CHAPTER 4

Health Care Reform

THE UNITED STATES SPENDS far more per capita on and devotes a much larger share of its income to health care than does any other country. In 1993, one out of every seven dollars that Americans spent—14.3 percent of gross domestic product (GDP)—went to health services. In 1991, the most recent year for which comparable international data are available, the United States spent 13.2 percent of GDP on health care, while no other industrialized country spent more than 10 percent. Indeed the average for all the industrialized countries of the Organization for Economic Cooperation and Development (OECD) was only about 8 percent. Yet despite this massive commitment of resources, the United States insures a much smaller fraction of its population than do most other industrial countries, and ranks comparatively poorly on such important overall indicators of health outcomes as life expectancy and infant mortality. Tens of millions of Americans remain uninsured and live in constant fear of bankruptcy should they become ill. Tens of millions more have inadequate insurance or risk becoming uninsured if they lose their jobs.

For the lucky Americans who have comprehensive benefits and little worry about becoming uninsured, the current system buys care of high quality and provides genuine health security. For others less fortunate, the system works less well or not at all. And even the lucky suffer from the shortcomings of the current system, as the costs of covering services for the uninsured and some of the costs for those served by government programs are shifted onto hospitals and other providers and ultimately onto private sector insurance premiums.

Health care spending is not only high but growing rapidly. In almost every year of the last three decades, health care costs have increased at more than twice the rate of total income. In the 1980s, real per capita health care spending increased at an annual rate of 4.4 percent in the United States, compared with an average of only 3.2 percent in Canada, France, Germany, Japan, and the United Kingdom. Current projections indicate that, without reform, the United States will devote nearly 18 percent of its GDP to health care by the turn of the century.

At the level of the individual, the family, and the firm, the inexorable growth in health care spending means ever-increasing insur-

ance premiums and ever-higher medical bills. And at the level of Federal and State and local governments, rising health care costs mean that health expenditures claim larger and larger budget shares, with less left over for essential competing demands like public safety, infrastructure maintenance and expansion, and improvements in education and training. Despite a sustained reduction in real discretionary spending, the Congressional Budget Office projects that escalating health care costs will be the dominant force pushing Federal budget deficits back up as the 20th century nears its end.

The facts speak for themselves: The United States faces a health care crisis that demands a solution, both for the health of its citizens and for the health of its economy over the long run.

For analytical purposes, this crisis can be divided into four separate but interrelated parts. First, the current system fails to provide health security for millions of Americans, both insured and uninsured. Insured Americans do not have health security when they face the prospect of losing their coverage if they lose or change their jobs. Some estimates suggest that such worries may reduce job mobility by as much as 25 percent. The health security of the uninsured is still more precarious: Even when they do manage to obtain care, the evidence indicates that they receive less treatment, are sicker, and suffer higher mortality rates than the insured. It is simply not true, as some claim, that all Americans get decent care when they need it.

Shortcomings in private insurance markets are a second and related problem. Under the current system people who are less healthy pay more, sometimes much more, for insurance than people who are healthy. Insurance for those with preexisting conditions is often either unavailable or available only at prices that put it out of reach for many Americans. And many insurance policies simply do not cover a variety of large financial risks—exactly the kinds of risks that insurance is designed to address in the first place.

The third problem in our current health care system is the lack of effective competition, which in turn weakens the incentives for both providers and consumers to make cost-conscious decisions. Inadequate competition is a major reason why the costs of the American health care system are so high. Studies suggest that a variety of common procedures are often performed in circumstances where they are inappropriate or of equivocal value on purely medical grounds. Fee-for-service providers clearly have an incentive to provide more care, including care that is inappropriate, because they are generally reimbursed for each additional test or procedure they perform. Consumers often do not have the information they need to evaluate whether a particular service is indicated, and some do not have the choice among providers that might allow them to

make cost-conscious decisions. In addition, many consumers have weak incentives to choose among health care services on the basis of cost, and among health care plans on the basis of price. Finally, because many insurance policies do not cover preventive care, consumers may underutilize cost-effective services at earlier stages of medical need.

The fourth problem with our current system is the burden it places on public sector budgets. Large and growing public health care expenditures force governments to make painful choices among cutting other spending programs, increasing revenues, or increasing budget deficits—each of which can have adverse consequences for long-term economic growth.

None of these four problems can be solved in isolation. For example, in the absence of systemwide reform, arbitrary caps on Federal health care programs, which some have proposed, would simply shift still more of government program costs onto the private sector. According to one recent estimate, uncompensated care and government programs that reimbursed hospitals below market prices shifted $26.1 billion onto the private sector in 1991. Caps on government programs would simply aggravate this problem. Similarly, any attempt to provide universal coverage without complementary measures to improve competition and sharpen the incentives for more cost-conscious decisions would mean even more dramatic increases in systemwide costs. And reforms designed only to address the most glaring shortcomings of private insurance markets would not solve either the problem of providing health security for all Americans or the problem of escalating public health care bills.

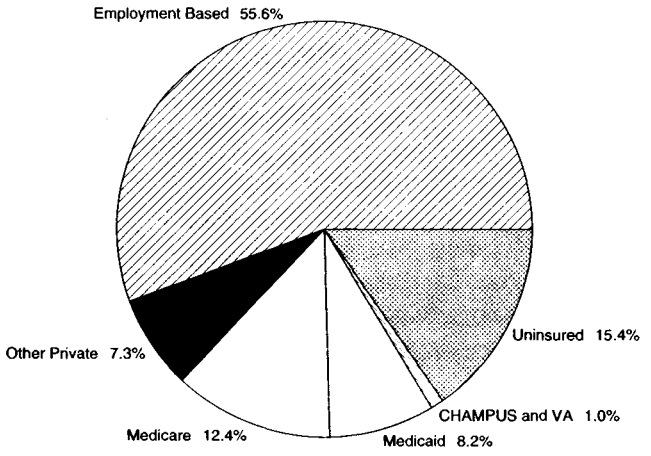
In short, a piecemeal approach will not work. Health care reform requires a comprehensive solution. At the same time, it requires a solution that preserves what is good about the current system and that maintains choice at all levels. This is indeed a daunting challenge, but one that the Nation can ill afford to ignore.

UNIVERSAL COVERAGE AND HEALTH SECURITY

Providing universal health coverage and security for all Americans is an essential objective of health care reform. Chart 4–1 shows the sources of health insurance for the American population. According to the Current Population Survey, over 15 percent of Americans—nearly 39 million people—were uninsured throughout 1992. That is one of the highest shares in the industrialized world. While some people remain uninsured for long periods of time, many more experience brief episodes during which they lack coverage, for instance when they lose a job. The Survey of Income and Program Participation (SIPP) found that over three times as many people

are uninsured at some time during a given year as are uninsured throughout the year. The SIPP estimates that more than one in four Americans were uninsured at some point in a 28-month period from 1987 to 1989.

Chart 4-1 **Distribution of Population by Source of Health Insurance Coverage: 1991**
Most Americans receive health insurance through their employers. Fifteen percent of Americans are uninsured.



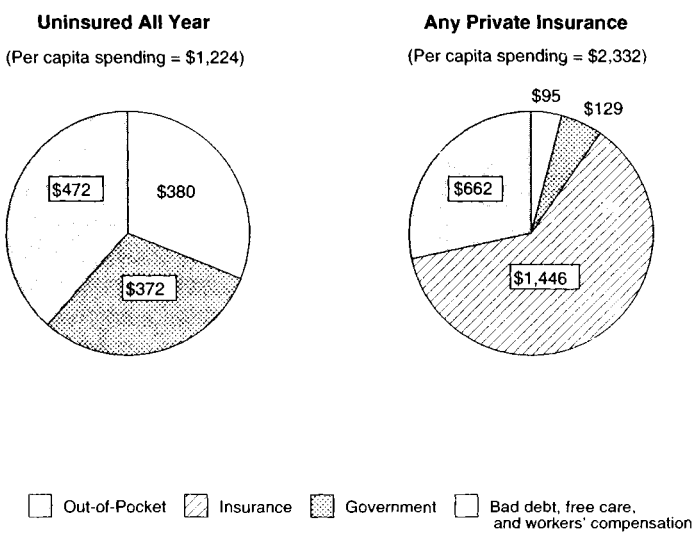
Note: Detail does not sum to 100 percent due to rounding.
Source: Employee Benefit Research Institute.

The fact that so many people are uninsured at least some of the time means that the prospect of being uninsured may influence the behavior of a large number of Americans. As long as people can lose their health coverage simply by changing employment, health insecurity will remain a barrier to changing jobs or starting new businesses. An important rationale for universal coverage is therefore to increase mobility and employment opportunities for those who already have insurance but do not have health security.

