PART III. Additional Policy Considerations and Conclusions

Additional Policy Considerations 9

This report presents a summary of available analyses of the potential economic impacts of four broadly-defined approaches to health care reform. OTA has attempted to gather and summarize studies that are likely to be the most credible given their institutional origins. However, the purpose of this document is neither to come to conclusions about the accuracy of either the size or the tendency of any of the estimates nor to synthesize the estimates and come to a conclusion about potential economic impacts of choosing any one approach over another. Moreover, even if these estimates might be used to suggest the direction or magnitude of potential economic impacts, quantitative analyses of the approaches in and of themselves cannot fully answer the question, ''Which route to health care reform? The answer is likely to depend on more than financial issues.

Most of the approaches to health care reform analyzed here assume, at least implicitly, the possibility of having a national health policy.[1] Arguably, this is a relatively new concept in the approach to providing health care in the United States, and it could promote a somewhat different way of appraising competing approaches to health care reform.

To date, much of the health care reform debate has been fueled largely by concerns about: 1) the rising health care costs; and 2) lack of access. Each sector has seemed to want relief from its own burden of costs or lack of access or both. Little attention has been paid to how the facets of the U.S. economy are interrelated and

[1] TWO important notes: 1) A national health policy is not the same as national health insurance or a national health system. 2) Even approaches that propose the use of individual vouchers or tax credits in a market-oriented system would probably have to make changes at the national level that would result in having a national health policy, and necessitate some monitoring at the national level of the effects of any changes.

dependent on one another, and perhaps even less to the social and political implications of change. The little that has been done related to the economy as an integrated whole, however, suggests that any change in health care spending and savings is likely to have repercussions in many of its sectors, both private and public. These areas—employers, employment, households, government at all levels—are in turn: 1) related to each other and 2) likely to influence the Nation's ability to spend money on health care and other services.[2] In turn, economic change-and changes in health care delivery systems--can affect the social and political landscape, potentially disrupting long-held American traditions (15).

In finding the appropriate route to successful health care reform, policymakers may find it useful to ask themselves a number of key questions. The basic issues relate to overriding values and social purposes, primarily:

1. the health- and health-care-related goals of health care reform; and
2. the other important social, political and economic values that they are trying to further through health care reform.

Listed below are key questions within each of these areas pertinent to comparing approaches.

THE HEALTH- AND HEALTH-CARE-RELATED GOALS OF HEALTH CARE REFORM

- Key questions pertinent to the health- and -health-care-related purposes of health care reform include:
  - —Is a fundamental purpose of health care reform to expand or achieve universal access to *insurance* coverage or expand or achieve universal access to *health care* services? And by access do we mean financial and/or physical access to health care services (e.g., for rural and/or inner-city Americans), and to what level of services?
  - —Is a fundamental purpose of health care reform to improve health status? If so, whose, and to what level?
  - —Is a fundamental purpose of health care reform to improve quality of health care? If so, how? And how will the Nation know when improvement has occurred?
  - -Should the provision of health care coverage and services be used to promote changes in lifestyles?
  - —Do we want insurance (that is, some protection from large and unexpected health care costs) or prepaid, comprehensive health care?

OTHER SOCIAL, POLITICAL, AND ECONOMIC VALUES

- Key questions pertinent to the social, political, and economic purposes of health care reform include:
  - —Is a fundamental purpose of health care reform to establish a right to health care? Should this right be moral or legal?
  - —Is a fundamental purpose of health care reform to reduce or contain health care spending (national health expenditures)? If so, to what purpose?
  - —Is a fundamental purpose of health care reform to redistribute the burden of payment for health care coverage and/or services? If so, to what extent? Should there be equity in payment for all Americans? If so, how is it to be measured?
  - —What is the appropriate role (including their respective shares of the burden for health care spending) of government versus the private sector in financing health care?
  - . What is the appropriate role (including their respective shares of the burden for

[2] Conversely, no change—that is, a continuation of trends that increase expenditures and decrease coverage—will also have widespread economic implications, both positive and negative (78).

health care spending) among levels of government (Federal, State and local)?

