only one payer and eliminating co-payments and other billing. These savings would be phased in over two years. No administrative savings are assumed for prescription drugs, dental and vision care, and other categories of personal health expenditures.

Efficacy of Expenditure Limits. H.R. 1300 would limit the rate of growth of spending for the national health insurance program to the rate of increase of gross national product for the previous year. The present estimate assumes that this limit, after allowing for the increase in demand for health care services and the reduction in administrative costs, would be 75 percent effective. The estimated savings equal the difference between the unconstrained demand created by the bill and the bill's expenditure limit, multiplied by its effectiveness rating of 75 percent.

H.R. 1300 contains many of the elements that, CBO has concluded, would make its expenditure limit reasonably likely to succeed. The bill establishes a single payment mechanism and a uniform system of reporting by all providers of health care. It sets up global prospective budgets for hospitals and nursing homes. And, by prohibiting participating providers from billing for covered services, it makes it unlikely that people would purchase health care outside the regulated system.

Nonetheless, the expenditure limit in H.R. 1300 is unlikely to be completely effective. Physicians and other noninstitutional providers would continue to be paid on a fee-for-service basis, and the bill fails to provide any

prompt feedback mechanism to assure that increases in the volume of services would not offset restrictions on their price. The experience of Canada and France, for example, suggests that price controls alone are not sufficient to rein in the growth of health care spending over a prolonged period of time.

Repeal of Existing Federal Programs

The new program would replace Medicare, Medicaid, Federal Employees Health Benefits, CHAMPUS, and most health benefits for veterans and Native Americans. Medicare benefits, Medicaid, and health benefits for federal retirees are considered mandatory, and the rest of these programs are discretionary. The savings from eliminating these programs equals CBO's baseline projections of spending, extrapolated through 2000. The reductions in discretionary programs would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

Changes in Revenues

The Joint Committee on Taxation estimated the impact of the provisions of the bill that would affect federal tax revenues. Three-quarters of the additional revenue generated by the bill would be raised by increasing the rates of income and payroll taxes and the amount of earnings or income subject to tax. In addition, the estimate assumes that most of the money currently paid by private and public employers for health insurance would be returned to workers in the form of higher wages. Federal revenues would rise because these additional wages would be subject to both personal income and payroll taxation.

In CBO's estimation, the revenues provided by H.R. 1300 are not sufficient to cover the bill's spending. The bill specifies that the House Committee on Ways and Means shall include in the reported bill such additional revenues as may be required to fund its expenditures. The present estimate, however, includes only those revenue increases specified in the bill as introduced.

EFFECT ON NATIONAL HEALTH EXPENDITURES

CBO estimates that enactment of H.R. 1300 would raise national health expenditures slightly at first but would reduce spending about 9 percent in 2000. The administrative savings from switching to a single-payer system would offset most of the cost of the additional services demanded by consumers who

would no longer face any out-of-pocket charges. Over the longer run, the cap on the growth of the national health budget--assumed to be 75 percent effective--would hold the rate of growth of spending on covered services below the baseline.

In addition to reducing national health expenditures in the long run, H.R. 1300 would shift a vast amount of health spending from the private sector and state and local governments to the federal sector. The new federal program would assume virtually all spending now covered by private health insurance. The only health spending remaining in the private sector would be out-of-pocket spending for services not covered by the federal program, such as over-the-counter drugs and most dental care and eyeglasses. State and local governments would also be relieved of the responsibility for Medicaid and for public hospitals and clinics. States would be responsible only for maintenance-of-effort payments to the federal government and various public health programs.

CHAPTER III

H.R. 5502, HEALTH CARE COST CONTAINMENT AND REFORM ACT OF 1992

H.R. 5502 was introduced by Congressman Fortney Pete Stark for himself, Congressman Richard Gephardt, and several other cosponsors. The Subcommittee on Health of the House Committee on Ways and Means ordered the bill reported, with amendments, on July 1, 1992. This paper provides an estimate of the major health reforms contained in Titles I, II, and III of H.R. 5502, as reported. It does not consider the relatively small amendments to Medicare in Title IV. The estimate assumes that the bill is enacted in 1993 and therefore delays the effective dates specified in the bill by one year.

Congressman Stark introduced a revised version of H.R. 5502 in January 1993 as H.R. 200 of the 103rd Congress. This estimate refers to H.R. 5502 and would not apply to H.R. 200.

SUMMARY OF THE BILL

The Health Care Cost Containment and Reform Act would change the current national health system in three major ways. First, it would attempt to rein in the growth of health care spending by establishing national limits on health care expenditures and setting rates for all personal health services. Second, the bill establishes national standards for health insurance plans and simplifies the administration of health insurance. Finally, the bill expands benefits under Medicare and Medicaid and establishes a new federal program to provide health insurance to all children under age 19.

Cost Containment

H.R. 5502 would establish a budget for national health expenditures, covering most public and private health spending. Annual budgets would be based on national health expenditures in the previous year, increased by the five-year moving average of the annual rate of growth in gross domestic product plus an adjustment factor. The adjustment factor would gradually be phased out, and after five years the rate of growth of the health budget would be limited to the rate of growth of GDP.

The Secretary of Health and Human Services would allocate the total budget among specified classes of health services, such as inpatient hospital

care, physician services, and mental health services. In addition, there would be separate allocations for services covered by the Medicare program and for expenditures not attributable to Medicare.

The Secretary would establish payment rates for each class of health service at the levels estimated to be necessary to stay within the national health budget. Rates would be set separately for Medicare and for other health spending. Qualified health maintenance organizations would not be subject to the maximum payment rates. Also, a state could be exempted from the maximum payment rates if it established its own program to control costs and provided assurances that spending for health services covered under the state program would not exceed what expenditures would have been if the maximum payment rates applied.

Health System Reforms

H.R. 5502 would reform the health insurance and health care industries by setting standards and requirements for health benefit plans, simplifying the administration of health insurance, establishing a national program to control fraud and abuse, and starting to collect data on patient outcomes.

