

Evaluating the Cost of Health-Care Reform Plans

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The cost of expanding access to acute medical care is one of the least understood aspects of health-care reform. As of January 1992, over twenty health-care reform proposals had been introduced before Congress, each with a different target population, scope of benefits, source of financing, and role for the public sector.¹ Analysis of these plans has produced a wide range of cost estimates, and as the debate over health-care reform intensifies, attention is likely to focus on the costs of reform. The purpose of this Article is to provide a framework for evaluating the costs of various health-care reform proposals.

Most spending estimates associated with current health-care reform proposals focus on total spending for one payer (e.g., government or employers). Such estimates are misleading because they fail to identify the total increase in spending on health care that will result from expansion of coverage and the distributional impacts of changes in health-care costs. For example, it was reported that the proposal submitted by the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) was removed from serious consideration due to its high costs.² In fact, while it was widely circulated that the acute care portion of the plan would cost \$24 billion in expenditures to the Federal Government the, *net new* spending from the plan would represent half this figure, or \$12 billion.³

To accurately and completely describe the costs of universal access or the effects of a plan to reform the health-care system, we believe that such proposals should be assessed from three perspectives:

- * NET NEW SPENDING: total new health-care spending generated by the expansions in insurance;
- * DISTRIBUTION OF SPENDING: shifts in financing among payers that occur under most health reform proposals; and
- * RISE IN HEALTH-CARE SPENDING: the impact of the proposal on the rise in health-care spending.

† *Authors' Note:* From Lewin-ICF, a Washington-based health policy consulting firm. We would like to thank Robert J. Rubin, M.D., Allen Dobson, Ph.D., Timothy J. Eckels, Jessica Miller, and the staff of the *Yale Law & Policy Review* for comments on drafts of this manuscript.

1. Victor Cohn, *Moving on Health Care Reform: The Challenge to the President and Congress*, WASH. POST, Jan. 21, 1992, (Health) at 10.

2. 1990: *A Year in Review*, MED. & HEALTH PERSP. (Janet Ochs Weiner ed., Dec. 24, 1990).

3. U.S. BIPARTISAN COMM'N ON COMPREHENSIVE HEALTH CARE, A CALL FOR ACTION 9 (Sept. 1990).

To illustrate this framework, we focus on the spending associated with three health-care reform prototypes. Although over twenty different proposals are currently under consideration by Congress, health-care reform options are essentially of three types: (1) tax credit proposals, whereby individuals are given vouchers or tax credits to purchase health insurance, (2) employment-based proposals, which build on the current system by requiring or placing strong incentives on employers to provide coverage, and (3) public insurance proposals, whereby the government would assume responsibility for providing health insurance to all citizens.

Concrete examples of these three prototypes exist in the current debate. The tax credit approach is exemplified by President Bush's plan⁴ to provide vouchers and tax credits to the uninsured. The Senate leadership advocates the employment-based approach.⁵ The public health insurance proposal, modeled after the Canadian health-care system, likewise has been proposed in Congress,⁶ as well as in over a dozen states.⁷ We present the specifics of these three plans in Exhibit 1.

In this paper, we seek to establish a framework for how the costs of each health-care reform plan should be evaluated, and to discuss how and why the costs of different types of plans can be expected to vary. We do not aim to provide specific estimates of the costs of each of these plans for two reasons. First, although some estimates have been made, it is difficult to estimate the costs of current plans accurately at this time since many details remain unspecified. Secondly, each plan will evolve as sponsors make changes to address both technical and political concerns.

I. NET NEW SPENDING

Presentations of spending estimates often confuse the relationship between total costs and net new costs. *Total spending*, the measure frequently used to evaluate health-care reform proposals, represents the costs of a plan including some costs that are currently in the system. This value, however, does not indicate how much additional spending will be added through reform. A more appropriate measure of the impact of health-care reform on system-wide costs

4. EXECUTIVE OFFICE OF THE PRESIDENT, THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM (Feb. 6, 1992).

5. S. 1227, 102d Cong., 1st Sess. §§ 331, 332 (1991).

6. H.R. 1300, 102d Cong., 2d Sess. (1991).

7. Universal health insurance bills are before state legislatures in California, Colorado, Florida, Indiana, Iowa, Kansas, Massachusetts, Minnesota, Missouri, Ohio, Oklahoma, Oregon, Vermont, West Virginia, and Washington. The District of Columbia also has such a bill. Some of these plans are reviewed in *Universal Insurance, Canadian Style: States Starting to Explore the Option*, 112 STATE HEALTH NOTES 1 (April 1991).

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is *net new spending*, which reflects the increase in health-care spending that will result from expansions in coverage.