Similarly, many people remain on welfare because they will lose their medicaid coverage if they take a job. Some estimates indicate that up to one-quarter of recipients of aid to families with dependent children (AFDC) would take a job if private health insurance equivalent to that provided by medicaid were available to them. A second rationale for universal coverage is thus to reduce the number of people on welfare and to further the Administration's goal of welfare reform.

A third rationale for universal coverage is to improve the health of the uninsured. The uninsured do use health care—they do not simply do without. It is estimated that those without insurance for all of 1994 will consume about $1,200 of medical care per capita—60 percent of which will be paid for by governments and private payers, not by the uninsured themselves (Chart 4–2). This expenditure is roughly half the over $2,300 per capita consumed by those who are currently insured.

Chart 4-2 **Sources of Payment for Health Care by Insurance Status: 1994 Estimates**
About 60 percent of care for the uninsured is financed by governments, other private payers, bad debt, free care, or workers' compensation.



Source: Department of Health and Human Services.

While the uninsured do receive care, it is often neither timely nor appropriate. The uninsured are more likely than the insured to receive care in the emergency room, are less healthy when they are admitted to a hospital, and receive less treatment than people with similar diagnoses once admitted. Some studies indicate—and common sense suggests—that the health of the uninsured suffers as a result.

Indeed, without reform, the problem of adverse health outcomes for the uninsured is likely to worsen over time. Historically, governments and private payers have shouldered the burden of financing care for the uninsured. As health care costs continue to esca-

late, however, these payers may become less willing to bear this burden.

Perhaps surprisingly, providing universal health insurance to cover those currently uninsured will not require a large increase in total health expenditures. While the uninsured are poorer than the population as a whole, they are also younger and healthier. Almost all of the elderly already have insurance—through medicare. Among the nonelderly population, 24 percent of those with employer-sponsored insurance are between the ages of 45 and 64, compared with only 17 percent of the uninsured. Only 9 percent of the privately insured are between the ages of 18 and 24, compared with 18 percent of the uninsured. And while uninsured adults often perceive themselves to be in poorer general health than the population as a whole, they are less likely than the insured to have chronic conditions (Table 4–1). Estimates that account for these demographic and health factors generally find that insuring the uninsured would increase national health spending by less than 10 percent.

TABLE 4–1.—*Health Perception and Health Status by Type of Insurance Coverage, 1987*

[Percent]

Characteristic	Insurance coverage	
	Private, employment related	Uninsured
Self-reported general health perception:		
Fair	10.6	18.1
Poor	1.3	2.4
Any chronic condition	33.1	26.1

Note.—The sample is composed of adults aged 18 to 64.
Source: Department of Health and Human Services.

A fourth rationale for universal coverage is to solve the "free rider" problem. At least some of the uninsured could afford to purchase insurance but choose to go without because they feel they do not need it, and because they know that if they do become sick they will be cared for on an emergency basis at little cost to themselves. For some, relying on such "free" catastrophic insurance can be more attractive than purchasing insurance in the private market. By requiring that all individuals pay something for coverage, health reform can help eliminate this problem.

Finally, as discussed below, universal coverage is essential if everyone in the population is to share equally in the costs of insurance (Box 4–1).

Box 4–1.—Moral Hazard and Adverse Selection

All insurance markets face two potential problems. The first, called moral hazard, involves incentives. Insurance may encourage those who are covered to use insured services more than they otherwise would, or it may discourage the insured from taking steps to lower their need for such services. Insurance against any kind of risk—including health risks—always involves some element of moral hazard. When people use health services more than they would without insurance, the total amount insurers must pay increases, and they in turn must increase their prices. Furthermore, because individuals pay less than the full social cost of the services they receive, too much of society's resources will be devoted to such services.

The second problem is adverse selection. People who know that they are more at risk than others of falling ill are more likely to purchase health insurance. Therefore, insurers who set their prices at the average cost for the population as a whole are likely to discover that their prices do not cover their costs, because their customers are on average sicker than the population at large. To address this problem, insurers have incentives both to charge prices that exceed the cost of covering the average person and to select risks as best they can. The higher prices of insurance that result from adverse selection have the perverse effect of discouraging some healthy people from purchasing insurance. Because of the adverse selection problem, all people must be required to purchase insurance if each of them is to be charged the average cost of providing insurance.

INSURANCE MARKET REFORM

Private insurance markets have a number of shortcomings that impede the realization of universal coverage.

INSURING MAJOR RISKS AND PREEXISTING CONDITIONS

Economic theory suggests that *at a minimum* well-functioning insurance markets should insure against the expenses that accompany large medical risks because those are precisely the ones that cause the most financial hardship to individuals and families, are the least susceptible to moral hazard, and have the lowest administrative costs as a share of benefits. In our current system, however, private insurance markets often fail even when judged against this minimal standard.

About 80 percent of conventional health insurance policies have limits—generally ranging from $250,000 to over $1 million—on the amount that the insurer will pay over the policyholder's lifetime. Many insurers also initially exclude coverage of "preexisting conditions"—health problems that exist before the policy takes effect. A typical rule, for example, is to exclude for 6 months a condition that was present in the 6 months prior to joining a plan. Some estimates suggest that up to 80 million Americans have preexisting conditions that could be excluded from any new coverage or would require payment of a higher premium.

Both the exclusion of coverage for preexisting conditions and the limitations on maximum lifetime payments are ways that insurers respond to the adverse selection problem discussed in Box 4–1. Such practices also reflect the fact that insurers who know in advance about the likely health status of their potential policyholders can choose which risks they are willing to insure and which they are not, and can choose to charge different prices to different individuals based on this assessment.

Such common insurance practices may be privately optimal for individual insurers, but they are not socially efficient. People with preexisting conditions and people who have exhausted their lifetime insurance limits may still require care, and someone must bear the costs. If they cannot obtain private insurance and they have exhausted their own funds, either they will get insurance through public sector programs, such as medicaid, or the costs of their care will be shifted onto the premiums of those who are able to obtain insurance. By compelling all insurers to cover preexisting conditions and by eliminating limitations on lifetime payments, the government could reduce the adverse selection problem in private insurance markets and thereby improve how they function.

COMMUNITY RATING

A second essential component of insurance reform is "community rating"—charging everyone in a large group the same price regardless of individual differences in demographic or health status. Currently, health insurance is often experience rated—the price for members of a particular group is based in whole or in part on that group's expected utilization of insured services. However, there are strong reasons for requiring community rating.

The rationale for any kind of insurance is to spread costs throughout the insured population. Complete health insurance would spread the cost of care across everyone in the population, regardless of their health status. Similarly, complete insurance would guarantee that the price paid by each individual for coverage would be the average cost of such coverage for the population. In contrast, experience rating means that the price one pays for insurance var-

ies depending on one's health status. But at least for those health problems and their associated costs that individuals cannot influence by their behavior, experience rating is at odds with the basic function of insurance—to insure against risk.

In principle, of course, one can distinguish between those health risks that individuals can influence and those that they cannot, and apply experience rating to the former. In practice, however, this is often difficult to do, because it would require detailed monitoring of personal behavior. In addition, many major health risks, with the obvious exception of those associated with smoking, are linked quite imperfectly to individual behavior, or the medical profession's understanding of the linkage remains rudimentary. Based on these considerations, community rating of health insurance, and continued public programs to deter smoking, are appropriate elements of health insurance reform.

However, community rating is difficult to enact without complementary reforms. The adverse selection issue described in Box 4–1 is one potential problem, which universal coverage could address by requiring people to have coverage. A related problem stems from the fact that insurers who are compelled to charge a community rate will have incentives to seek out the healthiest consumers, because they can be covered for the lowest cost and thus are likely to yield insurers the highest profits. This risk selection may involve high administrative costs, for example in determining the medical history of each member of a group. Resources devoted to this activity increase the overall costs of health care without providing any additional health benefits.

Several steps could be taken to minimize the possibility of such selection. First, a system of "risk adjustment payments" could be designed—monetary transfers from plans that have a healthier mix of enrollees to plans with a sicker mix of enrollees. If risk adjustment perfectly compensated for true differences in health risk, it would eliminate the incentives for selection on the part of insurers.

Second, all insurers could be required to offer the same package of benefits, thereby eliminating the opportunity to use the variations in the benefits package to attract better risks. Finally, "guaranteed issue" and "guaranteed renewability" of insurance could be required—that is, people could not be denied the right to enroll initially or renew enrollment in a health plan because of demographic or health status.