All plans would be prohibited from denying coverage on the basis of a person's health status or medical history. Exclusion of coverage for preexisting conditions would generally be limited to six months. Employers with fewer than 101 employees would be prohibited from offering a self-insured plan. Health insurers other than self-insured plans would be required to provide open enrollment year-round, guarantee renewability of coverage, and charge all purchasers the same rates regardless of health status. An excise tax would be imposed on any health plan not meeting the standards established in the bill.

Several provisions are designed to reduce costs by simplifying the administration of health insurance. The Secretary would establish uniform health insurance cards, claims forms, provider numbers, and codes for procedures and diagnoses. A national health claims network would be established to receive and process all claims for payment by providers. Public payers would be required to use the national network, and private payers would have the option of doing so.

Expansion of Health Benefits

The bill would increase access to health care by improving Medicare and Medicaid benefits, establishing a new federal health insurance program for children, and extending and expanding the tax deductibility of health insurance costs for the self-employed.

Medicare would be extended to cover additional preventive health services, including screening for colon cancer, certain immunizations, and annual screening for breast cancer. An outpatient prescription drug benefit would be added to Part B of Medicare, and the Part B premium would be increased to finance 25 percent of its cost. The drug benefit would be subject to an annual deductible, initially set at $850, and a copayment of at least 20 percent.

Medicaid benefits would be extended gradually to cover additional groups of low-income people. Under current law, Medicaid covers all pregnant women and children under age 6 with family income below 133 percent of the federal poverty level, and will cover all other poor children by 2002. Under H.R. 5502, as reported, Medicaid would eventually cover all pregnant women and children under age 19 in families with income below 200 percent of the federal poverty level, and all adults under age 65 with income below 125 percent of poverty. To improve the access of Medicaid beneficiaries to health care services, Medicaid's payment rates would be gradually raised to 90 percent of the rates in Medicare. The federal government would fully fund the cost of these additional benefit payments, except for the cost of long-term care services; under current law, the federal government and the states share the costs. Finally, low-income people who are eligible for the Qualified Medicare Beneficiary program--under which Medicaid pays for Medicare's premiums, deductibles, and coinsurance--would be automatically enrolled in the program.

Children not covered by Medicaid would be eligible for a new federal health insurance program under H.R. 5502. The program would be financed primarily by beneficiaries' premiums that would equal the expected value of the benefits, assuming that all eligible children participated. Benefits would include all items currently covered under Medicare. In addition, well-child care would be covered without copayments, and outpatient prescription drugs would be covered with 20 percent coinsurance. Firms would be permitted to cover all dependent children under the federal program, instead of under the employer's group health plan, if they paid at least 80 percent of the premium. If employers insured children under their group plan, however, they would not be permitted to cover children under the new federal program for the following two years.

The income tax deduction for 25 percent of health insurance costs for the self-employed, which expired on June 30, 1992, would be reinstated. After one year, the deduction would be increased to 100 percent of health insurance costs.

ESTIMATED FEDERAL COSTS

H.R. 5502 would increase federal spending by adding a prescription drug benefit and various prevention benefits to Medicare, expanding eligibility for Medicaid and raising its payment rates, and establishing a new health insurance program for children. The income tax deduction of health insurance costs for the self-employed would reduce federal revenues. The federal costs of the bill would be largely offset by the reduction in Medicare spending resulting from the proposed expenditure cap. Table 5 summarizes the estimated budgetary effects of the bill.

Limits on Health Expenditures

H.R. 5502 imposes separate limits on health spending covered by Medicare and on other health spending. CBO's estimate assumes that the limit on Medicare-related spending would be 75 percent effective, but that the limit on non-Medicare health spending would be only 25 percent effective.

Expenditure limits enforced by rate setting could be reasonably but not totally effective in controlling Medicare spending. The Health Care Financing Administration collects most of the data necessary to set rates and track spending relative to the budgeted amounts. It also has considerable experience in setting payment rates and estimating the responses of providers. Nonetheless, the history of cost control efforts both in this country and abroad strongly suggests that setting payment rates is not sufficient for achieving full control over health expenditures. H.R. 5502 does not impose budgets on hospitals, nursing homes, and other institutional providers of health care. For noninstitutional providers, such as physicians, the bill has neither a provision for continually adjusting payment rates to assure that the expenditure limits are not exceeded, nor a mechanism to recover any excess spending that might occur.

The limits on non-Medicare spending are likely to be subject to much greater leakage and to be far less effective. Participation in the national health claims network would be voluntary, and the data needed to determine compliance with the expenditure limits would be incomplete and would not be available in a timely fashion. States would be permitted to operate their own

TABLE 5. ESTIMATED BUDGETARY EFFECTS OF H.R. 5502
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000
Outlays						
Medicare						
Expenditure cap	-2	-6	-11	-18	-28	-41
Prevention benefits	1	1	1	1	1	1
Prescription drug benefit	0	0	10	14	14	15
Subtotal	-1	-5	a	-3	-13	-25
Medicaid						
Eligibility expansion	0	0	2	6	14	34
Floor on payments to providers	0	0	2	7	7	8
QMB enrollment	0	0	1	1	1	1
Subtotal	0	0	5	13	23	43
Health Insurance for Children	0	2	2	2	2	3
Other Mandatory Programs	a	a	-1	-1	-1	-2
Authorizations of Appropriations[b]	1	1	1	1	1	1
Total, Outlays	-1	-3	8	13	11	20
Revenues						
Deduction of Health Insurance for the Self-Employed	-1	-2	-2	-2	-3	-3
Effect of Expenditure Caps	a	a	1	2	3	4
Total, Revenues	-1	-2	-1	a	a	1
Deficit						
Total Effect of H.R. 5502	a	-1	9	13	11	19

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

NOTE: QMB=Qualified Medicare Beneficiary program.

a. Less than $500 million.

b. These changes would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

systems as long as the growth in health care spending did not exceed what it would have been under the maximum rates. This calculation would be very difficult to make, and specific data on states would not exist in usable form for at least several years. Finally, the bill exempts federally qualified HMOs from rate setting. Federally qualified HMOs are more broadly defined than group- or staff-model HMOs and include organizational forms that have not been shown to be cost-effective.