- What is the appropriate role of employers? Should employers continue to be the primary sponsors of health insurance-and, thus, gateways to health care-for AmeriCans?
- What is the appropriate role of the individual in paying for health care? Should sick people (or other high users of health care) be responsible for a greater share of overall health care costs?
- —What are the roles of competition and regulation in the health care system?
- . Should the purchase of insurance coverage be mandatory for either individuals or employers? What political, social and economic ramifications would that have?

These questions seem at least as important as quantitative analyses in helping to estimate the potential effects of specific legislative proposals.

Conclusions and a Provisional Checklist for Policymakers

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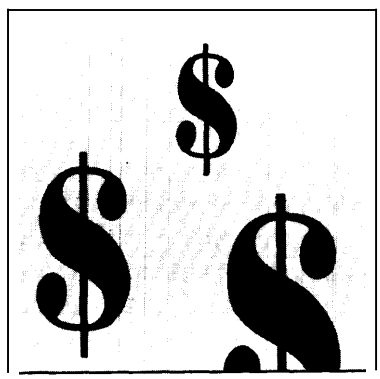
CONCLUSIONS

OTA's review suggests that estimates of the projected costs to various sectors of the economy and public vary for a variety of reasons. These reasons include but may not be limited to: basic assumptions about coverage, approaches to payment, and cost controls underlying the approaches; the year(s) subject to analysis; and proprietary features of the mathematical models used to analyze what might happen. There are likely to be various additional provisions, which in and of themselves could have a considerable economic impact, hidden within an approach named for its approach to health care cost containment or universal coverage. *

Policymakers should exercise caution when they are presented with any one analysis. In fact, they would likely benefit from having a guide available that includes some of the factors and assumptions that might explain how the various components of the reform approach being examined affect its impact on the various areas of the economy. Following summaries of the estimated impacts of major approaches to reform on national health expenditures and on effects in other areas of the economy,



[1] For example, while the term Managed Competition properly implies regulated competition among the collectors and distributors of health care coverage funds (15), approaches labeled Managed Competition may also include specific assumptions about:

- particular sources and flows of financing (e.g., employer mandates versus individual vouchers versus continuation of the Nation's voluntary system of health insurance; limits on the tax exclusion available for employer-sponsored health insurance premiums);
- the extent of coverage (core benefits); and
- expenditure targets or limits.

In the current environment, where labels come and go in terms of political popularity, these specifics are not readily apparent from the label, Managed Competition.

this chapter provides a provisional "checklist" that policymakers could use as they contemplate the relative virtues of competing approaches to health care reform.

Which Approaches Will Reduce National Health Expenditures?

OTA'S review finds that, *regardless of the approach to health care reform, the* **ways in** which analysts are able to project savings (in national health expenditures, at least-not with respect to distributive effects) appear to be limited to the extent to which the analysis (or plan):

- establishes a' 'cap' on expenditures at a certain level [i.e., Meyer (43); GAO (83)/both Single Payer; NLCHCR (49) and Silow-Carroll's "Optimistic Scenario' (66) regarding Play-or-Pay]; or
- assumes price controls at, for example, Medicare payment rates [i.e., CBO/Single Payer (77)]; or
- does not assume universal coverage [i.e., all analyses of the Bush Administration proposal (3,65,94); or
- assumes universal coverage but substantially cuts back on the scope of coverage [i.e., Heritage (6,35)]; or
- assumes high levels of savings from either managed care or administrative savings or both [i.e., Long and Rodgers, re: Managed Competition without a global budget (40)].

OTA finds that the reasons proposals, or analyses of them, need these assumptions to achieve savings are that:

- any approach that increases availability of coverage to people who are currently uninsured will not reduce national health expenditures because it is likely to increase the use of health care services. In this respect, ''any approach" includes the insurance market reforms that are designed to increase availability of coverage (e.g., guaranteed issue). Broader approaches to reform (Single Payer; Play-or-Pay; Managed Competition; Individual Vouchers or Tax Credits) either: a) would not inherently reduce national health expenditures without the imposition of a global budget (e.g., Canadian-style Single Payer); orb) have not been tried, so we do not know what their effects on health care spending might be (e.g., highly procompetitive private market approaches, including pure or Enthoven-type Managed Competition).
- administrative reforms alone are not likely to save enough money to expand coverage, especially over time, to those people who are currently uninsured.

