

# Impacts on National Health Care Spending and Savings | 2

## INTRODUCTION

s the Nation heads toward national health care expenditures' projected to be almost \$1.7 trillion by the year 2000 (4,79), considerable attention has been directed to the portion of the Nation's gross domestic product (GDP) devoted to health care spending, and its impact on other sectors of the economy. Recently, the U.S. Department of Commerce 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). At a projected average annual rate of growth of around 10 percent, the Health Care Financing Administration and the Congressional Budget Office (CBO) estimated that national health care spending will reach 18 percent of GDP by the year 2000 (4,79).<sup>2</sup> Although individuals debate what the correct level of spending on health care should be, many Americans want to lower the rate of growth in health care spending. Thus, the ability of a reform approach to control the rate of growth in national health care expenditures is one of the key issues in the debate over health care reform.

<sup>1</sup> National health expenditures are defined as: 1) health services and supplies (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) and 2) research and construction of medical facilities (89). National health care spending is the total amount spent by employers, governments and households in the United States on health care (89). National health care spending is usually calculated as either a set dollar amount or as a percentage of the Nation's total economic output (gross national product [GNP] or gross domestic product [GDP]). GDP "covers the goods and services produced by labor and property located in the United States . . . GNP covers the goods and services produced by labor and property supplied by U.S. residents" (90).

<sup>2</sup> CBO recently revised its projection of the average rate of growth in national health expenditures downward to 8.8 percent a year from 1992 to the year 2000. Nevertheless, it projected that health spending, as a percent of the gross domestic product, will be almost 19 percent, an increase of 1 percent over its earlier projections, in the year 2000 (32).



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## IMPACTS OF SINGLE PAYER APPROACHES

One goal of most proposed Single Payer systems is to limit or reduce the rate of growth in national health spending.

Key to cost control under a Single Payer system would be the type, extent, and enforceability of any cost-containment measures, including expenditure limits, incorporated. Estimates of the change in national health care expenditures under a Single Payer system vary considerably, as shown in table 1 in chapter 1. In a single year (1991), the change ranges from estimated *savings* of \$241.0 billion (43) to *increased spending* of \$21.2 billion (34). Estimates of future *savings* range, for the period from 1991 through the year 2000, from \$1.3 to \$5.5 trillion, in current dollars (43) (table 1).

The major assumption affecting the various estimates of the impact of a Single Payer system on health care spending and savings is the extent to which the approach incorporates specific cost-containment mechanisms and/or expenditure limits and, most importantly, the presumed effectiveness of such mechanisms and/or limits.

With respect to the estimates shown in table 1, for example, analysts with estimates at the extremes assumed either: 1) health care spending in the United States at the rate of 8.7 percent of GDP (the often-cited Canadian rate of health care spending) achievable immediately and continuously (savings of \$241.0 billion and \$5.5 trillion) (43), or 2) no change in the rate of spending in the first year of the system's implementation (increased spending of \$21.2 billion) (34). As shown in the notes to table 1, estimates that are more in the middle range assumed various combinations of cost-containing and cost-increasing features. For example, the U.S. General Accounting Office (GAO) assumed that some cost-containment (e.g., in administrative costs) and all cost-inducing (e.g., universal coverage) factors were effective in

the first year of implementation (82); the Congressional Budget Office assumed no overall limit on expenditures (e.g., a global budget), but assumed that costs would be lower because all providers would be paid according to a Medicare fee schedule (77).<sup>3</sup>

Analysts acknowledge that, left unresolved by any available estimates of the economic impact on the United States of a Single Payer system is:

... the extent to which the savings from controlling total expenditures represent true efficiencies, as opposed to sacrifices in the quality of health care or in availability of particular services (43).

This concern is true, of course, of other approaches that aim to control costs without addressing issues of access and quality.

## IMPACTS OF PLAY-OR-PAY APPROACHES

Under the Play-or-Pay approach, employment-based insurance as well as public coverage are expanded; therefore, health care spending is most frequently estimated to increase initially relative to current health care spending, due to increased utilization by the previously uninsured population.

As shown in table 1 in chapter 1, estimates of the change in health care expenditures under Play-or-Pay approaches range from *decreased spending* of \$36.0 billion in a single year, the second year of plan implementation (the year 1993) (49), to *increased spending* of \$33.6 billion (where the plan included expanded Medicare coverage through expanded Medigap coverage, which together with Medicare would meet the American Academy of Family Physicians' [AAFP] minimum benefit package; \$32.5 billion without expanded Medicare coverage) in a single year (the year 1993) (36,37).

Most analyses estimate that the cumulative impact of a Play-or-Pay approach will result in *savings*, but the estimated *savings* vary vastly, from \$111.3 billion in current dollars from 1993

<sup>3</sup>This CBO study was revised in April 1993 (81).

through the year 2000 (36,37), to \$2.7 trillion from 1994 through 2003 (66).

The difference in estimates appears to arise primarily from the degree to which the analysis assumed the Nation controls the rate of health care spending growth during the period examined. In the preceding estimates for example, the analysts assumed: an annual health care expenditures target, reducing the rate of growth in health care spending to the rate of growth in GNP, at a targeted rate of decrease of 2 percent each year (savings of \$36.0 billion) (49); that there was an initial 5 percent decrease in health care costs phased in over 5 years and future health care spending growth would be limited to the growth rate of the economy after the fifth year of implementation (\$2.7 trillion) (66); or that 1) increased utilization and improved provider reimbursement would be offset only somewhat by cost-containment savings (increased spending of \$33.6 billion) (36,37), and 2) the effectiveness of expenditure limits initiated in 1994 would eventually reduce per-capita health spending from a projected rate of 8.6 percent to 7.6 percent and 6.6 percent (cumulative savings of \$11.3 to \$333.5 billion, respectively) (36,37). Thus, Play-or-Pay approaches that estimate savings in national health care spending appear to achieve these savings principally through the addition of various cost-containment mechanisms, with the greatest savings projected under plans that incorporate expenditure limits (55) (table 1).

### IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

Individual vouchers or tax credits approaches expect to achieve control over national health spending *indirectly* through more “cost-conscious” behavior on the part of individuals regarding their health care coverage and services purchasing decisions.

All available estimates of the impact of the Individual Vouchers or Tax Credits approaches on health care spending project that such ap-

proaches would result in *savings*, both initially and cumulatively, although the projected savings are generally lower than those under other approaches. As shown in table 1 in chapter 1, these estimates range from *savings* of \$2.0 billion in 1994 for the Bush Administration plan (65), to *savings* of \$10.8 billion in 1991 for the Heritage Foundation plan (35). Other estimates place the level of savings between these extremes (3,94).

Cumulative estimates were not available for the Heritage Foundation plan. For the Bush Administration plan estimates of cumulative *savings* ranged from \$72.6 billion from 1993 through 1997 (3) to \$1.0 trillion from 1994 through the year 2003 (65) (table 1).

In arriving at these estimates of the impact of Individual Vouchers or Tax Credits proposals on health and care spending and savings, analysts made varying assumptions. With respect to the Bush Administration plan, for example: “much of the savings . . . are one-time in nature, and that after these efficiencies are achieved, the cost curve returns to its present course” (savings of \$158.0 billion) (65); that some success was achieved in insurance market and related reforms (savings of \$72.6 billion) (3); or that in the first 5 years, “the plan’s cost containment features are relatively successful in both reducing current expenditures . . . and slowing down the rate of spending growth” (savings of \$6.0 billion and \$1.0 trillion) (65). With respect to the Heritage Foundation plan, an analysis done on behalf of the Foundation assumed that increased utilization by newly insured persons and increased insurer administrative costs would be offset by reduced utilization by presently insured persons as a result of a more limited benefit package for most people, but made no assumptions about immediate changes in the rate of growth in health care spending (35). One major difference between the Heritage Foundation’s and the Bush Administration’s approach to individual tax credits or vouchers as the way to increase the number of Americans with coverage is that the Heritage Foundation plan would require individuals to purchase coverage while

the Bush Administration would have kept such purchases voluntary (6,94). As a consequence fewer people would have been insured, and health care utilization might have been less, under the Bush Administration proposal.

## IMPACTS OF MANAGED COMPETITION APPROACHES

**Proposals** founded on “pure” Managed Competition (17) generally expect to moderate the rate of growth in national health spending *indirectly* through increased competition among providers on the basis of price and quality with tax incentives to promote cost-conscious purchasing decisions (17). However, some versions of Managed Competition incorporate expenditure limits (e.g., global budget, capitation payments) that, if effectively implemented, would permit direct control of health care spending (70).

To date there have been few detailed estimates of the impact of Managed Competition on health care spending and savings. Enthoven recently wrote that “[i]t is altogether possible that a very efficient competitive system could get us back to 9 or 10 percent” of GDP (15), but he did not provide the specific assumptions upon which he based this estimate. In testimony regarding H.R. 5936,<sup>4</sup> a Managed Competition bill introduced but not enacted in the 102d Congress, the Director of the Congressional Budget Office, Robert Reischauer, estimated that after several years the system implemented would “leave national health expenditures at approximately the same level they would reach otherwise” (56), although Reischauer predicted that at the outset national health care spending would increase. The estimated increase assumed that the National Health Board, established under the bill, would require the health plans to deliver a “comprehensive set of benefits” that would be available to more people than are currently covered by health

insurance. Reischauer further testified that the rate of growth in national health expenditures would slow down due to increased enrollment in health maintenance organizations which he maintained could provide health care more efficiently than other organizational forms. Thus, he concluded that after a number of years, savings flowing from the reduced rate of growth in national health expenditures could offset the increased costs of expanded access to presently uninsured persons. Limited examples of aspects of managed competition exist (e.g., California Public Employees’ Retirement System) and are discussed in appendix B.

Estimates of the impact of Managed Competition approaches on national health care spending range from *increased spending* of \$47.9 billion in 1993 (63) to *decreased spending* of \$21.8 billion in 1994 (3) (table 1 in chapter 1). Cumulative estimates of the impact of Managed Competition were provided for one plan (President Clinton’s campaign proposals) and projected increased savings over time (savings of \$232.0 billion from 1994- 1997, \$745.7 billion in savings through the year 2000) (3).

Variations in assumptions with respect to the impact of Managed Competition that affect the range in estimates of health care spending include: 1) that savings achievable through managed care should be based upon the experience of all types of HMOs, not just group-model HMOs, but that the Nation would not impose overall expenditure limits (increased spending of \$47.9 billion) (63); and 2) the implementation of a national health budget which restricts the growth in national health spending to the rate of growth in family income (assumed to be approximately the same as the rate of growth in GNP) (\$21.8 billion, \$232.0 billion, and \$745.7 billion in savings) (3).

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<sup>4</sup> A bill to contain costs and improve access to **health** care through accountable health plans and managed competition and for other purposes (“Managed Competition Act of 1992”).

## SUMMARY

Available analyses suggest that at least some proposals under all approaches to health care reform would achieve universal coverage while saving money (i.e., reduce national health expenditures) in the long term. Yet it appears that the projected magnitudes of savings are far more

dependent upon the cost-containment mechanisms than upon the overall approach adopted. Thus, in selecting the appropriate approach to reform, the impact on health care spending and savings may become less of a distinguishing characteristic than differences in impacts on other areas of the economy.