The allowable increases in Medicare and non-Medicare health spending were computed using CBO's projections of the rate of growth of GDP and the formula specified in the bill. Under these assumptions, the allowable rate of growth of the two categories of health expenditures would decline from 8.7 percent in 1995 to 5.6 percent by 2000. The savings attributable to the Medicare cap were estimated to equal 75 percent of the difference between CBO's estimate of Medicare outlays under current law and the amounts that would be spent if the caps were fully effective. These savings grow from $2 billion in 1995 to $41 billion in 2000.

The limit on non-Medicare health spending, assumed to be 25 percent effective, would produce small savings for the federal budget but much larger savings for private payers of health care costs. Spending for other federal health programs, primarily benefits for retired federal employees, would grow less rapidly, reducing outlays by $2 billion in 2000. Slower growth in health costs would also reduce employers' spending on health insurance. CBO assumes that just under 40 percent of the reduction in non-Medicare costs would accrue to employer-sponsored health plans; almost all of this reduction in fringe benefits is assumed to lead to an increase in cash compensation, which would increase federal income and payroll tax revenues by $4 billion in 2000.

Medicare Benefits

The additional benefits for certain preventive health services and for prescription drugs would increase Medicare spending. H.R. 5502 provides that the expenditure limits for Medicare are to be increased by the estimated cost of these new benefits.

The cost of the preventive health benefits is based on estimates of the number of additional medical procedures and the average cost of each procedure. The total cost of these benefits is estimated to reach $1 billion in 2000, primarily for screening for colon and breast cancer.

The estimated cost of the prescription drug benefit is based on the methodology detailed in CBO's October 1989 study, *Updated Estimates of Medicare's Catastrophic Drug Insurance Program*. The distribution of spending on prescription drugs by Medicare beneficiaries under current policies is estimated using the 1987 National Medical Expenditure Survey, adjusted for underreporting in the survey and for subsequent increases in drug prices and use. Total spending on prescription drugs by Medicare beneficiaries under the proposal is increased to reflect additional demand for drugs stemming from expanded insurance coverage, and reduced because of the limits the bill imposes on drug prices. Medicare would pay for the portion of this spending that exceeded the specified deductible and coinsurance amounts. Of the increase in Medicare spending, 25 percent would be covered by an increase in premiums paid by beneficiaries, and the remaining 75 percent would have to be covered by general revenues. All things considered, the net budgetary cost of the prescription drug benefit would reach $15 billion in 2000.

Medicaid Benefits

Three provisions of H.R. 5502 would increase Medicaid spending--the expansion of eligibility, the increase in payment rates, and the automatic enrollment of people in the Qualified Medicare Beneficiary program.

Expansion of Eligibility. H.R. 5502, as reported, would gradually extend Medicaid benefits to pregnant women and children with income below 200 percent of the poverty level and to adults with income below 125 percent of poverty. The number of people eligible for these benefits was estimated using data from the March 1991 Current Population Survey. All pregnant women and infants who would become eligible for Medicaid and who currently lack insurance are assumed to participate in the program at the prompting of their physician or hospital. The participation rate for previously uninsured children and adults is assumed to be 85 percent. All eligible people who currently carry private nongroup insurance are assumed to drop that coverage in favor of Medicaid. Ten percent of eligible children and adults with employer-sponsored group insurance are also assumed to drop their coverage; half are assumed to retain their group insurance and also enroll in Medicaid, which would become the secondary payer to their private insurance. By 2000, Medicaid would provide benefits to an additional 0.4 million pregnant women, 0.4 million infants, 9.8 million children, and 6.3 million other adults. Of these, 8.6 million would be newly insured, and 8.3 million would previously have had private coverage.

The expansion of eligibility for Medicaid under H.R. 5502, however, would not be complete in the year 2000. At that point, Medicaid would cover all adults with income below 50 percent of the poverty level. By 2002, however, all adults with income below 125 percent of poverty would be eligible for Medicaid, and H.R. 5502 would add to the Medicaid rolls 15 million people who previously lacked insurance.

The cost of each additional Medicaid participant is generally assumed to equal the estimated cost of similar participants under current law. Beneficiaries who are also enrolled in an employer-sponsored insurance plan, however, are assumed to cost Medicaid only one-fourth as much as beneficiaries without other coverage. In 2000, the weighted cost per person is estimated to be $6,500 for pregnant women, $2,800 for infants, $1,300 for children, and $3,500 for adults. Thus, the total cost of the new beneficiaries would be $34 billion in 2000. The cost would be substantially more in 2002, when the provision would be fully phased in.

Increase in Payment Rates. H.R. 5502 would require Medicaid payments to hospitals and physicians to be raised to 90 percent of the payment that Medicare would make for the same service. The higher rates would be phased in over a period of four years. The bill would not affect Medicaid's supplementary payments to hospitals that serve a disproportionate number of low-income patients with special needs (so-called disproportionate share payments).

CBO's estimate of the cost of raising Medicaid's payments to providers is based on state-by-state estimates of the relative reimbursement rates of Medicaid and Medicare, as reported by the Prospective Payment Assessment Commission (for hospitals) and the Physician Payment Review Commission (for physicians) and extrapolated to reflect recent trends. CBO's baseline assumes that Medicaid payments to hospitals, excluding most disproportionate share payments, will average only 5 percent below Medicare's rates in 1997. The disparity is much greater for physician services, with Medicaid paying an estimated 35 percent less than Medicare. The cost of the payment floor in each state is calculated by multiplying the percentage difference between the current payment level in each state and the projected payment floor by the projected amount of Medicaid spending in each state.

At the same time as the floors on payments to providers in H.R. 5502 push Medicaid's payment rates up toward Medicare's levels, the bill's limits on expenditures will gradually drive Medicare rates down. On balance, the cost of the payment floors is estimated to rise from $2 billion in 1997 to $7 billion in 1998 and increase relatively little in 1999 and 2000.

QMB Enrollment. According to one recent survey, fewer than half of the eligible beneficiaries are participating in the Qualified Medicare Beneficiary program. Automatic enrollment would increase the participation rate to 100 percent. As a result, spending for Medicaid would rise by $1 billion a year.