Why Do Estimates Vary So Much?

The following illustrates the importance of identifying key assumptions if comparisons within and across approaches are desired. As noted above, most—but not all-analyses estimate that *any* of the approaches reviewed here will probably result in reductions in national health expenditures (table 1 in chapter 1). But the estimates of the impact on national health expenditures of just "Canadian-style' approaches varied in one recent year (the year 1991) from an estimated *increase* of $21.0 billion (34) to *savings* of $241.0 billion (43). In reviewing these estimates, it would be important for policymakers to be aware that the reason for much of the variation between these two extremes appears to be the assumption made by Meyer and his colleagues that national expenditure limits would reduce health care spending to 8.7 percent of U.S. GDP in the first year of the system's implementation, that is, in 1991 (43). This assumption was in large part responsible for the estimate of $241.0 billion in savings. The other analysis, by Lewin-VHI, assumed no change in national health spending in the first year of plan implementation, again, 1991 (34). Thus, two analyses of a similar Single Payer approach to health care reform arrived at two widely divergent estimates of the impact of the system in the United States in large part because their assumptions were essentially at the extremes

from one another. Even after this difference in assumptions is accounted for, however, a difference in the tens of billions between estimates may remain (61).

To the extent that they can even be compared with estimates of the impact of other approaches on national health expenditures, assessments of the impact of a Canadian-style Single Payer approach overlap considerably with approximations of the costs or savings from other approaches to reform (table 1 in chapter 1).

Further, the above illustrates the wide variation in estimates for just one initial year of a plan's implementation. Many analyses provide estimates for the first year of a plan that may not be indicative of the long-term effects, beneficial or adverse, of an approach. Despite the wide-ranging long-term impacts that any approach to health care reform is likely to have, there are few estimates of the cumulative impacts of competing approaches to health care reform on various areas of the economy.

Many analyses do not look at the impact of an approach on the various areas of the economy in relation to one another. This void tends to obscure the totality of change that might be expected from the implementation of a particular approach.

Not surprisingly, for example, the available estimates suggest that a Play-or-Pay approach to universal coverage will result in lower government spending than will a tax-financed approach to universal coverage (table 2 in chapter 1). Conversely, the employment-based approach seems more likely than the fully tax-financed (Single Payer), the Individual Voucher or Tax Credits, or various Managed Competition approaches to result in greater expenditures, relative to other sectors of the economy, by employers, unless, for example, the Managed Competition approach is implemented with an employer mandate (table 3 in chapter 1). When numbers are put forth independently, these relationships are generally obscured.

A PROVISIONAL CHECKLIST TO GUIDE POLICYMAKERS

Policymakers reviewing analyses of approaches to health care reform with an eye to identifying the key factors and assumptions behind the analyses would facilitate their own development of public policy by:

1. isolating specific components of reform proposals;
2. identifying the potential impact of these components; and
3. examining whether these impacts are acceptable or unacceptable.

OTA has identified key questions that can help policymakers understand why the results of analyses of competing approaches differ. These key questions, along with examples of how variations in the assumptions can materially affect estimates, are listed in Box 1O-A.

Box 10-A—Provisional Checklist: A Guide for Policymakers

Policymakers evaluating approaches to and proposals for health care reform, as well as analyses of them, could use this provisional checklist to guide them in their review. It presents some of the key questions that should be asked in order to analyze the economic impact of reform approaches and proposals, and provides examples of the possible effects that variations in particular assumptions or components may have. It is important to note that estimating the economic impacts of health care reform approaches and proposals is very difficult due to the paucity of details provided regarding the approach or proposal, in many cases, and the speculative nature of many of the assumptions about these details as well as changes in behavior under a new system. Therefore, while policymakers may not need to dissect every assumption, policymakers seeking to implement appropriate and feasible reforms may want to determine whether the assumptions are reasonable, both politically and operationally. This checklist is intended to assist policymakers in this endeavor.

