

Estimates of Other Reform Proposals

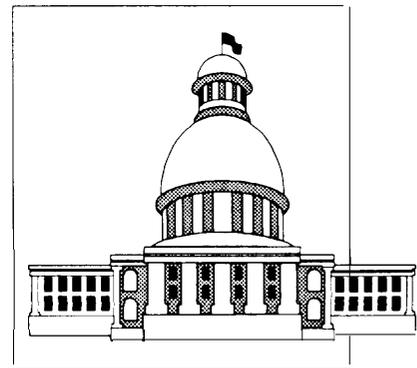
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The uncertainty and variations in analysts' estimates of the impact of health reform on the federal budget is not unique to the Health Security Act. This chapter provides a brief overview of potential areas of uncertainty in analysts' estimates of two other bills introduced in the 103d Congress: the American Health Security Act of 1993 (H. R. 1200/S.491) and the Managed Competition Act of 1993 (H. R.3222/S. 1579). So far only CBO has estimated specific provisions of these two bills. However, CBO'S analysis is likely to highlight areas of potential uncertainty that will also influence other analysts' estimates of these bills.

AMERICAN HEALTH SECURITY ACT OF 1993 (H. R.1200/S.491)

I CBO'S Estimates of the American Health Security Act

The American Health Security Act would create a national health insurance program modeled on the Canadian single-payer system. ¹CBO estimated only national health expenditures and fed-



¹The House and the Senate versions of the bill are similar except that the Senate version would prohibit coinsurance or copayments on all services, while the House version would only prohibit coinsurance or copayment for acute care or preventive services.

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eral outlays under the House and Senate versions of the bill, not the revenue effects (34,35).²

Compared with the estimation of the Health Security Act's effects on the federal budget, the estimation of outlays under a single-payer system is relatively straightforward. Under the new national health insurance program nearly all spending currently covered by private health insurance would be shifted to the public sector. Thus, the estimation of federal outlays can be ascertained by determining what is currently spent on private insurance coverage. A few adjustments have to be made, however, to account for the additional demand for health care services induced by better insurance coverage, as well as for the effects of possible savings due to "simplified" health insurance administrative structures and functions. Since the American Health Security Act also prescribes limits on the growth rate of public spending for health care, the effects of such limits also have to be taken into account.

Based on this general methodology, CBO estimated that total federal spending for the national health insurance program (essentially federal payments to the states for covered services) would amount to \$630 billion in 1997, \$939 billion in 1998, and \$1.1 trillion in 2000.³ Federal spending for the national health insurance program would be funded mostly by an increase in income and

payroll taxes, a hospital insurance tax, and additional excise taxes on certain products such as tobacco. Additionally, part of the federal expenditures for the national program will be offset by "savings" from repealing Medicare, Medicaid, and other existing federal health programs.

The estimation of savings from Medicare and Medicaid and the American Health Security Act is relatively straightforward. The amount essentially equals the estimates of baseline spending for the repealed programs.⁴ CBO estimated that baseline Medicare and Medicaid spending by the federal government would be \$265 billion and \$174 billion respectively, in 2000. Thus, repealing the two programs would save \$439 billion. Taking into account this revenue effect, net additional federal outlays under the act would be \$371 billion, \$556 billion, \$571 billion, and \$583 billion for the four years from 1997 through 2000.

| Potential Uncertainty in CBO'S Estimates

Conceptually the estimation of federal spending for covered services appears to be relatively straightforward, but in practice, many aspects of the process are subject to uncertainty. Four factors are critical to CBO'S estimate, none of which can be estimated precisely:

² Although a few analysts have projected the economic effects of health reform under a generic single-payer system, CBO's analysis is the only one that has provided expenditure estimates specific to the provisions of the proposed legislation. Most other analyses focus only on national health expenditures and have not addressed specifically the issue of federal budget effects of a single-payer system. For example, Lewin-VHI's two analyses, "O Canada: Do We Expect Too Much From Its Health System?" (23), and *National Health Spending Under A Single-Payer System: The Canadian Approach* (11), provide estimates only for national health expenditures and have not explicitly discussed the implications of a national health budget and changes in federal outlays. The Lewin-VHI analyses suggest that a system of health expenditure budgets would result in substantial savings in health spending. It estimated that if the single-payer program were to reduce the rate of growth in per-capita health spending by 1 percent each year, U.S. health spending would be reduced by \$137 billion over the period from 1991 through 2000. The estimated savings, however, are pertinent only to national health expenditures, and it is not possible to derive from Lewin-VHI's estimates what the federal budget effects would be of either a generic single-payer system or, specifically, the American Health Security Act.

³ The figures presented here are the projections for the House version of the bill. The projected federal outlays under the Senate version are slightly higher, as the bill would require no coinsurance or copayments for any covered services. Also note that the substantial increase in the additional outlays from 1997 through 1998 result from the fact that the projected figures are for fiscal years, not calendar years. While the bill is assumed to take effect in January 1997, FY 1997 actually includes the last three months of 1996, when the current system would still be in place.

⁴ Conceptually, the only uncertainty or variations across different estimates in such cases would be the differences in the baseline estimates of Medicare and Medicaid expenditures and growth rates of federal spending on these programs.

- the baseline health expenditures pertinent to the covered services and the growth rate of spending on these services,
- ° the additional demand for health services due to enhanced insurance coverage,
- the decrease in administrative spending resulting from the simplification of insurance administration and structure, and
- ™ the likely effectiveness of expenditure limits prescribed by the legislation.