Health Insurance for Children

H.R. 5502 establishes a federally administered health insurance program specifically for children. The estimated number and characteristics of children eligible to participate in the program are based on data from the March 1991 Current Population Survey, extrapolated through 2000.

The estimate assumes that no children in families with income below 200 percent of the poverty level participate in the program of health insurance for children, because Medicaid would provide better benefits. All children whose parents currently purchase nongroup health insurance (an estimated 1.2 million children in 2000) are assumed to be shifted to the public program, which is likely to provide better benefits at a lower cost.

For other currently uninsured children, the estimate makes other assumptions about participation. Forty percent of children of unemployed parents are assumed to participate. Between 10 percent and 15 percent of employers who do not now offer health insurance are assumed to offer coverage to employees' children through the new plan, and 90 percent of the previously uninsured children are assumed to become insured. These figures are based on tabulations by Lewin-ICF that relate the purchase of nongroup health insurance to its cost relative to income. In total, 0.6 million children would become insured for the first time.

Finally, firms that would insure children of employees but pay relatively high premiums for meager benefits might choose to cover those children under the new public plan. The bill's establishment of community rating and its prohibition on switching without a two-year lapse in coverage make it unlikely that existing firms would discontinue health insurance for children. But some new firms that would otherwise have covered children of employees under their own plan might opt instead for the public plan. Based on data on job creation in small businesses, the estimate assumes that the public plan would cover 1 percent of children who would otherwise be covered by employer-sponsored insurance in 1996 and 5 percent in 2000.

The premiums set in the bill are based on the assumption that all children would participate in the program. The children who actually

participate, however, are likely to be those for whom the public program would charge less than private insurance--a phenomenon known as adverse selection. The estimate assumes that the average health costs of children participating in the program would be 30 percent above average. The net federal cost would total $3 billion in 2000--equal to the difference between the average cost of the benefits and the premium, multiplied by the number of participants.

Tax Deduction of Health Insurance for the Self-Employed

The estimate of the cost of the tax deduction of health insurance for the self-employed was provided by the Joint Committee on Taxation. Self-employed people who already purchase insurance could deduct their current spending. In addition, the lower effective price of insurance would encourage some of them to purchase more insurance, and some uninsured people would become insured.

EFFECT ON NATIONAL HEALTH EXPENDITURES

CBO estimates that H.R. 5502 would reduce national health expenditures in 2000 by 4 percent below their baseline level. For the reasons given above, the estimate assumes that the limit on Medicare expenditures would be 75 percent effective and that the limit on other health spending would be 25 percent effective. The costs of the expansions in Medicare and Medicaid, however, would use up some of the savings produced by the expenditure limits.

The savings from the limit on non-Medicare health spending would accrue primarily to individuals, who would see reductions in out-of-pocket charges and the cost of health insurance. The estimate assumes that almost all of the reduction in the cost of employer-sponsored health insurance would be returned to workers in the form of higher wages.

State and local spending on health would be virtually unchanged because the federal government would pay for all the expansions in the Medicaid program.

CHAPTER IV

H.R. 5919, COMPREHENSIVE HEALTH REFORM ACT OF 1992

H.R. 5919, introduced by House Republican Leader Robert Michel, embodies much of the Bush Administration's program for health reform. The bill does not include, however, President Bush's proposed tax credit or deduction for the purchase of health insurance by low- and middle-income people or his proposed changes in the Medicaid program.

SUMMARY OF THE BILL

The Michel bill provides for allowing the self-employed to deduct their health insurance costs from taxable income, regulating employment-based health insurance to improve its availability and affordability, standardizing medical and health insurance information, and reforming the system of liability for medical malpractice.

Tax Deduction of Health Insurance for the Self-Employed

Before June 30, 1992, self-employed people were allowed to deduct up to 25 percent of their health insurance costs from their taxable income. The bill would allow self-employed individuals to deduct 25 percent of health insurance costs in the 1993 tax year, 50 percent in 1994 and 1995, and 100 percent in 1996 and thereafter.

Regulating Employment-Based Health Insurance

The bill would regulate private health insurance in ways designed to increase its availability and affordability. With the approval of the Secretary of Health and Human Services, states could establish their own programs to ensure compliance with the new federal requirements. Otherwise, the Secretary would enforce the requirements. The estimate assumes that the bill would be enacted in 1993, most states would enact enabling legislation in 1994, and the market reforms would generally become effective in 1995.

An insurer would not be allowed to refuse or cancel any employment-based health insurance coverage on the basis of an individual's health, except to the extent allowed by a state's assigned risk program. Employment-based

health insurance plans would also be limited in their ability to exclude coverage for preexisting health conditions, and no such exclusion could exceed six months.

Additional requirements would apply to insurers offering health insurance to small businesses--firms or nonprofit organizations that employ fewer than 51 workers on a typical day. With limited exceptions, each insurer offering a health insurance plan to any small business would have to make that plan available to every small business in the state and could not cancel or refuse to renew the plan. States could also choose to define a basic health insurance plan for small businesses and require all insurers selling health insurance to such firms to offer the basic plan. By 1998, states would be required to establish systems to pool some of the risks of providing health insurance to small businesses, and by 2003 all risks of providing insurance to small businesses would be pooled. As interim measures, insurers would be required to limit the variations in the level and the rate of increase of premiums charged to different employers, and states would be required to establish a reinsurance or assigned-risk program to help insurers comply with these limits.

Small businesses would be allowed to band together in health insurance networks to negotiate with insurers to provide health insurance for their employees. These networks are intended to enable small businesses to buy insurance at lower prices by increasing their market power and reducing administrative costs. The networks would not be required to offer health insurance to nonmember firms or to offer a basic insurance plan.

The bill would preempt state laws that require health insurance plans to cover specific services or types of care. It would also overturn state-erected barriers to managed care, including restrictions that prevent insurers from negotiating fees, limiting the selection of providers, or reviewing utilization.

Medical and Health Insurance Information

Title III of the bill aims to control health care costs by providing consumers with data on the cost of health insurance and the quality of health care and by promoting the electronic transmission of data. The estimate delays the effective dates specified in the bill by one year.

