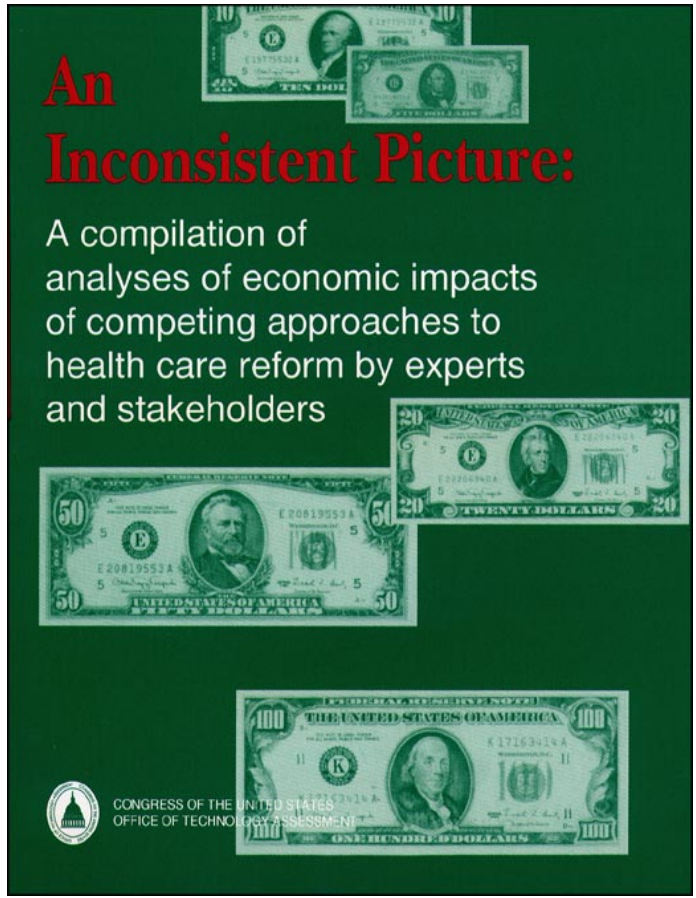
An Inconsistent Picture: A Compilation of Analyses of Economic Impacts of Competing Approaches to Health Care Reform by Experts and Stakeholders

June 1993

OTA-H-540
NTIS order #PB93-203719
GPO stock #052-003-01327-4



Recommended Citation:
U.S. Congress, Office of Technology Assessment, An Inconsistent *Picture: A Compilation of Analyses of Economic Impacts of Competing Approaches to Health Care Reform by Experts and Stakeholders, OTA-H-540* (Washington, DC: U.S. Government Printing Office, June 1993).

For sale by the U.S. Government Printing Office
Superintendent of Documents, Mail Stop SSOP. Washington, DC 20402-9328
ISBN 0-16 -041808-9

Foreword

Health care reform has become the focus of intense debate in government and in the private sector. But reform of the health care system, which represents about one-seventh of the Nation's economy, will pose daunting economic, as well as social and political, issues.

In their efforts to address these issues, health care policy experts and stakeholders have developed several general approaches to reform and sundry variants on those approaches. Numerous analyses of these approaches and proposals have yielded a multitude of quantitative estimates intended to measure their potential economic impact. Yet this abundance of information is not without its pitfalls-in terms of clarity and consistency—for policymakers attempting to weigh various routes to reform.

This Report reviews numerous analyses of the economic impacts of the major approaches to health care reform addressed in this Report-Single Payer, Play-or-Pay, Individual Vouchers or Tax Credits, and Managed Competition-and identifies some of the key issues and significant assumptions behind the estimates provided in these analyses. Through this review, OTA endeavors to facilitate policymakers' understanding of how various provisions tend to influence the economic impact of the approaches and proposals, thereby assisting them in their efforts to sort through the profusion of information provided as well as specify additional details they may require.

The request for this Report came from Senator Ted Stevens, a member of the OTA Technology Assessment Board at the time of his request.

OTA was assisted in this review by the advisory panel for the OTA assessment *Technology, Insurance, and the Health Care System,* and by numerous other health policy experts. OTA gratefully acknowledges the contribution of each of these individuals. As with all OTA reports, the final responsibility for the content of the Report rests with OTA.



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NOTE: OTA appreciates and is grateful for the valuable assistance and thoughtful critiques provided by the advisory panel members. The panel does not, however, necessarily approve, disapprove, or endorse this report. **OTA assumes full responsibility for the report and the accuracy of its contents.**

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PART I. Summary and Overview of Competing Approaches to Health Care Reform

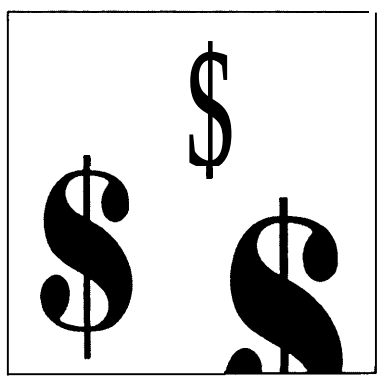
Summary and Overview of Competing Approaches to Health Care Reform

1

In this report, the Office of Technology Assessment (OTA) examines available analyses of the anticipated impact of selected competing approaches to health care reform—Single Payer, Play-or-Pay, Individual Vouchers or Tax Credits, and Managed Competition-on the following areas of the economy:

- national health care spending and savings;
- Federal, State and local budgets;
- employers;
- employment;
- households;
- other costs in the economy; and
- administrative costs.

The report is not a detailed critique of the analyses discussed, nor does it provide an independent OTA assessment of the economic impacts of the selected health care reform approaches. The estimates provided are those reported in the analyses without adjustment to a common year.



SUMMARY OF FINDINGS

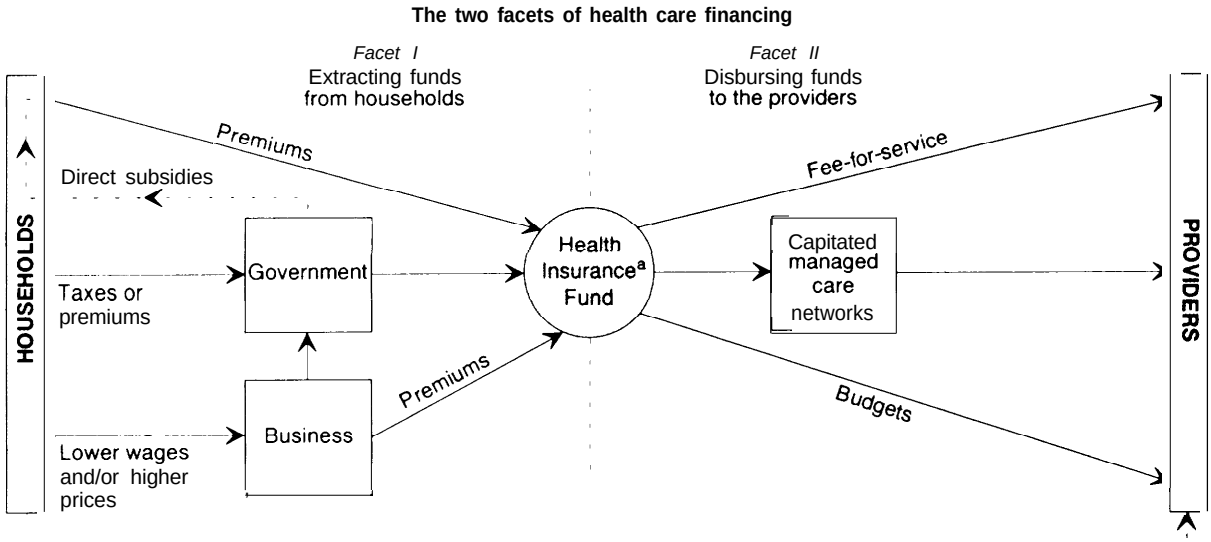
Below is a brief synopsis of the report's major conclusions:

- While the selected approaches to health care reform may be grouped together under the names Single Payer, Play-or-Pay, Individual Vouchers or Tax Credits, and Managed Competition, significant differences in specific proposals exist within as well as across these categories. Key factors contributing to these differences include what a particular approach does, if anything, with respect to: 1) extending access to coverage and/or services, and the scope of benefits provided; 2)

controlling the rate of growth in national health care spending and savings; and 3) redistributing the burden of financing health care coverage and services. The name of any one approach is not sufficient to alert policymakers—or the public-to how the approach deals with all of these key factors.

- *Regardless of the approach to health care reform, the* only way analysts appear to have been able to project savings in national health expenditures is by assuming one or more of the following:
  - —a cap on total health expenditures at a certain level and/or provider price controls at, for example, Medicare payment rates;
  - —the approach will not provide universal coverage or will provide universal coverage but will substantially cut back on the scope or depth of coverage; or
  - —strikingly high levels of savings derived from restructuring the institutions and processes related to health care delivery (e.g., managed care and/or administrative savings).
- The reasons proposals, or analyses of them, need these assumptions to achieve savings are:
  - —increased availability of coverage will likely increase the use of, and the total amount spent on, health services; and
  - —administrative reforms alone are not likely to save enough money to expand coverage, especially to those people who are currently uninsured.
- There is a startlingly wide range of estimates of the impact of the selected approaches to health care reform on the areas of the economy examined. For example:
  - —Estimates of the impact of Single Payer approaches on *national health care spending and savings in* a single year range *from* $21 billion in *increased spending* to $241 billion in *savings in 1991.*
  - —Estimates of the impact of Managed Competition approaches on *national health care spending and savings in* a single year range from *increased spending* of $47.9 billion (in the year 1993) to *savings* of $21.8 billion (in the year 1994).
  - —Estimates of the impact of Play-or-Pay approaches on *households in* a single year range from *increased spending* of $2.3 billion (in the year 1993) to $19.3 billion in *savings (in the year 1990)*.
  - —With respect to the impact of a Play-or-Pay approach on *employment,* one estimate suggested that 25,000 to 50,000 low-income workers might be displaced but others suggest much greater employment losses, for example, 710,000 jobs lost in the first year of plan implementation.
- Policymakers should be aware of the fact that the analyses of the health care reform approaches and proposals and, thus, the resulting quantitative estimates, are not comparable to one another. Therefore, policymakers should be wary of giving too much credence to any one analysis or estimate of an approach to health care reform, of comparing various analyses or estimates of an approach, and of comparing economic impacts across approaches. In order to properly evaluate such analyses, policymakers should be aware of: the specifics of the reform approach; the details, assumptions, and data used in the analysis; and, perhaps, on whose behalf the analysis was conducted. OTA suggests that policymakers use a guide containing factors likely to affect the economic impact of approaches to health care reform to assist them in reviewing analyses. OTA provides such a guide in chapter 10 of this report.
- Many analyses are based upon proprietary analytic models so that policymakers may not have all the relevant information available to them. OTA urges policymakers to request detailed information about the assumptions used by the analysts in their studies in order to avoid making inappropriate comparisons. If policymakers want to make comparisons among competing approaches to health care reform, they could facilitate the development of comparable analyses by asking analysts to compare

FIGURE 1: Flow of funds to and from areas of the U.S. economy



a In this report, the term 'health insurance" is used broadly to include various types of health pans that are designed to reimburse or indemnify individuals or families for the costs of medical care, or (as in HMOS) to arrange for the delivery of that care, including traditional private indemnity fee-for-service coverage, prepaid health plans such as health maintenance organizations, self-funded employment-based health plans, Medicaid, and Medicare.

SOURCE: Adapted from figure developed by Uwe Reinhardt, 1993. A version of this figure appeared in Health Affairs 12 (Supplement): 174, 1993.

their analytic approaches and results with those of others, as appropriate, using similar assumptions (e.g., regarding: numbers of people covered; the share of the gross domestic product (GDP) expected to be devoted to health care; ascribed Federal and State responsibilities for Medicaid, if relevant; payroll tax rate; scope and depth of the benefit package; and premiums or the actuarial cost of covered health care services).

- Policymakers should resist using estimates when they are provided for only 1 year, usually the first year of plan implementation. Such estimates, even if provided for the various areas of the economy, do not indicate the medium- or long-term impact of an approach on the economy.
- Policymakers should also be wary of making comparisons among approaches by looking only at their anticipated impact on discrete areas of the economy (e.g., Federal, State and local budgets; employers; administrative costs). Instead, policymakers need to look at all areas of the economy simultaneously and in relation to one another. While a reform approach may increase spending in one or more areas of the economy, it may decrease it in one or more other areas. For example, a proposal **may** decrease employers' health care expenses that, alone, may look quite impressive, but the same proposal may increase government expenditures tremendously. Thus, if policymakers do not look at all areas of the economy simultaneously, decisions will be made absent full information. However, the relationships between areas of the economy are complex and not fully understood, and few analyses examine the totality of change. Policymakers could use a visual aid such as that in figure 1 to help focus attention on the potential for competing impacts.

HISTORY OF REQUEST

The congressional Office of Technology Assessment is conducting an assessment entitled *Technology, Insurance, and the Health Care System.* Appendix A provides an overview of the full assessment.

Given the increased attention to health care reform in Congress, Senator Ted Stevens[1] of Alaska requested that the project provide an additional analysis related to the major health care reform approaches under congressional consideration, in terms of their anticipated economic consequences. Specifically, Senator Stevens requested that OTA assemble, and briefly describe, the findings of available analyses of the impact of basic reform approaches on:

- national health care spending and savings;
- Federal, State and local budgets;
- employers;
- employment;
- households;
- other costs in the economy; and
- administrative costs.

OTA'S METHOD OF REVIEW

For purposes of soliciting analyses, the basic health care reform approaches were initially characterized as ''single payer, '' "play-or-pay,' and ''market-based/consumer choice. ' Because the term ''market-based/consumer choice' is used to refer to a wide array of approaches, the term was broadly defined to include tax credits or vouchers for individual consumers as well as ''managed competition. ' In October 1992, OTA staff sent a letter to a wide array of individuals, think tanks, special interest groups, and government agencies requesting copies of existing analyses of these reform approaches. OTA also obtained materials identified through a literature search. A draft of this report was sent to those who provided relevant materials and other experts for review in February 1993. Those solicited demonstrated considerable interest in the project, and this report summarizes pertinent information provided to OTA staff. Appendix C lists the names of those who were particularly helpful to OTA during the development of this report.

It is important to note that this report is not intended to be a detailed critique of the analyses discussed, nor does it attempt to provide an independent OTA assessment of the economic impacts of the selected health care reform approaches. The estimates provided are those reported in the analyses without adjustment to a common year. While the report does provide some explanation of why the estimates presented differ from one another, it does not try to fully explain the bases for such variations. As noted above, OTA provides a list of key questions that policymakers might ask before accepting any reported projections (see chapter 10).

ORGANIZATION OF REPORT

This report frost describes the major health care reform approaches examined and major caveats concerning the approaches and analyses of them; these descriptions are in the next sections of this chapter. Throughout this report, the major approaches are referred to as Single Payer, Play-or-Pay, Individual Vouchers or Tax Credits, and Managed Competition. Tables summarizing the quantitative estimates of the impacts of these approaches to health care reform on the economy

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[1] Senator Stevens was a member of the OTA Technology Assessment Board at the time of his request.

[2] This paper does not address every approach to health care reform. Instead it focuses on the approaches included in the request to OTA, expanded to include major reforms of particular interest to the present Congress. Thus other approaches, e.g., Medical Savings Accounts (MSAs), agovemment-owned and -operated health care system, and the full array of approaches sometimes labeled managed competition (e.g., greater permission or encouragement for small employers to form health insurance purchasing groups), are not discussed in this report. Those interested in exploring them further may wish to look at the following sources: M! As—(21,73); H.R. 101 (Action Now Health Care Reform Act of 1993); Government-owned and -operated health care system-H.R. 3229 (U.S. Health Service Act), 1992; Managed Competition—(8,16, 17,70). Numbers in parentheses refer to OTA accession numbers for references listed at the back of this report.

follow. Part II of the report summarizes the potential effects of the implementation of the selected reform approaches, providing discussion of the findings of available analyses by area of the economy, including various issues and assumptions involved in estimating the impact of the reform approaches on that area (chapters 2 through 8). Part III of the report addresses additional policy considerations that may be of interest to those concerned with health care reform (chapter 9) and concludes with a series of key questions-in the form of a provisional checklist-that may be useful to policymakers as they contemplate health care reform (chapter 10).

MAJOR APPROACHES TO HEALTH CARE REFORM

The major approaches to health care reform attempt to address the fundamental issues of cost, access, and quality. Many factors may influence how the approaches deal with these issues (e.g., philosophy of government, belief in the effectiveness of market forces), and the approaches maybe categorized in diverse ways depending on the criterion of interest (e.g., whether and how the plan provides for universal coverage, whether and how it addresses cost containment).

An example of a strategy for categorizing reform approaches devised by Henry Aaron of the Brookings Institution addressed two objectives of health care reform and analyzed three different approaches to achieving each of the objectives; Aaron's strategy compared "national health insurance, " ''tax credits, ' and an "employment-based, public backup" system as approaches to achieving universal coverage, and ' 'competition, ' ''managed competition, ' and ''budget limits' as approaches to controlling the growth of health care costs (l). According to Aaron, "No necessary connection exists between cost control and extension of coverage, but most who advocate national health insurance espouse budget limits to control costs, and most who advocate tax credits support market competition to control costs. Advocates of extending employment-based insurance support managed competition or budget limits" (1)?

Terms Used in This Report

There is increasing agreement that the use of available terminology such as Single Payer, Play-or-Pay, Individual Vouchers or Tax Credits, and Managed Competition to describe any approach to reform is problematic. For example, the assumption may arise that the term ''play-or-pay" has a particular definition that clearly distinguishes it from other reform approaches. Marmor and Boyum, among others, have urged participants in the policy debate to question the use of such terminology:

> The classification of proposals into . . . broad categories-play-or-pay, single-payer, procompetitive--is clearly useful in organizing the debate about medical care reform. There are so many plans out there that we must group them in order to make sense of what would otherwise be hopelessly confusing. . . But if these classifications illuminate, they also obscure. Since classifications, by their very nature, stress differences *between* groups and similarities *within* them, they thus have a tendency to ignore their very opposites--that is, similarities across groups and differences within them (42).

This report continues to use the terms Single Payer, Play-or-Pay, Individual Vouchers or Tax Credits, and Managed Competition to refer to broad "approaches' to health care reform since

[3] Since Aaron arrived at his strategy for categorizing approaches to reform, some have proposed combining managed competition and budget limits (70,71). However, and in contrast to Aaron's conclusion some believe that certain components of their approaches must not be tampered with if the approach is to be successful (15).

this is the terminology typically used in the analyses examined.[4]

In contrast to the term "approaches," this report used the terms "proposal" or "plan" to refer to specific variants of the broad approaches, and the term ''analysis" to refer to an estimate of the impact of either an approach or a proposal. Most, but not all, analyses reviewed for this report resulted in estimates put in numerical, rather than narrative, terms. Most of the numbers are in dollars.

Figure 2 presents the specific proposals within the major approaches to universal coverage and cost containment.[5]

For example, the Heritage Foundation and Bush Administration *proposals are* usually considered variants of the Individual Vouchers or Tax Credits *approach* to achieving universal coverage. Various potential economic impacts of the Bush Administration's proposal were *analyzed* by several agencies andorganizations.67

It is important to note that: 1) not every proposal with a particular name includes every feature of a prototypical approach, and 2) not every analysis addresses identically every feature of similar proposals.[8] Even where similar features were included, specific assumptions about the

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[4] One exception is Individual Vouchers or Tax Credits. This title is used hereto distinguish this group of reform approaches from Managed Competition approaches. Both have been grouped together at times under the heading ''market-based/consumer choice" approaches, a term which can obscure their differences.

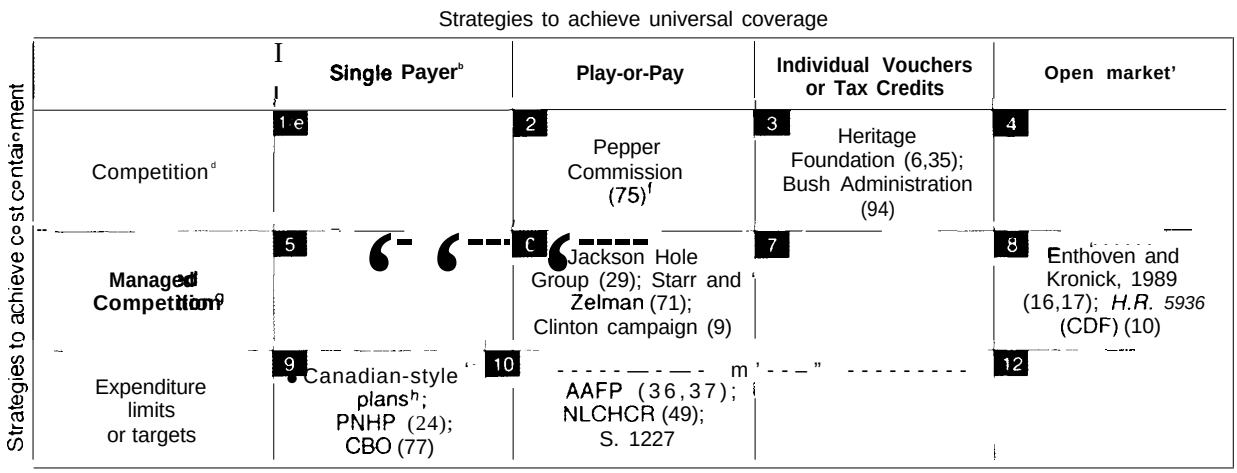
[5] OTA considers an approach 'major' if it attempts to achieve universal coverage. Nonmajor approaches, then, are reform proposals that address specific aspects of access to insurance coverage, such as efforts to increase affordability or availability for selected populations, markets, or individuals (e.g., by the rescinding of preexisting conditions provisions in insurance contracts).

6 These include: the Office of Management and Budget in the U.S. Executive Office of the President (94); the Health Care Financing Administration in the U.S. Department of Health and Human Services (93); Lewin-VHI for the Bipartisan Panel on Presidential Candidates' Health Plans, a panel convened by the organization Families USA in 1992 (3); and Silow-Carroll of the Economic and Social Research Institute (65).

[7] As shown in figure 2, the Heritage Foundation proposal would attempt to achieve *universal coverage* by subsidizing individuals' (or heads of households') purchase of health insurance through tax credits or vouchers made available directly to the individual purchaser. Cost *containment is* to be achieved through competition, according to the Heritage Foundation plan, in the following way: individual purchasers of health insurance will be more cost-conscious with respect to both their purchases of insurance coverage and the uses to which their insurance and other health care dollars are put (e.g., the purchase of health services) than they are currently. Under this theory, as insurers compete to sell health insurance at the lowest premiums, and individuals more aggressively negotiate with providers over the price and quality (i.e., the value) of health services, the rate of growth in national health expenditures will decelerate. Thus, the Heritage Foundation plan appears in the cell (cell 3) of figure 2 that combines "competition" and "individual vouchers or tax credits. ' It is important to note that the Heritage Foundation proposal-and all other proposals-includes other important features besides "competition" and "individual vouchers or tax credits. ' For the sake of relative simplicity, these features are not shown in figure 2, but they maybe of importance to any analysis comparing the Heritage Foundation plan and other specific proposals or approaches. These features may include, but are not necessarily limited to, the fact that Heritage's plan would: 1) require individuals to purchase health insurance coverage or face a fine; 2) provide subsidies at only certain family income levels; 3) have Congress develop and mandate many of the features of the benefit package; 4) have Congress rescind the current tax deduction/exclusion for employer-sponsored health insurance coverage (6,35), The level of the individual tax credit, the basic benefit package, and the rescission of the employers' tax deduction/employees' tax exclusion are all related in the Heritage plan (6,35).

8 In addition to specific variations within and across approaches and proposals, almost all major approaches to health care refol-m-except the Single Payer approach-include in some fashion the following reforms to the health insurance marketplace: 1) guaranteed issue of policies, regardless of preexisting conditions, current health status, or other factors that could potentially affect utilization and costs; 2) limitations or prohibitions on benefit plan exclusions for preexisting health conditions; and 3) an end to experience rating. However, many proposals would establish some form of risk-adjusted community rating, in which individual subscribers would all pay equal or relatively similar premiums (i.e., adjusted for family size or geographic area), but the amounts of the premium paid to insurers would reflect the risk status of their specific pool of subscribers. Other insurance marketplace reforms that are frequently suggested but that vary by approach or proposal include: requiring insurers to offer a specific benefit package; efforts to promote the use of managed care arrangements (e.g., by preempting State laws that inhibit their growth); efforts to encourage the formation of health insurance purchasing networks (e.g., by extending Employee Retirement Security Act [ERISA] preemptions that permit larger self-insured employers to avoid State-mandated health insurance benefits to small employers purchasing coverage through health insurance purchasing networks) (94). Common reforms that would reduce the administrative burdens of the current system include electronic claims processing and billing. None of these reforms are shown in figure 2.

FIGURE 2: Major approaches and specific proposals in analyses reviewed by OTA: strategies to achieve universal coverage and cost containment



[a] This figure is based upon Aaron's (1) strategy for categorizing health care reform approaches that compared approaches to achieving universal coverage and approaches to achieving cost containment. The figure shows approaches and proposals which served as the basis for analyses included in this report and categorizes them according to their approaches to universal coverage and cost containment.

[b] Names of approaches in uppercase and **BOLD** are the terms commonly used and/or used in this report to describe major approaches to health care reform. For example, **MANAGED COMPETITION**, a strategy to achieve cost containment, has been combined in several proposals with **PLAY-OR-PAY** or Open Market approaches to increase the number of people with coverage. It is important to know that both combinations are often referred to as **MANAGED COMPETITION** which obscures significant differences between these approaches and confuses debate over them.

[c] Open-Market-based approaches assume that universal (or near-universal coverage) will be achieved because market forces and limited insurance reforms will make insurance affordable and available.

[d] Competition in this context assumes some, but fairly limited, regulation aimed at reforming the health insurance market so that individuals and/or their employers will make more cost-conscious decisions in their purchase of health insurance coverage and/or services that will result in reduced health care expenditures.

[e] Numbers in the upper left hand corner of each box are cell numbers that are referred to elsewhere in this report. Some cells are empty because proposals combining these approaches to universal coverage and cost containment have not been made and analyzed although they are not necessarily mutually exclusive (1).

[f] Numbers in parentheses pertain to the references which are arranged alphabetically at the end of this report.

[g] Some **MANAGED COMPETITION** proposals also incorporate expenditure limits or targets. Starr and Zelman's approach to **MANAGED COMPETITION** does not require expenditure limits or targets (71), but, unlike Enthoven (15), they believe that broad budget limits are compatible with **MANAGED COMPETITION**.

[h] Approaches and analyses that are "Canadian-style" are based on Canada's national experience or the experiences(s) of selected Canadian provinces.

KEY: **AAFP**: American Academy of Family Physicians; **CBO**: Congressional Budget Office; **CDF**: Conservative Democratic Forum; **H.R. 5936**: The Managed Competition Act of 1992 (102d Congress); **NHE**: National Health Expenditures; **NLCHCR**: National Leadership Coalition for Health Care Reform; **PEPPER COMMISSION**: U.S. Bipartisan Commission on Comprehensive Health Care; **PNHP**: Physicians for a National Health Program; **S. 1227**: HealthAmerica: Affordable Health Care for All Americans Act (102d Congress).

SOURCE: Office of Technology Assessment, 1993, based initially on Aaron's strategy for categorizing reform approaches (1), and adapted based on findings of OTA'S review and analysis for this report.

features may have varied considerably, further affecting any estimates provided. Variations in plan features and in certain assumptions may be a function of the primary goals or the ideology of the proponents of the approach as well as, in some instances, the analyst's desire to provide numerous examples of potential effects for more purely analytical purposes.

The following descriptions attempt to provide the basic elements of the major approaches to health care reform as well as their major goals. That section is followed by a discussion of caveats that should be kept in mind as specific attempts at analysis are reviewed.

Policymakers should also note that, as approaches to health care reform continue to evolve,

they will likely be faced with new variants of existing approaches and new analyses of those modifications (20).

Single Payer Approaches

The Single Payer approach explored in most analyses proposes a system of tax-financed universal coverage with government as the sole purchaser of health services.[9] Most of the analyses reviewed for this report examined a "Canadian model' fashioned after the system operating in Canada.[10] Its key features are:

- a federally-specified health benefits package;
- universal coverage;
- tax-financed system;
- government as sole purchaser of services; and
- expenditure limits. In Canada, expenditure limits include global budgeting for hospitals and negotiated physician fee schedules and, in some provinces, controls on expenditures for physician services (e.g., expenditure targets and caps as well as limits on physician income). An approach in which government is the sole purchaser of services may or may not include expenditure limits.

Under the Single Payer approach, government would ensure that all Americans have financial access to broad health care services. Proponents of a Single Payer system believe that its implementation in the United States would:

- achieve universal coverage, because general revenues, rather than individual premiums, would be used to finance the system (a priority goal of this approach); and
- achieve a more equitable distribution of the burden of financing health care costs, to the extent that the system would be financed through general revenues (a priority goal); and
- stabilize or reduce the rate of growth in national health expenditures through the imposition of expenditure limits (a secondary goal of this approach); and
- drastically reduce administrative costs through substantially streamlined administrative procedures (a secondary goal).

Play-or-Pay Approaches

Play-or-Pay, sometimes known as the ''public-private combination' approach (88), would build upon the current system of employment-based coverage, requiring a combination of employment-based and tax-financed universal coverage with multiple purchasers of services. Its key features typically include:

- a federally -specified health benefit package that must be offered, at a minimum, by private insurers and any public backup plan;
- universal coverage (usually mandatory acceptance of insurance coverage); [11]
- financing by a combination of employer contributions, individual premiums and cost-sharing, and Federal and State monies including current Medicaid funds and general revenues;
- employers that, on behalf of their employees, make premium payments for private insurance ("play") or contribute a specified amount (e.g., 7 percent of total payroll) ("pay") to a public fund; and

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[9] Examples of legislation to establish a Single Payer system introduced in the 103d Congress include: S. 491 (American Health Security Act of 1993)/H.R. 1200 (American Health Security Act of 1993); in the 102d Congress: S. 2320 (Universal Health Care Act of 1992)/H.R. 1300 (Universal Health Care Act of 1991); S. 1446 (Health USA Act of 1991); H.R. 5514 (Health Choice Act of 1992).

[10] OTA acknowledges that different Single Payer approaches operate in other countries but since the system operating in Canada is the system most frequently discussed in terms of implementation in the United States, it is the system used by many analysts to infer what would happen in the United States under a Single Payer system.

[11] Examples of such legislation introduced in the 102d Congress include: S.1177 (Pepper Commission Health care Access and Reform Act of 1991)/H.R. 2535 (Pepper Commission Health Care Access and Reform Act of 1991); S. 1227 (HealthAmerica: Affordable Health Care for AU Americans Act)/H.R. 3205 (Health Insurance Coverage and Cost Containment Act of 1991).

- a public fund that provides coverage to all uninsured workers and to unemployed persons and their dependents, whether presently uninsured or otherwise insured.

In addition, expenditure limits are included in some proposals.[12]

Proponents of the Play-or-Pay approach believe that it would:

- achieve universal coverage, by insuring all Americans through employment-based or public-sponsored coverage, and by making coverage more affordable through health insurance marketplace reforms (the priority goals of this approach); and
- minimize the redistribution, and the potential disruption associated with it, of the burden of financing health care by building upon the current employment-based method of sponsoring health insurance (the secondary goal of this approach). 13

Approaches Employing Individual Vouchers or Tax Credits

The approaches that OTA calls Individual Vouchers or Tax Credits propose tax policy modifications and limited health insurance marketplace reforms to expand access to coverage while retaining multiple purchasers of services.[14] Their key features typically include:

- a specified (e.g., by Congress or the States) benefit package available for the amount of the maximum tax subsidy;[15]
- universal or expanded access to coverage;
- deduction, credit or voucher available to individuals to assist them primarily with the purchase of health insurance and secondarily with the direct purchase of health services;[16]
- financing by a combination of individual premiums and cost-sharing, Federal and State monies currently funding care to low-income and uninsured persons, general revenues, and employer contributions, at least initially, in some proposals;
- individuals purchase health insurance coverage directly or through their employers; and
- public programs (e.g., Medicaid, Medicare) continued with some modification possible to expand coverage to additional low-income people under Medicaid.

Proponents of the Individual Vouchers or Tax Credits approaches believe that these changes would:

- increase the affordability, accessibility, portability, and stability of health insurance, in particular for individuals[17] and small groups, thereby reducing the number of uninsured individuals (a priority goal of this approach); encourage individuals to assume a greater role than they presently do, and to be more cost-

12 Examples of such legislation introduced in the 102d Congress include: S. 1227 (HealthAmerica: Affordable Health Care for All Americans Act)/H.R. 3205 (Health Insurance Coverage and Cost Containment Act of 1991).

13 In 1990, 64 percent of insured persons underage 65 in the United States purchased insurance through an employer-sponsored group (either directly or as dependents) (89).

14 Examples examined in this report are the Heritage Foundation (6,35) and Bush Administration (94) proposals. In the 102d Congress, H.R. 5919 (Comprehensive Health Reform Act of 1992), incorporated some of the Bush Administration's proposed reforms. See also, Pauly, Danzon, Feldstein, et al., 1991 (52), 1992 (53).