Net new spending arises from an increase in utilization of medical services as persons who were uninsured obtain coverage, as the currently insured receive coverage for additional benefits, or from an increase in provider payment rates. Net new spending also provides the best basis for comparing the costs of reform proposals, since this estimate reflects the impact of each plan on total health-care spending.

EXHIBIT 1: THREE PROTOTYPICAL HEALTH REFORM PLANS

OVERVIEW OF THE PRESIDENT'S PLAN FOR COMPREHENSIVE HEALTH-CARE REFORM	OVERVIEW OF ILLUSTRATIVE EMPLOYMENT-BASED PROPOSAL	OVERVIEW OF ILLUSTRATIVE PUBLIC HEALTH INSURANCE MODEL
<ul style="list-style-type: none"> • Provide a transferable health insurance tax credit (certificate) for all poor families of \$3,750 to purchase health insurance. • Provide a tax credit of up to \$3,750 for families with incomes less than \$80,000. • Eliminate pre-existing condition exclusions. • Facilitate health insurance market reforms. • Encourage growth of coordinated care. • Reduce administrative costs through regulatory reforms. • Reform the malpractice system. • Expand services in underinsured areas. 	<ul style="list-style-type: none"> • Require employers to provide coverage or pay a tax to support a public plan. • Establish a public plan for those without employment-based insurance. • Subsume Medicaid into the public plan. • Increase state regulation of insurers. • Regulate employers' relationships with managed care plans. • Reimburse providers under the public plan based on Medicare rates. • Establish an independent national health-care cost containment board to negotiate provider payment rates and set spending limits. 	<ul style="list-style-type: none"> • All individuals are covered under a national health insurance plan. • Cost-sharing for covered services is reduced or eliminated. • Employment-based insurance is eliminated. • Cost containment is achieved through global budgets imposed on health-care providers.

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Estimates for net new spending of a variety of proposals to provide universal insurance for acute care services range from \$10 billion to \$25 billion.⁸ Variation in these estimates can be explained by differences in the design features of the individual plans, including: eligibility and enrollment; benefits; cost-sharing; and provider payment. Such variation in net new spending estimates, however, has little to do with whether the plan places the major financial responsibility on individuals, employers, or government: if the eligibility, benefits, cost-sharing and provider payment specifications are identical, expansion of insurance under any of the three prototypical plans would carry similar costs.

A. Eligibility and Enrollment

The net spending for any proposal to expand coverage is influenced both by the number of people who are eligible for the expansion and by the number of people who actually enroll. The characteristics of the eligible population also influence costs. Since medical-care use varies by age and health status, the costs of a plan would be higher if it enrolled primarily older or less healthy individuals. For example, medical spending for those over age 65 averaged \$5,360 per person in 1987 compared to \$1,286 per person for those under age 65.⁹

The President's plan targets uninsured persons below poverty as well as the uninsured near-poor. Under the plan, individuals with incomes below poverty would be able to obtain a transferable health insurance tax credit

8. These estimates refer only to acute care, and were obtained using the Lewin-ICF Health Benefits Simulation Model (HBSM), a microsimulation model of health insurance coverage, health services utilization, and sources of payments for health care. This model has been used to estimate the costs of health-care reform proposals for the Pepper Commission, (*see* U.S. BIPARTISAN COMM'N ON COMPREHENSIVE HEALTH CARE, *supra* note 3, at 67); the Advisory Council on Social Security; the Health Care Financing Administration; (*see* LEWIN-ICF, THE PUBLIC HEALTH INSURANCE MODEL FOR ACUTE CARE: ESTIMATED COST AND IMPACTS (1991); LEWIN-ICF, THE PUBLIC/PRIVATE PARTNERSHIP PLAN FOR UNIVERSAL ACCESS: ESTIMATED COST AND IMPACTS (1991) and LEWIN-ICF, THE INSURANCE MARKET REFORM PROPOSAL: ESTIMATED COST AND IMPACTS (1991)); the National Leadership Commission on Health Care; and over a dozen state governments (*see, e.g.,* LEWIN-ICF, ANALYSIS OF OPTIONS TO EXTEND HEALTH INSURANCE COVERAGE AND ACCESS TO PRIMARY CARE SERVICES TO THE UNINSURED (1990); LEWIN-ICF, HEALTH CARE FINANCING IN WEST VIRGINIA: ISSUES AND OPTIONS (1992) and LEWIN-ICF, PURSUING HEALTH CARE REFORM IN CONNECTICUT: ANALYSIS OF A PUBLIC HEALTH INSURANCE MODEL (1992)). It uses data from the Current Population Survey, 1980 National Medical Care Utilization and Expenditures Survey (NMCUES) aged to 1990 using National Health Account data, the National Health Interview Survey, the Lewin-ICF Employer Health Plan Survey, and a set of structural assumptions regarding their relationships, to estimate the impact of policies designed to expand insurance coverage. Assumptions regarding eligibility, benefits, cost-sharing and provider payment are input by the user to describe the plan under consideration. The estimates above assume that previously uninsured persons will adjust to levels reported by insured persons with similar characteristics, and that payments to providers will follow their historical patterns. Information on HBSM is on file at the *Yale Law & Policy Review*.