To assist consumers in evaluating health insurance plans and health care services, the bill would require each state to develop and implement a program for providing consumers with information on the comparative value of health

plans and services. Initially, the information made available would include the average prices of common health care services, the premiums charged for health insurance plans, and the value of health insurance benefits. Within four years of enactment, the states would have to publish data on quality and outcomes for health insurance plans and hospitals. Federal agencies that provide health care or health insurance would be required to make available similar information about their programs.

The bill would attempt to reduce the administrative costs of health care and health insurance by standardizing health insurance claims forms, electronic medical data, and the electronic receipt and transmission of health insurance information. The bill would preempt state "quill pen" laws, which require that medical or health insurance records be kept in written rather than electronic form. Hospitals that receive payments from Medicare would be required to maintain an electronic system of patient care information and transmit data electronically to Medicare's fiscal intermediaries and carriers starting in 1997. Other health care providers could be required to transmit data electronically to federal agencies starting in 1999.

Reforming Liability for Medical Malpractice

To reduce the costs of malpractice insurance and defensive medicine, the Michel bill would modify state laws governing medical malpractice, encourage the development of state quality assurance programs and standards of care, and require nonbinding arbitration of most health care liability claims.

States would be required to enact various changes in laws governing medical malpractice or would lose various federal grant payments. In any legal case, each defendant would be liable only for his or her share of any non-economic damages, such as pain and suffering. Noneconomic damages would be limited to $250,000 per case. Awards for damages would be reduced by the amount of any other public or private payments intended to compensate for the same injury. Health care providers would be permitted to make periodic payments to compensate for future economic damages and could generally not be required to make the payment in a lump sum. States would also be required to establish at least one alternative mechanism for resolving disputes, such as mediation or pretrial screening.

ESTIMATED FEDERAL COSTS

Several provisions of H.R. 5919 would affect federal revenues or outlays. The electronic filing of claims would produce some small savings in the Medicaid program. The deduction of health insurance costs for the self-employed and the expansion of employer-provided health insurance would reduce federal revenues. Table 6 summarizes the estimated budgetary effects of the bill.

Electronic Claims Filing

The development of requirements and standards for the electronic transmission of health insurance claims would reduce administrative costs in both the public and private sectors. It is widely held, although difficult to substantiate, that electronic processing and standardization of claims would result in savings of $1 to $2 per claim.

The federal share of any savings would be relatively small. The Health Care Financing Administration indicates that, by the effective date of this provision, Medicare should be electronically receiving and transmitting most claims. Therefore, this provision would result in no additional savings to the Medicare program. Although Medicaid programs in about half of the states have developed some elements of an electronic payments system, CBO assumes that this legislation would speed the transition to a fully electronic system. By 2000, federal and state governments would each save about $200 million per year, or about $1.50 per claim.

The estimate assumes that the provisions in H.R. 5919 regarding electronic claims processing and information on the comparative value of health care services would, on balance, have little impact on private health expenditures or on the number of people with private health insurance. Insurance companies are already taking steps to increase the number of health insurance claims that are handled electronically, and some further increases in the proportion of electronic claims are likely under current policies. By giving the Secretary discretion about whether to require electronic claims processing, the bill does not assure that more claims would be handled electronically. Universal electronic billing would require that providers submit all claims for their patients rather than collect payments directly from patients, who would then file for insurance reimbursement.

TABLE 6. ESTIMATED BUDGETARY EFFECTS OF H.R. 5919
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000
	Outlays					
Electronic Claims Filing	a	a	a	a	a	a
Authorizations of Appropriations[b]	a	a	a	a	a	a
Total, Outlays	a	a	a	a	a	a
	Revenues					
Deduction of Health Insurance for the Self-Employed	-1	-1	-1	-2	-3	-3
Regulating Employment-Based Health Insurance	a	a	-1	-1	-1	-1
Total, Revenues	-1	-1	-2	-3	-3	-4
	Deficit					
Total Effect of H.R. 5919	1	1	2	3	3	3

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

a. Less than $500 million.

b. These changes would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

Tax Deduction of Health Insurance for the Self-Employed

The estimate of the cost of the tax deduction of health insurance for the self-employed was provided by the Joint Committee on Taxation. The estimate reflects the cost of the deduction both for those who already have health insurance and those who would purchase insurance as a result of the reduction in its after-tax price. By 2000, this provision would cost the federal government $3.0 billion per year, add 200,000 people to the rolls of the insured, and increase national health expenditures by $0.6 billion.

Regulating Employment-Based Health Insurance

Several aspects of the bill would affect the availability or cost of employment-based health insurance. To the extent that these provisions increased employer spending on health insurance, they would reduce federal revenues by substituting untaxed fringe benefits for taxable cash compensation.

Guaranteed health insurance coverage for small businesses, the pooling of risk, and the prohibition on denying coverage on account of a person's health would reduce the cost of health insurance for people considered to be bad risks but would increase the cost of insurance for good risks. Firms employing above-average risks would be thereby encouraged to offer insurance, but some firms with below-average risks might drop insurance, and the estimate assumes that there would be no net change in the number of people with insurance. Private health expenditures would rise modestly, however, because the newly insured high-risk people would demand more health care. The increase in health expenditures would result in higher employer spending for health insurance, lower wages subject to income and payroll taxes, and lower federal revenues.

The preemption of state-mandated benefits would allow companies to sell less inclusive health insurance policies at a reduced cost. As a result, more individuals and firms would purchase health insurance coverage. The use of health care services by newly insured people would increase, but some individuals and firms would choose less comprehensive insurance policies and would end up using fewer services. The net effect on national health expenditures is not clear; this estimate assumes no change.

Malpractice Reform

As explained in Chapter I, the estimate assumes no reduction in national health expenditures and no increase in health insurance coverage as a result of the proposed reforms in malpractice insurance. Widespread adoption of medical practice guidelines would probably result in the increased use of some medical services and reductions in the use of others. Similarly, standardization of malpractice awards could result in more compensation in some cases and less in others.

EFFECT ON NATIONAL HEALTH EXPENDITURES

Two elements of H.R. 5919--allowing self-employed people to deduct the cost of health insurance from their taxable income and pooling risks among small businesses--would increase the use of health care services. Some of the increase in private spending for health care, however, would replace spending by state and local governments in public hospitals and clinics. The total effect on national health expenditures would be modest.