15 The Heritage Foundation plan would require Congress to delineate a "basic" benefit package (6). The Bush Administration plan would have delegated responsibility for specifying the benefit package to the States (94).

16 The Heritage Foundation plan requires individuals to purchase health insurance coverage unless they already have coverage under Medicaid, Medicare or another government program (6,35).

17 Currently, some people purchase health insurance coverage directly from an insurer for themselves and their families, in particular, those ineligible for employment-based coverage, Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Veterans Affairs, or military coverage (89). This is typically referred to as the "individual market' for health insurance to distinguish it from the "small group" and ''large group" markets.

conscious, with respect to their purchase of health care coverage and services (a secondary goal of this approach); and
- limit the Federal Government's regulatory role (a secondary goal).

Managed Competition Approaches

Managed Competition generally combines tax policy modifications with health insurance marketplace reforms designed to promote health care delivery system restructuring.[18] It is, according to its originator, Alain Enthoven,

> . . . a purchasing strategy to obtain maximum value for money for employers and consumers. . . Managed competition occurs at the level of integrated financing and delivery plans, not at the individual provider level. Its goal is to divide providers in each community into competing economic units and to use market forces to motivate them to develop efficient delivery systems (15).

Key common features typically include:

- a standardized benefit package (15,70), defined by a National Health Board or similar entity which must be offered by private insurers and any public backup plan;
- expanded access to coverage through sponsors (e.g., health insurance purchasing groups) authorized to structure and modify the market for competing health plans (15);[19]
- further development of integrated financing and delivery organizations (e.g., Health Maintenance Organizations [HMOs]) financially at risk for the total health care of enrollees and accountable to the public;
- limitation of the deduction from employer income and, in some proposals, the exclusion from employee income, of employer contributions for group health insurance premiums to the price of the least expensive, but minimally acceptable, standardized benefit plan in the area; and
- expenditure limits, in some proposals.

As noted above, the Managed Competition approach typically provides for health insurance purchasing groups which, by pooling large numbers of individuals together, are intended to foster competition among providers for enrollees and pool the risk of providing coverage. These group purchasing arrangements are particularly advantageous for individuals and small groups that are currently unable to achieve the economies of scale enjoyed by larger groups.

The primary purpose of this approach is to use a combination of market competition and targeted regulation of the health care insurance industry to promote change in the health care system. Some proponents of Managed Competition believe that it would:

- achieve universal access by making coverage more affordable through specific insurance and health care delivery reforms;[20]
- minimize the redistribution, and the disruption associated with it, of financing health care by retaining current arrangements, yet modify incentives related to the purchase of coverage

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18 Alain Enthoven originated the concept and the Jackson Hole Group initiated development of the framework for Managed Competition (16,17,29). Examples of such legislation introduced in the 102d Congress include: S. 3299 (Managed Competition Act of 1992)/H.R. 5936 (Managed Competition Act of 1992) (Conservative Democratic Forum); S. 3300 (21st Century Health Care Act). President Clinton has previously expressed support for this approach in principle (9).

19 Most proposals would permit large employers to continue to purchase coverage on their own—i.e., employers With 10,000 or more covered lives would deal directly with the insurers and/or providers. Some proposals would permit employers with 1,000 or more covered lives to deal directly with the insurers and/or providers (27).

20 Enthoven writes, "[b]y putting market pressure on providers to cut costs, market reforms promoting competition—if not accompanied by universal coverage—could exacerbate access problems. (This would be true of any serious cost containment program.) It would be more humane, economical, and rational simply to adopt a policy providing coverage to virtually everybody through an integrated financing and delivery organization that provides primary and preventive care as part of a comprehensive benefit package. A necessary condition for universal coverage is that everybody who can contribute to financing the system must do so" (15).

through tax modifications to encourage cost-conscious behavior on the part of individuals;[21] and

promote competition among providers on the basis of price and quality.

CAVEATS CONCERNING THE ANALYSES EXAMINED BY OTA

In reviewing analyses of approaches to health care reform, several problems arise that must be understood so that the import of the analyses for purposes of the health care reform debate is clear. These problems relate to:

- defining the various approaches to reform; and
- the content and capabilities of the analytic models used to examine the approaches to reform.

First, apparent from the descriptions of the major reform approaches is the fact that certain components of reform may appear in various approaches. Thus while the terms Single Payer, Play-or-Pay, Individual Vouchers or Tax Credits, and Managed Competition may be used in common parlance, they lack freed definitions. Therefore, the use of these terms is likely to confuse rather than enhance the debate unless the particular components under discussion are outlined and the specific combination is carefully scrutinized with respect to its unique impact.

In order to analyze health care reform approaches, analysts must decide upon a relatively specific proposal to analyze and obtain the relevant data.[22] While not a complete barrier to analysis, the age of and problems with available data have posed problems for analysts (30,45,62).

Some of the key assumptions affecting the estimates of the impact of the various reform approaches concern:

- the extent to which coverage is expanded in the population;
- the distribution of the direct burden and the means of financing health care;
- the extent to which an approach or spectific proposal incorporates specific cost-containment mechanisms and/or expenditure limits, and the assumed effectiveness of such mechanisms and/or limits;
- the content of the benefit package;
- the actuarial cost of coverage;
- employer/employee cost-sharing with respect to private insurance or enrollee cost-sharing with respect to public-sponsored coverage;
- savings or increases in spending due to modifications of the tax subsidy for health insurance premiums;
- savings or increases in spending due to modifications in administrative procedures;
- implementation of managed care; and
- cost-savings assumed from managed care.[23]

Unfortunately, available studies may not be helpful when it comes to evaluating these and other key issues. The report of an analysis may be incomplete or difficult to interpret, or the analytic model itself is proprietary. As a consequence, crucial assumptions are not available to readers.

Particularly troublesome are those analyses that do not explicitly say that new revenues will be needed to finance the proposals; however, the proposals are frequently described as "budget neutral' in summaries of the analyses. New revenues, of course, would require either new taxes or increased premiums.

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21 Some analysts maintain that Managed Competition is compatible with various financing mechanisms (e.g., alternatively, from a tax-financed approach "to an employer/employee mandate plus an individual mandate and subsidies for the nonemployed. . . . to an individual mandate' (15).

22 In many cases reviewed in this report, analysts were asked to analyze a specific proposal (35,36,37,75).

23 Note that most analyses of the costs of particular reform proposals do not deal with transition costs, that is, costs related to implementing the system, such as developing an appropriate information system, which may be significant.

An example of a very widely used proprietary analytic model is the Lewin-VHI Health Benefits Simulation Model (HBSM).[24] It has been used to analyze the impact of a wide range of proposals based on numerous approaches (3,34,35,36,37,63, 75), yet analysts who wish to check the numbers generated by the Lewin-VHl HBSM are likely to be stymied because some of the assumptions and data are not available to them.

OTHER POLICY CONSIDERATIONS

Despite the need for complicated analytic models for analyzing the potential impacts on the U.S. economy of large and simultaneous changes in financial incentives and organizational structures, leading users of these analytic models emphasize that such models cannot answer the fundamental questions about health care reform (13,39,50). These fundamental issues include:

- access to health care-Access for whom and to what? To health care coverage and/or services, and to what type of coverage or level of services?
- financing of health care-How much disruption of the current health care system, in terms of the distribution of the direct financing burden, is deemed acceptable and to what extent is equity sought? What is the appropriate role of government, employers and individuals in financing health care?
- to what extent and how should the Nation attempt to control national health expenditures, in both absolute terms and with respect to their rate of growth?
- the appropriate roles of competition and regulation.

The **estimates** provided in this report cannot independently resolve the fundamental political and social issues that are central to health care reform. However, despite this, and the caveats discussed above, a comparative review of analyses of the reform approaches may be useful in informing the policy debate to the extent that their results can be understood to:

- demonstrate the potential for a specific reform action to have an economic impact; and
- provide insight into *who or what will be* affected by, and the possible *order of magnitude* of the economic impact of, a specific reform action.

However, it is critical that such estimates be used cautiously. Policymakers need to know what an estimate refers to in some detail as well as the validity of the data used in the estimate, before relying upon it as a basis for decisionmaking.

SUMMARY OF THE ESTIMATES

Tables 1 through 5 provide a brief summary of the estimates of the economic impacts of major approaches to health care reform, in five different areas for which there was sufficient information to put in table format. It is important to note that: 1) the tables report numbers that are available publicly; 2) almost every estimate in the tables contains a footnote that provides some of the key reasons why the estimate differs from the others shown in the table; 3) additional information on the seven areas of the economy addressed in this report, and more detailed discussions of the estimates and why they vary so much, can be found in chapters 2 through 8, and appendix B, of this report; and 4) types of estimates that were not amenable to table format (e.g., impacts on other

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24 The Lewin-VHI Health Benefits Simulation Model (HBSM) was first developed in 1984 to analyze the Medicare Catastrophic proposals. Its purpose is to estimate the cost of access proposals, the impact of access proposals, distributional impacts, and to identify unintended consequences. It is a month-by-month simulation model including a household data file from the 1987 National Medical Expenditures Survey updated to the simulation year, And there is a statistical match with the Small Business Administration's survey of large and small firms (62). While the model itself is properly proprietary, to the extent that the detailed assumptions used by the analysts are not available to policymakers, analyses using the HBSM may not provide policymakers with adequate information upon which to base public policy decisions.

areas of the economy; impacts on employment; and per-capita and per-household effects) are also discussed in the appropriate chapters and in appendix B. The tables are as follows:

- Table 1 summarizes the range of quantitative estimates of the economic impacts of competing approaches to health care reform on national health care spending and savings;
- Table 2 summarizes the range of quantitative estimates of the economic impacts of competing approaches to health care reform on Federal, State, and local budgets;
- Table 3 summarizes the range of quantitative estimates of the economic impacts of competing approaches to health care reform on employers;
- Table 4 summarizes the range of quantitative estimates of the economic impacts of competing approaches to health care reform on households;
- Table 5 summarizes the range of quantitative estimates of the economic impacts of competing approaches to health care reform on administrative costs.

TABLE 1: Quantitative estimates of the impact of competing approaches to health care reform on national health care spending and savings (national health expenditures)[a]

SINGLE PAYER APPROACHES[b]

Change in expenditures (in $billions)	Estimate year(s)	Source[d]
Sing/e year estimates[e]:		
[illegible]	[illegible]	[illegible]
- $241.0 to + $[illegible]	1991	[illegible]
Estimates 0/future impacts[f]:		
-$1,300.0 to -$5.500.0	1991-2000	Meyer, et al.[j,k]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
- $ 600.0	2000	NLCHCR[n]

PLAY-OR-PAY APPROACHES

Change in expenditures (in $billions)	Estimate year(s)	Source
Single year estimates:		
+ $12.0	1990	Pepper Commission[m]
[illegible]	[illegible]	[illegible]
+ $ 1.0	1992	NLCHCR[n]
+ $[illegible]	[illegible]	AAFP[o]
- $[illegible]	[illegible]	NLCHCR[n]
+ $ 6.0	1994	Silow-Carroll & Meyer[q,r]
+ $ 1.0	1994	Silow-Carroll & Meyer[q,s]
-$ 5.0	1994	Silow-Carroll & Meyer[q,t]
Estimates 0/future impacts:		
[illegible]	[illegible]	[illegible]
- $ 111.3 to - $333.5	1993-2000	AAFP[o,u]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
- $ 600.0	2000	NLCHCR[n]

[a] Baseline assumptions of national health care spending and savings differ among analyses; that is, analyses use different starting points in terms of the year and/or amount of national health expenditures to arrive at their estimates. To the extent that these differ among analyses, the estimates are not comparable, all other things being equal.

[b] As discussed more fully in the text, terms used to describe the competing approaches to health care reform (e.g., Single Payer, Play-or-Pay, Managed Competition) may be misleading insofar as differences exist within as well as across groups. Some of these variations and specific assumptions about them that appear to affect the estimates are noted in the footnotes related to particular analyses. For more details, please refer to the report text.

[c] Estimates provided are in current dollars unless otherwise indicated. The symbol "+" signifies increased expenditures and the symbol "-" signifies decreased expenditures.

[d] Some analyses were conducted on behalf of the source by another individual or entity. Where this was indicated in the analysis, it is noted in the footnotes following this table. Reference numbers are listed at the end of each footnote. The full citations may be found in the list of references at the end of this report.

[e] Single year estimates are for the first year of implementation of the health care reform plan unless otherwise noted.

[f] Lewin-VHI analysis of Canadian-style system. Estimate equals the sum of $46.8 billion in administrative costs-savings plus $68.0 billion in increased utilization (not including $10.2 billion in increased long-term care services utilization). No change in the rate of national health spending was assumed during the first year of plan implementation (34).

[g] U.S. General Accounting Office estimate based upon the Ontario system. Estimate assumed some cost-containment and all cost-inducing factors effective in the first year, but did not take transition costs into account (82).

[h] Grumbach and colleagues' analysis of the Physicians for a National Health Program plan, a Canadian-style system. $18.0 billion savings estimate assumed that the increased costs of expanded care could be paid for initially from administrative savings. Note that PNHP projected a national health budget for the first year of plan implementation that assumed no savings in national health care spending over current policies. This budget assumed a more conservative level of savings in administrative costs (did not assume that the level of administrative efficiency in Canada was immediately achievable in the United States) and that significant savings from the adoption of cost-containment mechanisms would accrue over time. It further assumed that the $18.0 billion in savings would be consumed by new health initiatives and transition costs (24).

[i] Congressional Budget Office (77) estimates of a Single Payer approach that assumed provider payments based on Medicare rates, patient cost-sharing, and retention of a residual Medicaid program. CBO figures converted by GAO (83) from 1989 dollars (-$58.1 billion to +$7.4 billion). CBO study was revised in April 1993 (81).

[j] Meyer and colleagues' analysis of a Canadian-style system with health care spending at no more than 8.7% of U.S. GDP. Single year savings estimate: $241.0 billion; estimate of cumulative savings: $5,500.0 billion (43).

[k] Meyer and colleagues' analysis of a Canadian-style system with health care spending capped at its current share of U.S. GDP after including the cost of covering uninsured individuals. Single year savings estimate: $20.0 billion; estimate of cumulative savings: $1,300.0 billion (43).

[l] The periods for which estimates of future impacts are reported were usually provided by the analysts cited. However, in some instances, cumulative estimates were calculated by OTA by adding together multiple single year estimates provided by the analyses. In such cases, the period selected by OTA depended upon the years for which the single year estimates were provided and upon the period(s) for which other cumulative estimates of the approach were provided. Also, in some instances where estimates of the *cumulative* impact of a particular proposal were not provided by the analysts cited, estimates for additional single future years are provided [e.g., NLCHCR (49)].

[m] Lewin-VHI analysis for the Pepper Commission of the Commission's plan. Does not reflect adjustments for inflation or for cost-containment savings (75).

[n] National Leadership Coalition for Health Care Reform proposal and analysis. Analysis assumed 7% payroll tax rate and annual health care expenditures target, reducing rate of growth in health care spending (assumed to be 11% currently) to rate of growth in GNP, at a targeted rate of decrease of 2% each year. Some phase-in provided. +$1.0 billion in Yr. 1, -$36.0 billion in Yr. 2 of plan implementation (49).

[o] Lewin-VHI analysis of American Academy of Family Physicians plan for AAFP. Plan assumed 10% payroll tax rate, improved provider reimbursement for services previously covered under Medicaid, and increased utilization by previously uninsured persons (36,37).

[p] Estimate for plan with expanded Medicare through the private purchase of expanded Medigap coverage; $32.5 billion in increased costs for plan without expanded Medicare (Medigap) coverage (36,37).

[q] Silow-Carroll and Meyer analysis of S. 1227 (102d Congress) and Clinton campaign proposals (66).

[r] Estimate shown is for the analysis' "Pessimistic Scenario" that assumed no initial efficiencies; spending would increase as access expands and annual health care spending growth would decline slowly from approximately 11.3% (1994) to about 9.1% (in the year 2003) (66).

[s] Estimate shown is for the analysis' "Intermediate Scenario" that assumed initial efficiencies would result in a 2.5% reduction in spending phased in over 5 years and, over

TABLE 1: Quantitative estimates of the impact of competing approaches to health care reform on national health care spending and savings (national health expenditures)[a]—*continued*

INDIVIDUAL VOUCHERS OR TAX CREDITS APPROACHES

Change in expenditures (in $billions)	Estimate year(s)	Source
Sing/e year estimates		
-$10.8	**1991**	**Heritage Foundation**[v]
-$ 7.5	**1993**	**Bipartisan Panel**[w]
-$ 2.0	**1994**	Silow-Carroll[x,y]
-$ 6.0	**1994**	Silow-Carroll[x,z]
Estimates of future impacts.		
-$394.0	**1992-1997**	**Bush Administration**
-$954.0	1992-2000	Bush Administration[=]
-$ 72.6	**1993-1997**	**Bipartisan Panel**[w]
-$156.9	1993-2000	**Bipartisan** Panel[w]
-$158.0to -$1,000.0	1994-2(XI3	**Silow-Carroll**[x,y,z,bb]

MANAGED COMPETITION APPROACHES

Change in expenditures (in $billions)	Estimate year(s)	Source[cc]
Sing/e year estimates"		
+ $47.9	**1993**	**Sheils, et al.**[dd]
-$ 8.0	**1993**	**Long & Rodgers**[ee]
- $21.8	1994	Bipartisan Panel[ff]
Estimates of future impacts:		
-$232.0	**1994-1997**	**Bipartisan Panel**[ff]
-$745.7	**1994-2000**	Bipartisan Panel[ff]

10 years, the annual growth rate in health care would slowly decline in stages, eventually achieving a reduction of 3 percentage points, from 11.26% to 8.26% annual growth. Health care would continue to grow faster than the rest of the economy but by a much smaller margin than currently (66).

[t] Estimate shown is for the analysis' "Optimistic Scenario" that assumed plan would result in universal coverage, an initial 5% reduction in health care costs phased in over 5 years, and future health care spending growth limited to the growth rate of the economy after the fifth year of implementation (66).

[u] Estimated savings depend on the effectiveness of the expenditure limits (assumed to take effect in 1994). Analysis assumed expenditure limits would reduce per-capita health spending from projected rate of 8.6% to 7.6% and 6.6% (lower and higher cumulative savings estimates, respectively). Figure in table equals estimated cumulative savings for plan with expanded Medicare through the private purchase of expanded Medigap coverage; -$123.7 billion to -$345.9 billion estimated cumulative savings for plan without expanded Medigap coverage (36,37).

[v] Lewin-VHI analysis for the Heritage Foundation of the Foundation's plan. Proposal would eliminate tax deduction/exclusion for employment-based health insurance, require individuals to purchase insurance, and include limited refundable tax credits/vouchers as well as health insurance market reforms. Estimate takes into account the likely utilization responses of both newly and currently insured people and changes in administrative costs (35).

[w] Lewin-VHI analysis of Bush Administration proposals for the Bipartisan Panel on Presidential Candidates' Health Plans convened by Families USA. Estimates assumed the successful implementation of the proposed cost-containment measures (3).

[x] Silow-Carroll analysis of Bush Administration proposals which included limited tax subsidies and insurance market reforms (65).

[y] Estimate shown is for the analysis' "Pessimistic Scenario" that assumed that "much of the savings in the Bush plan are one-time in nature, and that after these efficiencies are achieved, the cost curve returns to its present course" (65).

[z] Estimate shown is for the analysis' "Optimistic Scenario" that assumed 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" (65).

[aa] Bush Administration estimates of the President's Comprehensive Health Reform Program (Feb. 6, 1992) which included limited tax credits, deductions, or vouchers, as well as insurance market reforms intended to expand the availability of private insurance (94).

[bb] Estimate range depends upon scenario assumed. Lower savings estimate: "Pessimistic Scenario"; higher savings estimate: "Optimistic Scenario" (65).

[cc] Alain Enthoven recently estimated with respect to Managed Competition (assuming universal coverage achieved through alternative methods and no global budgets) that "[i]t is altogether possible that a very efficient competitive system could get us back to 9 or 10 percent" of U.S. GDP devoted to health care services (15). Enthoven did not provide supporting calculations nor the target date for this reduction in the portion of GDP devoted to health care.

[dd] Sheils and colleagues' analysis of a Managed Competition approach that assumed an employer mandate to contribute to employee health coverage but did not include expenditure limits. Further assumed: 2% savings from Managed Competition based upon the experience of all types of health maintenance organizations (-$4.5 billion) and administrative savings (-$11.2 billion) offset by increased utilization for previously uninsured persons (+$30.6 billion), net the change in provider reimbursement (+$27.4 billion), and the impact of reduced patient cost-sharing under the low patient cost-sharing scenario only (+$5.6 billion). Estimate equals +$42.3 billion with high patient cost-sharing (63).

[ee] Long and Rodgers' analysis, based on a draft of Sheils and colleagues' analysis (mentioned above) of a Managed Competition approach, which assumed an employer mandate to contribute to employee coverage and low patient cost-sharing but did not include expenditure limits. Further assumed 8% savings from Managed Competition based upon the experience of group-model health maintenance organizations (-$37.0 billion) offset by increased spending due to expanded access to coverage (+$29.0 billion) (40,41).

[ff] Lewin-VHI analysis of President Clinton's health care reform-related campaign proposals for the Bipartisan Panel on Presidential Candidates' Health Plans convened by Families USA. Assumed establishment of a national health budget that would restrict growth in national health spending to the rate of growth in family income (3).

KEY: **AAFP**: American Academy of Family Physicians; **BIPARTISAN PANEL**: Bipartisan Panel on Presidential Candidates' Health Plans; **CBO**: Congressional Budget Office; **GAO**: U.S. General Accounting Office; **LEWIN-VHI**: formerly Lewin-ICF; **NLCHCR**: National Leadership Coalition for Health Care Reform; **PEPPER COMMISSION**: U.S. Bipartisan Commission on Comprehensive Health Care; **PNHP**: Physicians for a National Health Program.

SOURCE: Office of Technology Assessment, 1993. Full citations can be found in the list of references at the end of this paper.

TABLE 2: Quantitative estimates of the impact of competing approaches to health care reform on federal, state and local budgets[a]

SINGLE PAYER APPROACHES[b]

Change in expenditures (in $billions)		Estimate year	Source[d]
Single year estimates:			
Total	+ $143.6	1989	CBO[f]
Federal	+ $154.7		
State	-$ 11.1		
Total	**+ S?44.0 to + $252.0**	**1991**	HIAA[g]
Federal	na		
State	na		
Total	**+ .$225.0**	**1991**	Meyer, et al.[h]
Federal	na		
State	na		
Total	**+ $ 29.0**	**1991**	Meyer, et al.[i]
Federal	na		
State	rta		

PLAY-OR-PAY APPROACHES

Change in expenditures (in $billions)		Estimate year	Source
Single year estimates:			
Total	**+ $33.6**	**1989**	Zedlewski, et al.[j,k]
Federal	na		
State	na		
Total	**+ $23.1**	**1989**	Zedlewski, et al.[j,l]
Federal	na		
State	na		
Total	+ $16.6	**1990**	**Pepper Comm.[m]**
Federal	**+ $24.0**		
State	**-$ 7.4**		
Total	**+ $17.1**	**1991**	CBO[n]
Federal	**+ $13.1**		
State	**+ $ 4.0**		
T o na a l		**1992**	**NLCHCR[o]**
Federal	**+ $34.7**		
State	**na**		
Total	+ $41.7	**1993**	AAFP[p]
Federal	**+ $34.1**		
State	**+ $ 7.6**		

[a] Baseline assumptions of national health care spending and savings differ among analyses; that is, analyses use different starting points in terms of the year and/or amount of national health expenditures to arrive at their estimates. To the extent that these differ among analyses, the estimates are not comparable, all other things being equal.

[b] As discussed more fully in the text, terms used to describe the competing approaches to health care reform (e.g., Single Payer, Play-or-Pay, Managed Competition) may be misleading insofar as differences exist within as well as across groups. Some of these variations and specific assumptions about them that appear to affect the estimates are noted in the footnotes related to particular analyses. For more details, please refer to the report text.

[c] Estimates provided are in current dollars unless otherwise indicated. The symbol "+" signifies increased expenditures and the symbol "-" signifies decreased expenditures.

[d] Some analyses were conducted on behalf of the source by another individual or entity. Where this was indicated in the analysis, it is noted in the footnotes following this table. Reference numbers are listed at the end of each footnote. The full citations may be found in the list of references at the end of this report.

[e] Single year estimates are for the first year of implementation of the health care reform plan unless otherwise noted.

[f] Congressional Budget Office analysis of a Single Payer approach that assumed provider payments based on Medicare rates, patient cost-sharing and retention of a residual Medicaid program for which States would continue to finance their portion (77). CBO study was revised in April 1993 (81).

[g] Health Insurance Association of America analysis of a Canadian-style system. Estimate assumed health care spending growth of about 10% per year and was based on HIAA's estimate of $183.0 billion to $189.0 billion in increased government spending in 1988 dollars (25).

[h] Meyer and colleagues' analysis of a Canadian-style system with health care spending capped at its current share of U.S. GDP after including the cost of covering uninsured individuals (43).

[i] Meyer and colleagues' analysis of a Canadian-style system with health care spending at no more than 8.7% of U.S. GDP (43).

[j] Zedlewski and colleagues' analysis of a Play-or-Pay approach which assumed the purchase of insurance at 1989 prices. Examined the change in government health insurance costs, not in total government health spending. Estimate represents new government funds, that is, funds not currently spent by government to fund the Medicaid program. Medicare program would continue in its current form (100).

[k] Assumed a 7% payroll tax rate (100).

[l] Assumed a 9% payroll tax rate (100).

[m] Lewin-VHI analysis for the Pepper Commission of the Commission plan. State contributions to finance the Federal program replacing Medicaid would be held to their current Medicaid contribution level adjusted for inflation. Medicare program would continue in its current form (75).

[n] Congressional Budget Office analysis of a plan combining employment-based insurance with Medicaid expansion. Estimated $13.1 billion increase in Federal expenditures equals the sum of changes in Federal outlays for Medicare (-$3.6 billion) and Medicaid (+$10.2 billion) plus the loss of Federal revenues associated with individual income taxes (+$3.0 billion) and Social Security and Medicare payroll taxes (+$3.5 billion). Estimated $4.0 billion increase in State and local expenditures equals the sum of the increase in State and local outlays (+$3.0 billion) plus the loss of State and local income tax revenues (+$1.0 billion) (76).

[o] National Leadership Coalition for Health Care Reform proposal and analysis. Proposal includes improved Medicaid reimbursement and public subsidies to low-income persons. Medicare program continues in its current form. Plan assumed fully funded at Federal level; that is, the $34.7 billion (1992) in increased Federal government expenditures would be offset by various proposed financing sources (49).

[p] Lewin-VHI analysis of the American Academy of Family Physicians' plan for AAFP.

TABLE 2: Quantitative estimates of the impact of competing approaches to health care reform on federal, state and local budgets[a]—*continued*

INDIVIDUAL VOUCHERS OR TAX CREDITS APPROACHES			
Change in expenditures (in $billions)		Estimate year	Source
Sing/e year estimates			
Total	na	1991	Heritage[q]
Federal	+ $87.9		
State	+ $ 7.6		

MANAGED COMPETITION APPROACHES			
Change in expenditures (in $billions)		Estimate year	Source
Sing/e year estimates			
Total	na	1993	Sheils, et al.[r]
Federal	+ $ 47.7		
State	na		
Total	na	1993	Long & Rodgers[s]
Federal	+ $ 41.0		
State	na		
Total	na	1994	CDF[t]
Federal	+ $106.5		
State	na		

Proposal assumed expanded Medicare coverage through the private purchase of expanded Medigap coverage, improved provider reimbursement, public subsidies to low-income persons, and increased utilization by previously uninsured persons. Plan assumed fully funded at the Federal level; that is, the $34.1 billion (1993) in increased Federal government expenditures would be offset by increased taxes on businesses and households. States would continue to pay into the public-sponsored plan in the same proportion as they currently support Medicaid (37).

[q] Lewin-VHI analysis of the Heritage Foundation's plan for the Foundation. Plan was assumed to be fully funded at the Federal level; that is, the cost of tax credits to the Federal government plus any Civil Service Plan changes and corporate income tax loss ($87.9 billion) would equal current Federal tax expenditures related to health care expenditures ($69.1 billion), plus State and local government contributions ($18.8 billion). Increased State and local government expenditures ($7.6 billion) would equal increased State and local government revenues (35).

[r] Sheils and colleagues' analysis of a Managed Competition approach with an employer mandate to contribute to employee health coverage did not assume expenditure limits. Based lowest-cost plan premium on experience of group-model health maintenance organizations (HMOs) (8% savings) but based savings from Managed Competition on experience of all types of HMOs (2%). Total public costs estimated at $120.3 billion (1993) under a low cost-sharing scenario, assuming: a 7% of payroll cap on employer costs, 2% of income cap on employee premiums, 9% of income cap on non-employment insurance spending; and subsidies of $2.2 billion to persons below 200% of poverty for patient cost-sharing expenses. Estimated $47.7 billion in net new Federal revenue requirements after recouping current Federal and State Medicaid funds, and collecting taxes on employer contributions over 75% of the lowest-cost plan and an 8% payroll tax for part-time employees, less decreased income taxes resulting from reductions in wages resulting from the employer mandate. Additional savings to the Federal Government are possible if other measures are implemented, according to the authors. Medicare program would continue in its current form (63).

[s] Long and Rodgers' analysis of a Managed Competition approach with an employer mandate to contribute to employee health coverage did not assume expenditure limits. Based on a draft of Sheils and colleagues' analysis (41), Long and Rodgers' estimate of net new Federal revenues requirements assumed universal coverage with 8% savings from Managed Competition based upon the group-model HMO experience or upon administrative costs-savings (increased spending of $41.0 billion). Long and Rodgers also provided estimates of net new Federal revenues requirements that assumed universal coverage with no savings to the Federal Government from Managed Competition (increased spending of $52.0 billion) and 16% savings based upon the group-model HMO experience plus 8% administrative-costs savings (increased spending of $31.0 billion) (40).

[t] Conservative Democratic Forum analysis of H.R. 5936 (102d Congress). Plan did not include an employer mandate to contribute to employee health coverage nor expenditure limits. Plan was projected to be fully funded at the Federal level; that is, Federal Medicaid funds, a cap on the tax deductibility of health insurance benefits, and repeal of the Medicare taxable maximum (assumed to be $130,200 per worker) would raise the revenues to fund the required Federal government expenditures (10).

KEY: **AAFP**: American Academy of Family Physicians; **CBO**: Congressional Budget Office; **CDF**: Conservative Democratic Forum; **HERITAGE**: Heritage Foundation; **HIAA**: Health Insurance Association of America; **LEWIN-VHI**: formerly Lewin-ICF; **NLCHCR**: National Leadership Coalition for Health Care Reform; **PEPPER COMM.**: U.S. Bipartisan Commission on Comprehensive Health Care; **na** = not available

SOURCE: Office of Technology Assessment, 1993. Full citations can be found in the list of references at the end of this report.

TABLE 3: Quantitative est imates of the impact of competing approaches to health care reform on employers

SINGLE PAYER APPROACHES[b]			PLAY-OR-PAY APPROACHES		
Change in expenditures (in $billions)[c]	Estimate year(s)	Source[d]	Change in expenditures (in $billions)	Estimate year	Source
Single year estimates[e]:			*Single year estimates:*		
			+ *$29.8,* + **$44.4**	1989	Zedlewski, et al.[h]
-$76.0 to -$136.0	**1991**	Meyer, et al.[f]	+ $14.7	1990	**Pepper Commission**[i]
			+ $23.7	1993	**AAFP**[j]
Estimates of future impacts[g]:			*Estimates 0/future impacts:*		
-S2,200.0 to -$3,000.0	1991-2000	Meyer, et al.[f]	not available		

[a] Baseline assumptions of national health care spending and savings differ among analyses; that is, analyses use different starting points in terms of the year and/or amount of national health expenditures to arrive at their estimates. To the extent that these differ among analyses, the estimates are not comparable, all other things being equal.

[b] As discussed more fully in the text, terms used to describe the competing approaches to health care reform (e.g., Single Payer, Play-or-Pay, Managed Competition) may be misleading insofar as differences exist within as well as across groups. Some of these variations and specific assumptions about them that appear to affect the estimates are noted in the footnotes related to particular analyses. For more details, please refer to the report text.

[c] Estimates provided are in current dollars unless otherwise indicated. The symbol "+" signifies increased expenditures and the symbol "-" signifies decreased expenditures.

[d] Some analyses were conducted on behalf of the source by another individual or entity. Where this was indicated in the analysis, it is noted in the footnotes following this table. Reference numbers are listed at the end of each footnote. The full citations may be found in the list of references at the end of this report.

[e] Single year estimates are for the first year of implementation of the health care reform plan unless otherwise noted.

[f] Meyer and colleagues' analysis of Canadian-style system. Savings to employers before taxes, due on increased income from previously deductible health expenditures, are subtracted. Lower savings estimate was based on Canadian-style system with health care spending capped at its current share of U.S. GDP after including the cost of covering uninsured individuals. Higher savings estimate was based on Canadian-style system with health care spending at no more than 8.7% of U.S. GDP (43).