9. Daniel R. Waldo et al., *Health Expenditures by Age Group, 1977 and 1987*, 10 HEALTH CARE FINANCING REV. 111, 114 (1989).

(certificate) equal to \$3,750 to purchase health insurance.¹⁰ Tax credits of up to \$3,750 would be available to families with incomes less than \$80,000.¹¹ This plan is estimated to expand coverage for approximately eleven million Americans, assuming that all uninsured individuals below poverty receive the tax credit.¹² The cost of the President's plan would vary by the extent to which individuals decided to take advantage of the tax credit. Clearly, if all eleven million persons decided to use the insurance certificate, the cost would be substantially higher than if fewer people availed themselves of this option. However, the net new costs of covering a subset of the entire group would not necessarily be proportional to the fraction of individuals covered, since costs would depend significantly on the health-care utilization patterns of those who opt to use the certificate.

Why might some uninsured persons below poverty fail to take advantage of the tax credit certificates to purchase insurance? To the extent that the cost of health insurance exceeded the value of the certificate (\$3,750), individuals might not be able to afford the additional costs. For example, consider a health insurance plan costing \$5,000 per year for family coverage. After the tax credit, \$1,250 would have to be paid out-of-pocket. For a below-poverty family of three, the additional \$104 per month represents over 10% of its income and it might be unaffordable. Moreover, the insurance available for \$3,750 might not include the benefits considered to be of greatest value to a particular individual or family. In addition, the value of the tax credit would not adjust for age, health status, or geographic region, and so the amount of health insurance that could be purchased would vary enormously. Older persons and those living in areas with high health-care costs might have difficulty obtaining any coverage, and thus would be unable to take advantage of the tax credit.

By contrast, the Mitchell bill and a public insurance plan would provide coverage for all the uninsured and improve coverage for many of the under-insured. The Mitchell bill would create two types of insurance—insurance obtained from employers and insurance obtained through a public plan. The private and public plans would provide the same benefits. Nevertheless, the costs of these two sources of coverage are likely to be significantly different. Under the employment-based approach, employers would be required to either offer insurance to workers and their dependents or to pay a tax that is “the lowest level consistent with maintaining a fair balance between public and

10. EXECUTIVE OFFICE OF THE PRESIDENT, *supra* note 4, at 1.

11. *Id.*

12. ADVISORY COUNCIL ON SOCIAL SECURITY, CRITICAL ISSUES IN AMERICAN HEALTH CARE DELIVERY AND FINANCING POLICY 24-26 (1991). Lewin-ICF calculation based on data from the March 1990 Current Population Survey. Data and methods available on request (on file with the *Yale Law & Policy Review*).

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private health insurance coverage for employees.”¹³ Employers would have an incentive to provide coverage if the overall cost of providing coverage was less than the amount of the tax. Low-income, older, and less healthy workers, would be likely to obtain coverage from the public plan since the tax payment would involve a smaller expenditure than providing coverage through the employer-based plan. As the public plan would be comprised of older and less healthy workers, the cost of coverage through the all-public plan is likely to exceed the cost of employer-based insurance. The public plan would be financed by the employer payroll tax as well as by general government revenues, whereas the employer plans would be financed exclusively with private funds.¹⁴

B. *Benefits*

More generous benefit packages can be expected to result in both higher utilization of medical services and a more costly reform plan. The costs of individual benefits vary substantially, and some benefits add more to the cost of a plan than others. Benefits for which utilization is difficult to control—such as mental health and substance abuse services—tend to inflate the costs of a health-reform plan substantially, since insurers assume that many individuals will use them. For example, evidence suggests that mental health services are used whenever they are made available.¹⁵ In designing benefit packages, trade-offs need to be made between the cost of the benefit and the advantage of expanding utilization of such services.

The benefits in the President’s plan are not prescribed and are limited only by the amount of health insurance that can be purchased for \$3,750 for persons below poverty, and by less than this amount for persons eligible for the tax credit.¹⁶ Nationally, the average annual cost per employee for group health insurance in 1991 was \$3,573.¹⁷ Workers with incomes below poverty thus could obtain a benefit package with close to the average level of benefits for \$3,750, assuming they could gain coverage similar to the group coverage that many employees now enjoy.