CHAPTER V

H.R. 5936, MANAGED COMPETITION ACT OF 1992

H.R. 5936 was developed by the Conservative Democratic Forum's (CDF's) task force on health care reform, led by Congressmen Jim Cooper, Michael Andrews, and Charles Stenholm. The bill's sponsors describe it as "a 'pure' version of managed competition, in that it avoids global budgets or employer mandates."

H.R. 5936 was introduced in September 1992, as the second session of the 102nd Congress drew to a close. This estimate assumes that the bill is enacted in 1993 and delays the specified effective dates by one year.

SUMMARY OF THE BILL

The CDF bill would attempt to control costs and expand access to health insurance by restructuring the way health insurance and health care are provided. A national health board would oversee the health insurance market and establish criteria for accountable health plans (AHPs); regional health plan purchasing cooperatives (HPPCs) would allow individuals and small groups to purchase health insurance on the same terms as large groups. The tax deduction of health insurance premiums would be limited to the cost of the least expensive AHP in the region. The bill would replace the Medicaid program with a new federal program that would help low-income people purchase health insurance coverage through their local HPPC. Other provisions of the bill are designed to improve access to health care in rural and other underserved areas, expand preventive health programs, establish uniform standards for malpractice claims, and simplify the administration of health insurance.

Managed Competition

Managed competition is intended to encourage health insurers and health care providers to compete by offering high-quality, low-cost care and not by attempting to cover only the healthiest individuals. The system of managed competition created by the bill would not affect the Medicare program or private medigap health insurance policies.

The national health board would specify a uniform set of health insurance benefits that must cover all medical treatments that have been shown to be effective and must provide uniform deductibles and cost sharing. The board would also establish standards for reporting prices, health outcomes, and measures of consumer satisfaction and furnish information to consumers on the quality of the care provided by health plans. Plans that met the board's standards would be registered as accountable health plans.

Accountable health plans would be of two types. Closed plans would be limited to employees of large firms or to other groups of at least 1,000 people, such as members of a union. Open plans would be required to accept all applicants and could not turn people away because of poor health. AHPs would be prohibited from basing premiums on a person's health status or claims experience; they could vary premiums only on the basis of geographic location, family status, or age. An accountable health plan could offer more benefits or lower cost sharing than the standard package, but these items would have to be offered and priced separately from the uniform benefit package.

Changes in the tax code would strongly encourage the use of accountable health plans. Employer payments for health insurance or a self-insured plan above the cost of the lowest price AHP in the area, as well as all payments to a plan that is not an AHP, would be subject to a 34 percent excise tax. Individuals would be allowed to take a tax deduction for premiums paid to an accountable health plan, but the individual and the employer could together deduct no more than the cost of the cheapest AHP.

Health plan purchasing cooperatives would be established by each state. All individuals except those working for businesses with more than 1,000 employees (up to 10,000 employees at each state's option) would have to purchase their accountable health plan through the HPPC to receive a tax deduction, but no one would be required to obtain insurance. Each HPPC would cover an exclusive area--an entire state, a portion of a state, or an interstate region. An HPPC would offer each eligible individual the option of enrolling in any one of the open AHPs in its area. The HPPC would collect all premiums and distribute them to the open AHPs. Small businesses would have to provide for payroll deduction of an individual's premium, but employers would not be required to enroll their employees in a plan or contribute to the cost of coverage. Using a procedure established by the national health board, the HPPC would pay relatively more to AHPs that have enrolled high-risk individuals and less to AHPs with low-risk enrollees. The HPPC would also reconcile the payment of premiums and cost-sharing amounts for low-income individuals among both open and closed AHPs. The expenses of the HPPC would be financed by a surcharge on insurance premiums.

Large firms would be required to allow each employee to enroll in an accountable health plan costing the employee no more than the cheapest AHP. Like small businesses, large firms would have to provide for the payroll deduction of premiums and would not be required to pay any of the cost. Unlike small businesses, however, large firms would not participate in the local HPPC but would deal directly with an open AHP or offer a self-insured plan.

Assistance to Low-Income People

H.R. 5936 would repeal Medicaid and establish a new program to assist low-income people in purchasing health insurance. Except for those eligible for Medicare, individuals and families with income below the poverty level would be eligible to join AHPs with no premium and only nominal copayments. They would also receive assistance in obtaining types of health care that are now typically provided by Medicaid but would not be included in the uniform set of benefits. Those with income between 100 percent and 200 percent of poverty would be responsible for paying a portion of premiums and copayments based on a sliding scale. Low-income people eligible for Medicare would be helped to pay Medicare's premiums and cost sharing.

To help finance the assistance to low-income people, the bill would repeal the dollar limit (currently $135,000) on the amount of wages subject to the Medicare Hospital Insurance tax. If the increase in the Medicare tax, the other tax changes, and the savings from repealing Medicaid fall short of covering the full cost of low-income assistance, the bill provides for scaling back the amount of premium assistance provided to low-income people not eligible for Medicare.

As a result of the bill, states would no longer have to pay a share of Medicaid, but they would assume full responsibility for long-term care. The bill provides temporary federal financial assistance to those states in which state and federal spending on long-term care exceeds the state's share of Medicaid. This assistance would be phased out over four years.

Other Provisions

H.R. 5936 would improve access to health care in rural and other underserved areas by authorizing additional funds for migrant health centers, community health centers, the National Health Service Corps, and area health education centers.

The bill would expand preventive health services. It would increase authorizations for several public health programs, including immunization against vaccine-preventable diseases, prevention of lead poisoning, prevention of breast and cervical cancers, health information and health promotion, and the preventive health services block grant. The bill would also expand Medicare to cover screening for colon and breast cancer, vaccination against influenza and tetanus-diphtheria, and well-child care. The additional Medicare preventive services would be financed by an increase in the premium for Medicare's Supplementary Medical Insurance.

The bill would establish uniform federal standards for malpractice claims, including limiting claims for noneconomic damages and reducing long statutes of limitations. It would also authorize grants to states to develop systems of resolving malpractice disputes other than through court proceedings.