[g] The periods for which estimates of future impacts are reported were usually provided by the analysts cited. However, in some instances, cumulative estimates were calculated by OTA by adding together multiple single year estimates provided by the analyses. In such cases, the period selected by OTA depended upon the years for which the single year estimates were provided and upon the period(s) for which other cumulative estimates of the approach were provided.

[h] Zedlewski and colleagues' analysis of a Play-or-Pay approach. Estimates assumed the purchase of insurance at 1989 prices, and a 7% and a 9% payroll tax, respectively, and are not adjusted for uncompensated hospital care savings. Proportionate burden borne by size of employer would vary considerably (100).

[i] Lewin-VHI analysis for the Pepper Commission of the Commission's plan. Estimate assumed a 7% payroll tax, and mandatory acceptance of insurance by employees under either an employer-sponsored or the public plan. $14.7 billion, after taxes, in increased employer costs is the sum of savings to employers who currently offer health insurance to workers and dependents (-$12.8 billion, after taxes) plus costs to employers newly insuring (+$27.5 billion, after taxes). In 1990 dollars, estimated net savings (after taxes) to large employers was $5.6 billion; net cost to small employers was estimated at $18.8 billion, if they voluntarily provide insurance, or $20.6 billion, if they are mandated to provide insurance or contribute to the public plan (75).

[j] Lewin-VHI analysis of the American Academy of Family Physicians' plan for AAFP. $23.7

TABLE 3: Quantitative estimates of the impact of competing approaches to health care reform on employers[a]—*continued*

INDIVIDUAL VOUCHERS OR TAX CREDITS APPROACHES

Change in expenditures (in $billions)	Estimate year(s)	Source
Single year estimates		
+ $7,8	1991	Heritage Foundation[k]
- $2.0	1994	Silow-Carroll[l,m]
Estimates of future impacts:		
-$35.0 to -$84.0	1994-2003	Silow-Carroll[l,m,n]
-$ 4.0 to -$10.0	1994-2003	Silow-Carroll[l,o,p]

MANAGED COMPETITION APPROACHES

Change in expenditures (in $billions)	Estimate year	Source
Single year estimates:		
+ $8.0	1993	Long & Rodgers[q]
Estimates of future impacts:		
not available		

billion in increased costs to employers is the sum of a $2.8 billion increase for all firms that currently insure plus a $20.9 billion increase for all firms that do not currently insure. Change in costs varies by employer size (37).

[k] Lewin-VHI analysis for the Heritage Foundation of the Foundation's plan. Estimate assumed private employer health care expenditures, estimated at $124.3 billion in 1991, would be, for the most part, converted to wages for the first year of the plan. Employers would be responsible for increased OASDI and HI payroll taxes of $10.9 billion, which the analysis assumed would be absorbed by employers as reduced profits. As a result, employers corporate income taxes would decrease by $3.1 billion resulting in $7.8 billion in total increased costs to employers (35).

[l] Silow-Carroll analysis of the Bush Administration proposal which included limited tax subsidies and insurance market reforms (65).

[m] Estimates shown are for the analysis' "Optimistic Scenario" that assumed 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" (65).

[n] Estimates are in 1994 dollars, after taxes. Range depends upon distribution of savings to labor, 80% and 50%, respectively. Figures based on cumulative savings, before taxes due on increased income from previously deductible health expenditures are subtracted, of approximately $300.0 billion in current dollars (65).

[o] Estimates shown are for the analysis' "Pessimistic Scenario" that assumed that "much of the savings in the Bush plan are one-time in nature, and that after these efficiencies are achieved, the cost curve returns to its present course" (65).

[p] Estimate in 1994 dollars, after taxes. Range depends upon distribution of savings to labor of 80% and 50%, respectively. Figures based on cumulative savings, before taxes due on increased income from previously deductible health expenditures are subtracted, of approximately $33.0 billion in current dollars (65).

[q] Long and Rodgers' analysis of a Managed Competition approach. Estimate of change in business private insurance costs only. Analysis, based on a draft of Sheils and colleagues' analysis (41,63), assumed an employer mandate to contribute to employee coverage and low patient cost-sharing but did not assume expenditure limits. Further assumed 8% savings from Managed Competition based upon the experience of group-model health maintenance organizations or, in the alternative, administrative costs-savings, offset by increased spending due to expanded access to coverage. Medicare program would continue in its current form (40).

KEY: **AAFP**: American Academy of Family Physicians; **HI**: Hospital Insurance Program (Medicare Part A); **LEWIN-VHI**: formerly Lewin-ICF; **OASDI**: Old Age, Survivors, and Disability Insurance; **PEPPER COMMISSION**: U.S. Bipartisan Commission on Comprehensive Health Care

SOURCE: Office of Technology Assessment, 1993. Full citations can be found in the list of references at the end of this report.

TABLE 4: Quantitative estimates of the impact of competing approaches to health care reform on households

SINGLE PAYER APPROACHES[b]			PLAY-OR-PAY APPROACHES		
Change in expenditures (in $billions)	Estimate year(s)	Source[d]	Change in expenditures (in $billions)	Estimate year	Source
Single year estimates:			Single year estimates:		
			-$19.3	1990	Pepper Commission]
			+ $ 2.3	1993	AAFP[k]
~+ $20.0	1994	Silow-Carroll, et al.[f]			
-$10.0	1994	Silow-Carroll, et al.[g]			
Estimates of future impacts[h]:			*Estimates of future impacts:*		
-$3,000.0 to -$3,600.0	1994-2003	Silow-Carroll, et al.[f,i]	**not available**		
-$3,700.0 to -$4,400.0	1994-2003	Silow-Carroll, et al.[g,i]			

[a] Baseline assumptions of national health care spending and savings differ among analyses; that is, analyses use different starting points in terms of the year and/or amount of national health expenditures to arrive at their estimates. To the extent that these differ among analyses, the estimates are not comparable, all other things being equal.

[b] As discussed more fully in the text, terms used to describe the competing approaches to health care reform (e.g., Single Payer, Play-or-Pay, Managed Competition) may be misleading insofar as differences exist within as well as across groups. Some of these variations and specific assumptions about them that appear to affect the estimates are noted in the footnotes related to particular analyses. For more details, please refer to the report text.

[c] Estimates provided are in current dollars unless otherwise indicated. The symbol "+" signifies increased expenditures and the symbol "-" signifies decreased expenditures.

[d] Some analyses were conducted on behalf of the source by another individual or entity. Where this was indicated in the analysis, it is noted in the footnotes following this table. Reference numbers are listed at the end of each footnote. The full citations may be found in the list of references at the end of this report.

[e] Single year estimates are for the first year of implementation of the health care reform plan unless otherwise noted.

[f] Silow-Carroll and colleagues' analysis of a Canadian-style system. Estimate shown is for the analysis' "Pessimistic Scenario" that assumed that after expanding coverage to uninsured persons, the U.S. achieves a 2% reduction in spending in 1994 and, after the first 3 years, health care spending grows at a slightly faster rate than GDP (67).

[g] Silow-Carroll and colleagues' analysis of a Canadian-style system. Estimate shown is for the analysis' "Optimistic Scenario" that assumed "an immediate 10 percent reduction in spending, offset in part by an expansion in coverage, netting an 8 percent decline in total spending in 1994 . . . assumes that after the first three years, the growth in health care spending would be reduced . . . to the same rate as the economy, or about 7 percent per year" (67).

[h] The periods for which estimates of future impacts are reported were usually provided by the analysts cited. However, in some instances, cumulative estimates were calculated by OTA by adding together multiple single year estimates provided by the analyses. In such cases, the period selected by OTA depended upon the years for which the single year estimates were provided and upon the period(s) for which other cumulative estimates of the approach were provided.

[i] Range depends upon the distribution of savings to labor, 50% and 80%, respectively, by 1996 (67).

TABLE 4: Quantitative estimates of the impact of competing approaches to health care reform on households[a]—*continued*

INDIVIDUAL VOUCHERS OR TAX CREDITS APPROACHES		
Change in expenditures (in $billions)	Estimate year(s)	Source
Single year estimates:		
-$18.8	*1991*	Heritage Foundation[l]
- $ 7.0	1994	Silow-Carroll[m,n]
Estimates of future impacts:		
- $440.0 to - $700.0	1994-2003	Silow-Carroll[m,n,o]

MANAGED COMPETITION APPROACHES		
Change in expenditures (in $billions)	Estimate year	Source
Sing/e *year estimates:*		
- S6.0	**1993**	Long & Rodgers[p]
Estimates of future impacts:		
not available		

Lewin-VHI analysis for the Pepper Commission of the Commission's plan. Estimate is equal to the sum of reductions in employer and nongroup plan premiums and household out-of-pocket costs plus the increase in premium payments by nonworkers for their coverage under the public program (75).

[k] Lewin-VHI analysis for the American Academy of Family Physicians of AAFP plan. Estimate assumed expanded Medicare through the private purchase of expanded Medigap coverage, and reflects increases and decreases in various types of premiums, new tax payments, and decreased household direct payments for health care (37).

[l] Lewin-VHI analysis for the Heritage Foundation of the Heritage Foundation's plan. Estimate assumed $129.0 billion increase in households' health spending due to the direct purchase of insurance, offset by $148.7 billion in increased wages due to the conversion of the value of present employer contributions to employee health benefits to wages in the first year of the plan (35).

[m] Silow-Carroll analysis of the Bush Administration proposal which included limited tax subsidies and insurance market reforms (65).

[n] Estimates of -$7.0 billion and -$700.0 billion are for the analysis' "Optimistic Scenario" that assumed 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" (65).

[o] Estimate of -$440.0 billion is for the analysis' "Pessimistic Scenario" that assumed "much of the savings in the Bush plan are one-time in nature, and that after these efficiencies are achieved, the cost curve returns to its present course" (65).

[p] Long and Rodgers' analysis of a Managed Competition approach. Estimate of change in household private insurance costs only. Analysis, based on a draft of Sheils and colleagues' analysis (41,63), assumed an employer mandate to contribute to employee coverage and low patient cost-sharing but did not assume expenditure limits. Further assumed 8% savings from Managed Competition based upon the experience of group-model health maintenance organizations or, in the alternative, administrative costs-savings, offset by increased spending due to expanded access to coverage. Medicare program would continue in its current form (40).

KEY: **AAFP**: American Academy of Family Physicians; **LEWIN-VHI**: formerly Lewin-ICF; **PEPPER COMMISSION**: U.S. Bipartisan Commission on Comprehensive Health Care; ~ = "about."

SOURCE: Office of Technology Assessment, 1993. Full citations can be found in the list of references at the end of this report.

TABLE 5: Quantitative estimates of the impact of competing approaches to health care reform on administrate ive costs[a]

SINGLE PAYER APPROACHES[b]			PLAY-OR-PAY APPROACHES		
Change in expend itures[c] (in $billions)	Estimate year	Source[d]	Change in expenditures (in $billions)	Estimate year(s)	Source
Sing/e year estimates[e]:			*Single year estimates:*		
-$ 69.0 to -$83.2	1987	Woolhandler & Himmelstein[f]			
-$ 18.2 to -$58.3	1989	CBO[g]			
- $ 46.8	1991	Lewin-VHI[h]			
-$ 67.0	1991	GAO[i]			
-$ 67.0	1991	PNHP[j]			
-$ 90.0	1991	Meyer, et al.[k,l]			
-$113.0	1991	Meyer, et al.[k,m]			
			-$2.8	1993	AAFP[o]
Estimates of future impacts[n]:			*Estimates of future impacts:*		
not available			-$40.1	1993-2000	AAFP[o]

[a] Baseline assumptions of national health care spending and savings differ among analyses; that is, analyses use different starting points in terms of the year and/or amount of national health expenditures to arrive at their estimates. To the extent that these differ among analyses, the estimates are not comparable, all other things being equal.

[b] As discussed more fully in the text, terms used to describe the competing approaches to health care reform (e.g., Single Payer, Play-or-Pay, Managed Competition) may be misleading insofar as differences exist within as well as across groups. Some of these variations and specific assumptions about them that appear to affect the estimates are noted in the footnotes related to particular analyses. For more details, please refer to the report text.

[c] Estimates provided are in current dollars unless otherwise indicated. The symbol "+" signifies increased expenditures and the symbol "-" signifies decreased expenditures.

[d] Some analyses were conducted on behalf of the source by another individual or entity. Where this was indicated in the analysis, it is noted in the footnotes following this table. Reference numbers are listed at the end of each footnote. The full citations may be found in the list of references at the end of this report.

[e] Single year estimates are for the first year of implementation of the health care reform plan unless otherwise noted.

[f] Woolhandler and Himmelstein's estimates for a Canadian-style approach. Study compared insurance overhead, hospital administration, nursing home administration, and physicians' billing and overhead expenses in the U.S. and Canada. Estimates based on calculations of per-capita costs of health care administration in both countries (96).

[g] Congressional Budget Office analysis of a Single Payer approach that assumed provider payments based on Medicare rates, patient cost-sharing, and retention of a residual Medicaid program. Administrative costs defined as overhead expenses of providers and insurers, including public payers. Alternatives modeled to produce range of savings differed with respect to the maximum potential savings in providers' overhead expenses which would be realized and claimed for payers through lower payment rates (77). CBO study was revised in April 1993 (81).

[h] Lewin-VHI analysis of a Canadian-style system. Estimates based upon impact of a Canadian-style system on individual cost centers, e.g., billing, admitting, dietary (34).

[i] U.S. General Accounting Office analysis of costs and savings for the U.S. under a Canadian-style system based upon Ontario's health insurance system which "imposes minimal administrative and billing costs on the third-party payer, physicians, and hospitals" (83).

[j] Grumbach and colleagues' analysis of the Physicians for a National Health Program plan, a Canadian-style system. Estimate assumed that the level of administrative efficiency in Canada is achieved, but the authors conceded that this was not likely in the near term (cf. table 1, PNHP) (24).

[k] Meyer and colleagues' analysis of a Canadian-style system. Administrative costs included were savings related to private insurance overhead, hospital administration, and physicians' billing and overhead expenses (43).

[l] Estimate assumed a Canadian-style system but initial reform efforts focus on reducing administrative costs only (43).

TABLE 5: Quantitative estimates of the impact of competing approaches to health care reform on administrative **costs**[a]—*continued*

INDIVIDUAL VOUCHERS OR TAX CREDITS APPROACHES			MANAGED COMPETITION APPROACHES		
Change in expenditures (in $billions)	Estimate year(s)	Source	Change in expenditures (in $billions)	Estimate year	Source
Single *year estimates:*			*Sing/e year estimates:*		
+ S2.1	1991	Heritage Foundation[p]			
-$0.87	1993	Bush Administration	-$11.2	*1993*	Sheils, et al.[s]
-$4.3	1993	Bipartisan Panel[r]			
Estimates of future impacts:			*Estimates of future impacts:*		
- S60.5	1993-2000	Bipartisan Panel[r]	not available		
- S74.4	**1993-2000**	**Bush** Administration[q]			

[n] Estimate assumed a Canadian-style system with health care spending at no more than 8.7% of U.S. GDP (43).

[r] The periods for which estimates of future impacts are reported were usually provided by the analysts cited. However, in some instances, cumulative estimates were calculated by OTA by adding together multiple single year estimates provided by the analyses. In such cases, the period selected by OTA depended upon the years for which the single year estimates were provided and upon the period(s) for which other cumulative estimates of the approach were provided.

[p] Lewin-VHI analysis for American Academy of Family Physicians of AAFP plan. Estimate equals sum of savings from insurance market reforms and electronic claims processing plus increased administrative costs related to insuring previously uninsured individuals (36,37).

[p] Lewin-VHI analysis for the Heritage Foundation of the Foundation's plan that would replace the current employer/employee tax deduction/exclusion with limited refundable tax credits/vouchers for individuals to purchase their own insurance. Insurer administrative costs only. Assumed administrative costs would be the same as under current policy for employees whose employers now arrange payroll deductions for health benefits payments. For others directly purchasing individual insurance, assumed that administrative costs would be 21.9% of claims (6,35).

[q] Health Care Financing Administration (USDHHS) analysis of the Bush proposal embodied in the Medical and Health Insurance Information Act of 1992 related to automating health care information. Assumed that administrative costs would grow at the rate of total health care expenditures (93).

[r] Lewin-VHI analysis of the Bush Administration proposals for the Bipartisan Panel on Presidential Candidates' Health Plans convened by Families USA. Savings estimate for 1993 of $4.3 billion is the sum of $0.3 billion in savings from insurer and provider electronic claims processing reforms plus $4.0 billion in savings associated with insurance marketplace reforms. Estimate of future impact combines single year estimates for the same categories for 1993 through the year 2000 (3).

[s] Sheils and colleagues' analysis of a Managed Competition approach that assumed an employer mandate to contribute to employee health coverage but did not assume expenditure limits. Assumed insurer administrative costs would equal 3.6% of covered claims. Estimate includes insurer administrative costs only; estimate is the same under both high- and low-cost-sharing scenarios (63).

KEY: **AAFP**: American Academy of Family Physicians; **BIPARTISAN PANEL**: Bipartisan Panel on Presidential Candidates' Health Plans; **CBO**: Congressional Budget Office; **GAO**: U.S. General Accounting Office; **LEWIN-VHI**: formerly Lewin-ICF; **PNHP**: Physicians for a National Health Program; **USDHHS**: United States Department of Health and Human Services.

SOURCE: Office of Technology Assessment, 1993. Full citations can be found in the list of references at the end of this report.

PART II. Potential Economic Impacts of Selected Reform Approaches

Introduction to Part II

As noted in chapter 1, available analyses were reviewed for their insight into the anticipated impact of the selected reform approaches on:

- national health care spending and savings (see ch. 2);
- Federal, State and local budgets (see ch. 3);
- employers (see ch. 4);
- employment (see ch. 5);
- households (see ch. 6);
- other costs in the economy (see ch. 7); and
- administrative costs (see ch. 8).

Each of the following chapters provides an introduction to the impact of current health care spending on the area of the economy being examined in that chapter. Then, the chapter provides, for each of the four major approaches to health care reform addressed in this report, a summary of the range of available estimates of the impact of the approach on the area of the economy. Selected key assumptions made in the estimates are also noted.

The chapters in this section are not equal in scope or depth for several reasons. First, some health care reform approaches (e.g., Canadian-style system, employment-based expansions) have been discussed in depth over a period of time and have been the subject of many more studies than others (e.g., Managed Competition). Second, the potential impact of health care reform on some areas of the economy (e.g., national health care spending and savings) has been examined in greater depth than others. Third, the analyses reviewed varied markedly with respect to the level of detail provided regarding the assumptions they made.

Appendix B provides considerable additional detail on assumptions underlying specific analyses.

Impacts on National Health Care Spending and Savings

2

INTRODUCTION

As the Nation heads toward national health care expenditures[1] 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).[2] 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.



Harvard Community Health Plan



George Washington Medical Center

[1] 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).

[2] 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).

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).[3]

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

[3]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-cont ainment 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 1.3 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 approaches 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, cavitation 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,[4] 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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[4] A bill to contain costs and improve access to health care through accountable health plans and managed competition and forotherpurposes ("Managed Competition Act of 1992").

SUMMARY

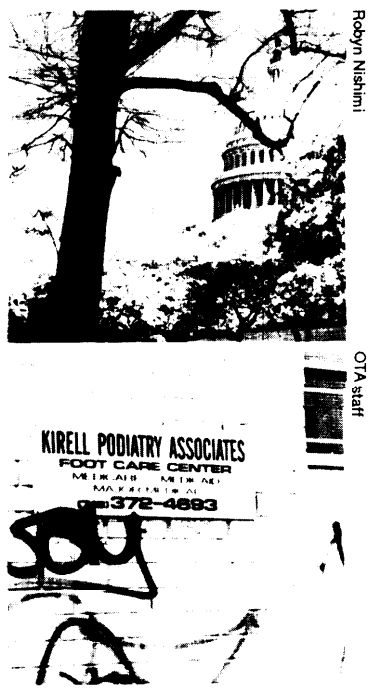
Available analyses suggest that at least some proposals under all approaches to health care reform would achieve universal coverage while saving money (i.e., reduce national health expenditures) in the long term. Yet it appears that the projected magnitudes of savings are far more dependent upon the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

Impacts on Federal, State and Local Budgets

3

INTRODUCTION

Federal, State and local governments contribute directly to the financing of health care through payment for public health insurance[1] programs (e.g., Medicare, Medicaid, CHAMPUS[2]) and public health programs (47). They also make an indirect contribution through tax policy, e.g., the exclusion of employer contributions to workers' health care benefits from employee taxable income (Internal Revenue Code of 1986, §§105 and 106); the personal deduction for a specified portion of health insurance premiums paid by self-employed individuals (Internal Revenue Code of 1986, §162 (1));[3] the Schedule A deduction from personal income of a portion of medical expenses over a specified proportion of adjusted gross income (Internal Revenue Code of 1986, §213); and the supplemental health insurance credit component of the earned income tax credit (Internal Revenue Code of 1986, §32). The Joint Committee on Taxation, U.S. Congress, projects that the tax expenditures associated with the tax exclusion, Schedule A



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[1] The term "health insurance" is used broadly to include various types of health plans that are designed to reimburse or indemnify individuals or families for the costs of medical care, or (as in HMOs) to arrange for the delivery of that care, including traditional private indemnity fee-for-service coverage, prepaid health plans such as health maintenance organizations, self-funded employment-based health plans, Medicaid, and Medicare.

[2] *CHAMP*US is the Civilian Health and Medical Program of the Uniformed Services.

[3] This tax code provision expired June 30, 1992. Legislation has been introduced in the 103d Congress to extend the deduction and to increase it to 100 percent of premiums paid (e.g., H.R. 162, H.R. 815, S. 381, and S. 571, all bills to amend the Internal Revenue Code of 1986).

[4] "Tax expenditures," as defined by the Congressional Budget and Impoundment Act of 1974, are "reductions in individual and corporate income tax liabilities that result from special tax provisions or regulations that provide tax benefits to particular taxpayers. These special tax provisions can take the form of exclusions, credits, deductions, preferential tax rates, or deferrals of tax liability" (86).

deduction, and supplemental health insurance credit will be $36.7 billion, $3.5 billion, and $.1 billion, in 1994, respectively (86).

The Congressional Budget Office projected that the government share of national health expenditures for 1992 would be 45.5 percent of total national health expenditures (79). Among levels of government, CBO projected the Federal Government's share to be 31.3 percent, and the State and local governments' share to be 14.2 percent. CBO estimates did not include the value of the aforementioned tax subsidies. Steuerle has estimated that in fiscal year 1992, Federal, State and local governments would pay more than one-half ($390.0 billion) of total health care expenditures in the United States (72). Unlike the CBO estimates, Steuerle's estimate *included $63.0 billion in* Federal tax subsidies, which, as indicated above, operate like other expenditures to the extent that they represent revenues forgone by government (72).

According to the Employee Benefit Research Institute, the government share of national health care expenditures has been fairly constant since the implementation of Medicare and Medicaid, but the share of government budgets devoted to health care has increased as budgets have been tightened but government health care funding responsibilities have not declined (14). Therefore, in addition to the impact of any health care reform approaches on aggregate (national) health expenditures as defined in chapter 2 of this report, at issue in the health care reform debate are:

- the extent to which alternative reforms might increase or decrease governments' share of health care spending; and
- the potential for redistributing the burden of financing among Federal, State and local government.

IMPACTS OF SINGLE PAYER APPROACHES

Proposals that would make the government the sole purchaser of health care services essentially redistribute the responsibility for purchasing health care services from a diverse group of purchasers to government. The proportion of this responsibility funded through Federal, State and local government revenues can vary, as can the means by which governments collect the revenues, that is, the types of taxes levied, to finance this burden. Regardless of how governments obtain the necessary funds, governments would bear tremendous responsibility for direct funding of, and control over purchasing, health care services in such a system.

Estimates of the impact of a Single Payer system on government budgets cover a wide range, from relatively modest *increased government spending in the* first year ($29.0 billion in 1991) with the promise of unspecified *savings* after the third year (43), to *large initial outlays* by government ($252.0 billion in 1991) (25) (table 2 in chapter 1; also see appendix B).

While no one maintains that Federal, State and local governments would save money initially under a Single Payer system, its long-term impact on government budgets is not clear, and quantitative estimates of the cumulative impact of a Single Payer system on government budgets were not provided in the studies reviewed. Assumptions about the degree to which a Single Payer system will control the rate of growth in health care spending greatly influence the long-term budgetary impact of the approach. For example, one group of analysts assumed that total health care spending would not exceed 8.7 percent of GDP (43). Another analysis assumed that national health care spending would continue to grow at about 10 percent each year under a Single Payer system (25). These assumptions help greatly to explain why one group of analysts expects government to save money on health care after 3 years (43).

Tax increases would be necessary to raise the revenues for governments to fulfill their obligations; however, it is likely that other sectors of the economy would realize gains (e.g., a decrease in or elimination of premiums paid to private

insurers) although these may be offset, at least in part, by such increased taxes. Proponents assume that the Single Payer system funded by taxes would result, nevertheless, in a more equitable distribution of health care spending.

IMPACTS OF PLAY-OR-PAY APPROACHES

The effect on government budgets of employment-based approaches that incorporate a public backup plan appears to depend primarily upon:

- the number of people enrolled in the public plan; and
- whether Federal and State Medicaid funds, and revenues from employment settings earmarked for the public plan (e.g., payroll taxes), are sufficient to cover the cost of insuring the public plan's enrollees and to fund any government subsidies under the plan.

Both the number of people enrolled in the public plan and the level of revenues required to fund the plan appear to be functions of numerous factors: employers' behavior (e.g., whether they choose to sponsor private insurance or contribute to the public fund to cover their employees); types of employers and employees covered by the employer mandate; the cost of health insurance; the payroll tax rate; employer/employee premium cost-sharing; public plan enrollee premium cost-sharing, if any; and the nature and extent of public subsidies (e.g., to small employers, to low-income persons).

While the employment-based approach places the bulk of the direct burden of financing health care coverage on employer-sponsored groups, it could increase direct and indirect outlays for health care at all levels of government (76). First, to the extent that the approach increases access to employment-based coverage without modifying the tax treatment of health benefits, tax revenues under current policy would be reduced by increasing the number of persons with respect to whom the employer deduction/employee exclusion would apply (76). Should the tax exclusion be limited, however, governments may expect some increased revenues flowing from increased personal and corporate income taxes. Second, Play-or-Pay approaches would shift any uninsured and individually insured persons not eligible for employment-based health coverage to the public plan, although some of these persons are expected to contribute directly to the cost of their coverage. To the extent that projected total funding of the public plan is adequate to cover both the cost of insuring its enrollees and the cost of required subsidies (e.g., to small employers, to low-income persons), the impact on government budgets would be lessened but costs to business and individuals would likely increase.

None of the analyses projected initial *savings* to governments overall from a Play-or-Pay approach, but one analysis estimated *savings* to State and local governments in the amount of $7.4 billion in 1990 at the same time it projected increased spending by the Federal government (75) (table 2 in chapter 1). Estimates of initial *increased spending* by governments resulting from an employment-based approach range from $16.6 billion (in the **year** 1990) (75) to $41.7 billion in 1993 (37). Several other estimates fall between these two extremes (49,76,100). Cumulative estimates were not available.

The above estimates at the extremes of the range of impacts of the Play-or-Pay approach on government budgets assumed that States support the public plan in the same proportion as their current level of contribution to Medicaid (37,75). And neither assumed that the cost-containment measures included in each plan would be effective in the first year of plan implementation. While the payroll tax rate selected will affect the magnitude of government spending (100), it appears that a plan's cost-containment measures will have a greater impact on the growth in government spending (55).

IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

For the most part, proposals that involve the use of individual vouchers or tax credits to expand coverage are specifically intended not to result in significant additional spending on the part of government. Analyses of the impact of such proposals suggest that a major assumption with respect to plans providing tax deductions, credits or vouchers is that a minimum benefit plan will be available for the dollar amount of the credit or voucher for those eligible for the maximum amount of assistance, and that the deduction will be adequate to make coverage affordable for the eligible population.

Lewin-VHI's analysis of the Heritage Foundation's individual voucher/tax credit proposal, executed on behalf of the Foundation, indicated that $87.9 billion in Federal funds and $7.6 billion in State funds would be necessary to implement the plan in 1991 (35) (table 2 in chapter 1). Specific estimates of the Bush Administration plan on government budgets were not available.

The Heritage Foundation's plan asserted, however, that the plan would be revenue neutral, that is, it would be fully funded at the Federal and State levels, and have no effect on the Federal deficit. To accomplish this, the analysis assumed that tax code modifications, in particular, would raise most of the funds necessary for the plan's implementation. Thus, the $87.9 billion in Federal funds necessary to implement the plan in 1991 would be raised through the elimination of the tax exclusion for employment-based premiums and of the deduction for health expenditures in excess of 7.5 percent of adjusted gross income, and from savings to State and local governments passed onto the Federal Government to fund the tax credits. State and local governments would be similarly affected by the proposal, as a result of transferring their savings of $18.8 billion to the Federal Government for the tax credit plan, as indicated above. State and local government total savings would be derived from several sources: the elimination of the State income tax exclusion; decreased expenditures on public hospitals offset to some extent by increased State and local workers benefits; and decreased revenues resulting from changes in premium taxes and State corporate income taxes.

IMPACTS OF MANAGED COMPETITION APPROACHES

Although Managed Competition is an approach that some say is consistent with several methods of financing (70,71), most Managed Competition approaches seek to minimize the role of governments in providing health care coverage, at least relative to tax-financed Single Payer approaches. Most approaches calling themselves Managed Competition would retain and/or build upon the current employment-based system, require individuals to contribute to the cost of their coverage to the extent possible, and mod@ the tax treatment of employer-sponsored coverage, thereby decreasing Federal tax expenditures associated with health insurance premiums. Thus, estimates of the impact on government budgets of Managed Competition approaches may depend upon assumptions about such interrelated factors as: the extent of public subsidies for coverage; the premium for the lowest-cost plan and any change in the tax policy regarding employer-sponsored benefits; the content of the standardized benefit package; whether there is an employer mandate; and recoupment of funds presently used to fired indigent care.

Estimates of the impact of Managed Competition approaches on government budgets range from $31.0 billion in total net new Federal revenues in 1993 (40) to $106.5 billion in Federal expenditures in 1994 (10) (table 2 in chapter 1). The estimate of $106.5 billion in Federal expenditures was, however, expected to be completely offset by revenues from Federal Medicaid funds; a cap, operationally, on the tax deductibility to employers of health insurance benefits; and the repeal of the taxable maximum income for

Medicare benefits. This would result in Federal budget neutrality, if all estimates of new spending and increased revenue were correct (10).

The variance in these estimates may ensue at least in part from major design differences between the proposals analyzed. That is, the Conservative Democratic Forum's (CDF) proposal did not include an employer or employee mandate nor did it modify the employee tax exclusion for employer-sponsored premiums (lo).

The Managed Competition plans analyzed by Sheils and his colleagues (63), and Long and Rodgers (40), differed substantially from the CDF'S proposal. Sheils and his colleagues based their estimates loosely on Paul Starr's version of Managed Competition, which assumes an employer mandate with a public backup and, thus, universal coverage (71). Long and Rodgers used many of the same numbers as Sheils and his colleagues, but varied some assumptions in order to answer three broad questions, including one about the impact of the approach on government budgets (40).

Long and Rodgers point out that Sheils and his colleagues did not indicate how much of the net new costs to the Federal Government would arise from savings from Managed Competition. As noted in table 2 in chapter 1, Long and Rodgers' three estimates of net new government costs were based on three illustrative scenarios: 1) no savings from Managed Competition; 2) 8 percent savings from either managed care or administrative-costs savings; or 3) 16 percent savings from adding together projected managed care savings and projected administrative costs-savings.

In their article, Sheils and his colleagues had assumed 2 percent savings resulting from increased use of managed care arrangements.[5] They also pointed out that their estimates may have understated potential savings because they were not able to fully explore the possible dynamics of Managed Competition (e.g., potential savings that concentrated buying power would have on the unit cost of services provided; incentives to contain costs even for HMOS by increasing consumers' price sensitivity and eliminating risk selection as a means of maximizing insurers profits) (63). On the other hand, no one--including CDF—seems to have built into their estimates of the impact of Managed Competition the full costs of administering all the new quasi-governmental bodies and disseminating all the information that appear to be an important part of Managed Competition (57). Some of these will undoubtedly be new costs to governments. Long and Rodgers' estimates thus illustrate how sensitive projections can be to variations in critical assumptions.