The Mitchell plan would mandate that employers provide a basic level of benefits, including inpatient and outpatient hospital and physician services, diagnostic and radiology services, 45 days of inpatient psychiatric services, and certain preventive services.¹⁸ The plan would exclude coverage for

13. S. 1227, *supra* note 5, at § 3601.

14. *Id.*

15. Jon R. Gabel & Gail A. Jerisen, *The Price of Mandated Benefits*, 26 INQUIRY 419, 425 (1989).

16. EXECUTIVE OFFICE OF THE PRESIDENT, *supra* note 4.

17. Diane Levick, *Employer Health Costs Up*, HARTFORD COURANT, Jan. 28, 1992, at B2.

18. S. 1227, *supra* note 5, at § 2721.

outpatient mental health and prescription drugs.¹⁹ The basic package would be the same for everyone, regardless of whether persons receive employment-based coverage or are covered under the public plan. A person with an income below poverty and a good health status probably would be able to purchase a benefit package similar to the one proposed in the Mitchell bill under the President's plan. However, an older person or an individual with chronic or disabling health conditions would have difficulty purchasing this level of coverage for \$3,750. To reflect the generally higher use of health services among the elderly and persons with disabling conditions, insurance premiums typically are adjusted upward.

C. *Cost-Sharing*

Cost-sharing refers to the amount individuals are required to contribute to the cost of their health care. Its general purpose is to control the utilization of health services. Cost-sharing may be of two types: deductibles and co-insurance. Deductibles refer to an amount of out-of-pocket costs that must be incurred before insurance benefits become available. Co-insurance refers to a specific percentage of the cost of each service (or a flat fee per service) that must be paid out-of-pocket. Results of the Rand Health Insurance Experiment (HIE), a major study designed to estimate the impact of cost-sharing on health-care utilization, demonstrated that utilization of health services is sensitive to the cost-sharing requirements of health insurance plans.²⁰ As cost-sharing decreased, utilization of health services increased. The cost of health-care reform proposals thus depends on the cost-sharing requirements of a particular plan.

The cost-sharing requirements of the President's plan are dependent on the type of insurance plan that can be purchased with the tax credit. For some persons, out-of-pocket costs may be substantial, while for others insurance may cover most of their needs. The Mitchell plan likewise incorporates some cost-sharing requirements, whereas most of the public health insurance plans eliminate cost-sharing altogether.

The elimination of cost-sharing is the principal reason that public health insurance plans appear more costly than other plans. The elimination of cost-sharing increases use and results in higher net new costs. Public health insurance plans usually eliminate cost-sharing because the proponents view health care as a right. Public health insurance plans could, of course, be structured

19. S. 1227, *supra* note 5, at § 2722 (calling for review of appropriateness of exclusion of services one year after enactment).

20. Kathleen N. Lohr et al., *Use of Medical Care in the Rand Health Insurance Experiment*, 24 MED. CARE S18, S22 (1986).

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with identical cost-sharing requirements of the employment-based plan or the President's plan.

D. *Provider Payment*

Health-care reform proposals typically vary the payment level to both physicians and hospitals providing care. In terms of physician payment, health reform plans may involve a range of provisions, some of which would reduce payments while others would increase them. The Mitchell plan specifies that providers under the public plan would be reimbursed at rates equal to Medicare payment rates.²¹ In contrast, all-public health insurance plans usually specify that providers would be reimbursed under a single fee schedule, similar to the Medicare program.²²

Many health reform proposals also propose to regulate hospital payment through the use of uniform rates or global budget limits. Under a global budget, a hospital is given a budget for annual expenditures. Hospitals are thus forced to make tradeoffs among competing demands in order to remain within the budget. The global budget provision can be found in the public health insurance model.²³ The President's plan does not specify changes in hospital payment.²⁴

In summary, if the three prototypical models were designed with the same eligibility and enrollment benefit packages, cost-sharing requirements, and provider payments, their net new costs would be similar. Any small differences would largely be attributable to differences in administering the health-care system.

II. DISTRIBUTION OF SPENDING

Health-care reform proposals typically involve substantial refinancing of current medical spending. The uninsured currently receive a large amount of care that is paid for out-of-pocket or as uncompensated care.²⁵ Refinancing occurs when this type of care—and any new care resulting from the expansion—is financed through insurance. While net new spending estimates range from \$10 to \$25 billion, changes in health-care spending for government, business, or consumers often differ substantially from these figures.

It is important to distinguish between two common meanings of "distribu-

21. S. 1227, *supra* note 5, at § 2105.

22. *See, e.g.*, H.R. 1300, *supra* note 6, at § 2123.

23. H.R. 1300, *supra* note 6, at § 2121.

24. EXECUTIVE OFFICE OF THE PRESIDENT, *supra* note 4.

25. This literature is reviewed in a Lewin-ICF Report. JACK NEEDLEMAN ET AL., *THE HEALTH CARE FINANCING SYSTEM AND THE UNINSURED* 32-56 (1990).

tion": *payment incidence* and *financing incidence*. Payment incidence refers to the amount that is actually paid by government, business and consumers. Financing incidence refers to how this money is generated. To illustrate this distinction, consider a public insurance plan: government bears the entire payment incidence, whereas business and consumers bear the financing incidence through increased taxes. The payment incidence is highly dependent on the political ideology underpinning the plan, while the financing incidence can be changed depending on political and economic circumstances. Our discussion will focus on payment incidence, as this is the distribution affected by the choice of a plan.