The bill would attempt to reduce the administrative costs of health insurance by establishing goals for standardizing claims forms and electronic transmission of data. If the goals were not met, the national health board would set standards and requirements for health plans.

ESTIMATED FEDERAL COSTS

H.R. 5936 would provide federal assistance to help low-income people purchase health insurance through their local health plan purchasing cooperative. The cost of this assistance would be largely covered by the savings from repealing Medicaid and by the additional tax revenues from limiting the deductibility of health insurance premiums. Table 7 summarizes the estimated effects of the bill on outlays, revenues, and the federal deficit.

Low-Income Assistance

The estimated cost of low-income assistance was calculated separately for poor people and for people with income between 100 percent and 200 percent of the poverty level. The number and characteristics of people in these categories are derived from the March 1991 Current Population Survey, extrapolated through 2000.

Under H.R. 5936, the federal government would subsidize the health insurance premiums of poor people. The subsidy would cover any premium not paid by the individual's employer, up to the cost of the lowest-priced AHP. Because group- or staff-model health maintenance organizations can provide

TABLE 7. ESTIMATED BUDGETARY EFFECTS OF H.R. 5936
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000
Outlays						
Low-Income Assistance						
For people in poverty	95	132	141	149	158	171
For people with income between 100 percent and 200 percent of poverty	5	9	12	14	17	19
Subtotal	99	141	152	163	175	190
Repeal of Medicaid	-75	-113	-126	-142	-160	-179
Assistance for Long-Term Care	1	1	1	a	0	0
Authorizations of Appropriations[b]	a	a	a	a	a	a
Total, Outlays	25	30	27	22	15	11
Revenues						
Income and Payroll Taxes on Additional Income	10	15	17	18	19	20
Deduction of Employee Share of Health Insurance Premiums	-3	-10	-11	-11	-12	-12
Deduction of Health Insurance for the Self-Employed	-1	-2	-2	-2	-2	-3
Tax Deductions for the Previously Uninsured	-1	-1	-1	-2	-2	-3
Repeal of Limit on Earnings Subject to Medicare Tax	6	7	7	8	8	9
Total, Revenues	11	8	10	10	11	11
Deficit						
Total Effect of H.R. 5936	14	22	17	12	5	-1

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

a. Less than $500 million.

b. These changes would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

health care more efficiently than other organizational forms, the estimate assumes that they would offer the lowest-priced plan in most areas. The annual premium is assumed to equal $2,130 per person in 1995, adjusted by the rate of increase of per capita national health expenditures thereafter.

H.R. 5936 does not specify the uniform package of health benefits but leaves it to be determined by the national health board. The premium figure used in this estimate represents the cost of a typical HMO for a group that would include most current Medicaid beneficiaries, who make relatively heavy use of medical care services. The estimated budgetary effects of H.R. 5936, however, are extremely sensitive to the assumed premium. A higher premium would increase the cost of low-income assistance, reduce tax revenues, and add to the deficit.

Because of limited capacity, HMOs would not be able to enroll all poor people immediately. Creating additional HMOs, especially the staff- and group-model varieties, requires managerial talent, capital investment, and time. Until more HMOs are established, poor people who are unable to enroll in the least expensive HMO would have to be covered by other plans. Although H.R. 5936 makes no provision for this situation, the estimate assumes that, during a five-year transitional period, the federal government would pay the extra insurance costs of those poor people who could not enroll in the cheapest plan.

In addition to subsidizing health insurance premiums for the poor, the federal government would pay for health care services that Medicaid now typically provides but the basic plan would not fully cover. The cost of these special services--for example, outpatient prescription drugs, dental care, eyeglasses and hearing aids, and mental health benefits--was estimated from tabulations provided by the Health Care Financing Administration, which administers Medicaid.

Enactment of the bill is likely to cause a few employers to drop their health insurance plan and allow the government to assume the cost of covering their low-income workers. The estimate assumes that one-third of the poor who work for firms with fewer than 25 employees and who currently have employer-sponsored insurance would lose that coverage and receive the full federal subsidy. For other poor people with employer-sponsored insurance, the employer is assumed to pay 90 percent of the total premium, with the government paying the remaining 10 percent. Based on experience with other benefit programs, the rate of participation in the program is assumed to be 90 percent. An additional 15 million poor people would receive insurance coverage under this provision in 2000.

People with income between 100 percent and 200 percent of poverty would receive a partial subsidy of their premium. All people in this income range who now purchase individual health insurance are assumed to claim the subsidy immediately. The subsidy would eventually encourage 30 percent of the uninsured in this income range (about 4 million people) to purchase insurance, assuming a long-run elasticity of demand of -0.6, although it would take five years to reach this rate of participation. For both categories of people, the average subsidy is estimated to be half of the minimum AHP premium. For those who have employer-sponsored insurance, the estimate assumes that the government pays the full amount of the employee's share, or 10 percent of the premium, starting in the first year.

To facilitate comparison with other bills, the estimates in Table 7 assume that the full amount of low-income assistance specified in the bill would be provided, even though the bill does not raise sufficient revenues to cover its costs in its early years. To make the bill deficit neutral, the amount of low-income assistance would have to be reduced by about 15 percent in 1995, and the AHPs would have to make up the lost revenues by raising their rates. In an official cost estimate, CBO would have to take these adjustments into account.

Repeal of Medicaid and Phaseout of Assistance for Long-Term Care

H.R. 5936 would repeal the Medicaid program. The estimated savings equal the total federal share of Medicaid in the CBO baseline.

Under current law, Medicaid provides comprehensive health insurance benefits to certain children, pregnant women, and others with high medical expenses whose income exceeds the poverty threshold. By 2000, Medicaid will cover an estimated 8 million nonpoor people. Under H.R. 5936, people with income above poverty would be eligible for only a partial subsidy of a more modest set of benefits. CBO estimates that about 6 million of these people would choose not to purchase health insurance and would become uninsured.