SUMMARY

None of the analyses reviewed for this report estimated savings to governments from the implementation of any one of the approaches to health care reform addressed. Efforts to expand access to uninsured persons will necessarily entail some new government spending since some form of subsidy will be necessary for many of these people and, in some proposals, for their employers. The Single Payer approach, as a tax-financed system, relies more on government to make direct payments for coverage and services as compared

[5] In an article in the same journal, Staines, an analyst with the Congressional Budget Office, suggests that national health spending might be almost 10 percent lower if all acute health care services were delivered through staff-or group-model HMOs (68). He further estimates that universal use of utilization review, managed care arrangements might result in spending that is only 1 percent lower than current national health expenditures (68). Sties did not estimate how much of these savings would accrue to the Federal Government under alternative health care reform plans. However, Staines' estimates suggest that Sheik and his colleagues' estimates differed from Long and Rodgers' estimate of changes in national health expenditures, and the subsequent distribution to the Federal Government of combining Managed Competition and Play-or-Pay, because of their differing ideas about the nature of managed care under Managed Competition. The extent to which staff- or group-model HMOs will be able to deliver health care---and achieve savings-should Managed *Competition become the* approach pursued for health care reform is a critical issue in the debate.

with the other approaches. Therefore, it is the approach most likely to increase government spending for health care. Yet the redistributive effects of this, or any other approach, on other areas of the economy (e.g., impacts on households) should be reviewed carefully, in order to evaluate any offsetting effects. Government budgets, in absolute terms, will be affected by the rate of growth in national health expenditures. Thus, the extent to which cost-containment is incorporated in an approach will be important to the impact of health care reform on such government budgets, regardless of the approach adopted.

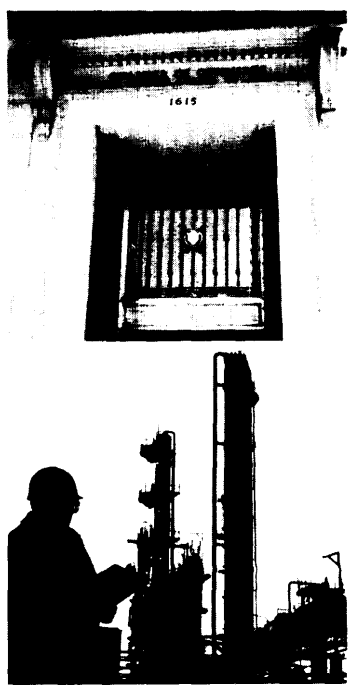
Impacts on Employers 4

INTRODUCTION

Health insurance in the United States is provided in large part through groups sponsored by employers. Employment-based insurance covered the majority (64 percent) of insured persons under age 65 in the United States in 1990 (89). Thus, employment-based coverage is the source of a considerable portion of national health care expenditures in the United States (34 percent in 1991) (19). Yet most of the uninsured people in the United States are employed, either full-or part-time (89).

Many of the uninsured workers are employed in small businesses (usually defined in reform proposals as no more than 100 employees, but sometimes defined as 25 or fewer). Due primarily to higher administrative charges and the increased underwriting risk to insurers, insurance coverage expenditures for small groups tend to be even higher than those for large groups.[1] To the extent that these factors increase small employers' costs beyond what they deem as affordable, they may not offer to sponsor insurance at all.

The problem for groups sponsored by large employers (usually defined as having more than 100 employees but sometimes as having more than 1,000) is somewhat different, insofar as they



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[1] Definitions of "large" versus "small" employers vary considerably in proposed legislation and illustrative reform proposals. Since employer size is an issue with respect to the application of certain provisions of some reform proposals, the specific definition used in a proposal is generally quite important (e.g., an employer mandate which includes all employers will have a different impact on employers, overall and by size, than one which excludes or subsidizes employers based on size).

are better able to control their total health plan costs.[2] Nevertheless, large employers have expressed concern with the issue of increasing health care costs (e.g., in terms of their groups' share of the financing burden and the impact of financing on their business or budget) (See also chapter 7).

While analyses of the impact of the various reform approaches on employers, both large and small, make many assumptions to project potential effects, the key ones pertain to:

- the extent to which the particular approach or proposal requires employers to finance health care coverage, either directly (e.g., to contribute to employees' health insurance premiums) or indirectly (e.g., to finance coverage through taxes);
- employer behavior, when employers are presented with choices between direct (e.g., to purchase private insurance for employees) and indirect (e.g., to pay into a public plan through which employees secure coverage) coverage; and
- the employers to whom any mandate applies.

It is important to note here that the idea that health care costs have an impact on a business's (or other employer's) bottom line is antithetical to economic theories of total compensation costs (69). According to economic theory, "employer-purchased" health insurance is actually part of the employee's total compensation package. That is, the employee trades off wages in exchange for the noncash benefit of health insurance. Thus, any costs or savings ''to the employer' for health insurance (e.g., the employer's "share" of the health insurance premium) is in reality a cost or savings to the employee.[3] Employers (i.e., management), employees (e.g., organized labor) and policy analysts rarely speak of health insurance costs in these terms, however. This report also uses the language of impacts on employers although it is important to note that the actual impacts may be broader.

IMPACTS OF SINGLE PAYER APPROACHES

Approaches that render government the sole payer for services would remove employers from direct involvement in the funding of health care. Businesses could, however, continue to fund health care coverage indirectly through broad-based Federal and State taxes. The impact of these taxes on employers would depend upon the specific tax system devised to implement the plan (55). For example, while employers' corporate income or payroll taxes may increase, if such increases are less than their current health care coverage payments, they will experience a net gain.

As summarized in table 3 in chapter 1, only one group of analysts has projected what the impact of a Single Payer system on employers might be. This one analysis estimated that a Canadian-style system would result in pretax *savings*[4] to employers in 1991 ranging from $76.0 to $136.0 billion (43). Estimates of cumulative pretax *savings* to this group ranged from $2.2 to $3.0 trillion in current dollars from 1991 through the year 2000 (43) (table 3). Behind the range in these estimates

[2] Large employers' health benefit plans tend to be larger in size, in terms of numbers of enrollees and, therefore, able to take advantage of many economies of scale to control administrative costs and to spread the risk. Furthermore, many large employers are self-funded (self-insured), which also allows them to self-administer their benefit plans or to contract for the administrative services portion of their plan with a private insurer or other entity. Whether self-administered or contracting for administrative services only, a self-funded insurer can have greater and/or more direct control over its health benefit plans' expenses.

[3] Employees without health insurance, under this theory, are or should be receiving alternative compensation. Thus, it is really the employees of small employers who are incurring the costs of higher health insurance premiums resulting from being part of a small group or being affected by the nonaffordability of insurance to the small group. The issue of total compensation is discussed further in ch. 5.

[4] Pretax savings are defined as savings before employers' liability for increased income taxes, due on increased income resulting from a decrease in deductible health care expenditures, has been met (43).

were the authors' assumptions about the degree to which the system would control the rate of growth in health care spending; that is, health care spending was capped at its current share of GDP after including the cost of covering uninsured persons (lower savings estimates), or health care spending was assumed to not exceed 8.7 percent of GDP (higher savings estimates). Thus, the greater the savings to the Nation overall, the greater would be the likely savings to employers in terms of taxes required to finance the system.

IMPACTS OF PLAY-OR-PAY APPROACHES

A major issue in the context of a proposal to mandate that an employer offer and contribute toward employees' health insurance is: Would such a mandate apply to all employers and employees and, if so, would it do so uniformly? If not, what are the criteria for not applying the mandate or for varying its application? Underlying the relevant policy decision is the fact that if a scheme does not require all employers to participate, the intent to achieve universal coverage primarily through an employment-based health insurance coverage system is subverted. A parallel dilemma is that if the system does not require all employers to participate what, if any, backup system is appropriate?

The impact of Play-or-Pay proposals on specific employers could vary considerably by the number of workers employed. Currently, larger firms are more likely to offer health insurance (38) and, therefore, are more likely to experience net savings due to shifts in the covered population and potential reductions in cost-shifting from uncompensated care and Medicaid (75). Smaller fins, which are less likely to offer health insurance, are more likely to experience a net increase in costs under this type of system. The impact of such an approach on both large and small employers will vary according to:

- the size of the employer to which the mandate applies;
- the length and design of any phase-in period;
- the payroll tax levied on employers (including provisions for its adjustment);
- the content of the benefit package; and
- any requirements regarding payment for dependent coverage (75).

Also relevant to employers' costs is any impact of the approach on the rate of growth in health care costs (see chapter 2 in this report).

All quantitative estimates of the impact of the Play-or-Pay approach projected *increased spending* by employers (37,75,100), ranging from $14.7 billion in 1990 (75) to $44.4 billion in 1989 (100) (table 3 in chapter 1). The estimates at the extremes assumed, respectively, a 7- and 9-percent payroll tax rate but there were also other differences in assumptions (See appendix B).

IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

The impact on employers of reforms that focus on providing individuals with tax incentives depends, at least in part, upon whether an approach:

- continues to rely on employment-based insurance;
- preserves or modifies the current tax benefit for employment-based health insurance coverage;
- requires that individuals purchase insurance; and
- achieves a decrease in both health insurance premiums and health care spending.

As summarized in table 3 in chapter 1, estimates of the impact of Individual Vouchers or Tax Credits approaches ranged from *savings* to employers of $2.0 billion in 1994 under the Bush plan (65) to *increased spending* of $7.8 billion in 1991 under the Heritage Foundation plan (35).

Silow-Carroll's analysis of the Bush Administration plan projected cumulative savings to employers for the period from 1994 through 2003 (65). Depending upon the model used regarding

the distribution of savings to employees,[5] as well as on other factors such as the rate of growth in health care spending, the estimates of the cumulative impact of the Bush Administration plan ranged, in 1994 aftertax dollars, from *savings* of $4.0 billion to *savings* of $84.0 billion for 1994 through 2003 (65).

The Heritage Foundation plan assumed that employers would no longer make premium contributions on behalf of their employees but would convert the value of the employer share of any premium to wages, in at least the transition year. The estimated increase in employers' spending under the Heritage Foundation plan was attributed to increased OASDI (Old Age, Survivors and Disability Insurance) and HI (Hospital Insurance Trust Fund) payroll taxes less employers' reduced corporate income taxes (35). Since estimates were provided for the frost year of the plan only, it is not possible to tell what the long-term impact of the Heritage Foundation plan on employers would potentially be.

The estimates of the impact on employers of the Bush Administration plan depended in large part upon the author's assumptions about the plan's impact on the rate of growth in health care spending. Thus, the study's ''Pessimistic Scenario, which assumed that 'much of the savings in the Bush plan are one-time in nature, and that after these efficiencies are achieved, the cost curve returns to its present course, ' estimated no initial but some cumulative savings (65). The "Optimistic Scenario" assumed 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' (65); therefore, the analysis projected some initial as well as greater cumulative savings under this scenario. The study noted, however, that [a]s a result of the incentive nature of the reforms, assumptions about the success of access expansion and cost containment under the Bush plan are more speculative than corresponding assumptions used in alternative proposals" (65), leaving questions about the long-term impact on employers (as well as on other areas of the economy) of the Bush Administration proposal.

IMPACTS OF MANAGED COMPETITION APPROACHES

In-depth studies of the impact of Managed Competition on employers were not available for this report. However, some Managed Competition approaches would use a Play-or-Pay approach to help achieve universal coverage. To the extent that this feature operates as suggested in studies of Play-or-Pay approaches to reform, employer health care spending would likely increase. However, there may be other changes in the system, for example, more extensive use of managed care, which may reduce such increased costs.

In a recent analysis of a Managed Competition approach, Long and Rodgers estimated that business private insurance costs would *increase* by *$8.0* billion in 1993 (40) (table 3 in chapter 1). This estimate, based on a draft of the analysis by Sheils and his colleagues of a Managed Competition proposal (41), was for a plan incorporating an employer mandate with a 7 percent cap on employers' costs, and assumed savings from Managed Competition of 8 percent based upon the experience of group-model health maintenance organizations or administrative savings. While Sheils and colleagues' analysis of a like plan did not estimate the impact on employers of Managed Competition, it assumed a 2 percent savings from Managed Competition based upon the experience of all types of health maintenance organizations (63), which would likely lead to a greater increase in business's private insurance costs.

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5 Employers are assumed to distribute 80 or 50 percent of savings to labor, respectively (65).

SUMMARY

In summary, the impact on employers of the competing approaches to health care reform rests on the extent to which the system selected requires employers to contribute toward health care coverage and the means by which employers contribute (e.g., taxes versus purchase of insurance coverage on behalf of employees). Not surprisingly, approaches that require employers to offer and support coverage for their employees have been estimated to cost employers more than would government-financed or individually-financed approaches (table 3 in chapter 1). However, vastly different analytic models' assumptions have been applied across approaches (table 3) and it remains unclear who would eventually pay any costs or save money. Furthermore, control of the rate of growth in health care spending will also affect employers' share of health care spending.

Impacts on Employment 5

INTRODUCTION

Estimates of the impact of any of the approaches to health care reform on employment are more speculative than quantitative.[1] Specific industries such as the health insurance industry may be particularly affected by changes in the health care financing structure.[2]3 similarly, expansions of access to services and/or restrictions in health care spending may affect employment in the health care sector.

Implicit in the fact that health care is 14 percent of the Nation's economy is that large numbers of people work in the health care sector. According to one analysis, '' [m]ore than 8 million U.S. workers have jobs in the health services industry, which indicates the great economic importance of the industry. . . Its employment growth rate has been little affected by changes in the growth of the overall economy, with the result that the industry has become a primary source of new jobs during economic downturns' (28). More broadly, concern has been expressed about the impact any requirements for employers to sponsor health care coverage might have on their ability to maintain or increase current hiring levels. At the same time, public or private subsidies to individuals may make it more feasible for individuals, who



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[1] Summaries of studies of the employment effects of the selected approaches to health care reform appear in appendix B. No table is provided given the nature of the available data.

[2] *The* Health Insurance Association of America estimates that in 1990 there were 1,725,380 employees, agents and service personnel operating in the health insurance industry, of whom approximately 460,000 (245,000 employees and 215,(XKI agents) operated solely in health insurance (26).

[3] By way of example, when Medicare implemented the Prospective Payment System in the mid- 1980s, health services employment growth slowed while health insurance employment increased (28).

currently remain out of the workforce in order to maintain coverage, to take a job.

IMPACTS OF SINGLE PAYER APPROACHES

A system in which government is the sole purchaser of services may have varying effects on employment. It could eliminate or otherwise modify the various functions served by private insurers in the current system, that is, underwriting health care benefits or processing claims for payment for health care services. This could lead to disemployment of insurance company and related workers who fulfill certain functions (e.g., claims processors, underwriters, insurance agents), although if private insurers continued to fulfill a claims processing function, shifts in employment could be relatively small (77). Workers engaged in direct health care services delivery or working in related employment sectors could also be affected according to one analysis (67). Some expect that such disemployment effects would be temporary and that persons displaced could be absorbed into other areas of the economy that would grow because of discretionary income made available by decreased spending on health care (67). Another analysis suggests that more health care personnel would be needed under a system of universal coverage with government as sole payer for services due to increased utilization of health care services[4] (77) (appendix B).

IMPACTS OF PLAY-OR-PAY APPROACHES

There is substantial debate about the impact on employment of an employer mandate to provide and/or contribute toward employee health insurance. If it is accepted that employers provide a *total compensation package* to employees (see chapter 4 in this report), then the argument goes that in cases where total employee compensation increases due to a new or increased fringe benefit requirement such as health insurance, employers will adjust by reducing wages or employment, or by increasing prices to consumers (99), who are, generally, the employees of other firms or organizations. In order to estimate the impact on employment of the aforementioned type of employer mandate, studies have tended to focus on the lessons provided by the minimum wage experience (45,46,99).

The studies examining the minimum wage literature advise caution with respect to their results regarding the employment effects of a mandate for employers to provide health insurance benefits, given the age of the literature and problems with the data. However, they do indicate that the disemployment effects of an employer mandate will likely be small and will tend to cluster around those workers at or near the minimum wage where the employer cannot offset the benefit through decreased wages (46).

A valuable result of the relevant studies is the identification of important factors related to the impact of an employer mandate, that is, firm size, industry type, employees' type of employment (full- versus part-time), average employee age, and employees' tenure with employer, as well as the amount of the increase in labor costs. Estimates can vary markedly depending on the assumptions made about these factors; for example, estimates of the impact of a Play-or-Play approach on employment range from 23,000 (60) to 710,000 jobs lost (87) (appendix B).

While increased labor costs may cause employers to decrease the numbers of workers used, increase hours worked by some workers *and fail* to make new hires, or contract work out (46,98), if some employers experience a net gain as a result of the implementation of a broader employment-based insurance system, increased employee compensation or employment may result. Increased health care utilization under universal coverage could even lead to an increased need for health care workers (100), assuming universal

4 This Congressional Budget Office study was revised in April 1993 (81).

coverage takes place without concomitant cost constraints (appendix B).

IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

A reform proposal that provides for individual vouchers or tax credits may modify the tax benefit to employers for providing health insurance coverage, by eliminating or capping the employer tax deduction for health insurance benefits. Yet disemployment or other adverse employment effects ensuing from such a proposal are unlikely since it requires no significant additional expenditures on the part of employers. In fact, to the extent that this leads employers to reduce payments or cease paying for employee health insurance coverage, they should experience an increase in income which, after taxes, they mayor may not use to increase employment or pass on to current employees (and/or consumers). Note that a proposal may require that employers pass any such savings on to employees, at least for a limited period (e.g., for a single or transition year as in the Heritage Foundation proposal) (6). Then-President Bush hypothesized that a tax credit for health insurance for low-income workers may strip away one barrier to seeking employment (94). Furthermore, if reforms decrease premiums, employers may have other additional income that they may distribute in the form of increased employee compensation or reduced prices. No quantitative estimates of the employment effects of reforms based on individual vouchers or tax credits were available for this report.

IMPACTS OF MANAGED COMPETITION APPROACHES

While quantitative estimates of the potential impact on employment of the Managed Competition approach to health care reform were also not available for this report, some Managed Competition approaches include several key features that would likely affect employment. First, most approaches would limit the tax deductibility of employer contributions to employee health insurance benefits. If this modification were to induce employers to limit their payments toward health insurance coverage, it should result in increased income to employers which, after taxes, could be used by employers to increase employment or wages. Second, some Managed Competition approaches would mandate employers to contribute toward employee health benefits. If implemented, employment effects similar to those discussed regarding the Play-or-Pay approach, above, could occur. As in the Play-or-Pay approach, the total compensation package provided to many workers would be modified by a mandate, and employers would likely attempt to alter wages and/or employment in response. Third, some Managed Competition approaches would include a global health care budget. If such budgeting is successful in controlling the rate of growth in health care costs, employment could improve to the extent that employers have additional income from decreased premiums to distribute and funds would be released to other areas of the economy stimulating growth. Fourth, most Managed Competition approaches would provide subsidies to low-income individuals for coverage that might remove current public program barriers to seeking employment.

SUMMARY

It is fairly certain that changes in the health care system will have an impact upon employment, but the nature of those impacts (e.g., lost jobs versus reduced wages versus displacement of workers to other sectors of the economy) is very uncertain. Most of the published analyses regarding the impact of competing approaches to health care reform on employment are more intuitive or speculative than quantitative. Where quantitative estimates exist, for example, regarding an employer mandate to offer and contribute toward employee health benefits, the minimum wage experience used as a basis for the estimates is not

necessarily parallel so that even the quantitative estimates remain rather speculative. However, the impacts of the approaches to health care reform on national health care spending, their redistributive impacts in terms of financing, and the type of restructuring of the health care system involved, should provide some indications, albeit indirect ones, of their likely impacts on employment.

Impacts on Households 6

INTRODUCTION

In the debate over health care reform, there is much discussion about the distribution of the burden of financing among various payers, that is, among government, business, and individuals. If, however, "ultimately. . . the individual bears the primary responsibility of paying for health care through health insurance premiums, out-of-pocket costs, philanthropic contributions to health organizations, income taxes, earnings reduced by increases in employers' health insurance costs, and higher cost of products' (33), as well as for the tax subsidy for employment-based health insurance premiums, then a key area of scrutiny is the impact of reform approaches on household income. Furthermore, the impact on households by income level and type of household (i.e., the so-called distibutiona1 effects among households at different income levels, different family compositions, and different health status) should be examined for any differential impacts ensuing from the various reform approaches.



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[1] Analysts reporting their estimates of the impact of health care reform on households tend to use the words "household" and "family" interchangeably and OTA did not attempt to redo analyses based on any standard definition such as that devised by the U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census; that is: "*[h]ouseholds* consist of all persons who occupy a housing unit., A household includes the related family members and all the unrelated persons, if any, such as lodgers, foster children, wards, or employees who share the housing unit' whereas *families*, which are a subset of households, ''are groups of two persons or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such persons . . . are considered as members of one family" (emphasis added) (91). In 1991, there were 95,669,000 households but 67,173,000 families in the United States (91). Thus, quantitative estimates of the impacts of health care reform on ''households' and 'families' are not comparable. And when the same analysis uses both terms without defining either one, the basis for any estimates is all the more unclear.

In evaluating and comparing analyses of the impact of health care reform on households, it is important for policymakers to keep in mind the scope and types of effects that the analysts considered. As suggested above, these consequences can be limited to the so-called *direct effects of households' share of national health expenditures,* as calculated by the United States Department of Health and Human Services, Health Care Financing Administration, Office of National Statistics (33); this is the method used by the Congressional Budget Office in its analyses.[2] More narrowly, analysts may restrict their estimates to impacts on households' *private health insurance costs* only (40). Less frequently, analysts may discuss the indirect costs of the tax burden on families to support the Federal Government's open-ended tax subsidy of employment-based health insurance premiums (72). Even more rarely, analysts may include potential gains in compensation (e.g., wages to working members of households) that may result from employers' reduced liability for employees' health insurance premiums (67). As noted throughout this report, all of these impacts may potentially offset each other, either partially or fully, at least for some people (e.g., gains in wages may be offset by increased taxes under a Single Payer or other plan; gains in wages maybe offset by additional out-of-pocket costs if a plan incorporates high patient cost-sharing), and analyses may not identify and discuss the implications of such potential offsets. As in other comparisons in this report, this chapter presents the quantitative results of analyses, providing explanations in the text, the tables, and in appendix B. The primary message for policymakers is the need to exercise caution when comparing numbers.

Direct and Indirect Spending in NHE Terms

While direct spending on health remained fairly stable from 1984 through 1991 as a percentage of nonaged household income (22), combined direct and indirect spending on health care in national health expenditures terms represent an increasing portion of the family budget (19). According to an analysis by Lewin-VHI conducted for Families USA, families' average annual health payments,[3] as a percentage of average family income, increased from 9 percent in 1980 to 11.7 percent in 1991 for an average of $4,296 in 1991. Moreover, Families USA projects an increase in average health payments by families to $9,397 in 2000, representing an increase of 439 percent since 1980 (19). The report stated that, "[t]hese estimates understate the burden of health care costs on families since there is no attempt to determine how much of business health expenditures are simply passed back to individuals through lower wages, higher prices or reduced payments to shareholders" (19).

According to the CBO, medical care cost increases have widened the distance between the growth in wages received by workers and that of total employee compensation paid by employers (54). CBO found that in almost every year in the 1980s, total fringe benefit costs, of which rising health insurance costs were a ''major factor, ' rose faster than wages and salaries (54). To the extent that this disparity decreases the real cash wages of employees, households may be adversely affected by increasing health care costs that consume income that they could put to other uses.

Indirect Spending Through Federal Taxes

In his examination of tax policy related to health care reform, Steuerle proposed that the

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2 ''Direct spending on health" as defined by the Congressional Budget Office, "includes the amount directly paid for health insurance premiums by a household, as well as other out-of-pocket expenses for health services' (22).

3 Health payments were defined by Families USA as 'the delivery of all health services and supplies and the purchase of medical products, including prescription drugs and vision products in retail outlets. It also includes government public health expenditures, the administrative costs of public programs, and the net cost of private insurance. ' It excludes non-patient revenue, research and construction (19).

current tax subsidy for employment-based health insurance benefits essentially constitutes an open-ended health program provided by government (72). Because this open-ended subsidy results in a tax impact on households, Steuerle maintained that individuals are ignorant of both the cost of the health care they receive and are deterred from knowing the cost of the health insurance that they purchase through their employer. He estimated that the average health care *expenditure* (which includes the value of the tax subsidy provided by government) per household in 1992 was $8,000, of which only about one-third was paid *directly* by individuals and of which a large portion was hidden (72).

Hence, the various reform approaches, to the extent that their design redistributes the financing burden placed on families (e.g., through mandating the purchase of insurance, eliminating or limiting the tax exclusion for employment-based health benefits, or mandating employer contributions to employee health benefits where they were not provided previously) will have an impact, be it obvious or hidden, favorable or adverse, on household income.

IMPACTS OF SINGLE PAYER APPROACHES

The economic impact on households of approaches in which the government is the sole purchaser of services will turn most on the financing mechanism adopted (e.g., general tax revenues, payroll tax, value added tax [VAT] [4]). Also significant will be the extent to which the system eliminates or limits cost-sharing at the point-of-service by individuals *(82).* Under a tax-financed universal coverage plan, employees (and thus, households) as a group may benefit to the extent that employers are left with additional funds after taxes which may be distributed, at least in part, to them. To a lesser extent, households may experience some gain due to reduced time expended handling health care administrative tasks (e.g., claims forms) (83).

Silow-Carroll's analysis of a Canadian-style system projected initial impacts on consumers (in the year 1994) ranging from net *savings* to consumers of $10.0 billion to a net loss of almost $20.0 billion (67). Cumulative estimates from 1994 through 2003 ranged, in current dollars, from *savings* of $3.0 to $4.4 trillion (67) (table 4 in chapter 1; also see appendix B). These estimates took into account changes in both consumers' direct spending and in their tax liability. The estimated impact on consumers depended primarily upon the degree to which the system gained control of the rate of health care cost growth. Also important was the extent to which employer gains, due to the elimination of their health insurance costs, were distributed to labors Thus, under the study's "Pessimistic Scenario,"[6] an initial loss and lower cumulative savings were estimated whereas under the study's ''Optimistic Scenario,' some initial savings and greater cumulative savings were projected (67).

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[4] 'Value ~&j tax'' or VAT is defined as " [a] tax which accumulates on goods as they move from raw materials through the production process. Each processor pays a tax according to the amount by which he has increased the value of items that were raw materials to him" (44).

[5] With respect to the cumulative estimates, the study assumed that, after taxes, 50 and 80 percent, respectively, of employer gains were distributed to labor (67).

[6] Silow-Carroll's ''Pessimistic Scenario' assumed that 'after expanding coverage to the uninsured, we achieve only a 2 percent reduction in spending compared with business as usual in year one. Further reductions are experienced in the second and third years, ' and the future health care spending growth rate is slightly faster than the rate of growth in GDP (67).

[7] Silow-Carroll's "Optimistic Scenario' assumed ''an immediate 10 percent reduction in spending, offset in part by an expansion in coverage, netting an 8 percent decline in total spending for 1994. The following two years would experience additional reductions of 5 percent each, representing a phasing-in of savings from conversion to a single-payer system, consolidation of duplicated services. . . . and other efficiencies. This scenario also assumes that after the frost three years, the growth in health care spending would be reduced . . . to the same rate as the economy, or about 7 percent per year' (67).

IMPACTS OF PLAY-OR-PAY APPROACHES

In general, critics of the Play-or-Pay approach claim that the required employer contribution is essentially a tax levied on those least able to afford it (i.e., low-income workers and their families) (5). They further maintain that it results in negative redistribution effects, posing a significant financial burden for working-poor and near-poor people who do not now have employer-sponsored health insurance and who ''most economists" believe "would effectively pay the full cost of their health insurance under 'play-or-pay' " unless employers absorb these increased costs (48).[8]

Some analyses of Play-or-Pay approaches to health care reform have increased premium cost-sharing for employees and/or their dependents, which would increase households' health insurance costs even if total health care costs are held constant (100). This raises the question of the ability of low-income families to afford their requisite premium share. Safeguards such as requiring all working adults to be insured through their own employers (thereby limiting the number of employees with adult dependents for whom, presumably, the sponsoring employer would pay a smaller share than would an individual's own employer), and government subsidies for low-income families, may help alleviate some of the increased burden on low-income households resulting from employer mandates to sponsor coverage (98).

Estimates of the impact of an employment-based approach on households range from *savings* of $19.3 billion in 1990 (75) to *increased spending in 1993* of $2.3 billion (37) (table 4 in chapter 1).

While not dispositive of the difference between these estimates, factors such as assumed increased taxes in one estimate (increased spending of $2.3 billion) versus no revenue-raising assumptions in the other (savings of $19.3 billion), differences in the assumed baseline year and health care costs of employers, and the payroll tax rate-7 percent where savings are estimated (75) and 10 percent where increased spending is estimated (37)-appear to contribute significantly to the difference in estimates.

To the extent available, detailed discussion of the impact of an employment-based approach on households, by income level, appears in appendix B.

IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

If Individual Vouchers or Tax Credits approaches to reform function as intended, insurance coverage should be more available and affordable, thereby decreasing the cost of health care to households in the aggregate and increasing many households' funds available for other purposes. If, however, the resulting tax credit, deduction or voucher is insufficient to purchase adequate coverage, households will be no better off and some may be worse off than under the current system (65).

Lewin-VHI's analysis of the Heritage Foundation plan on behalf of the Foundation estimated that households would save $18.8 billion in 1991 (35). Silow-Carroll's analysis of the Bush Administration proposal estimated savings in 1994 of $7 billion (65). Silow-Carroll also estimated cumulative net *savings* for the Bush plan, in current dollars, of $400.0 to $700.0 billion from 1994 through the year 2003 (65) (table 4 in chapter 1).

The Lewin-VHI analysis of the Heritage plan assumed that increased household health care spending (limited to households' direct spending for health insurance) would be offset by increased wages (given the proposal's provision that employers that discontinue coverage must convert the value their contribution to such coverage to employee income during the first year, and assuming that all employers discontinue cover-

[8] See also chapter 5 and appendix B regarding the potential employment effects of mandatory employment-baaed insurance.

age). Silow-Carroll's analysis of the Bush plan focused on the net impact of the proposal on consumers' from the tax credits or deductions, and changes in "after-tax wages, out-of-pocket spending for health care, prices of goods and services, and dividends and stock values' (65), It assumed varying degrees of success with respect to the proposal's ability to achieve ongoing reductions in the rate of health care spending given its voluntary, incentive-based approach.

IMPACTS OF MANAGED COMPETITION APPROACHES

As with Individual Vouchers or Tax Credits approaches, if Managed Competition approaches to health care reform function as intended (that is, improve access to and the affordability of health insurance) households' average health care costs should decrease. In some Managed Competition proposals, specific cost-containment mechanisms appear to heighten the potential for decreased national health care expenditures in the aggregate and, thus, for decreased households' health care costs. There are few analyses to date, however, of the specific impacts of Managed Competition approaches on households' health care costs. One recent analysis of a Managed Competition proposal by Long and Rodgers focused on its impact on households' private health insurance costs (as opposed to total household health care costs) (40). The authors estimated a reduction in households' private health insurance costs in 1993, the first year of plan implementation, of $6.0 billion. According to the authors, the analysis was based on an earlier draft of an analysis of a Managed Competition proposal by Sheils and his colleagues (41). Long and Rodgers' estimate assumed the implementation of universal coverage and Managed Competition, and further assumed savings from Managed Competition of 8 percent, based upon the experience of group-model health maintenance organizations or, in the alternative, upon the reduction in the administrative costs for employer plans (40).

It is important to note that the impact of a Managed Competition approach or proposal on households' *total* health care costs is an important factor in determining the reasonableness of the approach or proposal. To the extent that such costs are not even identified, the full impact of a proposal on households is hidden. Furthermore, assumptions about the extent to which components of Managed Competition (e.g., managed care, health insurance purchasing groups) will be adopted and effective in reducing health care costs are significant elements in estimating the economic impact of a proposal on households (as well as on other areas of the economy).

PER-CAPITA AND PER-FAMILY ESTIMATES

The estimates shown in table 4 (in chapter 1) and discussed above are limited to estimates of aggregate costs in billions of dollars. Other available estimates of the impact of the various reform approaches on households were calculated on a per-capita or per-family basis and are provided in appendix B. They range broadly and include:

- savings of $102 per capita under a Single Payer plan with price controls (77);
- savings of $1,382 for the average family under a Managed Competition plan with budget targets and price controls (3);
- increased spending, at least initially (i.e., before cost containment efforts could take effect) of up to $672 by families with incomes greater than $30,000 per year under a Play-or-Pay plan that would also increase provider reimbursement rates under Medicaid (37).

DISTRIBUTIONAL EFFECTS

Depending on the particulars of an approach or proposal, incomes of families of different income levels, compositions, and ages could be affected differently. One example is suggested in the illustration above (see "Per-Capita and Per-Family Estimates' '): in addition to estimating that families with incomes greater than $30,000 would

have to spend more under their plan, at least initially, Lewin-VHI, for the American Academy of Family Physicians, estimated that families with incomes under $30,000 would, on the average, save from between $2 to $385 initially (37). In general, analyses that provided estimates by family income assumed greater health expenditures by families at higher income levels and lower health expenditures by families at lower income levels as a result of their plans (see appendix B). An exception is the Heritage Foundation plan, under which very low-income families would spend more than they do currently (35). However, the income 'cuts' were defined differently by different analysts, and so they make distributional effects even less comparable than the aggregate effects shown in table 4 and discussed earlier in this chapter.

SUMMARY

Any estimated effects on households should be taken with a large grain of salt. In addition to basic differences in estimates derived from differences in estimated national health expenditures under plans, analyses differ in the types of effects on households that they identify as pertinent. In addition to direct health care spending, these can include household income taxes, total employee compensation, and tax expenditures related to health care costs.