As discussed earlier, the baseline growth rate of health care spending is a critical factor in estimating savings under reform. Analysts who assume different growth rate of health care spending under current law will arrive at different projections of savings under a new system. Similarly, behavioral responses to changes in insurance coverage and the extent of administrative savings under a single-payer system are all areas of contention among analysts.⁵

Rather than assume that the limits on expenditures would work as intended, CBO assigned an effectiveness rating to the limits.⁶ The effective-

ness rating of the expenditure limits is a critical factor for the estimates. Assigning an effectiveness score to expenditure limits is a very difficult exercise and one that depends greatly on analysts' judgments.⁷ CBO estimated what national health expenditures would be under the act using alternative effectiveness ratings, but they did not perform a similar analysis for the federal budget estimate.

MANAGED COMPETITION ACT OF 1993 (H. R.3222/S.1579)

I CBO's Estimates of the Managed Competition Act

The Managed Competition Act of 1993 would establish regional health plan purchasing cooperatives (HPPCs), which would allow individuals and small groups to purchase health insurance at prices comparable to what large groups pay.⁸ It would also provide subsidies to low-income families to purchase health insurance.

So far, only CBO has provided estimates of the federal budget effects of the act (39).⁹ According

⁵For a detailed discussion on the uncertainty associated with the potential savings from administrative streamlining, see the OTA report *Understanding Estimates of National Health Expenditures Under Health Reform* (44).

⁶A detailed discussion of CBO's estimation methodology for the American Health Security Act appeared in a separate OTA report, *Understanding Estimates of National Health Expenditures Under Health Reform* (44). The general methodology discussed there also applies to the estimates of federal budget effects under the American Health Security Act.

⁷For a detailed discussion on the effectiveness of expenditure limits and the assignment of effectiveness scores, see the OTA report *Understanding Estimates of National Health Expenditures Under Health Reform* (44).

⁸Managed competition, as defined by Alain Enthoven, one of the original architects of the concept, is a "purchasing strategy to obtain maximum value for consumers and employers, using rules for competition derived from macroeconomic principles" (4). Other than the Managed Competition Act, several health reform proposals in the 103d Congress, such as the Clinton Administration's Health Security Act (H. R.3600/S.1757) and the Health Equity and Access Reform Today Act (H. R.3704/S.1770), also have elements of managed competition.

⁹A few analysts have provided estimates of the economic effects of health reform either under a generic managed competition system or under the Managed Competition Act of 1992 proposed in the 102d Congress. For example, Sheils and colleagues' analysis, "Potential Public Expenditures Under Managed Competition," (22) provided expenditure estimates under a managed competition system proposed by Paul Star. Meyer and colleagues' analysis, *Managed Competition in Health Care: Can It Work?* (14), provided estimates of federal budget effects under the Managed Competition Act of 1992. However, estimates from these analyses are not directly comparable to CBO's estimates of the latest version of the legislation. There are important changes (e.g., the provisions of premium subsidies for low-income individuals) between the Managed Competition Act of 1992 and 1993 which would result in substantial differences in federal expenditures.

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to CBO, the bill, if implemented in 1996, would add \$19 billion to the federal budget deficit from 1996 through 2000.¹⁰

I Potential Uncertainty in CBO's Estimates

Two major provisions of the act would have the most significant and direct effects on the federal budget. One is the repeal of Medicaid; the other is the premium and cost-sharing subsidy to enable low-income families to purchase and use insurance through the HPPCs.

The estimate of federal outlays for the premium and cost-sharing subsidy is by far the most critical element in projecting the bill's effect on the federal budget. The level of the subsidy depends primarily on the estimated premium for the least expensive health plan in a region. Higher premiums would inevitably increase federal outlays. The act, however, does not specify a "standard benefit package." Analysts therefore are left to their own discretion in estimating premiums.¹¹

In addition, estimating the number of families eligible for the subsidy is complicated because the act does not require employers to sponsor or contribute to insurance benefits for their employees. It is plausible that some employers who currently pay a substantial share of their employees' insurance premiums may decide to drop the benefit and shift the costs of insurance to the federal subsidy program. Thus, the estimate of the number of eligible families depends not only on the income distribution but also on assumptions of employers' behavioral responses.

Estimates of Medicaid "savings" can be made simply from the estimates of baseline spending for the program. The only potential source of variations across different projections in this case is the baseline expenditure estimates and the growth rates of federal spending for Medicaid. Since most private analysts usually adopt CBO's baseline projections, differences tend to be negligible.

¹⁰ According to CBO's estimates, the federal deficit would be substantially higher (\$189 billion from 1996 through 2000) if individuals eligible for premium assistance were to receive the full amount of subsidies as prescribed in the legislation. However, under the funding mechanism specified in the act, the federal government would reduce the proportion of the premium subsidies it paid (for low-income people not receiving Medicare) if the savings from Medicaid and other revenue sources failed to cover the cost of the subsidies. The resulting shortfall in subsidies would have to be absorbed by the health plans.

¹¹ CBO's analysis provided two different estimates based on two benefit packages, one with comprehensive benefit identical to the "standard benefit package" in the Clinton Administration's proposal, the other with limited benefits that costs 20 percent less than the comprehensive plan. However, conceptually this is different from a sensitivity analysis that is based on two different premium estimates for the same benefit package.