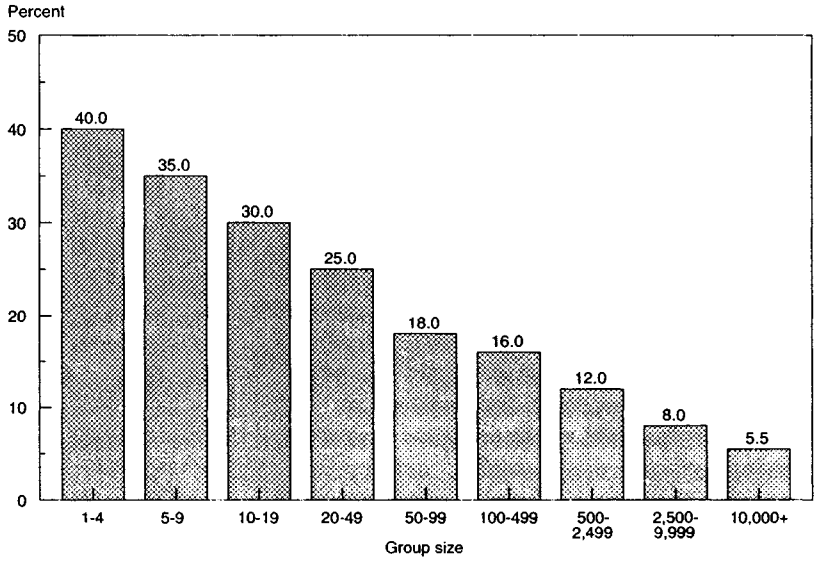
REDUCING ADMINISTRATIVE COSTS

In part because of the experience rating practices of insurance companies, there is insufficient standardization across insurers. Providers must deal with different insurers using different claim forms and covering different sets of services. Lack of standardiza-

tion results in high administrative expenses. In 1991 over 6 percent of all health care expenditures went for administrative expenses. This exceeds total spending on all public health service programs.

Standardizing benefits and billing procedures and increasing the automation of bill payment could produce substantial administrative savings. Grouping small firms and individuals into larger purchasing pools would have the same effect. As Chart 4–3 shows, the administrative load charged by commercial insurers for small groups (1 to 4 employees) averages about 40 percent of claims paid—in contrast to only about 5½ percent for large groups (over 10,000 employees).

Chart 4-3 **Administrative Expenses of Commercial Insurers as Percent of Claims Paid**
Administrative expenses are much higher in proportion to claims paid for small groups than for large groups.



Source. Hay/Huggins Company, Inc.

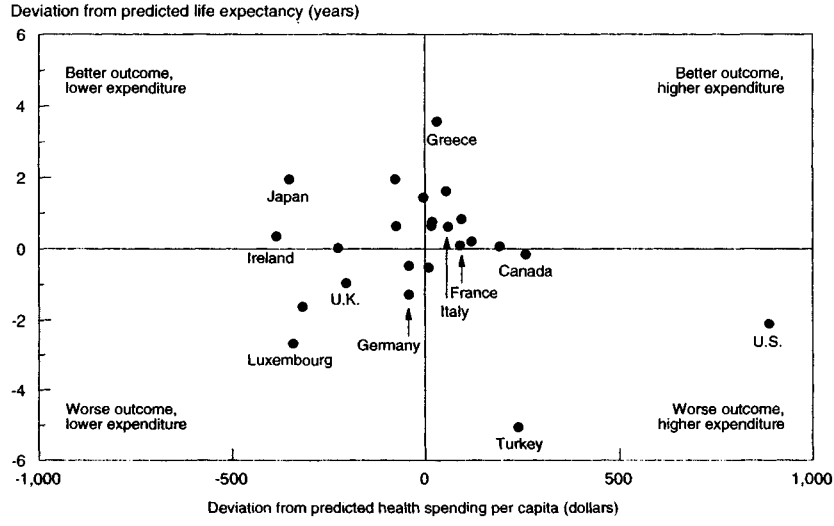
CREATING A MORE EFFICIENT MARKET AND CONTAINING COSTS

The third problem with the current health care system is that it appears to be far from efficient. As already noted, the United States spends a larger share of its GDP on health care than any other industrialized nation. If Americans valued medical care more

than people in other countries do, this might not be cause for concern. But the facts suggest otherwise.

Although the fraction of national resources devoted to health care in the United States is partially explainable by our higher income, Chart 4–4 reveals that the United States is an outlier—we spend considerably more per capita on health care yet achieve a somewhat lower life expectancy than our higher income would predict. Nor can these differences be explained away by the age of the American population. In fact, the percentage of the population over 65 is lower in the United States than in most of the other OECD countries. Since older people tend to use more medical care than younger people, the age distribution of the American population suggests that the United States should spend a smaller rather than a larger fraction of GDP on health care than do other industrialized countries.

Chart 4-4 **Health Expenditure and Life Expectancy in Industrial Countries**
The United States spends more on health care yet has lower life expectancy than would be expected given its level of income.



Note: Health spending and life expectancy are deviations from what would be expected given per capita income. The sample consists of the member countries of the OECD.
Sources: Organization for Economic Cooperation and Development and the World Bank.

It has been suggested that sociodemographic factors such as the greater prevalence of violence in American life may explain why health care spending in the United States is comparatively high. Existing research based on partial estimates suggests, however, that violent crime may add only about 2 percent to national health

expenditures. No comparative studies have assessed whether violence is a more important determinant of health care spending in the United States than elsewhere.

At least part of the higher health care costs in America stem from inefficiencies of various sorts. First, there are the administrative inefficiencies in the insurance market discussed earlier. Inadequate competition among providers and inadequate incentives for cost-conscious behavior by both providers and consumers are a second major source of inefficiency in the current health care system. Traditional fee-for-service plans, which pay providers for each test and procedure they perform, are used by 58 percent of private sector employees who receive health insurance through their employers. Such plans have built-in incentives encouraging providers to perform more care than may be appropriate. These incentives are sometimes reinforced by self-referral arrangements whereby providers prescribe tests or other services from laboratories or clinics in which they have a direct financial interest. For example, one study found that doctors who performed and charged for their own radiological tests prescribed them at least four times as often and charged higher fees than did doctors who referred their patients to unaffiliated radiologists.

Providers sometimes have an incentive to overprescribe tests and procedures because they fear malpractice suits. Available estimates suggest that such "defensive medicine" accounts for about 3 percent of total health spending.

Even when there are many providers in a particular health care market, competition among them is often weak. Only 53 percent of people insured through an employer, for example, can choose among alternative health care plans, and often the choice of a capitated plan, such as a health maintenance organization (HMO), is not available. Many small firms do not offer multiple policies. One study found that only 5 percent of workers in firms with less than 25 employees were offered any choice among health care plans. As a result, many consumers have only limited choices among both plans and providers. Consumers also may not have a choice of hospitals, since hospital selection is usually left to doctors, who choose on the basis of where they practice and may not choose on the basis of price.

Moreover, effective consumer choice depends on adequate consumer information. But many consumers rely primarily on their providers for advice about what services are indicated in a particular situation. Consumers often do not even know the prices of medical goods and services, and they seldom have the information they would need to evaluate the quality of the services they receive. This means that providers are often in a position to influence both the supply and the demand sides of their markets. In short, con-

sumers are ill equipped to bring strong competitive pressures to bear on providers to make cost-conscious decisions.

Nor do consumers themselves have strong incentives to exert such pressure. Even when they have a choice, consumers usually face weak incentives to opt for a low-cost health care plan. Many employers pay a fixed percentage—generally 80 percent—of whatever plan an employee chooses. Thus, when an employee selects a less expensive plan, 80 cents of each dollar saved goes to the employer and only 20 cents to the employee.

As the earlier discussion of moral hazard suggested, the current system of insurance may also encourage some consumers to use more care or more-expensive care options than they would if they were forced to pay higher out-of-pocket costs for services. On the other hand, if consumer copayments or deductibles were increased to reduce utilization, some of the value of insurance would be lost. Higher copayments might also discourage utilization of preventive services, with potentially adverse effects on health outcomes. Furthermore, even drastic increases in deductibles would provide only limited incentives. Table 4–2 shows that even if all families had a $5,000 deductible, only 29 percent of health dollars would be spent by individuals or families paying the full marginal cost of care.