Exhibit 2 presents the expected direction of change in the payment incidence under the three prototypical plans for health reform. Numerical estimates of the payment incidence under the President's plan or the Mitchell bill are not currently available. The payments under these plans can be expected to change substantially as they move through the legislative process and changes occur in their design (e.g., benefits and cost-sharing). However, their provisions can be used to estimate the direction of expected changes, as discussed below. Note that this discussion is restricted to the payments involved in expanding insurance, and does not include consideration of the financing incidence. The financing incidence can be altered depending on whether taxes are levied on consumers or employers.

Under the President's plan,²⁶ new payments would be borne primarily by the federal government in the form of reduced tax revenues resulting from the tax credits. Consumers also would bear part of the burden through higher out-of-pocket costs. We would expect a number of states to reduce their Medicaid programs and encourage individuals to obtain the tax credit certificate. Because it currently contains no "maintenance of effort" clause (which would require states to continue current levels of funding for health care), the President's plan could produce windfalls to state governments.²⁷ Similarly, employers who currently provide insurance to their low-wage workers would have an incentive to drop this coverage and encourage their workers to obtain the certificate. Thus, employers would be likely to reduce their total spending on health care under the plan. These savings, however, could disappear if taxes are increased to finance the plan.

26. EXECUTIVE OFFICE OF THE PRESIDENT, *supra* note 4, at 27-30.

27. *Id.*

EXHIBIT 2: CHANGES IN THE DISTRIBUTION OF PAYMENTS UNDER
THREE PROTOTYPICAL HEALTH REFORM PROPOSALS

Payments	Current Spending (billions of Dollars)	Tax Credit Proposal (Bush Plan)	Employment-based Proposal (Mitchell Plan)	Public Health Insurance Proposal
Households (includes both premiums and out-of-pocket spending)	\$223	+	-	-
Private Employers	\$150	-	+	-
Federal, State & Local Government	\$320	+	+	+
Change in Net New Health Spending				
		+	+	+

Under an employment-based plan such as the Mitchell bill,²⁸ payments would be borne primarily by employers as they must either provide coverage or pay a tax to fund the public plan. Government payments would also increase since the tax revenue raised would be insufficient to cover the public plan's full costs. Household out-of-pocket payments probably would decrease as the uninsured obtain coverage and as insurance covers the costs of much of their care.

The public health insurance plan²⁹ would shift health-care payments mainly to the federal government. Employers and state governments might nonetheless be required to maintain their financial contributions to health care or to contribute to the plan's costs. Out-of-pocket payments would decrease under the all-public plan if cost-sharing is reduced or eliminated; however, a tax increase to fund the government expenditures could erode these savings.

III. UNIVERSAL ACCESS AND THE RISE IN HEALTH-CARE SPENDING

To gain political acceptance, any plan to expand access to health-care insurance must address the initial costs of new medical care. Yet a more critical long-term question is this: does the plan address the overall rise in health-care spending? At this time, the persistent increase in acute-care costs contributes to the erosion of medical-care access. Additionally, as insurers have become more sophisticated at avoiding "risks," and as public programs have reduced eligibility benefits, numerous factors independent of access concerns have increased pressure to attenuate this cost surge. The following section discusses the problems associated with increasing medical-care costs (especially as they relate to access concerns), possible ways to curtail such costs, and cost-containment remedies provided by existing proposals.

A. *Control of Rising Health-Care Spending*

The rise in spending has directly affected access to medical care in a variety of ways. First, individuals and families are faced with higher insurance premiums and out-of-pocket payments in health care. The fraction of average family income spent on health care increased from 9% to 12% between 1980 and 1991.³⁰ Although this trend, in part, reflects an increase in co-payments (which, presumably, promotes more efficient use of health services), it also reflects the expanding financial barriers to adequate medical care. Thus, many

28. S. 1227, *supra* note 5.

29. H.R. 1300, *supra* note 6.

30. Lewin-ICF estimate based on health spending and personal income data. Methods and data available on request (on file at the *Yale Law & Policy Review*).

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American families and individuals who face large cost-sharing burdens now worry about their continuing ability to support themselves should they contract a debilitating illness.