What Assumptions Does the Analysis Make With Respect to *Access* to Health Care Coverage and/or Services?

Questions	Example of Possible Effects
• Are individuals required to obtain health benefits coverage or does coverage remain voluntary?	If coverage is mandatory, universal coverage (coverage for all Americans) would essentially be achieved. However, even if coverage is mandatory, access to health care services will be affected by the scope and depth[1] of coverage, and the cost of coverage and health care services (see below). If coverage remains voluntary, even if it is made more affordable, some people will undoubtedly remain uninsured. This will likely affect their access to health care services as well as have implications for the distribution of the burden of financing health care if they are unable to pay for their own care.
• If the proposal would provide universal coverage, what would the scope and depth of benefits be?	A more inclusive scope and greater depth of benefits is, all other things being equal, likely to result in higher levels of expenditures than is a narrow scope or shallower depth of benefits.
• What is the premium amount or the actuarial cost of coverage?	The premium or actuarial cost of coverage is used to calculate the total cost of coverage for the population which, in turn, affects the total amount of national health expenditures as well as the distributional impacts of the proposal among governments, households, and employers (see below). If the premium or actuarial cost of coverage dollar amount used is too high or too low, the resulting estimates of the impacts of the proposal will be inaccurate.
• Given the assumptions made about who would be covered by an approach or proposal, what is the assumed level of utilization of covered and noncovered services by: 1) people who are currently uninsured; and 2) people who currently have public or private insurance?	Most analyses assume, probably correctly, that currently uninsured people will increase their utilization of services when they become insured. Any changes in utilization in that group of potential beneficiaries, as well as among presently insured people, will affect national health expenditures by changing the total quantity and, thus, the total cost, of health services rendered to the population. The proposal scope and depth of benefits (see above) could affect assumptions about increases or decreases in utilization.

[1] The scope of coverage refers to the range of services, providers, and settings covered. The depth of coverage refers to the level of patient cost-sharing required under the plan (i.e., the deductibles, copayments, coinsurance, out-of-pocket maximums, maximum liability of the insurance plan).

What Assumptions Does the Analysis Make With Respect to *Controlling National Health Expenditures*?

Questions	Examples of Possible Effects
• **How are national health expenditures** defined in the proposal?	The current definition of national health expenditures is quite broad[2]. If a proposal, for example, narrows this definition for purposes of estimating costs, an analysis of the proposal may result in estimated savings in national health expenditures. These savings could not, however, be attributed to actual changes in health-care-related expenditures but merely to a change in the definition. *These expenses would still exist in the economy.* To date, no proposal appears to alter this definition but some analyses examine relatively narrow aspects of national health expenditures (e.g., businesses' liability for private insurance costs).
• **What is the baseline year used for estimating any quantitative impact** of **the proposal?**	Given that health care spending is projected to increase at an average annual rate of 9.6 percent from 1992 to the year 2000,[3] estimates which do not use the same baseline year will not be comparable, all other things being equal.
• **What is the baseline amount of national health expenditures used to estimate the impact of the proposal on national health care spending or savings?**	Given the projected rate of increase in national health expenditures, noted above, the baseline amount of national health expenditures used to calculate any changes in expenditures will affect any resulting estimates. Furthermore, if the same baseline dollar figures are not used, the resulting estimates will not be comparable.
• **Does the proposal assume the implementation of health care cost controls (e.g., a national health budget; hospital global budgets; provider price controls; controls on the use of services; regulation of capital decisions, and of the adoption of and dissemination of new technology; and incentives to alter consumer behavior, for example, cost-sharing[4])? If so, are these limitations enforceable?**	To the extent that health care cost control measures effectively limit the rate of growth in health expenditures to its present rate or reduce this rate, they will have a *major* effect on estimated savings in national health expenditures, particularly over time. Absent a future redefinition of aggregate health expenditures, *key to the success of such measures (and the accuracy of any projections) will be whether each measure is strictly delineated, mandatory, and enforceable.* Analyses which assume the implementation of stringent expenditure limits will most likely estimate larger savings, in particular over time. Whether these limits or other cost control measures are reasonable and feasible is a critical determination in assessing the economic impact of a proposal incorporating such measures.