TABLE 4–2.—*Distribution of Population and Health Spending by Spending Category, Estimates for 1994*

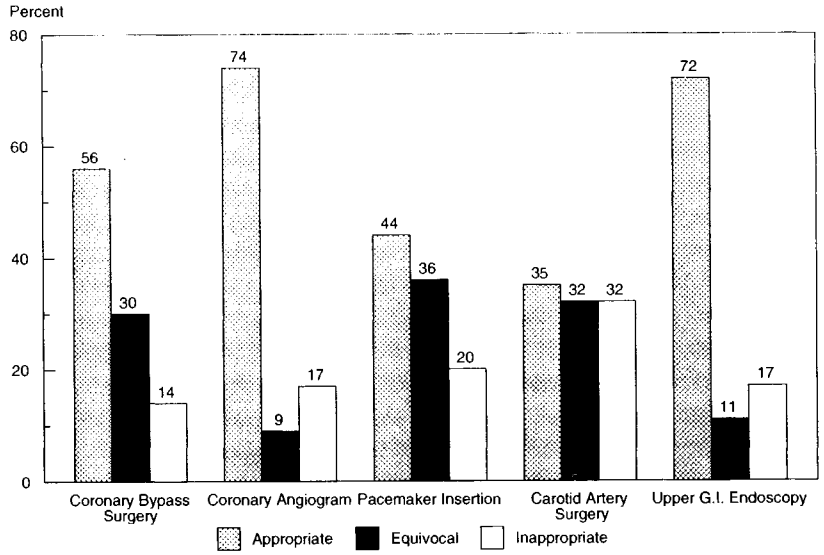
Annual health spending (dollars)	Percent of population	Percent of spending
0	7.8	0.0
1–500	26.0	1.4
501–1,000	13.1	2.5
1,001–3,000	25.2	13.4
3,001–5,000	10.4	12.0
5,001–10,000	9.3	19.4
10,001–30,000	6.5	31.0
Over 30,000	1.6	20.3

Note.—Health spending is in 1994 dollars. The estimates pertain to the noninstitutionalized population under the age of 65, excluding people who receive aid to families with dependent children or supplemental security income. The distribution presented is for health insurance units.

Source: Department of Health and Human Services.

Available evidence indicates that the weakness of effective competition in the health care marketplace results in substantial fraud and abuse as well as inappropriate care or care of equivocal value. Some estimates suggest that fraud and abuse may account for about 10 percent of total health care spending. And, as noted above and summarized in Chart 4–5, as much as one-third of some common procedures may be performed in cases where they are inappropriate or of equivocal value on medical grounds.

Chart 4-5 **Estimates of Inappropriate Care for Five Common Procedures**
Studies have shown that as many as one-third of some procedures may be inappropriate or of equivocal value.



Source: The RAND Corporation.

There are often large differences in the amounts of medical care that people receive in different regions of the country, and even in different areas within the same region. These geographic differences may be evidence of resource misallocation. In 1989, for example, medicare physician payments per capita were 57 percent higher in Detroit than in New York City. Other research has found that the level of use of hospital beds in a community is determined primarily by the number of beds in that community. People in areas with more hospital beds are not any healthier than people who live in areas with fewer beds, but they are more likely to die in a hospital.

EXPLAINING COST INCREASES

Not only are the costs of the American health care system high, but they are rising rapidly as well (Box 4–2). Several factors have been identified as possible sources of cost growth, including the aging of the population; the growth in incomes and the reductions in cost sharing by consumers; slow productivity growth in most health care services; and technological change.

By itself, the aging of the population can explain about 5 to 10 percent of the growth in health care spending. Some estimates of individual behavior based on controlled experiments suggest that roughly another quarter can be explained by more-rapid income growth and the reduction in the cost-sharing component of health insurance over the last 40 years.

Health care costs may also have risen rapidly because so much medical care consists of personally provided services rather than goods. On average, over long periods of time, the prices of personal services rise faster than the prices of goods because productivity advances more rapidly in goods production than it does in services. Unfortunately, there is no reliable estimate of the magnitude of this factor. If there were no productivity growth at all in the health sector, the relative price of health care would be expected to rise, on average, at the economy-wide productivity growth rate—about 1 to 1½ percent per year in recent years, which is about one-quarter to one-third of the observed increase in relative prices. There is, however, almost certainly *some* productivity growth in health care, so the so-called cost disease factor cannot account for even this much extra health inflation.

Finally, many health economists believe that technological change itself drives health care costs upward. Once again, however, no reliable measures of its quantitative importance are available. In theory, the introduction of a new technology may increase or decrease health care costs, depending on whether it substitutes for or complements existing methods of treatment and, if the former, on whether it costs more or less than the technology currently available. In addition, some technological change may consist of applying previously existing technologies to different diagnoses.

Technology's influence on future trends in health care costs is difficult to predict. Medical science is on the brink of new technologies made possible by the revolution in genetic research, and these may prove to be less costly substitutes for existing technologies. In addition, as historians of technological progress have demonstrated, technological change is not entirely exogenous—its form depends on the incentive environment in which it occurs. A health care reform that encourages more cost-conscious decisions by providers and consumers may in fact encourage new technologies that are more cost effective. Finally, an increase in competitive pressure in health care markets will exercise greater price discipline on both existing and new technologies and thereby moderate their effects on the growth of health care spending.

WHO PAYS FOR HEALTH CARE?

Table 4–3 shows who paid for health care in 1991, and where the money was spent. The largest amount of health care spending (38

Box 4–2.—Recent Reductions in Health Care Inflation

The rate of inflation in the health sector slowed in 1993, largely as a result of slower growth in prices for health services, including physicians and hospital care:

Inflation rate of:	Year ending December (percentages)		
	Average 1983–91	1992	1993
Total CPI	3.9	2.9	2.7
Health care	7.3	6.6	5.4
Excess of health care inflation over total	3.4	3.7	2.7

Source: Department of Labor.

Historically, health care inflation tends to move in parallel with inflation in the rest of the economy, but at a higher average level. In 1993 the gap between health care inflation and overall inflation narrowed somewhat, but the change does not appear to be statistically significant.

Some have argued that the recent slowdown in health inflation is a sign that reform of the health care system is not required. But despite the slowdown, the relative price of health care continues to increase: The medical care component of the consumer price index grew at twice the rate of total consumer price inflation in 1993. Moreover, this argument overlooks several other important motives for health reform: the lack of health security and universal coverage, the failures of the insurance market, and the burden of health care expenditures on government budgets. The cost problem will not be solved without reforms that increase competition in the health care marketplace.

percent) is for hospital care. Payments to physicians and other health care professionals are the second-largest category, at 29 percent of total spending. The remainder of personal health care is for home and nursing home care (9 percent), and drugs and other personal care outside of hospitals and nursing homes (12 percent). The costs of insurance administration are estimated at 6 percent of health spending. Finally, public health activities and research and construction total 6 percent of spending.

Health spending is financed in four principal ways. Businesses pay for health care directly through health insurance premiums ($153 billion in 1991) and workers' compensation and disability insurance ($18 billion). Total business spending ($171 billion) was about 23 percent of total health spending and 6.3 percent of total

TABLE 4–3.—*Sources and Uses of Health Care Funds, 1991*

[Billions of dollars]

Uses of funds	Total	Private spending					Government			
		Business		Household		Nonpatient revenue	Medicare	Medicaid	Employer	Other
		Premiums [1]	Workers' compensation	Premiums	Out-of-pocket					
Total	752	153	18	52	144	33	123	101	40	91
Hospital care	289	64	8	22	10	15	73	43	17	38
Physician care	142	42	7	14	26	0	33	7	11	3
Other professionals, dental visits	73	18	1	6	30	4	4	4	5	1
Home health and nursing home care	70	1	0	0	27	2	7	31	0	1
Drugs, vision, other personal care	87	6	1	2	52	2	3	12	2	7
Administration	44	22	1	7	0	1	3	4	6	0
Public health	25	0	0	0	0	0	0	0	0	25
Research and construction	23	0	0	0	0	9	0	0	0	14

[1] Includes household and employer premiums.

Source: Health Care Financing Administration.

compensation. Households pay for health care through insurance premiums ($52 billion in 1991) and out-of-pocket expenses ($144 billion). Total household spending of $196 billion was 26 percent of national health spending. The average household spent about $2,100 on health care in 1991. The health care industry receives additional nonpatient revenues of $33 billion (4 percent of total spending) from such activities as parking lot receipts.