As suggested in figure 1 presented earlier in this report (see chapter 1), policymakers and the public should realize that, ultimately, American households-in the aggregate-will face all the costs of whatever national health care costs are incurred.[9]

[9] Under this logic, and assuming that the estimates in table 1 in chapter 1 are considered valid, the estimates in table 4 in chapter 1 should be parallel to those shown in table 1, at least as household effects pertain to national health expenditures. That is, whatever health care savings are achieved or additional health care spending incurred should be attributed to the households of the United States.

Impacts on Other Costs in the Economy 7

To the extent that health care spending continues to consume an increasing portion of family and corporate income and government budgets, other areas of the economy are likely to suffer as they are squeezed out by health care (84). Some areas said to be suffering already are education, infrastructure, and corporate competitiveness. There is some controversy over whether there is a negative impact on international corporate icompetitiveness.[1]

According to Steuerle, "[b]udget data make obvious the possibility that expenditures on health may be helping to deter government action on almost every other domestic front. This reinforces the notion that health policy choices are seldom matters merely of health policy, but of budget, social, and tax policy, as well" (72).

Furthermore, according to the Congressional Budget Office, " [r]educing the size of the federal deficit by controlling Federal health spending could have a significant effect on the living standards of future generations by raising national saving, which would increase the nation's investment in new capital equipment and structures and reduce its indebtedness to foreigners" (78). CBO estimated that by the year 2002, real capital investment would be 22 percent higher, real capital stock would be 5.6 higher, and the output of the economy (i.e., GDP) would be 2.2 percent higher, than the CBO baseline if Federal spending on health care (Medicare and Medicaid) were held to its 1991 share and there were no offsetting increases.



USDA, Agricultural Research Service



OTA staff

[1] Some argue that in order to compare U.S. businesses with those of other countries, total labor costs, which are lower in the United States than in its major industrialized competitors (e.g., Germany, Japan), but are higher than in many developing countries (e.g., Mexico, Korea), are the relevant denominator, not health care costs to employers alone, which are higher in the United States than in its major competitors (84).

Concerns have also been raised about the impact of health care reform on technological innovation in health care. While there is research on the interactive relationship between health care costs and technological innovation (95), analyses addressing the impact of the approaches to reform discussed in this report on technological innovation were not available.[2] Therefore, no detailed discussion of this issue is presented here.

Specific quantitative estimates of the effects of the selected reform approaches on other costs in the economy, in general, were also not available for this report.

[2] Another OTA assessment entitled *International Differences in Health Care Technology and Costs is* underway. The goal of the assessment is to: 1) identify how differences in organization, dissemination and use of medical technologies among industrialized countries contribute to differences in costs; and 2) how differences in the structure of health financing, payment, and regulation among industrialized countries contribute to the different patterns of technology use among countries. In the process, the accuracy and comparability of the available data will be assessed. Project Director: Hellen Gelband, Senior Associate.

Impacts on Administrative costs 8

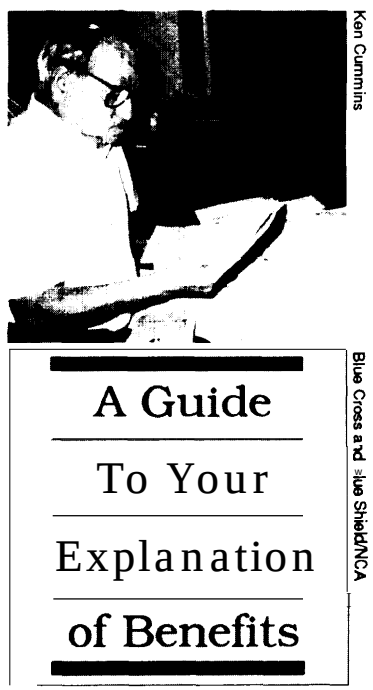
INTRODUCTION

For very small employers (one to four employees), health benefit administrative costs have been estimated to be as high as 40 percent of claims paid, compared with substantially lower percentages for larger firms (34). This percentage decreases as firm size increases (e.g., 25 percent for firms with 20 to 49 employees, 16 percent for firms with 100 to 499 employees, and 5.5 percent for firms with 10,000 or more employees) (34). The issue of administrative costs is important to the health care reform debate primarily because they are often perceived as waste (58,74,96). Yet discussion of the administrative efficiency of the health care system is hampered by the lack of a common definition of administrative costs, both in terms of *what* constitutes administrative costs and *whose* administrative costs are relevant to the discussion.

In their study of the administrative efficiency of the U.S. health care system, Woolhandler and Himmelstein examined four components of administrative costs—insurance overhead, hospital administration, nursing home administration, and physicians' billing and overhead expenses (96)-whereas Danzon maintained that:

> . . .a simple comparison of reported administrative costs can be grossly misleading. The true overhead of a health insurance system also includes all the hidden costs associated with insurance financing and operations as well as all insurance-induced distortions in the production and consumption of medical care (1 1).

Thorpe defines administrative costs as transaction-related costs, that is, benefits management, selling and marketing costs, and regulatory/compliance costs (74). These components can be examined across the health care delivery system since they are



incurred by health insurers, hospitals, nursing homes, physicians, firms and individuals. His definition is intended to facilitate the debate regarding administrative costs by permitting evaluation of them in terms of their "[s]ocial or economic cost: the value of resources used to produce administrative services as measured by their next-highest-valued alternative use" (e.g., to finance health coverage for uninsured persons) (74).

Review of the analyses of administrative costs demonstrates the importance of Thorpe's or a similar typology in furthering the debate over administrative costs. Differences in systems produce different incentives and different administrative costs. For example, Canada's global budgeting for hospitals provides fewer incentives to invest in health care information systems that collect patient cost data. This may reduce costs but it may also reduce the system's cost-management potential (82).

Underlying the debate, according to Lewin-VHI in its examination of the Canadian health care system, is a "[t]ension between product diversity and administrative cost" (34). Lewin-VHI maintained that the fundamental question behind the administrative costs debate is "[w]hether the costs of administering our multi-payer system are worth the benefits we derive from diversity in insurance products" (34).

Because studies to date have not used a common definition of administrative costs,[1] making comparisons of their findings with respect to the impact of a reform plan on these costs is extremely difficult. In order to arrive at estimates of administrative costs-savings that would accrue to the United States were one or another health care reform proposal implemented, studies have made some broad assumptions regarding what constitutes administrative costs, and about the ability to replicate (e.g., reduce U.S. administrative costs to the Canadian level) or implement a particular system in the United States. On the more technical level, for lack of better information, analyses of likely changes in administrative costs have used limited data or extrapolated from the experience of one geographic region (California) to another (United States) (24,34,96). Other assumptions include estimates regarding the maximum percent of claims expected to be submitted electronically, and the dollar savings associated with electronic claims submission.

The primary purpose of reforms that directly address the current health care services paperwork burden, such as electronic billing, claims submission, and processing, is to reduce administrative costs. Other insurance marketplace reforms directly affect the provision of insurance (e.g., guaranteed issue and renewal of coverage; requirement that policies be community rather than experience-rated; prohibition or limitation on preexisting condition clauses; prohibition on use of health status as basis for denying coverage). To the extent that these reforms simplify insurance administration, they are also likely to reduce administrative costs. Most approaches to health care reform include some or all of these reforms; therefore, most approaches would likely facilitate some reduction in administrative costs.

The Workgroup on Electronic Data Interchange (WEDI) reported to the Secretary of the Department of Health and Human Services in July 1992 that electronic data interchange (comprised of electronic enrollment and certification; electronic eligibility and verification of coverage; electronic claim submission and processing; electronic claim inquiry; and electronic payment and remittance) could produce administrative costs-savings from $4.0 to $10.0 billion, assuming implementation commencing in 1994 with several years to phase-in provisions (97).

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[1] For example, many analyses of specific proposals—Lewin-VHI for Families USA regarding the Bush administration and Clinton campaign proposals (3); Lewin-VHI for the Heritage Foundation regarding the Heritage Consumer Choice Health Plan (35)-look only at insurance administrative costs, whereas Woolhandler and Himmelstein looked at provider and insurer costs.

IMPACTS OF SINGLE PAYER APPROACHES

Canada's systems of health care financing and payment streamline health care administration by ''centralizing the source of payment for all covered health care services within each province under a single government program with uniform coverage and reimbursement rules' (34). The substantial reduction in the number of payers and transactions (e.g., claims) processed in the Canadian system are thought to reduce costs tremendously. The question has been posed whether the United States could implement a system with the same level of administrative costs as experienced in Canada, and even if the Nation could do so, whether it would want to (34).

Estimates of the impact of a Single Payer system on administrative costs range from *savings* of $18.2 billion in 1989 (77)[2] to *savings* of $113.0 billion in 1991 (43) (table 5 in chapter 1; see also appendix B). The lower estimate of savings assumed universal coverage at Medicare rates, patient cost-sharing and retention of a residual Medicaid program (77). Thus, it assumed decreases in insurance and provider administrative overhead given a simplified system involving a single payer. Yet since this estimate was not for a Canadian-style system, it assumed that some costs that would not exist in the Canadian system would remain (e.g., those associated with Medicare's hospital payment methods and copayment collection). The higher savings estimate assumed that nearly one-half of the estimated savings in national health expenditures in 1991 ($241.0 billion, assuming health care spending of no more than 8.7 percent of GDP) would flow from adopting a Canadian-style system that would yield administrative costs-savings related to private insurance overhead, hospital administration, and physicians' billing and overhead expenses.

IMPACTS OF PLAY-OR-PAY APPROACHES

While some studies have discussed the administrative cost impact of an employment-based approach, few studies have focused on such savings as a major outcome of the implementation of such an approach. Requiring broader implementation of employment-based insurance would not in itself alter the number of transactions taking place in the system since it would generally maintain the current number of payers involved and increase the numbers of people filing claims under the system. However, were the scope of benefits narrowed or the market reforms and billing practices discussed above implemented, such changes could generate cost savings, although not of the magnitude estimated under the Canadian-style system, according to the Congressional Budget Office (77).

Lewin-VHI's analysis of the impact of the America n Academy of Family Physicians' employment-based proposal on administrative costs projected *savings* of $2.8 billion in 1993 (36,37). The same analysis estimated cumulative administrative costs-savings in current dollars of $40.1 billion from 1993 through the year 2000 (37) (table 5 in chapter 1). Lewin-VHI's analysis attributed the savings to the sum of: increased administrative costs associated with insuring previously uninsured persons; savings from insurance market reform (e.g., guaranteed issue and guaranteed renewal of coverage, prohibition on use of health status as basis for denying coverage); and electronic claim submission utilizing a uniform billing system. Thus, none of the savings are inherent in the Play-or-Pay approach that AAFP favored.

IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

As in Play-or-Pay approaches (see above), administrative savings are not inevitable under approaches employing individual vouchers or tax

[2] This Congressional Budget Office study was revised in April 1993 (81).

credits; some would even expect administrative costs to increase as a result of having individuals instead of groups choose among plans. Consequently, Individual Vouchers or Tax Credits approaches frequently incorporate reforms related to the insurance market and the paperwork burden in order to directly or indirectly affect administrative costs generated by the health care system.

Estimates of changes in administrative costs resulting from the implementation of Individual Vouchers or Tax Credits proposals range from *increased spending* of $2.1 billion in 1991 (6,35), to *savings* of $4.3 billion in 1993 (3). Estimates of future impacts of the Bush Administration proposals ranged, in current dollars, from $60.5 billion in savings from 1993 through the year 2000 for electronic claims and insurance market reforms (3) to $74.4 billion in savings, also from 1993 through the year 2000, for automating health care information (93) (table 5 in chapter 1).

The variation in the estimates appears to reflect different assumptions regarding the impact of electronic claims processing and, where examined, other broader insurance marketplace reforms on the level of administrative overhead rather than the impact of the approach per se. For example, possible increases in administrative costs due to monitoring individual compliance with requirements to buy coverage as contained in the Heritage Foundation plan do not appear to have been considered in the estimates (35).

IMPACTS OF MANAGED COMPETITION APPROACHES

Managed Competition approaches are expected to achieve administrative costs-savings through insurance market reforms and health care delivery system restructuring. However, any such savings could be offset by substantially increased costs associated with the generation and provision of quality-of-care information to consumers. Making this information available is said to be an essential feature of Managed Competition, in that it would permit potential purchasers of health insurance to compare plans on quality as well as price (29). All available analyses of administrative costs impacts of Managed Competition approaches are flawed in that they do not include the costs of providing such information. According to Lewin-VHI, there are no studies analyzing the administrative costs-savings that might result from "the unique features of managed competition" but it would likely reduce insurer and provider administrative costs "by extending large-group economies of scale to employee groups of all sizes and by reducing the number of insurers that providers must work with' (63). Thus, Sheils and his colleagues, using Lewin-VHI's analytic model and an approach to Managed Competition based largely on Starr's proposal, estimated that Managed Competition could save $11.2 billion in *insurer* administrative costs in 1993 (63) (table 5 in chapter 1). The analysis assumed that insurer administrative costs would be 3.6 percent of covered claims; this percentage was based on current administrative cost data for insured groups having 10,000 or more members. The analysis noted that State insurance premium taxes, if continued to be permitted, and the ''expanded use of utilization review and case management under managed competition' could increase administrative costs. However, the latter would likely be offset by decreased utilization of health care services (63). Even gains to providers due to standardized coverage would likely be offset by the costs of complying with utilization management programs (63). In an article intended to be a comment on the analysis by Sheils and his colleagues about the various impacts of Managed Competition, Long and Rodgers used an assumed administrative costs-savings of 8 percent in their most optimistic analysis of potential savings to the Federal Government (40); this estimate of administrative costs-savings was not Long and Rodgers' own, but was based on assumptions made in a draft of the report by Sheds and his colleagues (41). However, Long and Rodgers did

not estimate a dollar figure for administrative savings alone (40).

SUMMARY

Most analyses assume that administrative costs-savings will be realized in any of the approaches to reform under consideration. Policymakers should be aware, however, that not all of the projected administrative costs-savings are due to inherent features of the approach to health care reform. For example, neither Play-or-Pay nor Individual Tax Credits or Vouchers approaches to universal coverage would automatically lessen or increase the administrative burden of the current system. Rather, the analyses typically rely on features of proposals explicitly addressed to administrative costs (e.g., electronic billing) in order to derive savings. Further, at least in part because of differences in the definitions of administrative costs, no analysis appears to have fully thought through the administrative burdens associated with various approaches and proposals. The magnitude of any savings or increase will most likely depend upon the degree to which the system moves to electronic systems, reduces the number of payers involved and transactions processed, and does not involve offsetting increases in utilization, utilization review, case management services and activities geared to quality improvement.

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.

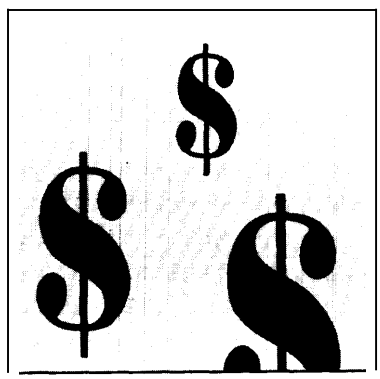
Conclusions and a Provisional Checklist for Policymakers

10

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.*

Contined on next page

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.

Continued on next page

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.

Appendix A: Overview of OTA Assessment: Technology, Insurance, and the Health Care System

Background

Congress has been concerned for many years with serious and growing problems of health care costs, access, and quality. In response to requests from the Senate Committee on Labor and Human Resources (Edward Kennedy, Chairman), the House Committee on Energy and Commerce (John Dingell, chairman), the House Committee on Ways and Means Subcommittee on Health (Bill Gradison, then Ranking Minority Member), Senator Charles E. Grassley (Committees on Budget, Finance, Special Committee on Aging), and Senator Ted Stevens,[1] OTA'S assessment, *Technology, Insurance, and the Health Care System,* addresses these congressional concerns by focusing on the following issues:

1. What does the available literature say about the impact of lacking health insurance on access to care and patient health outcomes?
2. Can a minimum benefit package be fashioned from the perspective of effectiveness and cost-effectiveness?
3. What cost implications do the leading types of health care reform proposals have in seven areas: national health care spending and savings; Federal, State, and local budgets; employers (large and small); employment; households (low, middle, and upper income); other costs in the economy; and administrative costs?

Schedule and Plan

The assessment was approved by the Technology Assessment Board in April 1991, and began in July 1991. In June 1992, the request letter for this Report was received from Senator Stevens.

An advisory panel for the overall assessment was formed in November 1991; the advisory panel met in January and December 1992; the final meeting of the advisory panel is scheduled for May 1993.

In addition to the release of this Report, OTA has released, or plans to release, the following documents related to the assessment:

1. *Does Health Insurance Make a Difference?—Background Paper (OTA-BP-H-99).*

   This interim report, requested by the Senate Committee on Labor and Human Resources, summarizes the state of the literature on the relationships among insurance coverage, access, and patient health outcomes; provides a conceptual framework for evaluating access to health care and the health effects of such access; and provides an overview of insured and uninsured populations in the United States as of 1990. The

[1] Senators Grassley and Kennedy and Representative Dingell are also members of the Technology Assessment Board ('TAB), the congressional body that governs OTA. Senator Stevens was a member of TAB.

background paper is available for congressional puposes from OTA (49241), and to the public from the U.S. Superintendent of Documents (phone number 202/275-3030; address: Washington, DC 20402; GPO stock number 052-003-01301-1,$5.00 per copy).

2. *Health Insurance: The Hawaiian Experience--Background Paper* (will not be printed).

   This background paper is available from OTA for congressional use by calling OTA at 49241, and to the public by calling OTA at 202/228-6140.

3. *Care for Depression: Issues Raised in Using Effectiveness and Cost-Effectiveness Information to Design a Mental Health Benefit—Background Paper.*

   This case study will be available from GPO in winter 1993.

4. *Primary Care for Uninsured People: Efficacy and Access--Background Paper.*

   This background paper will be available from OTA in summer 1993.

5. *Nonfinancial Barriers to Access--Background Paper.*

   This background paper will be available in late 1993; plans for distribution are not yet final.

6. *Benefit Design in Health Care Reform.*

   This, the main report of OTA'S assessment, will be available from GPO in fall 1993.

7. *Insurance Status and Health Care Utilization: Analysis of Four Data Bases and Cost Implications of Universal Coverage--Background Paper.*

   This background paper is scheduled to be available in fall 1993; plans for distribution are not yet final.

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Summaries of Specific Analyses of the Economic Impacts of Competing Approaches to Health Care Reform

Introduction

This appendix provides detailed summaries of the analyses reviewed for this report for the following areas of the economy: national health care spending and savings; Federal, State, and local budgets; employers; employment; households; and administrative costs. The appendix is organized by these areas of the economy and within each area of the economy is divided by approach to health care reform. Within each approach to health care reform, analyses are indicated in the headings by who published the analysis and then by who conducted the analysis, if the latter differs from the former. The specific proposal reviewed is then indicated in parentheses, unless the analysis was of the generic approach to reform under which the entry appears.[1]

Specific Analyses of Impacts on National Health Care Spending and Savings

Single Payer Approaches

Lewin-VHI[2]--Lewin--VHI, in a staff working paper, examined national health spending under a Canadian-style system (34). The authors identified two features of the Canadian system that could potentially reduce U.S. national health expenditures-simplification of the administration of health benefits, and regulation of the growth in health spending through aggregate expenditure limits for physicians and hospitals-and one feature that would increase expenditures, that is, primarily, expanded coverage.

Lewin-VHI maintained that a Canadian-style system in the United States would not necessarily achieve the level of health care spending achieved in Canada, at least not immediately, since:

- It is unlikely that the United States would make major changes in provider payment levels;
- The resource allocation systems in place in Canada would take time to develop in the United States;
- U.S. health spending includes amortization costs of existing capital;
- Data systems for expenditure budgeting need to be developed; and
- Due process rights in the United States have implications for medical malpractice reform and provider rate appeals, both of which affect health care spending (34).

Based upon their analysis, Lewin-VHI estimated a net increase in national health spending of $21.2

[1] Examples of how appendix entries are organized include: Lewin-VHI—Lewin VHI conducted an independent analysis of a generic approach (34); Physicians for a National Health Plan/Grumbach and Colleagues (PNHP)—Grumbach and his colleagues, on behalf of the Physicians for a National Health Program, analyzed the PNHP plan (24).

[2] Lewin-VHI was formerly known as Lewin-ICF.

billion in 1991, the first year of the plan. This was the sum of $46.8 billion in administrative costs-savings plus $68.0 billion in increased utilization ensuing from expanded access to uninsured individuals and the elimination of cost-sharing as well as the elimination of some utilization management programs. However, it does not include increased spending of $10.2 billion associated with long-term care services.

The analysis noted that a large portion of the increase in health spending in the first year could be averted by imposing patient cost-sharing, but such modification of the Canadian approach might significantly reduce the potential for administrative costs-savings flowing from the Single Payer system.

While Lewin-VHI projected an increase in spending in the plan's first year, it indicated that in future years substantial savings could be realized as the growth in health spending was controlled through health expenditure limits. They maintained that it is impossible to reliably predict savings ensuing from expenditure limits. "Health expenditure budgeting in the U.S. is sure to be a highly political process which may not always yield results consistent with the goals of cost containment" (34). However, by way of illustration, they showed that if the United States were to reduce its projected rate of growth in health spending by 1 percentage point per year, national health expenditures would be reduced by about $137.0 billion over the next decade. What impact such reductions would have on the quality of care and on health care technology is generally unknown (34).

Meyer and Colleagues-Meyer and his colleagues examined the long-term impact of the implementation of a national health plan with government as the sole payer for services on business and the economy (43). They projected U.S. health care savings over a 10-year period, from 1991 through the year 2000, under several scenarios that varied the assumptions about the level of health care spending under a Canadian-style system.[3]

Based upon these scenarios, the authors estimated a change in national health care spending in 1991 ranging from savings of $241.0 billion, under the "Full Savings Scenario," to increased spending of $20.0 billion, under the "Deceleration Scenario" Cumulative savings under these scenarios for 1991 through the year 2000 ranged from $1.3 ("Deceleration Scenario") to $5.5 trillion ("Full Savings Scenario") in current dollars ($1.0 to $4.3 trillion in 1991 dollars). Since neither of these scenarios account for a phase-in period, the savings achieved under them are likely to be upper limit projections. However, given the magnitude of the estimated long-term savings, the authors maintain that the analysis demonstrates [t]hat a conversion to a national health plan would release resources from the health care sector to the rest of the economy" (43).

U.S. General Accounting Off ice-in a 1991 report examining the Canadian health care system, the U.S. General Accounting Office (GAO) estimated that the implementation of a Canadian-style system in the United States would produce a net savings of $3,0 billion in 1991, about 0.4 percent of projected 1991 national health expenditures (82). This estimate: was based upon the system in place in Ontario; assumed effective in the first year some cost-containment and all cost-inducing factors; and did not take into account transition costs. GAO projected that long-term health care savings from implementation of a Canadian-style system would be possible given that the cost constraining features of the system *could* help control growth in national health care expenditures (82).

Physicians for a National Health Program/ Grumbach and Colleagues (PNHP)--The Physicians for a National Health Program (PNHP) support a publicly administered, tax-financed national health plan with a single public payer (24). The PNHP plan would: provide coverage to all Americans for "all medically necessary services including prescription drugs;" prohibit private insurance that duplicates the plan's coverage; eliminate patients' copayments and deductibles; and provide for annually negotiated global budgets for hospitals, and a negotiated fee schedule for fee-for-service physicians' services.

According to its proponents, the proposal "could initially pay for expanded care out of administrative

3 "Full Savings Scenario" assumed health care spending at no more than 8.7 percent of U.S. GDP, the portion of Canada's GDP devoted to health care. "Deceleration Scenario" assumed health care spending capped at its current share of U.S. output (GDP) *after* including the cost of covering uninsured individuals (43).

savings without adding new costs to the overall health care budget and would establish effective mechanisms for long-term cost control" (24) (See also "Specific Analyses of Impacts on Administrative Costs," this appendix). According to Health Care Financing Administration (HCFA) estimates cited by Grumbach and his colleagues, $602.0 billion would be spent in 1991 for personal health care plus insurance overhead and profits *under current policies.* The authors estimated that ''the net cost of personal health care and insurance overhead for universal coverage under the NHP, including expanded services for the previously uninsured, would be at most $547 billion *if the system operated with the administrative efficiency of the Canadian system"* (emphasis added). However, in calculating a national health care budget for the first year of plan implementation, the authors assumed a more conservative level of administrative costs-savings and that significant savings from the adoption of cost-containment mechanisms, such as global budgets for institutional providers and fee schedules for physicians' services, would accrue over time. Based upon these assumptions, the authors estimated that national health expenditures would be $18.0 billion less ($584.0 billion) than under current policies ($602.0 billion) in 1991. Nevertheless, the authors proposed a national health care budget in 1991 of $602.0 billion (equal to HCFA'S 1991 estimate under current policies), earmarking the difference in spending under their plan versus under current policies for new health initiatives and transition costs. The analysis indicated that in order to achieve this national health care budget in the initial year of the plan, given the increase in costs due to increased utilization of health care services by the previously uninsured population, the plan would "rely on the ability of a single payer to allocate and enforce prospective budgets for physician and hospital services' (24).

Congressional Budget **Office-In** a Congressional Budget Office (CBO) study,[4] CBO projected the change in national health expenditures for a Canadian-style system in which provider payments were made on the basis of Medicare rates (77). However, it varied the approach from the Canadian system to the extent that some patient cost-sharing and a residual Medicaid program were retained. It projected that under such a system, the net change in 1989 in national health expenditures would range from savings of $58.1 billion (9.6 percent) to increased spending of $7.4 billion (1.2 percent), under relatively optimistic and relatively pessimistic assumptions, respectively. Note that the above GAO report, which compared various estimates of the change in national health spending under a Canadian-style system, converted these 1989 figures to 1991 dollars; that is, savings of $69.0 billion to increased spending of $9.0 billion (83). In its study, CBO noted that" [t]he magnitude of savings achieved by limiting price increases would depend on allowed increases and the extent to which increases in volume would offset some of the potential savings from price controls" (77).

Play-or-Pay Approaches

Congressional Budget Of Office-CBO reviewed illustrative options for expanding health insurance including a variation of a Play-or-Pay approach (76). It found that in 1991, the three options--employer mandate, Medicaid expansion and combined employer mandate/Medicaid expansion-would not ''increase national health expenditures by more than 3 percent, but all of them would have redistributional consequences that would substantially exceed the modest net effect on overall health spending" (76).

U.S. Bipartisan Commission on Comprehensive Health Care/Lewin-VHI (Pepper Commission)--The U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission) reviewed three alternatives-Medicaid expansion, national health insurance (through a refundable tax credit to purchase coverage available to all Americans or government as sole payer), and ''job-based and public coverage, ' before recommending the latter in its final report in September 1990 (75).

The Commission rejected the Medicaid expansion alternative because it determined that an estimated 14 million people would remain without access to affordable coverage and that currently inadequate coverage available to others would not improve. To the extent that such a plan would not achieve universal access, the cost shift to private payers for uncompensated care

[4] This Congressional Budget Office study was revised in April 1993 (81).

would continue. Furthermore, the Federal Government would be responsible for the entire cost of insuring low-income workers. The Commission also rejected the two means of achieving what it termed "national health insurance" because it determined that they were controversial and disruptive, especially for those covered by the current employment-based system, and that they would totally shift the financing burden from employers to the taxpayers.

Thus, the Commission recommended the adoption of a proposal combining job-based and public coverage. The recommended reforms, designed to achieve universal access, would be phased in over a 5-year period. The projections for the plan assumed that employers would seek to minimize costs in choosing between the private and public options, and that they would be able to elect separately between private insurance and coverage under the public plan for their full- and part-time workers.

The Commission, using Lewin-VHI's estimates, estimated that the system's implementation would increase national health spending less than 2 percent. Thus it projected, based upon full implementation in 1990, an increase of $12.0 billion in 1990 in national health expenditures. In practice, the plan would be phased in. Therefore, the $12.0 billion does not reflect adjustments for inflation or for savings resulting from various cost-containment measures. Not all sectors of the economy would experience increased costs as a result of the plan implementation (75) (See 'Specific Analyses of Impacts on Employers,' this appendix).

American Academy of Family Physicians/Lewin-VHI (AAFP)--The American Academy of Family Physicians' Rx *for Health* provides for an employer mandate with a government backup insurance plan coupled with global budgeting for health care spending as well as miscellaneous other reforms (2). An analysis of the plan conducted by Lewin-VHI for AAFP estimated an initial increase in health care spending of $33.6 billion (with expanded Medicare coverage through the private purchase of expanded Medigap insurance; $32.5 billion without) in 1993 due to increased utilization, and increased provider reimbursement for care provided to persons currently covered by Medicaid, offset, only in part, by cost-containment savings (36,37). It further projected that savings resulting from the implementation of the plan's cost-containment measures (e.g., patient cost-sharing, expenditure limits for hospitals and physicians, medical liability reform, global budget) would offset additional outlays in the future. Thus, it estimated a net reduction in health spending from $111.3 to $333.5 billion (with expanded Medicare coverage through the private purchase of expanded Medigap insurance; $123.7 to $345.9 billion without) from 1993 through the year 2000, in current dollars. These projected savings depend, in particular, upon the effectiveness of the plan's expenditure limits, assumed to take effect in 1994, and assume that such measures reduce per-capita health spending from a projected rate of 8.6 percent to 7.6 percent and 6.6 percent, respectively, beginning in 1994 (36).

Lewin-VHI concluded that its higher estimate of savings under the AAFP proposal, which would require a reduction in health spending of approximately 3.5 percent over 8 years (reflecting a 25 percent reduction in the rate of growth in health spending), "seems modest, " given that State all-payer hospital rate setting programs have been shown to reduce the rate of growth in health spending by 30 percent (36).

National Leadership Coalition for Health Care Reform (N LCHCR)---The National Leadership Coalition for Health Care Reform, also projected substantial savings in health care spending over current policy for its proposal, which is similar to the AAFP proposal. After an initial increase in outlays of $1.0 billion in 1992, the plan projected savings of $36.0 billion in 1993 increasing to over $600.0 billion annually in the year 2000 (49).

Silow-Carroll and Meyer (HealthAmerica: Affordable Health Care for All Americans Act; Clinton Campaign)--Silow-Carroll and Meyer examined S. 1227 (HealthAmerica: Affordable Health Care for All Americans Act), introduced (but not passed) in the 102d Congress, and then-candidate (now President)

Clinton's campaign proposal,[5] both of which incorporated an employer mandate to contribute toward employee health insurance benefits as welI as global health care spending budgets and fee schedules (66).

While the authors noted that in all three scenarios modeled,[6] some of the cost savings were offset by the increased cost of providing health care coverage to uninsured persons, cumulative savings in health care spending accrue under all three from 1994 through 2003 for both plans. They further noted that it would be misleading to judge the impact of the proposals based upon first-year expenditures.

Thus, under an "optimistic Scenario, " net savings in national health spending over business as usual during the first year of the plan (1994) would be $5.0 billion with cumulative savings of about $2.7 trillion in current dollars ($1.7 trillion in 1994 dollars) from 1994 through 2003,

Under the "Intermediate Scenario, " the authors found that the expansion of coverage to uninsured individuals would offset initial savings under the plan, resulting in a net increase in national health spending of $1.0 billion in 1994. However, savings would exceed new costs beginning in 1995 with cumulative savings from 1994 through 2003 of about $1.2 trillion in current dollars ($712.0 billion in 1994 dollars).

The "Pessimistic Scenario" would take the longest to yield savings since under its assumptions, health care spending would exceed expected spending under business as usual for about 5 years, at which point net savings would be realized. Cumulative savings would be about $457.0 billion in current dollars ($260.0 billion in 1994 dollars) from 1994 through 2003.

The authors maintain that small changes in health care spending growth can have a significant impact, emphasizing "the extreme importance of the exact spending targets set by the federal board and the effectiveness of the mechanisms put in place to achieve those targets" (66).

Approaches Employing Individual Vouchers or Tax Credits

Bush Administration/U.S. Executive Off ice of the President (Bush Administration)—Fcmmr President Bush's reform proposal included tax credits, deductions, or vouchers as well as insurance market reforms intended to expand the availability of private insurance (94). The Bush Administration estimated that 95 million Americans would be affected by the Administration's various reform measures. And it estimated that based on 34.1 million persons currently uninsured, the plan would newly cover 29.2 million of them. Of the 4.9 million Americans remaining uninsured, the Administration held that many of them would be eligible for a credit or deduction.

Bush Administration projections of the impact of its various reforms on national health expenditures estimated that they could reduce national health expenditures by 6 to 14 percent, yielding cumulative systemwide savings from 1992 through 1997 of $394.0 billion and through the year 2000 of $954.0 billion, in current dollars. The Bush Administration also expected the reforms to reduce the rate of growth of real per-capita medical expenses thus reducing the share of the GDP devoted to health care in the long-term. Looking forward to 2030, the U.S. Office of Management and Budget projected that 19 percent of GDP would be devoted to health care spending if the Bush Administration reforms were implemented, rather than 27 percent, the middle range projected estimate under the current system (94).