[2] "National health expenditures," as defined by the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), Office of National Health Statistics, are divided into two broad categories: 1) health services and supplies, and 2) research and construction of medical facilities. Health services and supplies, in turn, consist of expenses related to personal health care, public and private program administration and the net cost of *private health insurance* (administrative costs), and government public health activities.

[3] U.S. Congress, Congressional Budget Office, *Projections of National Health Expenditures*, October 1992 (79). CBO recently revised its projections of the average annual rate of growth in national health expenditures downward from 9.6 percent to 8.8 percent for the years 1992 to 2000 (32). The U.S. Department of Commerce recently reported that health care spending increased by 11.5 percent from 1991 to 1992 bringing it to 14 percent of the Nation's GDP (92).

[4] A chapter addressing the current state of knowledge of the impact of patient cost-sharing on the use of health care services, the cost of services, and on health status, will appear in the forthcoming main report of OTA's assessment *Technology, Insurance, and the Health Care System.*

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Box 10-A—Provisional Checklist: A Guide for Policymakers—Continued

• **Does the proposal assume savings from insurance market and paperwork (administrative) reforms and, if so, are these savings reasonable?**	Most proposals would modify the insurance market as well as streamline the paperwork burden, for example, through electronic claims submission and billing. The first problem in comparing administrative costs across analyses is definitional; that is, what administrative costs are included in the estimates. Second, are the savings estimates from modifications in administrative costs related to insurance market and paperwork reforms reasonable. Third, are there offsetting costs dictated by the development of new systems, for example, the collection and dissemination of health care information to consumers.

What Assumptions Does the Analysis Make With Respect to the *Redistribution* of the Burden of Financing Health Care?

The redistribution of health care costs among households, governments, and employers has important political significance. In the near-term and possibly the long-term, reforms may produce "winners" and "losers," to the extent that different actors are liable for the direct costs of health care.

Questions	Examples of Possible Effects
• **Does the proposal assume a limit on the tax deduction or exclusion for employer-sponsored health insurance benefits or a limit on an individual tax credit? If so: what changes in individual as well as corporate behavior are assumed to flow from the particular tax policy modification; what likely effects on health care spending are assumed; and are these effects reasonable?**	Limits on the tax deduction or exclusion for employer-sponsored health insurance benefits will result in additional dollars due to the Federal government to the extent that the dollar limit is below current average individual or family health insurance expenses. The extent to which this limit will actually change individual and corporate behavior regarding the amount of health insurance coverage purchased and the utilization of health care services is unknown (51). Thus, assumptions about the likely behavior of individuals and corporations are important yet fairly speculative factors in the estimates of resulting savings.
• **Are the redistributive effects discussed in terms of national health expenditures or only a subset of such expenditures, for example, private health insurance costs only?**	In order to evaluate the redistributive effects on financing of an approach or proposal, total national health expenditures are the usual baseline used (although certain related effects may not be captured by such an analysis [see below]). If an estimate deals with only a subset of these expenditures, the actual redistribution is obscured. For example, if an estimate deals with the change in household private insurance costs, but not with household out-of-pocket costs, a possibly significant cost of reform to households is not available to policymakers.
• **Does the analysis take into account the redistributive effects beyond those pertaining to national health expenditures, for example, impacts on employment?**	A reform approach or proposal may release funds to other areas of the economy thereby stimulating growth and improvements, or may result in employment losses due to changes in the systems of health care coverage and delivery. These changes are not captured by analyses which look strictly at the change in and redistribution of national health expenditures. These types of changes may have important social and political as well as economic implications. Such consequences may be harder to assess, however, given difficulties in amassing appropriate data.