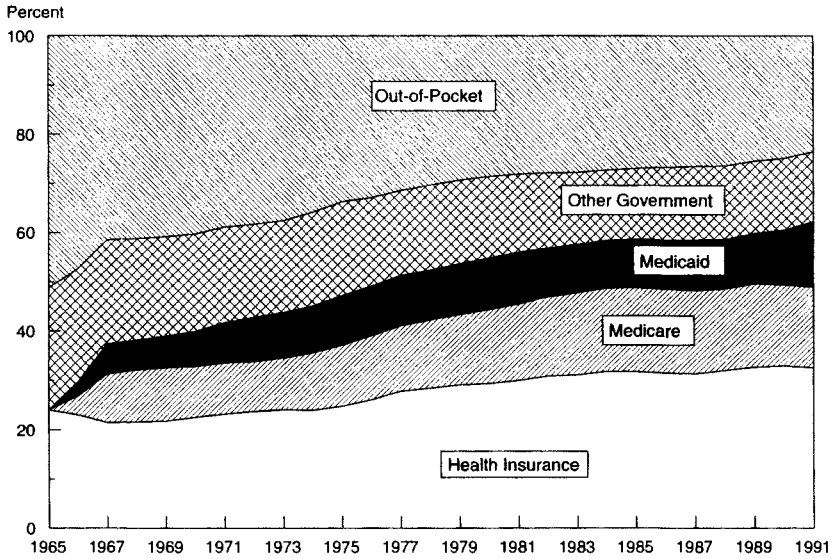
Finally, governments pay for 47 percent of all health spending ($355 billion), most of it for medicare and medicaid. There is additional spending on health insurance for government employees and on activities of the Department of Veterans Affairs, the Department of Defense, and the Public Health Service. About 21 percent of Federal Government revenues and over 21 percent of State and local government revenues are devoted to health care.

Governments also subsidize health care indirectly, by excluding employer-provided health insurance from taxable income. In 1991 this tax expenditure cost the Federal Government an estimated $36 billion in individual income taxes. The government lost Social Security revenues as well, although Social Security payments in the future will also be somewhat lower.

Chart 4–6 shows the evolution of these payment sources over time. Between 1965 and 1991, payments by health insurers, medicare, and medicaid increased from 24 percent to 62 percent of total health care spending. Other government spending fell from 25 to

14 percent, and out-of-pocket spending declined from 46 percent to 20 percent of the total. The dramatic extension of insurance coverage—in both the public and the private sectors—may be both a response to and a cause of increased costs.

Chart 4-6 **Sources of Health Care Financing as Percent of Total Expenditures**
Health insurance and government-financed expenditures have been rising as a share of total spending, while out-of-pocket expenditures have been falling.



Source: Health Care Financing Administration.

While Table 4–3 shows who is responsible for paying for health care, it does not show the economic incidence—whose income is ultimately reduced because of high health care costs. In response to higher costs, businesses have several options: They can reduce health benefits; lower workers' wages or other benefits so that total compensation does not rise; reduce employment; lower returns to shareholders; reduce payments to other factors of production; reduce investment in plant and equipment or research and development; or raise prices to their customers.

Economic theory suggests that most of the increase in health care costs will be reflected in lower wages. The reason is simple. Firms are indifferent between spending a dollar on wages or on health premiums. But since wages are taxed while health insurance premiums are not, employees should be willing to "buy" increased health insurance by sacrificing wages until the marginal dollar of health insurance is worth one dollar of *after-tax* wages, or

about 65 to 70 cents for a typical family. At this point, the worker should also be indifferent between contributing more to health insurance or to wages.

Empirical research suggests that the dominant long-run response of businesses to rising health care costs has indeed been to lower the rate of increase of workers' wages. Between 80 and 100 percent of increases in health care spending appears to be reflected in lower wages. As noted in Chapter 1, the share of wages in total compensation has been falling since 1960, while the share of business health insurance spending has increased markedly.

When firms slow wage increases to offset rising health insurance costs, they limit the increase in their total labor costs, and thus limit the job losses that might otherwise result. The slower wage growth due to rising business health expenditures has led to slower increases in incomes than would otherwise have occurred. If business spending on health care were the same share of compensation today as it was in 1975, wages per employee could be over $1,000 higher.

If increases in business spending on health insurance are not entirely balanced by reductions in other forms of labor payments, total compensation will rise. In this case, some other business decisions are likely to be affected, such as employment, pricing, or investment decisions. Empirical research, however, has not explored such alternative responses in any depth.

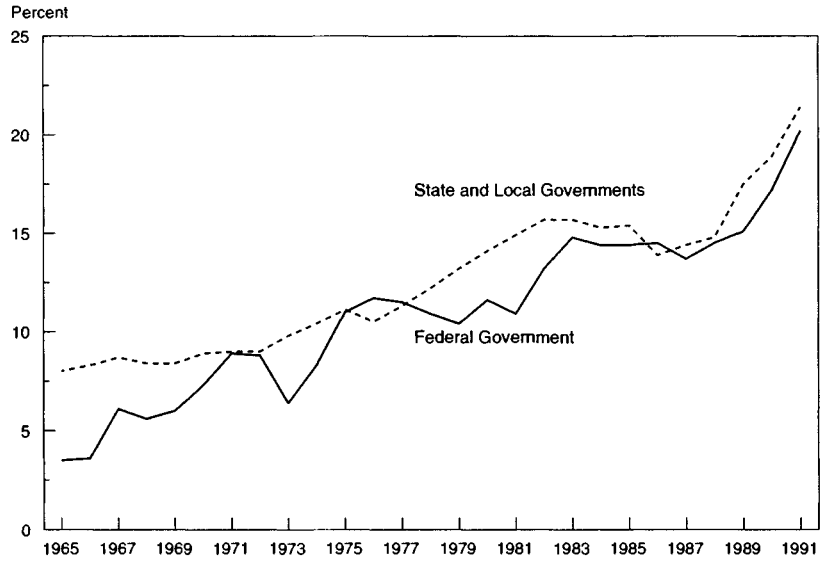
In summary, the economic literature on the incidence of health care costs suggests that employees eventually pay for most of their employer-provided health coverage by taking home lower cash wages. Reforms that enhance the efficiency of the health care market will allow employees to have both more health care coverage and higher take-home pay at the same time. Greater efficiency will therefore translate into an improvement in living standards for society as a whole.

HEALTH CARE AND GOVERNMENT BUDGETS

The final problem in the current health care system is the growing burden it places on government finances. Because governments pay for such a large share of health spending, increases in health costs contribute directly to pressures on Federal, State, and local budgets. Public sector spending on health care grew over 2 percentage points faster than private sector spending in the 1970s, and at about the same rate as private sector spending in the 1980s. The result has been an increasing share of health spending by governments. In addition, as was pointed out in Chapter 1, health spending is growing four times as rapidly as any other component of the Federal budget. Over the two decades ending in 1991, Federal

health spending increased from 9 percent to 21 percent of total Federal revenues (Chart 4–7). Similar changes have occurred in State and local government spending.

Chart 4-7 **Government Spending on Health Care as Percent of Total Government Revenues**
Federal and State and local spending on health care account for increasing shares of total government revenues.



Sources: Department of Commerce and Department of Health and Human Services.

The Federal Government has responded to increasing health care costs in part by attempting to limit the reimbursement rates paid by public programs to health care providers. This approach in turn has resulted in the substantial shifting of costs to the private sector described earlier. In the absence of systemwide reform, the imposition of caps on Federal health care programs would either further aggravate the cost-shifting problem or gradually limit access to care.

Without health care reform, escalating health care costs will continue to confront the Federal Government—as well as State and local governments—with painful choices among additional taxes, cuts in spending on education and other programs that promote economic prosperity, or increases in budget deficits. As already noted, projected increases in Federal spending on medicare and medicaid are the main force behind a projected increase in the Federal deficit toward the end of this century.

THE ARCHITECTURE OF THE HEALTH SECURITY ACT

The Administration's approach to health care reform, while bold and comprehensive, builds on the strengths of the current market-based system. The Administration considered but rejected radical approaches such as a single-payer system or government-set health care prices in favor of restructuring the current system and relying on the forces of market competition. The Administration's framework preserves and expands consumer choice among providers and preserves the current employer-based system of health insurance. The Administration's plan also allows large firms to continue operating self-insured plans. Such firms generally provide comprehensive benefits, and many have managed to control health care spending. Indeed, the Administration's plan reflects many of the lessons learned from the experience of such firms.

ELEMENTS OF REFORM

To address the Nation's health care problems, meaningful reforms must address the four interrelated issues identified in the preceding discussion: universal coverage and health security; reform of the private insurance system; efficiency improvements and cost control; and sustained deficit reduction. The Health Security Act, which the Administration proposed in 1993, contains reforms that simultaneously meet these objectives. The principal features of the Administration's reforms are outlined in this section and discussed in greater detail in the remainder of this chapter.

Universal Coverage

The Health Security Act guarantees all Americans a health insurance package with a comprehensive set of benefits. The medicare program will be left largely unchanged, and medicare will remain the insurer for most Americans over the age of 65. Most medicaid recipients under 65 will be absorbed into the new system. With very few exceptions, all other Americans will receive their health insurance from the "health alliances" described below.