Second, the rise in spending has made it increasingly difficult for providers to care for the uninsured and underinsured. Hospitals historically have subsidized uninsured and underinsured patients with revenues from commercial insurers and other payers that reimbursed hospitals for more than their own costs.³¹ But, in recent years, as the number of uninsured patients has increased,³² the number of paying patients has decreased, thus making it increasingly difficult to subsidize patients who are unable to pay. The deterioration and closing of hospitals in poor inner-city areas and rural areas has exacerbated both geographic and financial access problems. Many inner-city and rural areas have reported a lack of physicians, especially those willing to provide primary care in disadvantaged areas.³³

There has also been considerable pressure to address the rise in health-care spending independent of the access issue. Rising health-care spending has caused concern among a variety of interest groups, including government, business, providers, and consumers.³⁴ Projections by the Congressional Budget Office indicate that 19.5% of the federal budget will be spent on health care by 1996.³⁵ Rising Medicaid and public health costs have further strained state budgets.³⁶ For business, health-care costs represent an increasing portion of employer payroll; the fraction of employee compensation represented by health insurance has grown from 2% in 1965 to over 6% in 1987.³⁷

To put the rise in spending in perspective, it is instructive to compare the annual increases in spending with the cost of establishing universal access. Health spending increased by an average of \$52 billion annually between 1987 and 1990,³⁸ a rise that dwarfs the estimated \$10 to \$25 billion in new spending that would be required to insure all of those currently lacking coverage.

31. Paul B. Ginsburg & Frank A. Sloan, *Hospital Cost Shifting*, 310 *NEW ENG. J. MED.* 893, 893 (1984).

32. ADVISORY COUNCIL ON SOCIAL SECURITY, *supra* note 12, at 18.

33. NATIONAL ASS'N OF COMMUNITY HEALTH CTNS., *ACCESS TO COMMUNITY HEALTH CARE: A DATA BOOK 3* (1990).

34. ADVISORY COUNCIL ON SOCIAL SECURITY, *supra* note 12, at 10.

35. CONGRESSIONAL BUDGET OFFICE, *RIISING HEALTH CARE COSTS: CAUSES, IMPLICATIONS, AND STRATEGIES 1* (1991).

36. ADVISORY COUNCIL ON SOCIAL SECURITY, *CRITICAL ISSUES IN AMERICAN HEALTH CARE DELIVERY AND FINANCING POLICY 101* (1991).

37. Katharine R. Levit et al., *Health Spending and Ability to Pay: Business, Individuals, and Government*, 10 *HEALTH CARE FINANCING REV.* 1, 8-9 (1989).

38. *HHS News*, U.S. Dep't of Health and Human Servs., Oct. 2, 1991 at 6.

1. *Determinants of Rising Spending*

Effective long-term control of health spending in the United States poses daunting challenges for future legislators. The rise in acute-care costs can be attributed to three major factors: diffusion of new technology, the rising costs of the labor and supplies required to provide care, and the growth and aging of the population (which cannot be controlled by policy intervention).³⁹ Some reductions in spending may be achieved by improving the efficiency and effectiveness of health-care providers. But, once these savings have been realized, legislators will be able to control spending only by targeting the factors responsible for the rise in spending.

Increases in spending on technology and labor have been responsible for many dramatic improvements in patient care. For this reason, costs in both these areas will prove highly difficult to control in future years. Medical technology almost always adds to the total costs of care, as new therapies bring more benefits to a wider population.⁴⁰ Cost-saving technologies ultimately may serve to reduce the rise in costs without reducing benefits; however, few such technologies have been deployed or are expected to be deployed in the near future.⁴¹ Increases in the cost of labor and supplies are also difficult to control, since hospitals are highly labor intensive, and must compete for skilled personnel in competitive labor markets. Similar increases in costs are observed by economists in other labor-intensive activities, such as the performing arts.⁴²

Observers of the health-care system frequently point to a variety of other targets which, if removed, might reduce health-care spending substantially. These include eliminating unnecessary care, and reducing the costs of malpractice insurance. In the short run, the savings and increased efficiency resulting from attacks on such targets might attenuate the increase in health spending. In the long run, however, such efforts will have no effect on the real culprits of rising costs: technology, labor, and demographics.

Elimination of useless and inappropriate care provides a case in point. Efforts to eliminate the number of hospitalizations and the length of hospital stays reduced system-wide costs substantially during the 1980s, and might bring additional savings in the future.⁴³ But the rise in spending is hardly

39. William Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief*, 257 JAMA 220, 220 (1987).

40. Henry J. Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 SCIENCE 418, 418-22 (1987).

41. *Id.*

42. WILLIAM BAUMOL & WILLIAM BOWEN, *PERFORMING ARTS: THE ECONOMIC DILEMMA* 212 (1966).

43. William B. Schwartz & Daniel N. Mendelson, *Hospital Cost Containment in the 1980s: Hard Lessons Learned and Prospects for the 1990s*, 324 NEW ENG. J. MED. 1037 (1991).