• **Does the system require the collection of new funds by the Federal government in order to implement the proposal? If so, what methods are assumed to raise these revenues (e.g., elimination of tax benefits, new taxes, program benefit reductions)? Does an estimate of "budget neutrality" assume no problems in collecting these revenues? Does it take into account the assumed redistributive effects of these measures?**	Governments' financing obligations for health care shift to some extent pursuant to all proposals for health care reform. It is important to identify whether governments' obligations are new ones or merely the reallocation of current funds (e.g., Federal and State Medicaid funds, Medicare funds, Veterans Affairs funds, public health program funds, block grants). Some analyses assert that a proposal is "budget neutral;" that is, it is fully funded at the Federal level. However, this does not mean that no new government funds are necessary to implement the program. It merely means that the necessary revenues will be raised from various sources in such a way that the Federal deficit will not be affected. The means by which these funds are raised may have important redistributive effects, for example, "sin" taxes v. capping the tax deduction and/or exclusion for employer-sponsored health insurance benefits v. payroll tax v. repealing the Medicare taxable maximum income rate.
• **Does the system require State and local governments to collect new funds? What does the proposal assume with respect to current State and local government health care funds (e.g., State Medicaid share, indigent care programs, public health programs)?**	Many reform proposals shift obligations related to health care, which have most recently been shared among levels of government, to the Federal government (e.g., Medicaid acute care services). In order to avoid shifting the full amount of the financial obligations associated with providing these services to the Federal government, most proposals would require State and local governments to continue to devote all or most of these funds to the Federal program.
• **Do some or all employers take on new obligations with respect to health care financing or are they relieved from present ones? If the former, is there a "cap" on employers' liability? What is the relative impact of the obligations on employers by size, by industry, or by geographic region?**	Some proposals increase employers responsibility for providing health care coverage whereas others relieve them of it. The redistributive effects may differ among employers based upon numerous factors such as size, industry, and workforce characteristics.
• **What is the ultimate or total cost—direct payments plus indirect payments—to households for health care coverage and/or services? And what is the distribution of these expenses among households by income level?**	The total cost of health care is borne, ultimately, by individuals. It is essential to look at what the impact of a proposal is on individuals and families or households, in the aggregate and by income level, in order to determine whether the system will result in acceptable or unacceptable effects.

What Assumptions Does the Analysis Make With Respect to the *Delivery of Health Care*?

Questions	Examples of Possible Effects
• **Is a specific mode of delivery, with particular assumptions about projected changes in the costs of care, required by the proposal; for example, does the proposal assume universal or near-universal enrollment in group-or staff-model health maintenance organizations?**	Assumptions about the ability of the system of health care delivery to manage service delivery and costs can affect estimates regarding the cost of coverage and care.

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Box 10-A—Provisional Checklist: A Guide for Policymakers—Continued

What *General Operational Assumptions* Does the Proposal Make?

Questions	Examples of Possible Effects
• What is the phase-in period, if any, for the proposal? If the proposal is phased in, are any estimates of spending and/or savings adjusted for the phase-in period?	If a proposal is phased in, any new costs and savings resulting from a proposal may occur over time. However, a simplifying assumption made by many analyses is that such costs and savings are incurred or accrue immediately, an assumption that will skew the true spending and/or savings effects of a reform proposal.
• Are the transition costs from the current system to the new system included in the spending and/or savings estimates?	Any new system will most likely require money to implement. Many analyses take into account the direct costs and savings of the reforms and ignore the indirect costs and savings. These costs may be significant with respect to establishing the infrastructure to support a new system.

What *Background Information* Regarding the Approach, Proposal and/or Analysis is Provided?

Questions	Examples of Possible Effects
• On whose behalf was the analysis prepared, following which rules, with what level of transparency?	Some analyses are prepared by independent researchers without any apparent stake in the results of the analysis; however, many others are prepared by the proponents of an approach or by researchers or consulting firms working on the proponents' or opponents' behalf. Further, similar groups of analysts may use different rules to guide their assumptions, depending on the needs of particular clients. The fact that many analytic models are proprietary —i.e., not open to public scrutiny—makes it difficult to compare analyses and their results. It is important for policymakers to be aware of the potential for a conflict of interest in the preparation of an analysis. Policymakers could require or strongly encourage analysts to routinely compare the assumptions that guided any particular analysis with assumptions used by other analysts, and/or they could require or strongly encourage analysts to make their assumptions public, using a standard list of key assumptions.