Universal coverage is essential for the reasons noted earlier. Comprehensive benefits are equally important if health security for all Americans is to be achieved. Some reform proposals promise universal coverage but guarantee coverage only for catastrophic expenses. In practice, people with high incomes may be able to afford additional coverage beyond catastrophic, but many other Americans cannot. Plans that guarantee only catastrophic coverage leave many people without genuine health security—subject to the risk that their insurance coverage will deteriorate if they lose their jobs, just when their incomes are falling.

Since the Administration's comprehensive benefits package includes a prescription drug benefit for the under-65 population, the Administration's proposal also calls for a comparable drug benefit to be added to the medicare program. In addition, the proposal includes funding for long-term care services, primarily to expand the amount of home- and community-based care.

Reforming Insurance Markets

Under the Health Security Act, individuals and families will receive coverage through regional or corporate "health alliances"—pools of individuals who purchase from a set of health plans. No insurer will be able to impose restrictions on preexisting conditions or lifetime limitations on insurance benefits, or to deny people the right to initiate or renew enrollment because of demographic or health status. Insurers will have to charge a community rate to everyone in an alliance.

Because there will be only one regional alliance in each geographic area, and coverage will be universal, healthy people in each area will naturally be pooled with sicker people. Pooling health risks makes insurance affordable for everyone. It also provides the healthy with the knowledge that their insurance premiums will not rise if they or a family member become ill.

Eliminating exclusions for preexisting conditions and lifetime limitations on benefits guarantees that large financial risks will be covered. Providing for guaranteed issue and guaranteed renewability allows individuals to exercise their choices among health plans.

Efficiency Improvements and Cost Savings

To encourage cost-conscious decisions, the Health Security Act allows consumers a choice among several plans with identical benefits, gives them information about the quality of competing plans and their customers' satisfaction, and allows them to receive more of the savings if they choose a less expensive health plan. In addition, the act sets a limit on the growth of premiums in the alliances.

Promoting choice among health plans is essential to controlling costs. By encouraging plan choice, the act attempts to create a more efficient health care delivery system and thus lower overall spending.

The act's proposed limits on the allowable growth of premiums are intended to guarantee control over the growth of costs, in case enhanced private incentives fail to have the anticipated effect. These limits are an important safeguard because they reduce the risk to the government of runaway health spending.

Deficit Reduction

Over time, cost savings from the provisions just described and from reimbursement changes in public programs will provide budg-

etary savings for the Federal Government. As noted above, long-run success in keeping the Federal deficit under control is directly tied to success in reducing the growth rate of Federal health care spending. In the short term, the Health Security Act entails some new Federal costs—discounts for the poor and for small and low-average-wage businesses, a new drug benefit for medicare, and coverage of long-term care. The savings from slowing the rate of growth of health care spending start right away, but they are small at first. Over time, these savings grow larger, and deficit reduction increases accordingly.

Maintaining Choice

The Health Security Act allows families, doctors, firms, and States to make significant choices about the nature of their involvement in the new health care system.

Households will get to choose their own doctors, and many families that currently have no choice over their health plan will be given several options. Doctors will get to choose the plan or plans in which they work, and may remain in the fee-for-service sector if they wish. Large firms may choose to form corporate alliances or to join regional alliances. And each State will be allowed to adjust its health care system to its particular circumstances—including the establishment of a single-payer system if it so chooses.

PROVIDING COMPREHENSIVE BENEFITS

All health plans organized under the Health Security Act must offer the same set of comprehensive benefits. These benefits include hospital services; services of health professionals; clinical preventive services; mental illness and substance abuse services; family planning services; hospice care; home health care; extended care services; ambulance services; outpatient laboratory, radiology, and diagnostic services; outpatient prescription drugs and biological agents; outpatient rehabilitative services; durable medical equipment and prosthetic and orthotic devices; vision care; and pediatric dental care. The guaranteed benefit package to be in effect through the year 2000 provides the level of benefits currently offered by a typical medium-sized to large firm. In the year 2001 the benefit package expands to include services not fully covered previously—principally, adult dental benefits and broader coverage for mental illness and substance abuse.

Health plans will offer one of three forms of cost sharing. The first is a "higher cost-sharing" option similar to those in traditional fee-for-service plans. There is a general deductible of $200 per year for a single individual and $400 per year for a family, with separate deductibles for mental illness and substance abuse treatment, prescription drugs, and dental services. After the deductible is met, the insured individual pays 20 percent of the cost of most services.

The second option is a "lower cost-sharing" option similar to those in HMOs. This option has only a $10 copayment for most services, a $5 copayment for prescription drugs, and higher copayments for services such as hospital emergency room services, inpatient mental illnesses services, outpatient psychotherapy, and orthodontic care. Preventive services are covered without cost sharing under either schedule. The final option is "combination cost sharing" similar to that in preferred provider organizations (PPOs). This option follows the lower cost sharing for services provided inside a network and the higher cost sharing for services outside of the network. Under all cost-sharing schedules, out-of-pocket payments will not exceed $1,500 per year for a single individual or $3,000 for a family. All of the cost-sharing limits are in 1994 dollars and are indexed in subsequent years to the rate of premium growth.

ORGANIZING THE INSURANCE MARKET

The organizing mechanism for health insurance under the Health Security Act is the health alliance. The alliance is the "broker" between consumers and plans—negotiating with health plans and offering choices to consumers, and accepting premium payments from consumers and distributing them to plans.

The act creates two types of health alliances: regional alliances and corporate alliances. Regional health alliances are designed for workers in firms with fewer than 5,000 employees, nonworkers, and most medicaid recipients. Each State will have one or more regional alliances, but alliances may not overlap geographically. Boundaries of the regional alliances may not be drawn to segregate people with high expected health care costs in one area. Firms with over 5,000 employees will have the option to form a corporate alliance, but they must provide the guaranteed package and will not receive any discounts on their premium contributions.

The alliance structure is designed to enhance competition and thus produce efficiency savings. Within an alliance, consumers have a choice of health plans. Plans will be either fee-for-service, PPOs, or HMOs. HMOs must offer consumers the opportunity to purchase a point-of-service option, allowing them to use care outside the HMO as in a fee-for-service plan if they choose. All plans will offer the same set of benefits, so individuals will not fear changes in covered services if they switch plans.

There will be an annual open enrollment period during which consumers can switch from one health plan to another without loss of coverage. To increase consumers' ability to evaluate competing plans, the alliance will also publish price and quality data about the different plans. Consumers are required to pay the cost of the plan they select, less the amount their employers are required to contribute. Employers are allowed to supplement their required

contribution, within limits. Outside of collective bargaining agreements, employers must offer the same supplementation to every worker in a given rating pool (rating pools are described in the next section). The supplementation cannot cause the total employer contribution to exceed the premium of the highest cost plan for that rating pool in the alliance. Employers who choose to contribute more must give full rebates to employees who choose a plan that costs less. Thus, the consumer will realize the full savings (subject to taxes) from choosing a less expensive health plan.

Individuals may also use after-tax dollars to purchase health coverage for benefits beyond the guaranteed package or for supplemental policies to reduce out-of-pocket payments. The Health Security Act specifies a floor for coverage below which individuals should not fall, rather than a ceiling on the generosity of health benefits an individual can receive.

On the provider side, the health alliance solves many of the problems inherent in the current market. As a requirement for selling insurance in an alliance, plans must agree to community rating, guaranteed issue, and guaranteed renewability, and must cover individuals with preexisting conditions. The health alliance must accept all qualified health plans into the alliance, with the exception that the alliance can exclude plans that charge over 120 percent of the average premium.

Some economists have argued that the Federal Government should tax employer contributions for health insurance as if these benefits were paid as wages. Such a tax change would raise the price to consumers of more-expensive health plans, thereby providing an incentive to limit health care spending. There are several ways to reform the tax treatment of health benefits. First, employees could be prohibited from contributing pretax dollars to health insurance under certain employee benefit arrangements called "cafeteria plans." This limitation is a part of the Health Security Act. Second, employer payments for covered services beyond the guaranteed benefit package—whether in reduced cost sharing or in additional services—could be considered taxable income. This limitation is scheduled to occur in the year 2004 under the Health Security Act. Finally, all or part of the cost of a guaranteed benefit package above some level could be considered taxable income. This change is not part of the Health Security Act.

PAYING FOR INSURANCE

The Health Security Act classifies people into four rating pools: singles, couples with no children, families with children and one adult, and families with children and two adults. Table 4–4 shows the estimated premiums in 1994 for policies for these four pools. For a two-adult family with children, for example, the national av-

erage premium in 1994 is estimated to be $4,360. The actual premiums will vary by region of the country, as health spending does currently.