Bipartisan Panel on Presidential Candidates' Health Plans/Lewin-VHl (Bush Administration)--Lewin-VHI, for the Bipartisan Panel on Presidential Candidates' Health Plans convened by Families USA, analyzed then-President Bush's reform proposal (3). It estimated that health care spending would decrease by

[5] While Silow-Carroll and Meyer examined then-candidate Bill Clinton's proposal, since none of the core components of Managed Competition were included in either S. 1227 or then-candidate Clinton's proposal, the study has been categorized as one examining Play-or-Pay approaches to reform.

[6] ''Optimistic Scenario'' assumed the plan would result in universal coverage, an initial 5 percent reduction in health care costs phased in over 5 years, and future health care spending growth limited to the growth rate of the economy after the fifth year of implementation. ''Intermediate Scenario' assumed initial efficiencies would result in a 2.5 percent reduction in spending phased in over 5 years and, over 10 years, the annual growth rate in health care would slowly decline in stages, eventually achieving a reduction of 3 percentage points, from 11.26 to 8.26 percent annual growth. Health care would continue to grow faster than the rest of the economy but by a much smaller margin than currently, ''Pessimistic Scenario' assumed no initial efficiencies, spending would increase as access expands, and annual health care spending growth would decline slowly from approximately 11.3 percent (in 1994) to about 9.1 percent (in 2003) (66).

$7.5 billion in **1993, and** would continue to decrease **annually with the cumulative net decrease in spending estimated to be** *$72.6* billion through 1997 and $156.9 billion through the year 2000, in current dollars. These estimates assumed the successful implementation of the proposed cost-containment measures including insurance market reform, electronic claims processing, medical liability reforms, expanded use of coordinated care, preemption of State mandated minimum benefits, promotion of competition, and increased funding for prevention programs.

Silow-Carroll (Bush Administration)---Silow-Carroll examined the long-term impact (1994 through the year 2003) of then-President Bush's tax credit proposal on the economy under two scenarios that varied the assumptions about the magnitude of savings achievable under the proposa1[7] (65).

The analysis found that either scenario would entail some increase in overall health care spending due to the expansion in coverage, but that any such increase would be mostly offset by cost-containment savings in the initial years of the plan. Under the "Pessimistic Scenario," health care spending would decrease by $2.0 billion in 1994 relative to the current system; under the 'Optimistic Scenario, " by $6.0 billion. The analysis estimated cumulative savings of $158.0 billion to nearly $1.0 trillion, in current dollars ($107.0 to $600.0 billion, in inflation-adjusted, 1994 dollars), under the "Pessimistic" and 'optimistic" scenarios, respectively, from 1994 through 2003. The study did not project whether savings would continue under the "Optimistic Scenario." However, it noted with respect to the "Pessimistic Scenario" that if health care spending were to continue on the same course, savings in national health care spending resulting from former President Bush's tax credit reforms would taper off after the first decade (65).

Congressional Budget Office (Bush Administration)--**The** Congressional Budget Office, in testimony before the Senate Committee on Finance, estimated that a proposal combining tax subsidies with market reforms would increase national health care spending 2 percent initially (55). With respect to former President Bush's proposal, CBO Director Robert Reischauer testified that the combined effect of the proposal's cost-control measures could produce a modest one-time reduction in national health spending but that it was not likely to significantly slow the rate of growth in such spending (85). He attributed the limited impact of the reforms on the rate of growth in health spending to their voluntary nature and the relatively small financial incentives involved.

Heritage Foundation/Lewin-VHI (Heritage Foundation)--Lewin-VHI analyzed the Heritage Foundation's health care reform proposal on behalf of the Foundation (35). The proposal replaces the tax deduction/exclusion for employment-based health benefits with individual refundable tax credits/vouchers, includes health insurance market reforms, and requires individuals to purchase insurance. Employers, in particular those who now offer coverage, would continue, as a general rule, to arrange payroll deductions for benefits payments. The analysis assumed that the newly insured individuals would increase their utilization of services to the level reported by insured persons with similar characteristics while the utilization of some workers would decline as they ''downgrade' their coverage (35). Taking into account the utilization responses of both newly and currently insured persons as well as changes in administrative costs, Lewin-VHI estimated that implementation of the Heritage Foundation proposal would reduce national health spending by $10.8 billion in 1991 (35).

Managed Competition Approaches

Enthoven--Enthoven has estimated with respect to Managed Competition, generally, i.e., without specifying some of the details which tend to vary in the proposals (e.g., employer mandate, tax policy modifications, and expenditure limits), that" [i]t is altogether possible that a very efficient competitive system could get us back to 9 or 10 percent" of GDP (15).

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7 ''Pessimistic Scenario'' assumed that "much of the savings in the Bush plan are one-time in nature, and that after these efficiencies are achieved, the cost curve returns to its present course. " "Optimistic Scenario' ' assumed that in the fii 5 yearn of the program, "the plan's cost containment features are relatively successful in both reducing current expenditures. . . and slowing down the rate of spending growth" (65).

Bipartisan Panel on Presidential **Candidates' Health Plans/Lewin-VHI (Clinton Campaign)--Lewin-VHI, in** its analysis for the Bipartisan Panel on Presidential Candidates' Health Plans convened by Families USA, mentioned above, examined then-candidate (now President) Clinton's health care reform proposal. As outlined during the presidential campaign, it incorporated an employer mandate to provide benefits directly or pay toward public-sponsored, but privately operated, plans that would provide "the specified core benefits package,' and annual national health care budget targets (3). Lewin-VHI's estimates assumed that the national health budget would restrict 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 the GNP). Making additional assumptions about the phase-in of the various aspects of the proposal, with the first year of the plan being 1994, Lewin-VHI projected that health care spending would be reduced in 1994 by $21.8 billion. Cumulative savings (in current dollars) under then-candidate Clinton's campaign proposal would be $232.0 billion from 1994 through 1997, and $745.7 billion from 1994 through the year 2000, relative to current policy (3).

Sheils and Colleagues--Sheils and his colleagues recently prepared estimates of the impact on national health spending of a Managed Competition approach (63). The approach was a variation of Paul Starr's approach to Managed Competition (71). It included an employer mandate requiring employers with more than five employees to contribute at least 75 percent of the premium of the lowest-cost plan in the area for all full-time workers (defined as working 17.5 hours or more per week), and to pay an 8 percent payroll tax for part-time employees. Any employer contribution over 75 percent of the lowest-cost plan premium would be taxable to the employee as income. Subsidies would be available to some employers, low-income employees and people without employment-based insurance or Medicare.

In order to calculate the average lowest-cost plan premium, the authors adjusted "the average premium estimated with HBSM," the Health Benefits Simulation Model developed by Lewin-VHI, "to reflect the savings that one can expect to achieve in a well-managed HMO' (63). Thus, the authors assumed an 8 percent reduction in the lowest-cost plan premium, based upon the experience of group-model HMOS.

Furthermore, according to the authors, key assumptions affecting their estimates regarding national health spending concerned ''managed care savings, " estimated to be 2 percent based upon the experience of all types of HMOs, "uncompensated care costs, behavioral responses to cost sharing, reimbursement improvements, and administrative savings." The analysis also acknowledged that "further sensitivity analysis is needed" to determine the impact of these various assumptions on the results (63).

Based upon the various assumptions described above, Sheils and his colleagues provided two estimates of the impact on national health spending in 1993 of the variation of Managed Competition they examined:

- increased spending of about $47.9 billion, assuming low patient cost-sharing (no patient deductible and a $10 copayment per visit); and
- increased spending of about $42.3 billion, assuming high patient cost-sharing $250 deductible per individual ($500 per family) with 20 percent coinsurance required up to a maximum of $2,000 per individual ($3,000 per family).[8]

The authors attributed the $5.6 billion difference to expected lower services utilization under the higher cost-sharing scenario (63).

Long **and Rodgers-Long** and Rodgers reviewed the preceding Lewin-VHI analysis and responded with estimates of the impact of the Enthoven/Kronick Managed Competition proposal (which the authors maintained was similar to the plan analyzed by Sheils and his colleagues) on national health spending (40). The authors' estimates assumed the implementation of universal health insurance which they estimated would increase national health spending by $29.0 billion (the

[8] HMOs do not usually have deductibles or cost-sharing as a percentage of the fee at the point-of-service, thus this scenario is a significant departure from current HMO practice (23).

cost of expanded access to coverage) in 1993.[9] Assuming savings of 8 percent based upon the experience of group-model HMOs (or, in the alternative, based upon reductions in administrative costs in employer plans), the authors estimated savings from Managed Competition of $37.0 billion in 1993. Since these savings would be offset by the $29.0 billion increase in spending, the authors estimated that national health spending would decrease by $8.0 billion in 1993 under universal insurance with Managed Competition.

Long and Rodgers attribute the difference between their estimate (savings of $8.0 billion) and those of Sheils and his colleagues (increased spending of $42.3 and $47.9 billion, assuming high and low patient cost-sharing, respectively) to differences in the underlying assumptions. For example, Long and Rodgers indicated that Sheils and his colleagues included:

> . . . $27.4 billion in net reimbursement increases by Medicaid as an addition to national health spending; we choose not to count these additional outlays as added real spending, since they do not correspond to any additional health care services provided and simply reverse cost shifting under the current system (40).

And the estimates differ further in terms of their assumed savings based upon the experience of HMOS (Sheik and colleagues: 2 percent; Long and Rodgers: 8 percent, using an estimate from an earlier version of the paper by Sheils and his colleagues), leading to far different estimates of the impact of Managed Competition on health care spending (40,41,63).

Data from the California Public Employees' Retirement System-The California Public Employees' Retirement System (CalPERS) functions as a group purchaser of health care benefits for 887,000 covered lives including employees and retirees of the State of California, 787 other public employers in California, and the California State University system, and their dependents (7). Seventy-six percent of the employers employ fewer than 100 people. CalPERS offers 25 health plans including 19 HMOS, 2 self-funded preferred provider organizations (PPOS), and 4 "association" plans. Beginning with the 1993 policy year, CalPERS has insisted on a standard benefit design among all HMOS with which it contracts, in order to make comparisons among the HMOS' premium offerings.

CalPERS has been put forth by some proponents of Managed Competition as an example of a successful health insurance purchasing group, reducing health care costs for its members by providing all employer participants with the advantages of the large purchaser of health care benefits.

As the purchasing agent on behalf of its covered population, CalPERS secured a 1.4 percent overall increase in 1993/94 premium rates (HMOs: 0.4 percent decrease; PPOS: 7.9 percent increase; Associations: 5 percent). According to CalPERS, combined with a 6.1 percent overall premium increase for 1992/93, the 2-year combined increase of 7.5 percent was one-fourth the national average of 30 percent (7).

CalPERS recent low increase in HMO premiums was achieved in part via increases in patient cost-sharing at the time of service (i.e., copayments). CalPERS' efforts to reduce premiums may have been aided by the California State budget crisis and other factors (59).

A recent issue paper published by the Service Employees International Union (SEIU) examined the CalPERS experience in terms of its impact on health care costs, and concluded that ''[competition alone did not constrain costs; tough negotiations over premium increases--one form of rate control--did" (59). SEIU noted that while CalPERS premium rate increases were in the single digits for 1992/93 and 1993/94, its overall average rate increases in 1990/91 and 1991/92 were 16.9 percent and 11.3 percent, respectively, and that "[throughout the 1980s, CalPERS experienced higher premium increases than employers nationally. Thus, SEIU attributes CalPERS lower rates of increase in premiums for the past two contract negotiations to several recent initiatives taken by CalPERS which SEIU deemed health cost control measures: change in premium contribution formulas (1991/92); request for a zero percent increase in premiums (1992/93); detailed cost and performance information required from plans (1993/

9 A background paper concerning the potential impact of expanding coverage to people who are currently uninsured is being prepared by the Rand Corporation for OTA and the Congressional Research Service. Its release is planned for fall 1993.

94); and standardized benefits for all HMO options (1993/94).

Therefore, while CalPERS may be succeeding in reducing premium rate increases, it is important to determine what is driving such decreases.

Specific Analyses of Impacts on Federal, State and Local Budgets

Single Payer Approaches

Meyer and Colleagues-Meyer and his colleagues examined the long-term impact of the implementation of a system of universal coverage with government as the sole payer for services on business and the economy (43). Under the study's ''Full Savings Scenario,' [10] they found that additional public revenues of **$29.0** billion would be required in 1991, the first year of implementation. The study notes that this estimate rests upon achieving the Canadian level of health care spending as a proportion of GDP. This may account for the disparity between this analysis' estimate of additional public revenue requirements and those of various other studies (43). The analysis further indicated that the revenue shortfall would be temporary, and that by the third year of implementation, the government would recognize a gain, even though it would have assumed a larger burden, proportionately, with respect to health care financing.

Under the study's ''Deceleration Scenario,''[11] government spending would increase by $225.0 billion in 1991, due to smaller systemwide savings under this scenario coupled with the shift from private to public sector financing.

Health Insurance Association of America-The Health Insurance Association of America (HIAA) studied the implications of the Canadian public health insurance system for the United States (25). It estimated that the implementation of this system in the United States would require $183.0 to $189.0 billion (1988 dollars) ($244.0 billion to $252.0 billion in 1991 dollars) in additional public funds assuming an annual increase in health care spending of about 10 percent. This increase in the public financing burden would be offset by a reduction in private financing of health care.

HIAA postulated that implementing a Canadian-style system funded solely by the Federal Government would require a 46 percent increase in Federal income tax receipts, a 59 percent increase in payroll tax receipts, or a 62 percent reduction in defense spending (25). If, in the alternative, the system were funded solely at the State level, it would necessitate a 71 percent increase in State tax revenues. These estimates were based upon HIAA's 1988 midpoint estimate of $186.0 billion in additional public expenditures to finance the implementation of a Canadian-style system.

According to HIAA, the States would assume the vast majority of the financing burden were the distribution allocated as it is in Canada. Using 1987/88 data, HIAA estimated that under their respective systems, the U.S. and Canadian governments currently fund about the same proportion of total health spending (United States: 29.2 percent; Canada: 29.6 percent). While HIAA did not think that the U.S. system would necessarily reflect Canada's distribution of the burden, it indicated that a government-financed system might be unstable for the States were the Federal Government to experience, as it is now, budgetary difficulties, compelling it to restrict its contribution to health care expenditures (25).

Congressional Budget Office-As a recent Congressional Budget Office Staff Memorandum noted, the Canadian Government limits its contribution to national health spending by making per capita payments to the provinces, determined in accordance with a formula based on growth in the GNP, not on actual health care expenditures in each province. The result is that the provinces have become increasingly more responsible for the cost of health care services for their populations (80).

In testimony, CBO estimated that the implementation of a Single Payer public plan in the United States would increase direct Federal Government outlays by 75 percent initially. Federal outlays would be offset by

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10 ''Full Savings scenario' assumed implementation of a Canadian-style system with health care spending at no more than 8.7 percent of U.S. GDP, the proportion of Canada's GDP devoted to health care (43).

11 ''Deceleration Scenario'' assumed national health care spending is capped at its current share of U.S. GDP after including the cost of covering uninsured individuals (43).

a 95 percent decrease in tax expenditures, including those related to income and payroll taxes, as a result of the elimination of the health insurance tax exclusion. Thus, CBO estimated total Federal health expenditures would increase by 34 percent initially. This estimate assumed that the Federal Government would pay all costs of the public plan, but acknowledged that such costs could be shared between Federal, State, and local governments (55).

In a study of universal health insurance coverage using Medicare's payment rates, and assuming the continuation of a residual Medicaid program for which States would continue to finance their portion, CBO found that even if national health expenditures decreased, government spending under a Single Payer approach would increase (77). Based upon a midrange group of assumptions, CBO projected that government health spending would increase by 56.7 percent or $143.6 billion (1989). Among levels of government, this increase would be allocated as follows: Federal spending would increase by $154.7 billion and State spending would be reduced by $11.1 billion. Implementation of the plan (again using midrange assumptions) would require an increase in taxes of approximately $560 per capita. However, other offsetting gains (e.g., to the private sector whose costs would decrease by $662 per capita) would be likely, leaving individuals, on average, with additional discretionary dollars (77).

Play-or-Pay Approaches

Milliman & Robertson--The actuarial firm of Milliman & Robertson examined the effects on government budgets of a simple employer mandate; that is, they did not take into account individual premium cost-sharing with respect to either the employer or government plans, but assumed a 7 percent payroll tax rate, and did not make assumptions regarding insurance market reform (12). Under this scenario, the firm found that the government plan is likely to be ''consistently underfunded" at the 7 percent payroll tax rate. The firm attributed this instability to the fact that the government plan funding source, payroll taxes, would not be very sensitive to the cost of delivering care to plan enrollees.

Congressional Budget Office--In testimony, CBO estimated that the implementation of an employment-based approach combined with insurance market reforms would increase direct Federal Government outlays by 17 percent initially (55). This estimate assumed no change in overall or full-time employment; that all people eligible for free insurance under the public plan, but only some people from other eligible groups, would enroll in the public plan; and that increased taxes from employers and employees would offset more than 70 percent of the cost of insuring employees enrolled in the public plan. Given continued favorable tax treatment of employment-based insurance, tax expenditures would increase by 9 percent initially, due to an increase in the number of persons covered by employment-based insurance. Thus, total Federal Government health expenditures would increase by 15 percent initially. CBO assumed that the Federal Government would pay all costs of the public plan, but acknowledged that such costs could be shared among Federal, State, and local governments, thereby lessening the impact on the Federal budget.

CBO, in a report reviewing selected options for expanding health insurance coverage, looked at the impact of an employer mandate combined with Medicaid expansion, and estimated that it would increase the Federal budget deficit by $13.1 billion (1991) (76). This figure is the sum of changes in Federal outlays for Medicare (savings of $3.6 billion) and Medicaid (increased spending of $10.2 billion), plus the loss of Federal revenues associated with individual income taxes (a loss of $3.0 billion) and Social Security and Medicare payroll taxes (a loss of $3.5 billion). Likewise the illustrative option would increase State and local government spending as well as reduce their tax revenues. CBO estimated that State and local government outlays would increase by approximately $3.0 billion and that income tax revenues would decrease by approximately $1.0 billion (1991). CBO also projected that in the longer term, other State and local tax revenues would decrease due to a shift in spending from taxed to untaxed (e.g., medical goods and services) purposes. CBO noted that many States and local governments operate under balanced budget requirements, thus the increased outlays detailed above would require the implementation of either revenue raising or spending reduction measures (76).

U.S. Bipartisan Commission on Comprehensive Health Care/Lewin-VHI (Pepper Commission)--Lewin-VHI's analysis of the plan of the U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission) estimated that State and local governments would save about $7.4 billion in current (1990) payments for financing care for uninsured persons (75). Further, the plan would hold State contributions to finance the Federal system replacing Medicaid to their current Medicaid contribution level adjusted for inflation. Thus, the plan would alleviate the increasing drain that Medicaid poses to State budgets. The analysis estimated that new Federal expenditures required to cover nonworkers, to subsidize insurance costs for individuals and employers, and to pay providers in accordance with Medicare payment rules, would be approximately $24.0 billion (1990). These expenditures would require additional Federal revenues.

Zedlewski and Colleagues--Zedlewski and her colleagues, in a study conducted under the auspices of the U.S. Department of Labor, examined the first-round effects of a Play-or-Pay plan (100). This study did not examine the impact of the approach on the change in *total* government health care spending. However, by looking at the single component of health insurance costs, defined as health insurance premiums, it tended to show the sensitivity of the resulting system to system design (e.g., which employers and employees the mandate applies to, payroll tax percentage, employer/employee share of premium) and to changes in employer behavior, and the consequences for the distribution of the burden of health care financing.

The authors used 1989 data with the Urban Institute's Transfer Income Model (TRIM2) to arrive at their estimates. The authors found that the proportion of the nonelderly population enrolled in the public-sponsored plan has important implications for the health insurance costs of government, as well as those of other payers. In general, the lower the payroll tax rate, the greater the number of nonelderly enrolled in the public-sponsored plan, if employers select the less expensive alternative which the public plan is assumed to be, and the greater the cost to government. This is based upon the assumption that the funds coming into the government plan to insure employed enrollees will be less *than the* **actuarial cost** of insuring them (otherwise the employer would probably have purchased private insurance), thereby requiring government to fund the difference. However, the study found that government costs would not increase linearly with the proportion of workers enrolled in the public plan because the government would only be paying a portion of each individual's costs.[12] And,

> . . . at certain tax rates some employers would pay taxes higher than the government's cost of insuring their workers (thereby partially subsidizing costs for the low-income population), because the premium for the public-sponsored plan would be less expensive than the premium available to small employers (100).[13]

Assuming the purchase of insurance at current prices (1989) and that employers would pay 80 percent of the premium, the study estimated that at a 7 percent payroll tax rate, $64.4 billion or 23.9 percent in additional government funds (over and above those funds collected pursuant to the payroll tax) would be necessary to cover insurance costs, whereas at a 9 percent payroll tax rate, $53.2 billion or 19.5 percent more would be necessary. Note that only part of these funds ($33.6 billion and $23.1 billion, under each payroll tax rate, respectively) are new government funds (i.e., funds not currently spent by government to fund the Medicaid program). Also, these estimates are based on what maybe "upper bound' estimates of the numbers of persons who would be enrolled in the public plan according to Zedlewski and her colleagues (loo).

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12 The study assumed some level of cost-sharing of the premiums for the public-sponsored plan by plan enrollees except to the extent that such enrollees would be eligible for a subsidy (e.g., income below the poverty level) (100).

13 The study indicated that under all assumptions with respect to employer behavior, premiums or tax rates, the public-sponsored insurance plan under this reform approach would include 40 to 50 million people since a large proportion of the plan's enrollees are nonelderly nonworkers, self-employed workers, part-time workers (i.e., work fewer hours per week than required by the mandate to be covered by an employer), and work for very small employers with very low payrolls. Given the anticipated large size of the public-sponsored plan, it is likely that the government would be able to provide coverage for the plan's enrollees at a price less than that which some employers would have paid if purchasing coverage directly in the private insurance market (loo).

American Academy of Family Physicians/Lewin-VHI (AAFP)-Lewin-VHI, analyzing the American Academy of Family Physicians' reform proposal, estimated that in 1993, the first full year of anticipated implementation, the system would require $34.1 billion in new Federal Government revenues, largely resulting from the government's share of subsidizing coverage under the public plan (37). However, the plan would be budget neutral; that is, the plan would be fully funded at the Federal level through increased taxes levied on businesses and households and, therefore, it would not have an impact upon the Federal deficit. The plan would require that States continue to pay into the public-sponsored plan in the same proportion as they currently support Medicaid, which would increase State outlays due to an increased number of people eligible for public-sponsored coverage. Thus, despite savings to other State programs serving the medically indigent, this increase in expenditures as well as other more minor ones, would result in a $7.6 billion increase in State and local government health care spending in 1993.

National Leadership Coalition for Health Care Reform (NLCHCR)-Estimates of new government spending provided by the National Leadership Coalition for Health Care Reform for its plan, which is similar to the AAFP plan, were close to Lewin-VHI's projections for the AAFP plan-$34.7 billion in 1991 dollars (49). The Coalition also projected that the plan would be budget neutral at the Federal level due to increases in taxes to fund the plan. State and local budget impact estimates were not provided.

Approaches Employing Individual Vouchers or Tax Credits

Silow-Carroll (Bush Administration)--Silow-Carroll analyzed the long-term impact of then-President Bush's tax credit proposal on the economy (65). The study specifically addressed the issue of equity in financing among various payers with respect to the proposal. It submitted that certain efficiencies would be achieved under the Bush plan, thus saving the Federal Government money in its current public health programs vis-à-vis "business as usual. " But it further stated that because the cost-containment provisions (e.g., managed care, administrative efficiencies, malpractice reform, provider price and quality information) in the Bush plan are of a voluntary nature, such efficiencies would not be adequate to control costs, particularly in the near term. Thus, the study theorized that the Federal Government would seek "efficiencies" in its existing public programs, which might have an effect in terms of reduced payments to the States for the Medicaid program. This might lead to an adverse impact on Medicaid beneficiaries (e.g., reduced access and/or quality of care) if the States could not adjust accordingly (e.g., manage care more effectively or increase taxes),

Heritage Foundation/Lewin-VHl (Heritage Foundation)-The Heritage Foundation maintained that its reform proposal is structured to be revenue neutral at the Federal, State and local levels; that is, the cost of the tax credits to the Federal Government plus any Civil Service Plan changes and corporate income tax loss to the Federal Government ($87.9 billion) would equal current Federal tax subsidies related to health care expenditures, plus a direct contribution by State and local governments (35). Lewin-VHI's analysis of the Foundation's plan indicated that the States and local governments would be expected to contribute their net savings ($18.8 billion) from changes in taxes due to them, their provision of care to uninsured persons in public hospitals, and in coverage of State and local government employees, to the Federal Government. Requiring the States to contribute such savings to the Federal Government would maintain budget neutrality at the State level (35).

Managed Competition Approaches

Conservative Democratic Forum (H.R. 5936)-With respect to the impact of Managed Competition, the Conservative Democratic Forum submitted that its proposal, "The Managed Competition Act of 1992," H.R. 5936 (102d Congress), would be budget neutral; that is, its financing provisions—a cap, in essence, on the tax deductibility of health insurance premiums by employers, repeal of the Medicare taxable maximum (assumed to be $130,200 per worker), and Federal Medicaid funds-would totally cover any additional Federal expenditures ($106.5 billion in 1994) generated by the proposal (10).

Jackson Hole Group--The Jackson Hole Group, in setting forth the 21st Century American Health Care System, an approach similar to the Conservative Democratic Forum's except that it incorporates an employer mandate, did not specifically address any impact on Federal, State or local budgets (29). However, the group has said that the plan does not require a large new government spending program. Rather it expects that monies saved due to the cap on the tax exclusion of health benefits would fund coverage for uninsured and unemployed persons (18).

Sheils and Colleagues--Sheils and his colleagues recently prepared estimates of the impact on public expenditures of a Managed Competition approach (63). The approach included an employer mandate requiring employers with more than five employees to contribute at least 75 percent of the premium of the lowest-cost plan in the area for all full-time workers (defined as working 17.5 hours or more per week), and to pay an 8 percent payroll tax for part-time employees. Any employer contribution over 75 percent of the lowest-cost plan premium would be taxable to the employee as income. Subsidies would be available to employers, low-income employees and people without employment-based insurance or Medicare.

Public costs under the plan would depend in large part upon the types and extent of the subsidies provided. Assuming the implementation of an employer cost cap of 7 percent of payroll, an individual cap of 2 percent of income on employee premiums, an individual cap of 9 percent of income on nonemploy - ment insurance spending, and subsidies of $2.2 billion to persons below 200 percent of poverty for patient cost-sharing expenses under a low cost-sharing plan (no patient deductible and $10 copayment per visit), the authors estimated that $120.3 billion in public funds would be required to fund the proposal in 1993. Based upon further calculations related to the use of current Medicaid funds as well as revenue increases and decreases due to the plan's provisions, Sheils and colleagues' estimated that $47.7 billion in total ***net*** new Federal revenues would be required, and suggested *other* means that could be used *to further* reduce this amount (e.g., recover State and local funds for indigent care programs rendered unnecessary by the universal health insurance plan; reduce the minimum benefit package by increasing individual cost-sharing; raise premium subsidy caps) (63).

Long and Rodgers-Long and Rodgers reviewed the preceding Lewin-VHI analysis and responded with estimates of the impact of the Enthoven/Kronick Managed Competition approach (similar to the plan analyzed by Sheils and his colleagues according to Long and Rodgers) on public expenditures (40). The authors' estimates assumed that the implementation of universaI health insurance wouId require public subsidies of $92.0 billion. However, these subsidies would be offset by $52.0 billion in savings in current public spending for Medicaid, Medicare, and the Department of Veterans Affairs. Assuming an 8 percent savings due to the implementation of Managed Competition, based upon the experience of group-model HMOS or, in the alternative, based upon reductions in administrative costs in employer plans, as cited by Sheils and his colleagues, the authors estimated that Federal health spending would increase by $41.0 billion under Managed Competition ($1 1.0 billion less than universal coverage without Managed Competition). The authors then further assumed that Managed Competition would:

> . . . have a 16 percent effect. (This is roughly equal to the sum of the HMO effect and the administrative savings.) With this level of savings—perhaps for a fully implemented plan under the Lewin-VHI assumptions-federal spending would increase by $31 billion, or $21 billion less than under the proposal with no managed competition [but with universal coverage] (40).

Specific Analyses of Impacts on Employers

Single Payer Approaches

Meyer and Colleagues--Meyer and his colleagues, in their analysis of the impact of the implementation of a Canadian-style system in the United States on employers, estimated substantial savings to the business sector (employers) over a lo-year period (1991 through the year 2000) (43). The magnitude of the estimated savings depended upon the degree to which costs savings were projected to be achieved in the United States under a Canadian-style system, and upon the taxes collected by the government to finance health care coverage. Making assumptions about the success

of cost control measures under the plan, the authors estimated that employers would save, in 1991, $136.0 billion, pretax,[14] under the study's "Full Savings Scenario' '[15] or $76.0 billion, pretax, under the study's ''Deceleration Scenario. "1[6] Estimated cumulative pretax savings to employers ranged from $2.2 to $3.0 trillion in current dollars ($1.7 to $2.3 trillion in 1991 dollars). The distribution of these savings would vary by industry depending upon the comprehensiveness of the industry's current health care benefits. Industries currently paying greater health care costs (e.g., the basic steel industry) would save more than those with lower health care costs (e.g., high-tech electronics, retail trade).

Play-or-Pay Approaches

Zedlewski--Zedlewski, in a study conducted under the auspices of the U.S. Department of Labor, used the Urban Institute's analytic model to examine the effects on employers and employees of expanding the employment-based health insurance system (98). Based upon simulations that varied numerous aspects of an employment-based plan, Zedlewski found that the results were sensitive "to requirements about including part-time workers, exemptions for small employers, family insurance choices, and different employer/employee premium-sharing arrangements" with respect to both employee and dependent coverage (98). She further found that expansions of the employment-based system that would include most part-time employees would affect firms of all size and industry categories. Thus, Zedlewski noted that expansion of the employment-based health insurance system would make expenditures on this fringe benefit more equitable across firms, by **size** and industry.

Zedlewski and Colleagues-Another study under the auspices of the U.S. Department of Labor, conducted by Zedlewski and her colleagues, further examined the impact on insurance coverage and costs of employer mandates requiring an employer contribution (100). The authors found that the payroll tax rate selected was key to employers' insurance costs. Any increase in the payroll tax acts as an increase in employers' maximum liability for insurance coverage costs. Thus, savings to employers would occur when the payroll tax option is less expensive than premiums for private coverage. Further savings would accrue to some employers if they were required to provide coverage for fewer of their employees' dependents.

In 1989 dollars, using "baseline assumptions,"1[7] the authors found that at a 7 percent payroll tax rate, employers' health insurance costs would increase by $29.8 billion or 23.1 percent, and by $44.4 billion or 34.4 percent at a 9 percent payroll tax rate, for all employers. Neither estimate is adjusted for uncompensated hospital care savings (100).

Again, the rate of change would vary considerably depending upon employer size, and the payroll tax rate assumptions would significantly affect the estimated effects. At the 7 percent payroll tax rate, the change in employers' health insurance costs would range from an increase of 13.4 percent for employers with greater than 500 employees to 69.7 percent for employers with between 1 and 24 employees. At the 9 percent payroll tax rate, the change would be even more dramatic, ranging from an increase of 19.6 percent for firms with more than 500 employees to 100.1 percent for firms with between 1 and 24 employees.

According to the study by Zedlewski and her colleagues, small employers, defined here as those with fewer than 25 employees, would experience the largest relative increase in insurance costs under both options because health insurance would be a new expense for many of these employers. While the health insurance costs of employers with more than 500 employees would increase on average, such increases, due for the most part to covering previously excluded employees and upgrading current plans, would be

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14 Pretax savings are defined as savings before employers' liability for increased income taxes, due on increased income resulting from a deerease in deductible health care expenditures, has been met (43).

15 ''Full Savings Scenari0" assumed implementation of a Canadian-style system with health care spending at no more than 8.7 percent of U.S. GDP (43).

16 ' 'Deceleration Scenari '' assumed implementation of a Canadian-style system with health care spending capped at its Current share of Us. GDP after including the cost of covering the uninsured (43).

17 ''Baseline assumptions'' : Assumed coverage is available at current premium prices and employer/employee premium cost-sharing is 80/20 for employee and dependent coverage (100).

substantially smaller. The impact in terms of actual dollars would not consistently decrease as size of employer increases. According to the authors, it would be highest for the smallest employers at either the 7 or 9 percent payroll tax rates (an increase of $10.8 and $15.6 billion, respectively) and, in fact, second highest for the largest employers (an increase of $10.5 and $15.3 billion, respectively) and lowest for employers with 25 to 99 and 100 to 500 employers (an increase of $5.3 and $3.2 billion, at the 7 percent rate, and an increase of $7.7 and $5.7 billion, at the 9 percent rate, respectively) (100).