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caused by useless and inappropriate care. In recent years, there has been only a small decrease in hospital days despite hospitals' efforts to become more efficient.⁴⁴

It is also unlikely that expansion of managed care will significantly alter the rise in spending, even if such providers do not restrict the flow of beneficial new technology. The principle feature of managed care organizations which accounted for their lower acute care costs was the use of some 30% fewer hospital days.⁴⁵ While managed care costs at any given time were lower, the rise in those costs has been indistinguishable from that of fee-for-service care.⁴⁶

Although spending on medical malpractice has received much attention in recent years, malpractice expenses compose only a small fraction of acute-care spending. For example, hospital malpractice premium costs increased total hospital costs during 1983 and 1985 by an average of only 0.17% annually.⁴⁷ While a similar estimate is not available for the physician sector, the overall effects are still likely to be small: physician malpractice premiums constituted only about 4.8% of physician spending in 1989.⁴⁸ It is harder to estimate the portion of the rise in spending resulting from "defensive medicine,"—provision of care for the sole purpose of avoiding malpractice litigation—since the use of tests carrying little expected benefit is often associated with small incremental improvements in the standard of care. Even assuming that 18% of all physician care results from efforts to avoid malpractice suits, Moser and Musacchio estimated that premiums and "defensive medicine" combined only contributed one percentage point to the annual rate of growth in physician expenditures between 1982 and 1989.⁴⁹ Thus it seems unlikely that reform of the malpractice system will substantially limit the rise in costs in the long run.

44. *Id.*

45. Joseph P. Newhouse et al., *Are Fee-for-Service Costs Increasing Faster than HMO Costs?*, 23 *MED. CARE* 960 (1985); HAROLD S. LUFT, *HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE* (1981).

46. *Id.*

47. Lewin-ICF calculation using data on hospital malpractice spending and total hospital costs. Data (obtained from General Accounting Office and American Hospital Association) and methods available upon request (on file at the *Yale Law & Policy Review*).

48. James W. Moser & Robert A. Musacchio, *Health Care Statistical Highlights*, 7 *J. MED. PRAC. MGMT.* 3, 7 (1991).

49. *Id.* at 9.

2. *Effective Control of Spending*

Once the efficiency savings discussed above have been achieved, cost control of spending will require regulation of medical technology diffusion. One way to achieve this is to impose "non-price rationing" (strict regulation on the spread of medical technology). The British experience illustrates the effects of such regulation.⁵⁰ The rise in England's spending has been slowed by explicit and implicit health-care rationing. Decisions regarding the allocation of health care are made by the federal government and physicians. The delay or denial of beneficial care has, of course, been difficult for the British people to accept, and some have sought care outside the government-regulated system.⁵¹

The explosion in medical spending could also be controlled through price-rationing. For example, an HMO could restrict its rise in costs if it went beyond the strategy of reducing unnecessary care, and offered low-price options that did not provide the most up-to-date technology. Studies of health care in California also have suggested that increased competition can produce significantly lower overall costs.⁵² Although the source of these savings has not been identified, the California experience suggests that promotion of price competition helps stem the rise in costs.

The costs of services directly administered by the government ("direct services") can readily be controlled through budgets that are directly managed by government. The availability of new technology through direct services programs could be monitored and limited. Government-funded services provided through managed care organizations could be controlled in a similar way: if a strict limit on per-capita spending were specified, the provider would be forced to stay within that limit. Either way, this type of cost control inevitably will result in some people not getting the most current or expensive care. Spending on those services not under government control would be expected to rise unless explicitly regulated.

50. HENRY J. AARON & WILLIAM B. SCHWARTZ, BROOKINGS INSTITUTION, *THE PAINFUL PRESCRIPTION: RATIONING HEALTH CARE* 89-112 (1984).

51. *Id.* at 106.

52. *See, e.g.*, Jack Zwanziger & Glen A. Melnick, *The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California*, 7 J. HEALTH ECON. 301, 301 (1988).

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B. *The Effect of Health-Care Reform on the Rise in Spending*

Any proposal to reform the health-care system could, in theory, include provisions that would effectively control the rise in medical spending. In practice, however, few plans could achieve long-term control of spending. As we have shown, control of spending is not easy and will inevitably involve the denial of new beneficial technologies to some patients. Additionally, the limits on hospital and other provider budgets contained in a number of current proposals involve large-scale government intervention which is unpalatable to a market-oriented administration. Although regulating the rise in costs is important to addressing fundamental access concerns, in our opinion it decreases the political acceptability of the plan. To date, no health reform plan has squarely addressed the need for health-care rationing as a device to control spending.