TABLE 4–4.—*Estimated Premiums in the Regional Alliance, 1994*

Rating pool	Average premium	Payments by:			
		Family (20 percent)	Employer		
			Per-family requirement (80 percent)	Average number of workers per family	Per-worker requirement
Singles	$1,932	$386	$1,546	1.00	$1,546
Couples (no children)	3,865	773	3,092	1.45	2,125
One-adult family	3,893	779	3,409	1.38	2,479
Two-adult family	4,360	872			

Note.—Premiums are national averages. Actual premiums will differ from alliance to alliance. Employer payments for one-adult and two-adult families are pooled.

Source: Administration estimates.

Employers are required to pay 80 percent of the average premium for each family. Single individuals are considered to have one worker per family. An employer of a full-time single worker therefore pays 80 percent of the $1,932 premium cost, or $1,546. In the case of childless couples, there are on average in the United States about 1.45 workers per family. Since 80 percent of the premium for childless couples is $3,092, the amount per worker is only $3,092 divided by the number of workers per family, or $2,125. Employers must pay this amount for each worker. Workers in families with children—whether the family has one adult or two—are pooled. The alliance computes total requirements ($3,409 per family) and divides this by the number of workers per family (about 1.38 as a national average). The employer payment for a full-time worker in a family with children is therefore $2,479. Because these amounts are independent of the number of workers in a family, employers do not have to coordinate payments with employers of other family members. This system is thus relatively simple to administer.

Employer payments for part-time workers are prorated, based on the percentage of a 120-hour month (about 30 hours per week) that the person works. If the employee works 60 hours per month, the employer would owe one-half of an employer premium. No employer payment is required if the individual works fewer than 40 hours per month. Thus, an employee who worked at two 60-hour-per-month jobs would be credited with two half-payments, or one full-time payment. An employee who did not work at any job for at least 40 hours per month is treated as a nonworker.

Self-employed people will make their own employer payments, as they do now. However, if a self-employed worker also has wage and

salary income, payments from the employer will be credited against the amount owed on the worker's self-employment income. Thus, a worker who earns wages or a salary for half the year and is self-employed for the other half would owe only half of an employer payment on his or her self-employment earnings, with discounts available for those with low self-employment earnings. In addition, self-employed people will be able to deduct all their payments for health insurance in computing taxable income, compared with the 25-percent deductibility under current law.

The equivalent of at least one employer premium must be collected for each family. In cases where no family member receives employer coverage, or the family members worked less than 12 full-time months in a year, the balance of the premium is the responsibility of the family. If the family members worked 6 full-time months, for example, the family would owe one-half of an employer share, the employer having paid the other half.

Finally, each family owes any difference between the employer contribution and the price of the plan they select (but low-income families will be eligible for discounts on their share). For the average family, this difference will be 20 percent of the total premium, or $872 in the case of a family with children. If the family chooses a more expensive plan, it will pay the additional cost. If the family chooses a less expensive plan, it will keep the savings.

PROVIDING DISCOUNTS

The government provides discounts on the cost of insurance to small and low-wage businesses and low-income families. There are five types of discounts in the Health Security Act, which are detailed in Table 4–5: discounts to families on their 20-percent share of the premium; discounts to families that (for reasons just explained) owe some of the employer payment; discounts to early retirees; discounts to firms; and discounts to low-income families facing high out-of-pocket payments. The cost of providing these discounts is made up by government payments.

Low-income families in the regional alliances receive a discount on their 20-percent share of the premium. No payment at all is required on the first $1,000 of income. The discount phases out at 150 percent of the poverty line—about $23,000 for a family of four in 1994. Income for these purposes is defined as adjusted gross income plus tax-exempt interest income. The $1,000 disregard and the poverty line are indexed to the consumer price index.

Additional discounts are provided for families that owe part of an employer payment. No payment is required if nonwage income is below $1,000, and full payment is expected if nonwage income is greater than 250 percent of the poverty level, or about $39,000 for a family of four in 1994. Nonwage income is defined as adjusted

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TABLE 4–5.—*Discounts Under the Health Security Act in 2000*

[Billions of dollars]

Discount	Purpose	Amount
Employer	Limit firm payments to 7.9 percent of payroll or less	29
Household		
Nonretiree	Limit payment for 20 percent share of premiums and for time spent not working	47
Nonworker discounts to retirees.	Limit employer payments for time spent not working	7
Early retirees	Eliminate remaining employer payment	5
Out-of-pocket	Lower cost sharing for poor families	3
Cushion	Allowance for behavioral effects and unfavorable economic circumstances	13
Total		103

Source: Administration estimates.

gross income less unemployment compensation and wage and salary and self-employed income (up to $60,000 per year), and including tax-exempt interest. Labor income is excluded from this calculation because it is assumed that families have already "paid" for their employer's contribution through lower wages and salaries.

Beginning in 1998, if a retired individual is between the ages of 55 and 64, has less than $90,000 in income, and meets the Social Security earnings test, the government pays the entire employer share of the retiree's premium. This discount supplants any payment for the employer share that the individual or his or her employer would have made. The largest benefit to corporations with early retirees, however, will come not from this special provision for retirees (which will save firms about $2 billion), but from community rating of premiums, which will save about $7 billion. From 1998 through 2000, firms that are currently providing health insurance to their retirees must pay the government 50 percent of the savings they realize from this provision.

Total household discounts are expected to be $59 billion in the year 2000. This total includes $47 billion in nonretiree discounts, $7 billion in low-income discounts given to retirees, and almost $5 billion in additional discounts to early retirees.

Some firms will also receive discounts on their required payments. Contributions from each firm in the regional alliances are capped at 7.9 percent of payroll. If a firm's required payments would be greater than 7.9 percent of payroll, the government pays the overage. Small, low-wage firms are capped at even lower percentages of payroll, as detailed in Table 4–6. Employer discounts total $29 billion in 2000 (Table 4–5), about three-quarters of which are for firms with fewer than 25 employees.

Finally, low-income individuals can receive discounts for their out-of-pocket payments if they live in areas where there are no

TABLE 4–6.—*Caps on Premiums by Firm Size*

[Percent of total payroll]

Average wage (dollars)	Firm size (number of workers)			
	Less than 25	25–49	50–74	75 and over
Less than 12,000	3.5	4.4	5.3	7.9
12,000–15,000	4.4	5.3	6.2	7.9
15,000–18,000	5.3	6.2	7.1	7.9
18,000–21,000	6.2	7.1	7.9	7.9
21,000–24,000	7.1	7.9	7.9	7.9
Over 24,000	7.9	7.9	7.9	7.9

Source: Administration estimates.

health plans that offer lower cost sharing or that charge premiums at or below the average-cost plan. These discounts end at 150 percent of the poverty level. The total cost of these discounts is estimated to be $3 billion in the year 2000.

Numerous behavioral effects could influence the discounts the government is obligated to pay. For example, firms that have high average wages, and therefore pay the full premiums for their workers, may find it in their interest to contract out for low-wage services from firms that receive discounts. To allow for this and other behavioral reactions, the projected discounts were increased by 15 percent above the static estimate, or $13 billion in the year 2000.

USING SAVINGS TO GUARANTEE HEALTH SECURITY AND REDUCE THE DEFICIT

At the broadest level, the Health Security Act is designed to finance new spending and deficit reduction out of savings from reduced expenditures relative to the no-reform baseline. Savings are expected to result from reduced administrative costs, consumers switching to less expensive plans, and lower costs from improved incentives.

Insurance reform will save money through lower underwriting costs. On net, the cost of insurance administration should decline by about 3.5 percent of claims paid. Since current premiums for the population that will be included in the health alliances are about $200 billion, the savings from the insurance reforms in the health alliances should be about $7 billion annually.

There are also likely to be savings from consumers switching to lower cost plans. Several studies have found that managed care arrangements have lower health spending than open-ended plans. The most comprehensive forms of managed care—group and staff model HMOs—save an estimated 15 percent on health spending by, for example, finding alternatives to hospitalization.

A number of governments and corporations have experimented with paying a fixed amount for health insurance, regardless of the

plan the employee chooses, and have found that these payment rules have a large effect on individual choices. The State of Minnesota, for example, implemented a fixed-dollar contribution for public sector employees in 1989. Between 1988 and 1993, the share of employees in the highest cost plan fell from 42 to 17 percent, while the share in the lowest cost plan increased from 28 to 54 percent. The State of Wisconsin implemented a similar system for its public employees in 1984. In one year, enrollment in HMOs increased by over 60 percent. Similar responses have been observed in several private companies.