In exchange for the federal government's assuming responsibility for the cost of acute health care services for the poor, the states would become fully responsible for long-term care. Although states in the aggregate would gain from this trade, many small states would initially be worse off. To ease the transition, the bill would provide funds to states that spend a very large share of their Medicaid funds on long-term care. The cost of this temporary assistance for long-term care was estimated using state-by-state data on Medicaid spending from the Health Care Financing Administration.

Other Spending

The additional prevention benefits in Medicare would not increase outlays because they would be financed by an increase in Medicare premiums. For the reasons cited in Chapter I, the estimate assumes no savings from reforms in malpractice insurance or in the administration of health insurance.

Changes in Revenues

The Joint Committee on Taxation estimated the effects of the provisions of the bill that would affect federal tax revenues. CBO and JCT assumed that firms would avoid paying the 34 percent excise tax on excess health insurance premiums by limiting their contributions to the cost of the minimum AHP and returning the excess to workers in the form of higher wages. Under this assumption, the proposal would be equivalent to treating employer-paid health insurance premiums in excess of the limit as taxable income for employees. In either case, federal revenues would rise because more compensation would be subject to both personal income and payroll taxation. Because of uncertainties about the distribution of health insurance premiums paid by employers, the estimate of this provision is very preliminary and subject to revision.

The revenue loss from the deductibility of health insurance premiums was estimated in three parts--the cost of deducting the employee share of premiums for those who are currently covered by insurance, the cost of deducting premiums currently paid by the self-employed, and the cost of deductibility for those who would obtain health insurance as a result of the bill. More people would purchase insurance because the tax deductibility of premiums, the subsidy for people with income below 200 percent of poverty, and reductions in administrative costs would lower the effective price of insurance. Also, people could no longer be denied coverage because of their health status. Based on CBO's estimate of the elasticity of demand for the purchase of health insurance, the revenue estimate assumes that 30 percent of the uninsured with income between 100 percent and 200 percent of poverty (4 million people) would buy insurance, and that 15 percent of the uninsured with income over 200 percent of poverty (another 2 million) would do so.

EFFECT ON NATIONAL HEALTH EXPENDITURES

CBO's study *Managed Competition and Its Potential for Reducing Health Expenditures* (May 1993) identifies features that would help maximize the

savings in national health expenditures from adopting managed competition. H.R. 5936 contains some of these items:

- The creation of HPPCs to oversee and operate the insurance market and help consumers make better-informed choices;
- A limit on the tax-exempt amount of employee health benefits;
- The development of data on costs, outcomes, and quality.

The bill lacks several features, however, that would eliminate selection of favorable risks by insurers and would cause competition to focus on price and quality alone:

- Participation in HPPCs would be far from universal. Medicare beneficiaries, employees of large firms, and individuals who were willing to forgo the tax deductibility of their premiums would not be included.
- All individuals would not be charged the same rates. Closed plans could be self-insured, and the risk adjustment of payments to insurers would not apply to them.
- Benefits would not be fully standardized. Insurers would not be prohibited from offering plans with more generous benefits or lower cost sharing than the uniform package, although the add-ons would have to be offered and priced separately.

Although the introduction of managed competition could result over time in a reduction in the rate of increase in national health spending, the omission of these elements would significantly lessen its potential effectiveness.

CBO estimates that, after a few years, H.R. 5936 would leave national health expenditures only a little higher than they would otherwise be. Because the bill would make relatively comprehensive health insurance benefits available to a much larger group than is currently covered, national health expenditures would be higher in the first few years. The estimate assumes that the newly insured would increase their use of health services by 80 percent. The growth in per capita health expenditures would gradually slow, however, as more people enrolled in health maintenance organizations.

Because group- or staff-model HMOs can provide health care more efficiently than other organizational forms, they would probably be the lowest

bidders in many HPPC areas. H.R. 5936 would increase the difference in effective prices between HMOs and fee-for-service plans because people would have to pay the extra cost out of after-tax rather than before-tax income. The standardization of benefits would also make differences in prices much more apparent. Therefore, more people would be expected to enroll in HMOs and fewer in fee-for-service plans, and the growth in national health expenditures would slow. Capping the amount of health insurance that would be tax deductible would also encourage some workers to choose only the standard benefit package, which would also tend to reduce their health expenditures. The estimate assumes that the tax cap and the increase in HMO enrollment are the only elements of the bill that would significantly reduce the growth in national health expenditures during the period of the estimate. By restructuring the market for health insurance, however, this version of managed competition might produce additional savings over a longer time horizon.

Based on the experience of California and Wisconsin--states whose health insurance programs for public employees are similar to managed competition--CBO assumes that three-quarters of the nonpoor, urban population would ultimately choose HMOs instead of more expensive fee-for-service plans. These rates of coverage would be achieved gradually over five years.

For those who shift from traditional health insurance to HMOs, the use of health care services would fall. CBO's review of the literature suggests that group- and staff-model HMOs reduce personal health expenditures by about 15 percent from their levels under traditional private health insurance with typical copayments. Other types of HMOs, such as independent practice associations, may also reduce health care costs, but the evidence is less conclusive. This estimate assumes that enrolling additional people in HMOs will, on average, reduce their use of health care services by 7½ percent.

For those who remain covered by traditional health insurance, however, the use of health care services would rise. Under H.R. 5936, all accountable health plans must offer the same package of benefits, including the same deductibles and coinsurance. Based on the results of the RAND health insurance experiment, the estimate assumes that reducing coinsurance from the levels now typical of indemnity insurance plans to the nominal amounts charged by HMOs would increase medical expenditures by 20 percent. This assumption adds almost $40 billion to national health expenditures in 2000.

H.R. 5936 would increase federal and private health expenditures while reducing spending by state and local governments. Federal spending would rise as a result of the additional low-income assistance. Some of the cost of

assisting low-income people, however, would be borne by nonsubsidized participants in the HPPCs, whose health insurance premiums would rise to reflect the relatively heavy use of medical care services by current Medicaid beneficiaries. Private health expenditures would also grow because of the increased use of services stemming from the reduction in coinsurance requirements in fee-for-service plans, partly offset by the decreased use of services by those joining HMOs. State and local governments would, on balance, benefit from being relieved of their share of Medicaid's payments for acute care, while being made totally responsible for long-term care. State and local spending on care for the uninsured would also fall.