The President's reform plan⁵³ contains three major provisions designed to contain costs: malpractice and antitrust reform; reductions in administrative costs; and expansions in the use of coordinated care. As discussed above, these provisions might have some small effect on costs in the short run. Because they do not control the diffusion of medical technology, however, they cannot control the long-run rise in costs. Furthermore, the plan proposes to provide services through an expansion of insurance access but provides no mechanism for controlling the accompanying expansion in the costs of these benefits.

The Mitchell bill⁵⁴ includes the calls for increased efficiency contained in the Administration's plan. In addition, it currently contains a mechanism that could (in theory) be used to control spending: expenditure targets designed to constrain hospital budgets. A number of reform proposals designed to establish a single payer for health care in the United States contain similar provisions.⁵⁵ Under these plans, the federal government would establish an independent "Federal Health Expenditure Board," an agency responsible for setting national goals for health spending and conducting negotiations with providers to achieve these goals. To be successful, the Federal Health Expenditures Board would probably have to create a system of binding budget ceilings on health-care providers. Whether these budget caps actually work in the United States would depend critically on the increases in medical costs allowed under the law.

The Canadian experience illustrates why the Federal Health Expenditure Board would not necessarily curb rising costs. Canada's increase in health-care spending mirrors the one observed in the United States even though the

53. EXECUTIVE OFFICE OF THE PRESIDENT, *supra* note 4.

54. S. 1227, *supra* note 5.

55. *E.g.*, H.R. 1300, *supra* note 6, at § 2132.

Canadian system contains mechanisms to strictly regulate spending increases.⁵⁶ Similarly, voluntary efforts to control the rise in costs, and state-operated Certificate of Need programs designed to control the diffusion of medical technology have not been effective in reducing hospital costs.⁵⁷

IV. CONCLUSIONS

Debate on the costs of expanding health insurance has been confused by the many ways in which costs may be evaluated. As we have shown, the spending of any plan to reform the health-care system must be assessed along three dimensions: (1) net new spending; (2) distribution of spending; and (3) the rise in spending. Failure to distinguish between net new costs and the distribution of spending may cause a plan's dismissal even though its costs are relatively low. For example, as discussed above, many believe that the proposal submitted by the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) was removed from serious consideration due to its high costs.⁵⁸ Yet careful analysis shows that the net new spending from the plan was half the figure circulating on Capitol Hill.⁵⁹

Estimates of net new spending to cover all currently uninsured U.S. citizens range from \$10 to \$25 billion.⁶⁰ Variance in net new spending across proposed plans generally reflects differences in eligibility and enrollment, benefits, cost-sharing, and provider reimbursement. Net new spending can also vary due to assumptions about consumer behavior and the effect of plans to reduce inefficiency in the health-care system. Government's role in the health reform plan is not necessarily a determinant of the size of net new spending.

By contrast, the way in which payments are distributed and the anticipated role of government depend critically on the type of reform that is chosen by legislators. Tax credit proposals whereby individuals are given vouchers or tax credits to purchase health insurance will tend to increase consumer payments through the conventional insurance system. Employment-based proposals, which build on the current system by requiring or placing strong incentives on employers to provide coverage, tend to increase the burden on business. Public insurance proposals tend to shift payments to the federal government.

56. See data in George J. Shieber & Jean-Pierre Poullier, *International Health Care Expenditure Trends: 1987*, 8 HEALTH AFF. 174 (1989).

57. Frank A. Sloan & Bruce Steinwald, *Effects of Regulation on Hospital Costs and Input Use*, 23 J.L. ECON. 81, 105 (1980).

58. 1990: *A Year in Review*, *supra* note 2.

59. U.S. BIPARTISAN COMM'N ON COMPREHENSIVE HEALTH CARE, *supra* note 3, at 9.

60. Lewin-ICF calculation, based on the Health Benefits Simulation Model, *supra* note 46.

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A more important long-term measure of spending is whether an insurance plan puts forth a credible and effective case for how the rise in spending is to be controlled. Control of spending is of critical importance since access can be expected to continue to erode in its absence. To date, no plan has recognized that in order for spending to be controlled, the diffusion of expensive new technology will have to be slowed. Any of the three prototypes discussed above could, in theory, contain effective spending controls. But the presence of such mechanisms is no substitute for the strong political will necessary to face the difficult political situation naturally arising from a decision to limit the diffusion of new medical technology.

Although estimates indicate that the net new spending required to insure the uninsured is small (\$10-25 billion) relative to the annual rise in spending, the overall cost problem remains unresolved. Political consensus on a reform strategy has been thwarted by a lack of agreement on the proper role of government in financing and delivering health care and by disagreement over the distribution of financing expansions in care. Moreover, our inability to temper the explosion in health-care spending has made policymakers cautious about expanding coverage without simultaneously adopting strategies to control costs. As the debate moves forward, understanding the interplay among the three dimensions of cost—net new spending, the distribution of spending, and the rise in spending—will be critical to evaluating competing medical-care reform proposals.