Thus, the authors maintained that the simulations demonstrated the sensitivity of employment-based reform approaches to changes in the payroll tax rate. At the 9 percent rate, it is more likely that it will be less expensive for employers overall to obtain private insurance than to pay into the public plan. As a result, the higher tax rate tends to impose more direct costs on employers. The lower tax rate leads to a larger public plan and higher government costs. The authors emphasized that the ultimate impact of employment-based insurance proposals would hinge upon employer behavior (100). That is, employers may respond to incentives other than the payroll tax rate, such as employees' interests in having their employers sponsor group health insurance.

U.S. Bipartisan Commission on Comprehensive Health Care/Lewin-VHI (Pepper Commission.--The U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission) recommended the implementation of an employment-based approach incorporating a payroll tax to fund a public-sponsored plan (75). Lewin-VHI's estimates for the Commission assumed the imposition of a 7 percent payroll tax and mandatory acceptance of insurance by employees under either the employer's or the public plan. Accordingly, they found that employers who currently offer health insurance to workers and dependents would save an estimated 10.2 percent or $12.8 billion (1990 dollars) in employment-based health insurance costs per year. These savings were attributed to the fact that while some employers would have to improve coverage and insure some people not previously covered, overall, employers would no longer be making payments for the premium costs of employees' dependents who work for other firms and the costs shifted to them to fund uncompensated care, including the cost shift from Medicaid. On the other hand, newly insuring employers would have new costs of $27.5 billion (which is equal to an average of less than 4 percent of payroll after taxes) (75). As with similar employment-based approaches, the public plan option would limit an employer's risk with respect to employee health insurance benefit costs to the payroll tax due on the employer's eligible employees.

While the Pepper Commission recommended the implementation of an employer mandate, it likewise recommended different treatment for large (defined as firms with 100 or more employees) versus small (defined as firms with fewer than 100 employees) employers. The Commission found that larger firms were more likely to provide health insurance now, and therefore, they were more likely to benefit from the Commission's recommendations. Lewin-VHI estimated net savings to large employers of $5.6 billion (1990 dollars) or 5.8 percent of their health care spending. Since smaller firms were less likely to provide health insurance currently, their costs would increase pursuant to a mandate. Thus, the Commission recommended incentives (as opposed to a mandate), initially, for smaller firms to provide insurance. It further recommended that a mandate should be imposed if the incentives did not work after a specified period. Lewin-VHI estimated that if small employers were to offer health insurance in response to the incentives provided under the plan, their costs would increase $18.8 billion (1990 dollars), after taxes, or by 1.8 percent of payroll (75).

The Commission noted that the plan would also affect current health benefit plans that did not meet the minimum-benefit and premium-sharing standards of the Commission's plan. Including these plans in the estimates of increased costs for small firms would bring their additional costs to about $20.6 billion (1990 dollars), after taxes, or 2.1 percent of payroll. Note that the Commission recommended that tax subsidies be available to some small employers.

American Academy of Family Physicians/Lewin-VHI (AAFP--Lewin-VHI prepared estimates of the impact on employers of the employment-based approach proposed by the American Academy of Family Physicians (36,37). The estimates were based upon a plan fully phased-in in 1993 using a payroll tax rate of

10 percent. The AAFP plan would allow only businesses with fewer than 25 employees, rather than all employers, to opt for the public plan. Lewin-VHI estimated that 1993 aftertax employer costs under the AAFP plan would be $2.83 billion for all firms that *currently insure,* and $20.9 billion for all firms that do *not currently insure. The* majority of the total increased cost, or $10.5 billion, would be on firms with fewer than 10 workers who do not currently insure. Firms that do not now insure would, for every firm size category, incur increased and substantially higher costs than firms that currently insure. For firms that currently insure, in a couple of size categories (25 to 99 and 500 or more employees), the costs would decrease.

Approaches Employing Individual Vouchers or Tax Credits

Silow-Carroll (Bush Administration)--Silow-Carroll, analyzing the impact on employers of the Bush Administration plan, found that for the period from 1994 through 2003, employers would realize a net savings in health care spending compared to 'business as usual' (65). The author found that the plan would ease access to insurance at more affordable prices for employers, especially for small groups, but that it was not clear how many employers not currently offering insurance would do so absent a mandate.

Silow-Carroll estimated that in an "Optimistic Scenario,' [18] total health care costs for all employers would decrease $2.0 billion in 1994 with cumulative pretax savings of about $300.0 billion ($200.0 billion in 1994 dollars) through 2003. Cumulative net savings (after taxes and after the distribution of a portion of employers' savings to labor) would range from $35.0 to $84.0 billion (1994 dollars) through 2003 under the "optimistic Scenario," depending upon the distribution to labor.

In a' 'Pessimistic Scenario,' [19] the cost of expansion of employment-based coverage would fully offset any gains from cost containment in 1994 and savings achieved thereafter would be minimal. Thus, the author estimated, under this scenario, cumulative pretax savings to employers through 2003 of about $33.0 billion ($22.0 billion in 1994 dollars), However, net savings to employers in this scenario would be no more than $1.0 billion (1994 dollars) per year. Thus, cumulative net savings to employers under the "Pessimistic Scenario' would be fairly insignificant; that is, they would range from $4.0 to $10.0 billion (1994 dollars) through 2003, again depending upon the distribution to labor.

Heritage Foundation/Lewin-VHl (Heritage Foundation)—The Heritage Foundation plan makes individuals, assisted by tax subsidies, responsible for the purchase of health insurance, rather than employers (6). The plan requires employers, in the first (transition) year of the plan, if they cancel their group plan or an employee switches to another plan, to include the cash value of the employer's contribution to the plan in the employee's income. It further requires employers to pay the increased FICA (Federal Insurance Contributions Act) tax liability of the employee accruing from the increase in cash wages. Except for these initial adjustments affecting employers, the Heritage plan eliminates the current tax deduction available to employers for employee health benefits. Thus, direct payment for health insurance coverage no longer rests on employers in a significant and direct way. If employers *choose* to continue to fund employee health insurance, such benefits would no longer be deductible by employers and their value would be deemed taxable income to employees.

Accordingly, Lewin-VHI, on behalf of the Heritage Foundation, assumed that private employer expenditures for health care, estimated at $124.3 billion in 1991, would, for the most part, be converted to wages (35). Employers would be responsible for increased OASDI (Old Age, Survivors and Disability Insurance) and HI (Hospital Insurance Trust Fund) payroll taxes of $10.9 billion that Lewin-VHI assumed would be absorbed by employers as reduced profits. As a result, employer corporate income taxes would decrease by $3.1 billion, producing a net cost to employers in 1991 of $7.8 billion (or $104.80 per worker).

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18 ''Optimistic Scenario'' assumed 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" (65).

19 ''Pessimistic Scenario'' assumed that ''much of the savings in the Bush plan are one-time in nature, and that after these efficiencies are achieved, the cost curve returns to its present course'' (65).

Managed Competition Approaches

Long and Rodgers—In a recent analysis of a Managed Competition approach, based upon an earlier draft of an analysis by Sheils and his colleagues, Long and Rodgers estimated that business private insurance costs would increase by $8.0 billion in 1993 (40,41,63). This estimate was for a plan incorporating an employer mandate with a 7 percent cap on employers' costs, and assumed savings from Managed Competition of 8 percent based upon the experience of *group-model* health maintenance organizations or, in the alternative, from administrative costs-savings associated with employer plans.

Sheils and Colleagues--The analysis by Sheils and his colleagues did not estimate the impact on employers of Managed Competition (63). However, it assumed a 2 percent savings from Managed Competition based upon the experience of *all* types of health maintenance organizations. This assumption would likely lead to a greater increase in business's private insurance costs.

Specific Analyses of Impacts on Employment

Single Payer Approaches

Congressional Budget Office-In its study of a Single Payer system with provider payments at Medicare rates, the Congressional Budget Office maintained that such a system would narrow the insurer market, which would most likely result in significant shifts in investment dollars and employment to other areas of the economy (77). The study noted, however, that if private insurers continued to fulfill the claims processing function for the system, shifts in employment would be relatively small.

Silow-Carroll and Colleagues--Silow-Carroll and her colleagues projected that for a Canadian-style health coverage system, fully implemented in 1991, any costs savings accruing to the nonhealth sectors of the economy would "[c]ome largely at the expense of" people employed in health-related fields (67). "As prices of health care goods and services become more tightly controlled and much private insurance administration becomes obsolete (with uniform billing and claims, the elimination of medical screening, etc.), profits and some personal incomes (e.g., for physicians) within the health care sector will decline" (67). According to the authors, dislocation, unemployment, and stunted wage growth would occur among people employed in health insurance, medical product manufacturing, and direct health care services. However, the authors suggested that these consequences would be temporary, due to the relatively high skill levels of the people involved, and the resulting growth in other areas of the economy from an influx of additional discretionary income made available by decreased spending on health care.

Play-or-Pay Approaches

Morrisey—Morrisey maintained that newly insured workers would pay for an employer mandate to provide and contribute toward health insurance in the form of reductions in other forms of compensation, most importantly, in wages (46). Morrisey suggested that mandated insurance operates differently from the minimum wage; that is, it acts as a lump sum tax on each worker, and that it creates an incentive for employers to reduce the number of workers subjected to the mandate. Reduction in the number of workers to whom the mandate applies might be accomplished through a reduction in the number of hours worked by each employee, thereby creating more part-time employees who would presumably be exempt from the mandate; by increasing the use of consultants; and by contracting out certain tasks. According to Morrisey, the disemployment effects of a mandate would most likely have an impact at or around the minimum wage because the employer could not offset the benefit through decreased wages (46). Morrisey did not provide specific quantitative estimates of the disemployment effects of a Play-or-Pay approach.

Monheit and Short—Monheit and Short looked at the impact on employment of an employer mandate that did not include a public backup plan (45). They suggested that the mandate would have little or no effect on employment if there were no barriers to adjusting employee wages accordingly so that total compensation remained the same. This would not be the case though given the existence of the minimum wage legislation, Therefore, if employers were required to provide health insurance benefits, some decline in employment of eligible employees would be

likely. However, concluding from the labor economics literature that labor demand is not very sensitive to changes in employment costs, the authors estimated that under a mandate "2.4 percent of low-wage workers (197,000 people) might lose their jobs and that, even *under the most pessimistic assumptions* (no wage reduction for higher-paid workers and long-run adjustment of capital-labor ratios), the jobs of at *most 2.5* percent of affected employees (or 847,000 people) would be affected' (64). Note that the plan examined by Monheit and Short did not include a public backup plan, the existence of which might alter the effects predicted by the authors.

Zedlewski---In a study conducted under the auspices of the U.S. Department of Labor, Zedlewski looked at the distributional issues related to an employer mandate without a public backup plan (98). She found that certain characteristics of employees with employment-based coverage differ from those of employees without such coverage; that is, the latter tend to work for small firms in the retail and service industries, and are generally young, part-time employees who have worked for their employer for less than 1 year. Zedlewski postulated that if employers were required by a mandate to pay the same share toward the health care benefits of all workers, regardless of the number of hours worked by an employee, adverse employment effects might be expected (e.g., employers would use more hours per worker and reduce the size of their workforce). The extent of such employment effects would depend upon the amount of the increase in labor costs.

Zedlewski and Colleagues-Another study con-ducted under the auspices of the U.S. Department of Labor by Zedlewski and her colleagues noted that some employers would save money under a Play-or-Pay approach (100). These savings would enable employers to increase compensation and profitability. The authors suggested that universal access to health care provided through the employment-based, public backup plan approach would have other positive economic impacts (e.g., an increase in the demand for health care services which would result in an increase in the need for health care workers). On the other hand, the authors noted that small employers might have difficulty absorbing the new costs imposed on them by a mandate. This is because their average payrolls are relatively low, and they are less able to adjust wages and other compensation to pay the new benefit costs since more of their workers are at or near the minimum wage (100).

Klerman-Klerman, in a study also conducted under the auspices of the U.S. Department of Labor, estimated the employment effects of mandated health benefits based upon the experience of the minimum wage legislation (30). Klerman noted that, in general, it is thought that employers would shift compensation from cash wages to health benefits if they were mandated to provide health benefits they do not currently provide. However, this adjustment would not be possible for employees who are at or around the minimum wage because this would violate the minimum wage requirements. Therefore, Klerman concluded that it is likely that workers whose productivity is below the value of the combined mandatory compensation would be laid off.

Klerman went on to look at the anticipated extent of such disemployment and concluded that the group of workers who would be directly affected by mandated health benefits would be small. He estimated that the requirement would affect between 2 and 3 percent of *teenage* employment and would be even less among older workers. However, Klerman noted that the enactment of mandatory employment-based insurance at this time would follow a previously authorized, sizable increase (30 percent) in the minimum wage. Klerman cautioned that for a number of reasons related to both the analytic model and the data used, there is considerable uncertainty in calculating the employment effects for the group of workers whose current compensation would fall below the new combined (minimum wage plus mandatory employment-based health insurance) statutory levels, that is, one-third of uninsured persons and one-third of workers insured currently by a source other than their own employer. Moreover, Klerman maintained that the employment effects of the Play-or-Pay approach would be very sensitive to the implementation details of the specific plan.

U.S. Bipartisan Commission on Comprehensive Health Care (Pepper commission)--The U.S. Bipartisan Commission on Comprehensive Health Care

(Pepper Commission) reported that reductions in employment due to expanding employment-based insurance depend upon the number of minimum and near-minimum wage employees affected, as well as the increase in cost of providing insurance (75). The Commission cited surveys of the minimum wage literature which indicate that each 10 percent increase in the minimum wage reduces employment by 0.5 to 3 percent. And that the research indicated that the effects on adults were in the lower range. Based upon these surveys, the Commission estimated that 25,000 to 50,000 low-income workers could be displaced by its recommended coverage requirements. The Commission submitted, citing Bureau of Labor Statistics data that 39,000 jobs were created in June 1990, that this effect was small enough that it could be offset by job creation that would come about through the normal workings of the economy.

Sheils (HealthAmerica: Affordable Health Care for All Americans Act--On behalf of Lewin-VHI, Sheils testified that S. 1227 (HealthAmerica: Affordable Health Care for All Americans Act), a Play-or-Pay bill introduced but not enacted during the 102d Congress, would result in 23,000 to 63,000 jobs lost, based upon Lewin-VHI's review of empirical studies of previous increases in the minimum wage (60).

Heritage Foundation/Butler (HealthAmerica: Affordable Health Care for All Americans Act)- Butler of the Heritage Foundation contended with respect to S. 1227 (HealthAmerica: Affordable Health Care for All Americans Act) that the Play-or-Pay approach would,

> . . . regardless of the nature of the required basic plan, or the size of the tax imposed as an alternative to providing insurance, . . . set in motion an unintended cycle of adverse selection and employment discrimination. . . . Mandating extra employer-provided benefits, like increasing by law any other cost of hiring employees, depresses cash wages and/or reduces employment. Furthermore, the cost of those actions is borne not by employers but by the workers themselves, and the hardest hit are the lowest wage workers--the same ones who are most likely to lack health insurance. . . Before enacting such a system, I suggest that Congress stop to consider the possibility that low-income families might consider a job to be more valuable than a . . . health plan (5).

Joint Economic Committee/GOP Staff—Ac- cording to a health care briefing paper, prepared for Representative Richard K. Armey by the Joint Economic Committee/GOP (i.e., Republican) Staff of the U.S. Congress, over 710,000 workers would lose their jobs in the first year of implementation of a Play-or-Pay approach (87). This estimate assumed a 7 percent payroll tax and applied supply and demand elasticities regarding low-wage labor. The paper asserted that 43 percent of these job losses (308,265 jobs) would occur in small businesses that employ fewer than 20 workers,

Congressional Budget **Office--In a study of an illustrative** employer mandate coupled with Medicaid expansion, CBO found that the mandate would raise labor costs that could result in layoffs or reduced hours for affected firms and workers (76). This would affect small employers, in particular, which employ more than one-half of all uninsured workers. CBO suggested that exemptions for small firms would protect them but would also reduce the effectiveness of the employment-based approach for expanding coverage. While subsidies to small firms would reduce this problem, they would increase the Federal deficit.

Approaches Employing Individual Vouchers or Tax Credits

Bush Administration/U.S. Executive Office of the President (Bush Administration--The Bush Administration reform proposal maintained that the subsidy of health insurance for low-income workers through the tax credit would encourage reentry into the work force, particularly among Medicaid recipients who may lose coverage if they resume employment under current policy (94). The Bush Administration further maintained that broader health insurance should lead to productivity gains resulting from improved health status of uninsured unemployed persons and the working poor.

Specific Analyses of Impacts on Households[20]

Single Payer Approaches

Silow-Carroll and Colleagues--Silow-Carroll and her colleagues estimated that in a Canadian-style system, consumers would experience a net loss in the first year of the plan under a‘ ‘Pessimistic Scenario’ ’[21] but would ultimately experience again over ‘business as usual’ under both the ‘‘Optimistic”u and ‘ ‘Pessimistic” scenarios (67). Specifically, assuming a reduction in out-of-pocket health care expenses as indicated by the Canadian experience, and an increase in payroll and income taxes, the initial impact (1994) on households ranged from net savings of $10.0 billion, under the study’s “Optimistic Scenario,” to a net loss of almost $20.0 billion, under the study’s “Pessimistic Scenario. ” Depending upon the model followed with respect to distribution of gains to employees by employers (50 or 80 percent, respectively), cumulative estimates from 1994 through 2003 ranged, in current dollars, from savings of $3.0 to $3.6 trillion ($1.9 to $2.3 *trillion in* inflation-adjusted, 1994 dollars) under the ‘Pessimistic Scenario,’ to savings of $3.7 to $4.4 trillion ($2,5 to $2.9 trillion in inflation-adjusted, 1994 dollars) under the “Optimistic Scenario” (67). Individuals would be effected differently depending upon their specific circumstances (e.g., the most favorable financial impact would accrue to an individual who currently purchases family coverage independently, not through an employer).

Congressional Budget Off ice-In its report examining a system with government as sole payer using Medicare’s payment rate, the Congressional Budget Office estimated that in the aggregate, the population would have more funds to spend-$102 per capita in 1989-for purposes other than health care (77). However, CBO cautioned that the actual effects on individuals would vary considerably (e.g., if taxes are used to finance universal coverage then higher-income people would be more likely to pay additional taxes under this system).

Play-or-Pay Approaches

Zedlewski and Colleagues--Zedlewski and her colleagues, reviewing potential effects of a Play-or-Pay approach, simulated plans using two different premium rates, current (1989) and lower, and two different payroll tax rates, 7 and 9 percent (99). They found no significant difference among the four alternatives in individuals’ *insurance* costs (net of government subsidies to low-income persons), which ranged from 16.6 to 17.2 percent of total insurance costs. Note that these costs are not all new costs nor are they individuals’ *total* health care costs. According to these simulations, individuals’ insurance costs would be relatively unchanged under this approach regardless of the option selected compared with current policy. However, the authors pointed out that:

> Individuals will pay indirectly for all of the insurance costs shown. Employers will shift costs either to workers (in the form of lower compensa-

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20 Analysts tend t. use the words‘ ‘household” and ‘‘family’’ interchangeably even though they differ in their composition and, therefore, the total numbers of households and families in the United States differ. As defined by the U.S. Department of Commerce, Economics and statistics Administration, Bureau of the Census, ‘‘*[h]ouseholds* consist of all persons who occupy a housing unit. . . A household includes the related family members and all the unrelated persons, if any, such as lodgers, foster children, wards, or employees who share the housing unit’ whereas *families*, which are a subset of households, ‘‘are groups of two persons or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such persons . . . are considered as members of one family” (emphasis added) (91). In 1991, there were 95,669,000 households but 67,173,000 families in the United States (91). Thus, quantitative estimates of the impacts of health care reform on “households’ and ‘‘families” are not comparable. And when the same analysis uses both terms without defii either one, the basis for any estimates is all the more unclear.

21 ‘‘Pessimistic Scenario ” assumed that ‘‘after expanding coverage to the uninsured, we achieve only a 2 percent reduction in spending compared with business as usual in year one. Further reductions are experienced in the second and third years, ” and the rate of growth in future health care spending is slightly faster than the rate of growth in GDP (67).

22 ‘‘Optimistic Scenario’’ assumed ‘‘an immediate 10 percent reduction in spending, offset in part by an expansion in coverage, netting an 8 percent decline in total spending for 1994. The following two years would experience additional reductions of 5 percent each, representing a phasing-in of savings from conversion to a single-payer system, consolidation of duplicated services.. ., and other efficiencies. This scenario also assumes that after the first three years, the growth in health care spending would be reduced. , , to the same rate as the economy, or about 7 percent per year” (67).

tion) or to consumers (in the form of higher prices) (99).

Given that individuals ultimately pay for the health care they receive, a key issue for households is the way in which the burden of payment placed upon businesses and/or government is financed because it will affect the specific impact on individual households. According to the authors:

> . . . systems with higher payroll tax rates would rely more on a proportional tax scheme to finance health care, while lower payroll tax rates and higher government costs would be financed through the more progressive federal and state income tax system (99).

U.S. Bipartisan Commission on Comprehensive Health Care/Lewin-VHl (Pepper Commission)--Lewin-VHI, for the U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission), estimated that the Commission's employment-based reform plan, if fully implemented in 1990, would save individuals and families $19.3 billion (1990 dollars) (75). This figure equals the sum of reductions in employer and nongroup plan premiums and household out-of-pocket costs flowing from insurance reforms, improved reimbursement for public plan enrollees relative to Medicaid, and expanded employer-sponsored and public coverage, plus the increase in premium payments by nonworkers for their coverage under the public plan.

American Academy of Family Physicians/Lewin-VHI (AAFP)--Lewin-VHI examined the American Academy of Family Physicians' employment-based plan which incorporated global spending budgets. However, the analysis assumed the continuation of current reimbursement rates per unit of service in 1993, the first year of the plan, except with respect to services now provided under Medicaid for which the rates would be increased to Medicare reimbursement levels. Lewin-VHI estimated an increase in aggregate household spending for health care in 1993 of $2.3 billion (37). This figure reflects increases and decreases in various types of premium payments, new tax payments, and decreased direct payments for health care. The net impact in 1993 of the AAFP plan on families with differing income levels would be a decrease in average family health spending for families with incomes less than $30,000 (savings of $2.00 to $385.00), and an increase for families with incomes above that amount (spending of $130.00 to $672.00). Physician income would increase ($14.3 billion) in 1993 due to increased payment rates for services now rendered under Medicaid (36,37).

Approaches Employing Individual Vouchers or Tax Credits

Bush Administration/U.S. Executive Office of the President (Bush Administration)--kcording to the Bush Administration projections, then-President Bush's reform proposal would affect households by making coverage more affordable for uninsured persons. Through the plan's initiatives-tax credits, deductions or vouchers, and market and other reforms-the Bush Administration estimated that it would, after five years, insure 29.2 people previously uninsured. Of these, 15,3 million would have household incomes below 100 percent of poverty (defined by the plan designers as "[t]he income level at which individuals, couples, and families must begin paying income taxes" (94), and 5.6 million would be between 100 and 150 percent of poverty. Overall, the Bush Administration projected that 95 million individuals would benefit from the health insurance tax credit and deduction once it was fully phased-in. Then-President Bush's proposal provided examples of its potential impact on families including that it would make a basic health insurance plan accessible to families below the poverty level, that it would remove the incentive for parents receiving Aid to Families with Dependent Children (AFDC) to not return to work, and that for higher income families without employment-based coverage, affordable coverage would be more readily available through a tax deduction and access to group purchasing arrangements that offer broader risk pooling (94). No quantitative estimates of the impact on households in the aggregate or by income level were provided.[23]

23 The Bush Administration proposal provided some illustrative examples of the benefits specific families would be eligible for (94).

Silow-Carroll (Bush Administration)--According to Silow-Carroll, the actual impact of the Bush Administration plan on consumers' health care spending would depend, in part, upon whether the tax credit would enable individuals or families to purchase adequate coverage.[24]

Silow-Carroll's analysis of the Bush Administration proposal found that consumers would save initially under the study's "Optimistic Scenario,"[25] but not under its "Pessimistic Scenario," as compared with "business as usual" (65). That is, in 1994, consumers would realize savings of $7.0 billion. And they would realize savings in health care spending over the 10-year period from 1994 through 2003 under both scenarios with net cumulative savings ranging from $440.0 to $700.0 billion in current dollars (about $300.0 to $500.0 billion in 1994 dollars). While achieving some savings over time, the author maintained that certain subgroups, specifically Medicaid enrollees and possible Medicare enrollees, could suffer in terms of access and quality of care. This would be the likely result because, in order for the government not to raise taxes as promised in the proposal, it would attempt to reduce government spending through "efficiencies" in existing public programs (65).

Bipartisan Panel on Presidential Candidates' Health Plans/Lewin-VHl (Bush Administration)--In their analysis of then-President Bush's proposal for the Bipartisan Panel on Presidential Candidates' Health Plans convened by Families USA, Lewin-VHI projected that without any reform Legislation, American families' average health spending would be $10,601 (1992 dollars) by the year 2000, whereas such spending would be reduced to $10,398 in the year 2000 under the Bush Administration proposal (3).

Heritage Foundation/Lewin-VHl (Heritage Foundation)--The Heritage Foundation plan would require that individuals purchase insurance unless they are covered by Medicare or Medicaid, and would provide limited tax credits to heads of households (taxpayers) to assist in this purchase. Under the plan, individuals who have employment-based insurance currently would be "held harmless" initially; that is, in the first year of the plan, if an employee switches plans or an employer cancels its plan, the employer would add the cash value of the employer's share of the premium to the employee's income. According to Lewin-VHI's analysis of the plan, in 1991, assuming that all employers discontinue their health benefit plans, households' total health spending would increase by $129.9 billion. Such spending would be offset by increased wages of $148.7 billion resulting in net savings to households of $18.8 billion in 1991 (35).

Lewin-VHI also looked at the average net impact of the alternative tax credit options provided in the plan on families by family income. Under all alternative tax credit options, 1991 aftertax health spending would decrease for most families, but it would *increase in* some instances for very low- or high-income brackets (i.e., family income less than $15,000 or greater than $75,000).[26] The average net impact on all households under any alternative tax credit for which estimates were provided was $168.00 in aftertax savings in 1991. In the same year, the maximum estimated savings to families of $534.00 would accrue to households with from $30,000 to $39,000 in family income; the maximum estimated aftertax increased spending of $574.00 would be by households with family income of $100,000 or more.

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24 Silow-Carroll states with respect to the Bush Administration proposal that "[t]here is some doubt, however, that the amount of the tax credits and deductions specified in the proposal would be sufficient to purchase adequate coverage. With average group policies expecting to cost $2,445 for individuals and $5,327 for families in 1993 (HIAA, 1992), the proposed tax credits of $1,250 and $3,750, respectively, may not be enough to purchase even a basic package" (65).

25 Silow-Carroll made estimates for savings under the Bush Administration proposal with respect to two scenarios. The "Optimistic Scenario" assumed that in the first 5 years of the program, "the plan's cost containment features are relatively successful in both reducing current expenditures. . . and slowing down the rate of spending growth." The "Pessimistic Scenario" assumed "much of the savings in the Bush plan are one-time in nature, and that after these efficiencies are achieved, the cost curve returns to its present course" (65).

26 In 1991, 16.9 percent of families (or 11,352,237 families) had family incomes below $15,000 and 13.1 percent Of families (8,799,663 families) had family incomes above $75,000 (91).

Managed Competition Approaches

Bipartisan Panel on Presidential Candidates' Health Plans/Lewin-VHl (Clinton Campaign)--Then-candidate (now President) Clinton's reform proposals, as set forth during the 1992 presidential campaign, were analyzed by Lewin-VHI on behalf of the Bipartisan Panel on Presidential Candidates' Health Plans convened by Families USA (3). While they did not have a detailed plan to work with, Lewin-VHl assumed annual budget targets under which the rate of growth in health care costs would not exceed the rate of growth in average family income, and delivery of health care services by managed care networks, Based upon these assumptions, Lewin-VHI estimated that the reforms would reduce average health care spending per family, which is projected to be $10,601 (1992 dollars) in the year 2000 without any reform, to $9,219 (1992 dollars) (3).

Long and Rodgers--k their analysis of **a Managed** Competition approach assuming universal health insurance, with coverage sponsored through three systems, that is, employers or unions, public insurance (Medicare or Medicaid), and health insurance purchasing cooperatives, Long and Rodgers estimated that households' *private health insurance costs* would decrease by $6.0 billion in 1993 as compared with current law (40). This estimate assumed savings from Managed Competition of 8 percent based upon the experience of group-model HMOS or, in the alternative, upon the reduction in administrative costs for employer plans. Estimates of changes in total household health care spending were not made.

Specific Analyses of Impacts on Administrative Costs

Single Payer Approaches

Wool handler and Himmelstein—Woolhandler and Himmelstein compared the U.S. and Canadian health care systems in terms of their administrative efficiency by studying four components of administrative costs (insurance overhead, hospital administration, nursing home administration, and physicians' billing and overhead expenses) in the United States and Canada for 1987 (96). Based upon their calculations of the per-capita costs of health care administration in the United States and Canada (using two methods to arrive at physicians' billing and overhead costs), Woolhandler and Himmelstein found that for 1987, the United States would have saved $69.0 to $83,2 billion or 13.8 to 16.6 percent of total spending on health care if U.S. health care administration had been as efficient as Canada's. They identified the United States' "fragmented' or multipayer, micromanaged system as the primary culprit for this differential, as well as for the increase in the costs of the ''health care bureaucracy' in the United States from 1983 to 1987, claiming that it is inherently less efficient than the Single Payer system in Canada. Other factors cited as contributing to increased administrative costs are a lack of comprehensiveness in coverage and the extensive involvement of private insurers. Note that Woolhandler and Himmelstein did not look at the issue of added costs due to increased utilization, a likely and possibly significant outgrowth, in terms of its impact on systemwide savings, of the adoption of a system designed to cover all Americans at no direct cost to them.

Physicians **for a National Health Program/ Grumbach and Colleagues (PNHP)--The** Physicians for a National Health Program (PNHP) support a publicly administered, tax-financed national health plan providing universal coverage with a single public payer (24) (See also ''Specific Analyses of Impacts on National Health Care Spending and Savings," this appendix).

According to an analysis of the PNHP proposal by Grumbach and his colleagues, large administrative costs-savings would be possible during the proposal's implementation considering the administrative efficiencies possible under a Single Payer system. For example, "[providers would be relieved of much of the expense of screening for eligibility, preparing detailed bills for multiple payers, responding to cumbersome utilization review procedures, and marketing their services. ' In order to estimate administrative costs-savings under the plan, the analysis calculated hospital and physician administrative costs as a percentage of revenues or expenditures, respectively, in the United States and Canada in 1987. The analysis assumed hospital administrative savings of 11.2 percent for the United States based upon the difference in the percentage of revenues devoted to hospital administrative functions in California-20.2 percent-and

the percentage devoted to the same in Canadian hospitals-9.0 percent—in 1987. The analysis assumed physician administrative savings of 6.25 percent, based upon the difference between billing costs for physician time and practice expenditures of 8.25 percent of total physician expenditures in the United States, and Canadian physician costs for the same, or 2.0 percent of total physician expenditures. Thus, the analysis estimated potential provider administrative costs-savings of $40.0 billion under the plan versus under current policies. In addition, the analysis estimated that the administrative costs of the public insurance plan would be $8.0 billion or $27.0 billion less than under current policies. Combined, a total of $67.0 billion in administrative costs-savings could accrue under the PNHP *"if the system operated with the administrative efficiency of the Canadian system'* (emphasis added) (24).

However, when calculating the national health care budget for 1991, the first year of the plan, the authors did not assume an outright reduction in health care costs of $55.0 billion; that is, $67.0 billion in administrative costs-savings offset by $12.0 billion, assumed to be the cost of increased utilization by previously uninsured persons. Instead, the analysis assumed that reductions in administrative costs would be achieved by: 1) realizing the full amount of the change in insurance administration and overhead due to moving from multiple payers to a single public payer, 2) establishing hospital operating budgets at the 1991 Health Care Financing Administration's projected baseline level; and 3) reducing physician fees by 6.25 percent but setting the target for physician expenditures at 6.0 percent above the baseline for such expenditures (24). Presumably these levels of provider expenditures would prompt providers to make administrative changes in order to shift funds to clinical services to accommodate the increased utilization by previously uninsured persons within their budgeted or targeted expenditures.

U.S. General Accounting Office--A 1992 report of the U.S. General Accounting Office estimated costs and savings for the United States under a Canadian-style system, using Ontario's health insurance system as the basis for comparison (83). Focusing upon three major areas-insurance, physicians and hospitals--with respect to administrative costs, GAO estimated savings of $67.0 billion (1991 dollars) due to a substantial reduction in administrative and billing costs (83), It estimated that further savings (no dollar figure provided) would accrue to U.S. businesses and households, whose administrative duties would also be reduced. Furthermore, GAO noted but did not include in its calculations the value of hospital nurses' time devoted to administrative tasks.

GAO provided estimates of offsetting additional costs resulting from increased utilization, finding that the new costs of a Canadian-style system would be approximately equal to administrative savings. GAO maintained that new costs arise from increased utilization, that is, "induced demand" anticipated in a "free" care system. It calculated the costs of insuring the currently uninsured and eliminating cost-sharing provisions across the board. GAO indicated that its estimates of increased utilization due to the elimination of cost-sharing are the 'largest and most uncertain components of our national cost assessment" (83). GAO further noted that if the United States were to implement a Canadian-style system, it might want to retain certain features of its current system, that is, with respect to administrative costs, collection of detailed statistical and financial data from hospitals. Canada's information systems are less developed than those in the United States since, under the global budgeting approach, hospitals have fewer incentives to collect detailed patient-per-diem or per-case-cost information. Detailed information systems can enhance cost management but this was not factored into GAO's estimate (83).

Congressional Budget Off ice-The Congressional Budget Office looked at administrative costs, defined as overhead expenses of providers and insurers including public payers, in the context of achieving universal coverage using Medicare's payment rates in a Single Payer system (77). Based upon its calculations, CBO prepared *illustrative* estimates of changes in these costs. The study found that in a Single Payer system, insurers' administrative costs for those currently insured would decrease after the system was fully implemented. Various costs (e.g., eligibility determinations, marketing, risk assessment, claims payment, coordination of benefits, profit margin) would be significantly reduced or eliminated. The study assumed that insurers' overhead costs would decrease

from 6.7 to 2.3 percent of *personal* health expenditures in a Single Payer system. Similarly, providers' overhead expenses would decrease as a result of reduced collection costs. Some or all of these savings would likely be captured by government through reduced provider payment rates. The study did not calculate the transition costs, which it acknowledges could be substantial, which would follow from a change in the current payment system. According to the CBO illustrative estimates, a Single Payer system would produce a net reduction in overhead costs of $18.2 to $58.3 billion in 1989.

Meyer and Colleagues--Meyer and his colleagues, reviewing the implementation of a Canadian-style system in the United States, estimated that a fully phased-in system, with health care spending at no more than 8.7 percent of U.S. GDP, would yield $241.0 billion in savings the first year (1991) of which nearly one-half ($1 13.0 billion) would be derived from reduced administrative costs, especially private insurance overhead, hospital administration, and physicians' billing and overhead expenses (43). The authors also estimated administrative costs-savings for a scenario in which they assumed the implementation of a Canadian-style system which "focuses its initial reform efforts on reducing *administrative costs only.* Under this scenario, administrative costs would be reduced by about $90.0 billion (1991) (43).

Lewin-VHI--According to Lewin-VHI, 'prior studies have estimated the potential administrative savings under the Canadian model based upon the cost of administration in Canada. We find this approach unsatisfactory for three reasons' relating to the composition of administrative costs reported for Canada, U.S.-specific health care system factors (e.g., wage levels, investment in health care technologies), and the impact on claims adjudication of due process rights guaranteed by the U.S. Constitution (34).

Lewin-VHI estimated the administrative costs-savings of implementation of the Canadian system in the United States based upon "a detailed evaluation of how individual cost centers (e.g., billing, admitting, dietary, etc.) will be affected under the single-payer model" (34). Using this method, Lewin-VHI estimated administrative costs-savings of $46.8 billion for a proposal fully implemented in 1991.

Play-or-Pay Approaches

American Academy of Family Physicians/Lewin-VHI (AAFP)--Lewin-VHI analyzed the American Academy of Family Physicians' reform plan in terms of its impact on administrative costs (36). It found that the proposal would reduce health care administrative costs by eliminating certain insurer underwriting practices (e.g., medical underwriting, preexisting condition limitations, large premium variations across insurers) and by promoting use of electronic claims processing systems. The study estimated savings, if the plan was implemented in 1993, of $4.7 billion. These savings would be partially offset by administrative costs related to insuring the 35 million currently uninsured persons, estimated to be $1.9 billion (36). Estimates of net cumulative administrative savings for the period from 1993 through the year 2000 were $40.1 billion. Note that the net administrative savings projected to follow from implementation of the AAFP proposal result, primarily, from insurance marketplace reforms included in the proposal rather than from electronic claims processing requirements.

Zedlewski and Colleagues--In a Study of an employer mandate to contribute toward private or public insurance for employees, conducted pursuant to a U.S. Department of Labor contract, Zedlewski and her colleagues noted that the government might incur administrative costs to administer eligibility requirements for government subsidies. These potential administrative costs were not reflected in the study's spending/cost figures regarding the implementation of a Play-or-Pay approach (100).

Approaches Employing Individual Vouchers or Tax Credits

Bush Administration/Health Care Financing Administrate ion (Bush Administration)--Former President Bush's reform proposal included insurance market reforms as well as tax credits, deductions or vouchers, intended to expand the availability of private insurance (94). The Bush Administration estimated that its proposal would cut administrative costs by as much as 25 percent under its five major reform initiatives, four of which streamlined paperwork. The fifth dealt with insurance market reforms intended to reduce overhead costs by prohibiting insurers from

refusing coverage based on health status and by discouraging frequent changes of insurers by employers. Also included in this latter group of reforms was the creation of Health Insurance Networks for small businesses, which were intended to help reduce insurer administrative and marketing costs by promoting group purchasing of health insurance benefits.

Specific costs-savings estimates for the Medical and Health Insurance Information Reform Act of 1992, which embodied then-President Bush's major administrative reforms related to automating health care information but which was not enacted, were prepared by the Health Care Financing Administration (HCFA) (93). The estimates include an offset for fixed investment costs necessary to implement the reforms. Assuming that administrative costs would grow at the same rate as total health care expenditures, HCFA estimated savings from changes in administrative costs alone of $870.0 million ($0.87 billion) in 1993 with cumulative savings through the year 2000 of $74.4 billion.

Bipartisan Panel on Presidential Candidates' Health Plans/Lewin-VHl (Bush Administration)-lEwin-VHI, for the Bipartisan Panel on Presidential Candidates' Health Plans convened by Families USA, examined then-President Bush's reform proposal (3). Lewin-VHI estimated administrative costs-savings of $300.0 million ($0.3 billion) in 1993 from electronic claims processing reforms under former President Bush's plan, with savings of $3.0 billion per year by the year 2000. Lewin-VHI also estimated administrative costs-savings due to the implementation of the plan's insurance market reforms; they estimated that these reforms would yield savings of $4.0 billion in 1993, increasing to $7.5 billion in the year 2000. In general, Lewin-VHI estimated that the reforms included in then-President Bush's plan would reduce insurer administrative expense, currently said to be as much as 40 percent of insurance claims for very small firms (1 to 4 employees), to 18.9 percent. Reductions of increasingly smaller magnitude would accrue to all other firms up to 499 employees. While no similar savings would accrue to larger firms, neither would they incur any increased expense (3).

Heritage Foundation/Lewin-VHl (Heritage Foundation)--The Heritage Foundation's reform proposal includes tax credits, health insurance market reforms, and requires *individuals* **to** purchase insurance with employers, in particular those who now sponsor coverage, arranging payroll deductions for benefits payments. Estimates of the administrative costs-savings under the Heritage plan were prepared by Lewin-VHI (35). They assumed that administrative costs would be the same as under current policy for employees whose employers now arrange payroll deductions for health benefits payments. For others purchasing individual insurance, they assumed that administrative costs would be 21.9 percent of claims (down from as much as 40 percent, based upon estimates for groups with 1 to **4** members). Thus, Lewin-VHI estimated increased insurer administrative costs of $2.1 billion in 1991 under this reform proposal (6,35).

Managed Competition Approaches

Conservative Democratic Forum (H.R. 5936)-The Conservative Democratic Forum's bill, H.R. 5936 (the "Managed Competition Act of 1992"), proposed in the 102d Congress, was a Managed Competition approach with neither a global budget nor an employee mandate but with, effectively, a limit on the employer deduction for employee health insurance benefits. The bill's sponsors maintained that administrative costs-savings could be realized by reducing the paperwork currently necessary to satisfy the requirements of the estimated 1,500 health insurance companies in the United States (e.g., standard claims forms, electronic submission of data) (10). Specific estimates of this type of administrative savings under the bill were not available.

Sheils and Colleagues--Sheils and his colleagues analyzed a Managed Competition approach with no global budget but with an employer mandate, and a limit on the exclusion from employees' income of employer contributions to employees' health benefits to the cost of the lowest-cost plan in the area (63). The analysis found that under Managed Competition, insurer, hospital, and physician administrative costs would be reduced ''by extending large-group economies of scale to employee groups of all sizes and by reducing the number of insurers that providers must

work with" (63). The analysis assumed insurer administrative costs under Managed Competition would equal about 3.6 percent of covered claims, based upon administrative cost data for insured groups of 10,000 or more members. Thus, the analysis estimated ''potential net savings in insurer administrative costs of $11.2 billion" in 1993, under both their high- and low-cost-sharing scenarios. The authors noted that certain factors not factored into their analysis (e.g., State insurance premium taxes, utilization review and case management programs) could increase insurers' administrative costs (63).

Appendix C: Acknowledgments

OTA wishes to thank the individuals and organizations listed below for their assistance with this Report. These individuals and organizations do not necessarily approve, disapprove, or endorse this Report. OTA assumes full responsibility for the Report and the accuracy of its content.

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Appendix D: Acronyms and Glossary of Terms

Acronyms

AAFP —American Academy of Family Physicians
AFL-CIO —American Federation of Labor-Congress of Industrial Employees
CalPERS -California Public Employees' Retirement System (State of California)
CBO -Congressional Budget Office (U.S. Congress)
CDF -Conservative Democratic Forum (U.S. Congress)
CHAMPUS -Civilian Health and Medical Program of the Uniformed Services
DHHS —U.S. Department of Health and Human Services
ERISA —Employee Retirement Income Security Act of 1974
FICA —Federal Insurance Contributions Act
GAO -General Accounting 0ffice (U.S. Congress)
GDP -Gross domestic product
GNP -Gross national product
HBSM —Health Benefits Simulation Model (Lewin-VHI)
HCFA —Health Care Financing Administration
HI —Hospital Insurance Trust Fund (Medicare Part A)
HIAA —Health Insurance Association of America
HMO —Health maintenance organization
NHE —National health expenditures
NLCHCR —National Leadership Coalition for Health Care Reform
OASDI -Old Age, Survivors, and Disability Insurance
OTA -Office of Technology Assessment (U.S. Congress)
PPO —Preferred provider organization
VAT —Value added tax

Terms

Access to health care: Potential and actual entry of a population into the health care delivery system. Elements of access include availability, affordability, and approachability.

Accountable health plans: Organized systems of health care delivery and financing.

Actuarial cost of coverage: The expected dollar value of a health plan's benefits. The method for determining this value may be based entirely on a plan's provisions, or may adjust for the geographic location and demographic characteristics of enrollees, the actual health care utilization level by plan participants, or the type of plan under which the benefits are provided (e.g., fee-for-service plan vs. health maintenance organization).

Administrative costs: Expenses related to the management or supervision of the provision of health care coverage and services. Analyses of reform approaches, proposals or plans frequently do not share a common definition of what components constitute administrative costs but most commonly refer to insurer, including government programs and private plans, and provider, including hospital and physician, administrative costs.

Administrative costs-savings: Reductions in expenditures related to changes in the administrative costs associated with the provision of health care coverage and services.

Aid to Families With Dependent Children (AFDC): A federally-supported, State-administered program established by the Social Security Act of 1935 that provides financial support for children under the age of 18 (and their caretakers) who have been deprived of parental support or care because of the parent's death, continued absence from the home, unemployment, or physical or mental illness.

All-payer system: All insurers use the same payment schedule.

Analysis: A separation of a whole entity into its complex parts, and an examination of its elements and their relations.

Approach: An organized group of broad ideas designed to achieve specific goals with respect to reform of the health care financing and/or delivery systems.

Beneficiary: A person entitled to receive covered health care services and reimbursement for such covered services rendered under a health insurance plan.

Benefit package: In this report, benefit package refers primarily to the services and providers that are covered by a *health insurance* plan, and to the financia1 and other terms of such coverage (e.g., patient *cost-sharing,* limitations on amounts and numbers of visits or days). See also, *scope of benefits or coverage* and *depth of benefits or coverage.*

Benefits: The covered health care services and the amount payable by a health insurance plan to a beneficiary under the terms of the plan.

California Public Employees' Retirement System (CalPERS) Health Benefits Program: A health insurance program available to California's public employees and their dependents whose current strategy focuses on the maintenance of a large risk pool, the promotion of *managed care* strategies and a standard *benefit package* required to be offered by participating HMOs.

Canadian-style system: A health care financing system based upon the system in place in Canada which provides tax-financed universal coverage with the government as sole purchaser of services. Typically, in Canada, patients choose their own physicians and incur no deductibles or copayments. Physicians are paid according to a negotiated fee schedule and hospitals operate under global budgets, both of which are established by the provinces.

Cap: In this report, refers to a limit on the dollar amount an employer can deduct from its corporate income taxes or that an employee can exclude from his or her taxable income for an employer's contributions to an employee's health benefits' premiums.

Cavitation **payment:** A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served in a set period of time, usually a year, without regard to the actual number or nature of services provided to each person. This is the characteristic payment method in *health maintenance organizations.* Compare *fee-for-service.*

Civilian Health and Medical Program of **the** Uniformed Services (CHAMPUS): A Department of Defense program supporting private sector health care for dependents of active and retired members of the uniformed services.

Coinsurance: A fixed percentage of covered expenses paid by a health plan and an enrollee for covered expenses after any deductible has been met; for example, 80/20 coinsurance means 80 percent is paid by the plan and 20 percent is paid by the person covered by the plan. Compare *copayment.*

Community rating: A method of determining health plan premiums by basing the premiums on the average costs of health services for all subscribers within a specific geographic area. Under community rating, the premium does not vary for different groups or subgroups of subscribers based upon their specific claims experience. Compare *experience rating.*

Competition: If not qualified by some phrase (such as **nonprice competition),** competition as used by economists means price-competition (competition based on price). Enthoven has suggested that ''value-for-money **competition**' would be a more apt phrase of what is typically meant when economists refer to price competition. In standard economics, **pure competition** is characterized by many sellers (and buyers) of a standardized product,

free entrance to the market, and no collusion or price fixing.

Consumers: In this report, individuals who fund, either through out-of-pocket expenses or indirect payments (e.g., taxes), health care coverage and/or services and/or use them.

Copayment: A fixed dollar amount that a health plan enrollee is required to pay for a covered service (e.g., $10 per office visit, $3 per prescription drug).

Cost containment: The control or reduction of inefficiencies in the consumption, allocation, or production of health services that contribute to higher than necessary costs.

Costs: Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (e.g., allowable, direct, indirect, and operating costs). It is important not to confuse *costs* with charges which are the price of a service or the amounts billed for services rendered, which may or may not be the same as or based on costs.

Cost-sharing: The provisions of a health benefits plan that require the enrollee to pay a portion of the cost of services covered by the plan, typically exclusive of *premium cost-sharing* (sharing of the cost of a health care plan premium between the sponsor and the enrollee). Usual forms of cost-sharing include deductibles, coinsurance, and copayments. These payments are made at the time a service is received or shortly thereafter, and are only made by those insureds who seek treatment.

Cost-shifting: The condition which occurs when health care providers are not reimbursed or are not fully reimbursed for providing health care so charges to those who do pay are increased.

Coverage: Promise by a third party to pay for all or a portion of expenses incurred for specified health care services.

Covered services: Services eligible for reimbursement by a health plan. See *benefit package.*

Current dollars: The value of dollars spent or received at the time of the transaction, without adjusting for inflation or deflation since the transaction date. Compare *inflation-adjusted dollars.*

Current Population Survey: A cross-sectional survey which can provide a series of snapshots of the socioeconomic conditions that exist at different fixed points in time. The survey is conducted by the U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census.

Deductible: A specified amount of money (e.g., $200, $500, $1,000) that must be paid during a given time period (usually a year) by the enrollee and/or his or her dependents for covered services before any payments are made by a health plan.

Depth of benefits or coverage: Refers to the level of patient *cost-sharing* required under a health insurance plan (i.e., the deductibles, copayments, coinsurance, out-of-pocket maximums, maximum liability of the insurance plan).

Direct spending on health: Includes the amount directly paid for health insurance premiums by a household, as well as other out-of-pocket expenses for health services.

Employer mandate: Refers to a requirement that employers offer health insurance to employees and, in some cases, contribute toward the cost of employees' health benefits' premiums,

Employers' share of health insurance premiums: The employers' share of health insurance premiums is the share of the premium charged by the insurer that the employer, rather than the covered employee, is on record as contributing. The term employers share can be a misnomer, however, because, according to most economists, the employers' share of the premium is part of the total employee compensation package, and thus paid, ultimately, by the individual insured. The employment setting is the most frequent form of group sponsorship of health insurance purchases.

Employment-based health insurance plan: A group health plan that is sponsored by an employer for its employees and their dependents,

Enrollee: An individual who qualifies for benefits under a health benefits plan and has taken any required action to register or otherwise signify his or her participation in the plan.

ERISA: Employee Retirement Income Security Act of 1974. Exempts companies that self-insure, or fund their own insurance plans, from State regulations. Most large companies began to self-insure in the 1980s. Now, 70 percent of firms with 5,000 or more workers do it. Only Hawaii has an ERISA waiver, allowing it to regulate such plans.

Expenditure: In the context of health care, monies spent on the acquisition of health care coverage

and/or services. See *national health expenditures.*

Expenditure limits: With respect to health care, expenditure limits include various mechanisms which limit the maximum amounts that may be spent to acquire health care coverage and services (e.g., negotiated fee schedules, hospital global operating budgets, national health budget).

Expenditure targets: With respect to health care, established goals as to how much money may be spent on health care coverage and services.

Experience rating: A method of adjusting group health plan premiums based wholly or in part on the historical utilization data of the specific group. Compare *community rating.*

Family: As defined by the U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census, a family is a group of two persons or more (one of whom is the householder) related by birth, marriage, or adoption and residing together, all such persons (including related subfamily members) are considered as members of one family. Beginning with the 1980 Current Population Survey (CPS), unrelated subfamilies (referred to in the past as secondary families) were no longer included in the count of families, nor are the members of unrelated subfamilies included in the count of family members. The term is often used interchangeably with *household.*

Federal poverty level: The official U.S. Government definition of poverty based on cash income levels for families of different sizes. Responsibility for changing poverty concepts and definitions rests with the Office of Management and Budget in the Executive Office of the President of the United States. The poverty thresholds for the continental United States in 1992 were $8,810 for one person, $9,190 for two persons, $11,570 for three persons, and $13,950 for four persons. Alaska and Hawaii have higher thresholds.

Fee-for-service: A method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of services are provided or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita or other prepayment systems, where the payment to the practitioner is not changed with the number of services actually rendered. Compare *cavitation payment.*

Fee-for-service plan: As used by the Office of Personnel Management and others, a traditional or conventional health insurance plan that permits employees to select providers of services and pays the providers according to the fees charged for such services. The term is used to distinguish such plans from HMOS, under which the enrollee generally must obtain services from the HMO providers whose payments from the HMO are not necessarily directly related to the type or quantity of services actually provided.

Financing (of health care): Refers to where the money to pay health care providers for the delivery of health care services comes from (e.g., government/taxpayers). Compare *payment.*

Fiscal year: Any accounting period of 12 successive calendar months, or 52 weeks, or 365 days, used by an organization for financial reporting. Beginning with October 1, 1977, the Federal fiscal year extends from October 1 through September 30.

Fringe benefits: Noncash benefits provided to a worker by an employer.

Global **budget:** Generally, an overall budget limit on health care services, regardless of where the funds originate. Global budgets can take the form of a State or national maximum limit on total health care expenditures, but usually imply national limits. In some contexts, global budgeting has come to mean setting a limit on spending by sector (e.g., specific allocations for physicians, hospitals).

Gross **domestic product** (GDP): Covers the goods and services produced by labor and property located in the United States.

Gross national product (GNP): Covers the goods and products produced by labor and property supplied by U.S. residents regardless of whether produced in the U.S. or in foreign countries.

Group health insurance: Health insurance purchased through a group that exists for some purpose other than buying insurance, such as a workplace, labor union, or professional association. Currently, the majority of Americans under age 65 are covered by employment-based group health insurance.

Group-model HMO: An HMO that uses a single large multispecialty group practice as the sole (or major)

source of care for an HMO's enrollees. The group may or may not have existed prior to the formation of the corporately distinct HMO, and has an exclusive contract with the HMO. Some groups also see fee-for-service or preferred provider organization patients; others are not allowed to do so.

Health Benefits Simulation Model (HBSM): An analytic model developed by the private consulting firm Lewin-VHI in 1984. The purpose of the HBSM is to estimate the cost of access proposals, the impact of access proposals, distributional impacts, and to identify unintended consequences. It is a month-by-month simulation model including a household data file from the 1987 National Medical Expenditures Survey updated to the simulation year. There is a statistical match with the Small Business Administration's survey of large and small firms.

Health Care Financing Administration (HCFA): An agency within the U.S. Department of Health and Human Services (DHHS) that oversees the Medicaid and Medicare programs, and is responsible for making payments to the States for the Medicaid program, and to providers under Medicare for care rendered to program beneficiaries. HCFA is also responsible for assuring that health care services provided to Medicare and Medicaid beneficiaries meet professionally recognized and Federal standards of care and are delivered effectively and efficiently.

Health care provider: An individual or institution that provides medical services (e.g., a physician, hospital, laboratory, etc). This term should not be confused with an insurance company which "provides" insurance.

Health insurance: In this report, the term "health insurance" is used broadly to include various types of health plans that are designed to reimburse or indemnify individuals or families for the costs of medical care, or (as in HMOs) to arrange for the delivery of that care, including traditional private indemnity fee-for-service coverage, prepaid health plans such as HMOS, self-funded employment-based health plans, Medicaid, and Medicare. Private health insurance: With respect to health insurance, refers to a plan run or sponsored by an entity other than government. Public health insurance: With respect to health insurance, refers to a government-run or -sponsored plan.

Health insurance network (HIN): An arrangement that would aggregate the purchasing power of small businesses by allowing them to make group purchases of insurance. As proposed by the Bush Administration, these would have been voluntary arrangements.

Health insurance purchasing cooperative **Or group: An arrangement** to make group purchases of health insurance that would be established under a Managed Competition approach to health care reform. It would aggregate the purchasing power of large populations and provide economies of scale to small businesses and individuals.

Health maintenance organizations (HMOS): An organization that, in return for prospective per capita ***(capitation)*** payments, acts as both insurer and provider of comprehensive but specified health care services to a voluntarily enrolled population. Prepaid group practices and individual practice associations are types of HMOS.

Hospital Insurance Trust Fund (HI): The Federal hospital insurance trust fund is a trust fund of the Treasury of the United States in which the monies collected from taxes on the annual earnings of employees, employers, and self-employed persons covered by Social Security are deposited. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the hospital insurance program (Medicare Part A). See *Medicare.*

Household: As defined by the Bureau of the Census within the U.S. Department of Commerce, all the persons who occupy a housing unit (i.e., a house, an apartment or other group of rooms, or a single room occupied or intended for occupancy as separate living quarters).

Individual insurance: Policies purchased without the benefit of group sponsorship that provide protection to the policyholder and/or his or her family. Sometimes called personal insurance as distinct from group insurance.

Individual Vouchers or Tax Credits approach: Approach to health care reform that focuses on tax incentives to encourage the purchase of coverage and expand access to it. Usually combined with some insurance market reforms.

Inflation-adjusted dollars: Dollars expressed in terms of their purchasing power in a base year. They are adjusted for changes in buying power due to inflation (or deflation) between the base year and the year of measurement.

Insurance: Protection by written contract against the financial hazards (in whole or in part) of the happening of specified fortuitous events.

Insurer: An insurance company, HMO, government program, or "self-funded" group (e.g., employer) responsible for providing protection against financial loss.

Internal Revenue Code of 1986: The most recent codification of the U.S. statutes pertaining to taxation including any amendments thereto since 1986,

Jackson Hole Group: Described by the group itself as an *ad hoc* and changing group of health executives, leaders, and experts who have been meeting (over the past several years) to discuss and address the deficiencies of the health system.

Managed care: A general term applied to a range of initiatives from organized health care delivery systems (e.g., HMOS) to features of health care plans (e.g., preadmission certification programs, utilization review programs) that attempt to control or coordinate enrollees' use of (and thus to control the cost of) services.

Managed Competition approach: An approach to health care reform that would combine health insurance market reform with health care delivery system restructuring. The theory of Managed Competition is that the quality and economy of health care delivery will improve if independent groups compete with one another for consumers in a government-regulated market.

Market: In economics, an area within which buyers and sellers are in such close communication that prices of the same goods tend to equality throughout the area. Some markets are virtually worldwide, others are national, and some are local or regional. Many economists have noted that markets for health care differ from markets for most other goods. For example, the market in health care is subject to considerable problems regarding the lack of knowledge (and, sometimes, lack of rationality) among consumers, and the influences of health care providers as agents of patients.

Medicaid: A joint Federal-State program of Federal matching grants to the States to provide health insurance for categories of the poor and medically indigent. States determine eligibility, payments, and benefits consistent with Federal standards.

Medicare: A Federally administered health insurance program covering the cost of services for people who are 65 years of age or older, receiving Social Security Disability Insurance payments for at least 2 years, or have end-stage renal disease. Medicare consists of two separate but coordinated programs--hospital insurance (Part A) and supplementary medical insurance (Part B). Health insurance protection is available to insured persons without regard to income.

Medigap: A private health insurance policy (also called a Medicare supplemental policy) designed to pay for services not covered by the Medicare program. Medigap policies generally cover some or all of Medicare's cost-sharing requirements and may also cover other costs or services not covered by Medicare (such as dental services).

Minimum benefit package: A health insurance benefit package consisting of specified benefits which must be offered.

National health budget: Establishes a dollar amount to be spent on health care nationally, usually geared to a limitation on the percent increase in the rate of growth of national health expenditures.

National health care: A system in which government both finances and delivers health care (e.g., the system in place in the United Kingdom). This term is sometimes used as a synonym for the Canadian-style system, even though the Canadian Government does not deliver care.

National health expenditures: An estimate of national spending on health care made up of two broad categories: 1) health services and supplies, which, in turn, consist of personal health care expenditures (the direct provision of health care), program administration and the net cost of private health insurance, and government public health activities; and 2) research and construction of medical facilities.

Negotiated fee schedule: Fees set through an organized bargaining process, Usually used to help determine a global budget. Also called negotiated payment schedule.

Out-of-pocket expenses or spending: Payments made by a plan enrollee, beneficiary or insured for medical services that are not reimbursed by the health plan. These may include payments for deductibles and coinsurance for covered services, for services not covered by the plan, for provider charges in excess of the plan's limits, and for enrollee premium payments.

Payer: The person (e.g., patient) or organization (e.g., self-funded employer, insurance company, government) that makes full or partial payments for health care services rendered to and/or for health commodities received by a patient.

Payment **(for health care): The** amounts and methods used to pay for health care that is supplied. Compare *financing.*

Payroll tax: A tax which is a direct function of the size of an employer's payroll.

Per-capita: On an individual basis.

Plan: In this report, used to refer to a specific variant of an *approach* to health care reform. Distinct from a health benefit or health insurance plan. Also called a *proposal.*

Play-or-Pay approach: Approach to health care reform that would provide employment-based health benefits coverage combined with public programs to cover the uninsured. Employers can either "play" (provide coverage for their employees in the private market) or "pay" (pay into the public health insurance program), most often through a *payroll tax* which sets a maximum limit on employers' liability for coverage, as a percent of payroll.

Preexisting condition: A physical and/or mental condition of an insured which first manifested itself prior to the issuance of the insured 's policy or which existed prior to issuance and for which treatment was received.

Preferred provider organization (PPO): A term that refers to a variety of different insurance arrangements under which plan enrollees who choose to obtain medical care from a specified group of participating providers receive certain advantages, such as reduced cost-sharing charges. Providers usually furnish services at lower than usual fees in return for prompt payment by the health insurance plan and a certain assured volume of patients.

Premium: The price or amount which must be paid periodically (e.g., monthly, biweekly) to purchase insurance coverage or to keep an insurance policy in force. Virtually all health insurance programs require the payment of a premium by the enrollee, insured or beneficiary and/or by someone else (such as the employer) on the individual's behalf. Premiums paid to *health maintenance organizations* or similar organizations are often called *cavitation* payments.

Premium cost-sharing: The sharing of the cost of the health plan premium between the employer or other group sponsor and the enrollee.

Price-competition: See *competition.*

Proposal: In this report, used to refer to a specific variant of an *approach* to health care reform. Also called a *plan.*

Prospective payment system: A payment system under which health care providers are paid for their services according to a predetermined fixed amount. Although prospective payment rates may be related to the costs providers incur in providing services, the amount a provider is paid for a service under a prospective payment system is unrelated to the provider's actual cost of providing that specific service. Medicare and CHAMPUS use prospective payment systems to pay for inpatient hospital services,

Provider: See *health care provider.*

Quality of (medical) care: Evaluation of the performance of health care providers according to the degree to which the process of care increases the probability of outcomes desired by the patients and reduces the probability of undesired outcomes, given the state of medical knowledge. Which elements of patient outcomes predominate depends on the patient condition.

Revenue: As used in an accounting sense, the increase in assets (or decrease in liabilities) that results from operation. Revenues result from: 1) services performed by the Federal Government and 2) goods and other property delivered to purchasers.

Scope of benefits or coverage: Refers to the range of services, providers, and settings covered by a health benefit plan.

Self-insurance: Payment of employees' health care expenses through the use of a special fund established by an employer rather than by arranging for

an insurer to provide such coverage. The employer directly assumes the functions, responsibilities, and liabilities of an insurer, although an employer may arrange for another entity (e.g. insurer) to handle the administrative tasks associated with running the plan.

Single Payer approach: Approach to health care reform that would provide tax-financed universal coverage with government as the sole purchaser of services. A single entity, usually government-run, reimburses all medical claims. Consumers typically pay a uniform tax rather than premiums. Money goes to a single health care trust fund, used only for health care expenditures.

Small group market reform: In the context of U.S. health care financing reform, these are measures aimed at alleviating problem areas in the private insurance marketplace. Typically, they include: guaranteed issuance of policies, regardless of health status; limitations or prohibitions on benefit plan limitations or exclusions for preexisting health conditions; and an end to experience-rating (although some form of risk-adjusted community rating is often proposed).

Sponsors: The employers (or sometimes unions) who offer group health benefit plans.

Staff-model HMO: An HMO in which physicians practice solely as employees of the HMO and are paid a salary.

State-mandated benefits: Certain minimum benefits that health insurers (but not self-insured groups which are exempt under ERISA) are required by State law to offer in their insurance policies.

Tax credit: An amount that offsets or reduces tax liability. It is subtracted directly from the tax liability that would otherwise accrue, and thus, it is not contingent upon the marginal tax rate. When the allowable tax credit amount exceeds the tax liability, and the difference is paid to the taxpayer, the credit is considered refundable. Otherwise, the difference can be: 1) allowed as a carryforward against future tax liability, 2) allowed as a carryback against past taxes paid, or 3) lost as a tax benefit. See also tax *deduction* and tax *expenditure.*

Tax deduction: An amount that is subtracted from the tax base before tax liability is calculated.

Tax expenditure: Defined as reductions in individual and corporate income tax liabilities that result from special tax provisions or regulations that provide tax benefits to particular taxpayers. Further defined as a revenue loss attributable to a provision of the Federal tax laws that: 1) allows a special exclusion, exemption, or deduction from gross income or 2) provides a special credit, preferential tax rate, or deferral of tax liability. Examples of tax expenditures include the personal income tax exclusion for health insurance premiums paid by employers on behalf of employees, and the personal tax deduction for unreimbursed medical expenses.

Third-party administrator (TPA): A private firm that administers a group health plan on behalf of the insurer or policyholder. TPAs are responsible for at least some (if not all) administrative functions, but a TPA bears no financial risk associated with the insurance function.

Third-party payer: An organization (private or public) that pays for or insures the health care expenses of its beneficiaries. Third parties include Blue Cross/Blue Shield, commercial health insurers, Medicare, and Medicaid. The individual receiving the health care services is the first party, and the individual or institution providing the service is the second party.

Third-party payment: Payment by a private insurer or government program to a health care provider for care given to a patient.

Total compensation **package: The** total amount of compensation received by a worker for services rendered including wages or salary and fringe benefits.

Underinsured: People with *public* or *private insurance* policies that do not coverall necessary medical services, resulting in *out-of-pocket expenses* that exceed their ability to pay.

Uninsured: People who lack private *or public* health insurance coverage.

- **Universal coverage: An** all encompassing plan which would provide all 37 million uninsured Americans with health insurance.
- Utilization: Use; commonly examined in terms of patterns or rates of use of a single service or type of service (e.g., hospital care, physician visits, prescription drugs). Measurement of utilization of all medical services in any given period is sometimes done in terms of dollar expenditures. Use is also expressed in rates per unit of population at risk for

a given period (e.g., number of admissions to a hospital per 1,000 persons over age 65 per year or number of visits to a physician per person).

Utilization management: A set of techniques used on the behalf of purchasers of health benefits to manage health care costs by influencing patient care decisionmaking through case-by-case assessments of the appropriateness of care prior to, or sometimes following, its provision. See *utilization review.*

Utilization review: The review of services delivered by a health care provider or supplier to determine whether those services were medically necessary.

Value added tax: A tax which accumulates on goods as they move from raw materials through the production process. Each processor pays a tax according to the amount by which he has increased the value of items that were raw materials to him.

Voucher: A form or check indicating a credit against future purchases or expenditures.

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