Finally, there is the case of California, which passed laws in the early 1980s increasing the ability of plans to contract selectively with providers. Since then, growth in health care costs has been much lower in California than in other States. Between 1982 and 1991, real per capita costs for hospitals, physicians, and prescription drugs increased 2.8 percent annually in California, compared with 4.8 percent annually in the rest of the United States. As a result, California's per capita costs fell from 18 percent above the average State in 1982 to 2 percent above the average in 1991.

As a backup to the market incentives it provides, the Health Security Act places a limit on the growth of premiums in regional and corporate alliances. Up to the year 2000, growth in total premiums is constrained to the growth of inflation and population, plus an adjustment factor ranging from 1.5 percent in 1996 to zero in 1999 and 2000 (Table 4–7). This reduction in growth rates is in anticipation of one-time savings in health expenditures. After 2000 the growth rate of spending is expected to increase, but not to the level in the current system.

TABLE 4–7.—*Allowed Growth Rates of Alliance Premiums*

[Percent]

Growth rate	1995	1996	1997	1998	1999	2000
Baseline	9.0	9.5	9.2	9.0	8.9	9.0
Reform [1]	9.0	5.8	5.3	4.8	4.3	4.2
Adjustment factor [2]	.....	1.5	1.0	.5	.0	.0

[1] Projected average annual growth rates. Some alliances may experience higher annual growth rates prior to 1998.

[2] Adjustment factor added to inflation plus population growth to find reform growth limits.

Source: Baseline projections are from Congressional Budget Office, updated for higher estimates of inflation by the Administration. Reform projections are Administration estimates.

Each year, plans will submit bids on the premiums they propose for serving the alliance population. If an alliance's expected weighted-average premium is above the premium limit, and plans do not voluntarily reduce their bids, the premiums of the plans that exceed the limit will be reduced so that the cap is met.

An example will illustrate the process. If the average premium in one year is $4,000 and the target growth rate is 5 percent, the allowed increase in the average premium in the next year is $200. Suppose there are two plans with equal enrollments, one of which wants to increase the premium by $100 and the other by $400. Under the cap, the second plan would be allowed to increase its premium by only $300, so that the average increase would be $200.

Finally, if more people than expected join high-cost plans, so that actual premiums exceed the target, the premium target is reduced in the next 2 years to recoup the overage.

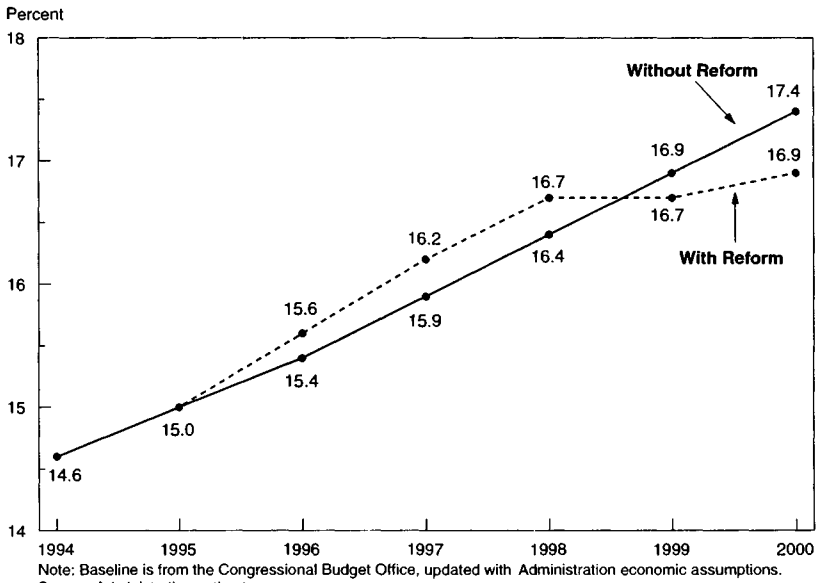
Chart 4–8 shows the projected change in national health expenditures under the act. Spending initially increases, because of the extension of coverage to the uninsured. By 1998, when universal coverage is complete, spending is above baseline by 0.3 percent of GDP. Over time, however, the savings from the market reforms—or, as a backstop, from the caps on premium growth—rise and spending falls relative to the baseline. In 1999 and 2000, spending is projected to grow at almost the rate of nominal GDP, so that health care as a share of GDP rises by only 0.2 percentage point. By the end of the decade, health expenditures with reform are projected to be below the level estimated to occur without reform.

Both the new Federal health spending and deficit reduction are financed out of savings in the existing system (Table 4–8). Spending rises with the implementation of universal coverage, but the slower growth of costs generates savings to the government. Health reform is essentially deficit-neutral in the first 4 years and deficit-reducing thereafter. By 2000, new Federal spending is projected to be $94 billion, and savings are projected to be $132 billion, yielding deficit reduction of $38 billion.

The new spending comes in five principal areas, detailed for the year 2000 in Table 4–9. First, net premium and other discounts total $42 billion. These discounts are the difference between $103 billion in gross spending and $61 billion in medicare and medicaid "offsets," as people leave these programs and receive coverage in the alliances instead. There is additional spending for the Department of Veterans Affairs, public health (including WIC [women, infants, and children] expansions and funding for academic medical centers), administration ($10 billion), the prescription drug benefit to the medicare program ($17 billion), and long-term care. Finally, allowing 100-percent tax deductibility of health insurance premiums for the self-employed will cost $3 billion in forgone revenues.

These new costs are financed by seven sources of funds. First, a tobacco tax will raise $11 billion, and a 1-percent payroll assessment on corporations that choose to form their own corporate alliances will raise $5 billion. There are also savings in public sector

Chart 4-8 **Health Expenditures as Percent of GDP**
Health expenditures will increase in the short term but will fall below baseline by the end of the decade.



Note: Baseline is from the Congressional Budget Office, updated with Administration economic assumptions.
Source: Administration estimates.

TABLE 4–8.—*New Federal Spending and Savings Due to Reform*
[Billions of dollars]

Item	1995	1996	1997	1998	1999	2000
New spending	3.5	23.5	50.9	79.4	88.8	92.1
Savings	14.5	26.7	44.0	74.7	107.0	129.8
Change in deficit	–11.0	–3.2	6.9	4.8	–18.2	–37.7

Note.—A negative number for change in deficit denotes a reduction in the deficit.
Source: Administration estimates.

programs. Medicare savings are projected at $39 billion in the year 2000. These savings result from 28 specific changes, ranging from lower hospital payment updates to increased premiums for the high-income elderly. Medicaid savings are projected to be $27 billion in 2000, due to lower payments for hospitals that treat the uninsured (since everyone will be covered) and slower growth of costs for medicaid beneficiaries in the health alliances, resulting from the improved incentives. Other programs such as those of the Department of Veterans Affairs, the Department of Defense, and the Federal Employees Benefit Program are projected to realize sav-

TABLE 4–9.—*Sources and Uses of Federal Funds Under Reform, 2000*

[Billions of dollars]

Source	Amount	Use	Amount
Tobacco tax	11	Discounts:	
Corporate assessment	5	Gross spending	103
Medicare	39	Offsets	–61
Medicaid	27	Net	42
Other Federal programs	11	Veterans Administration, Public Health, New Administration	10
Other revenue effects	35	Medicare drug benefit	17
Debt service	2	Long-term care	20
		100 percent tax deduction for self-employed	3
Total	130	Total spending	92
		Deficit reduction	38

Source: Administration estimates.

ings of $11 billion from slower cost growth, the provisions related to early retirees, and the increase in payments from private payers. Additional revenue amounting to $35 billion comes from a combination of factors, including additional tax revenue from the reduction in employer health care costs over time, removing health insurance premiums from "cafeteria plans" offered by employers, payments from corporations with early retirees, dedicated premium revenue for academic health centers, and other tax changes. Finally, the plan generates $2 billion in lower debt service as a result of deficit reduction in years prior to 2000.

To protect the Federal budget against open-ended commitments, the Health Security Act sets a ceiling on discounts that can be paid (Box 4–3). Authorized discount payments that are not utilized in any one year can be carried forward into future years to increase the maximum payment. This reduces the probability that the limits will be exceeded.

ECONOMIC EFFECTS OF THE HEALTH SECURITY ACT

The Health Security Act is certain to have impacts both on the overall American economy and on the health care sector in particular.

MACROECONOMIC EFFECTS

One important concern about health care reform is its effect on employment. Because employer mandates to provide insurance may initially increase labor costs to firms that are not now providing or

Box 4–3.—Capped Entitlements

Both the premium discounts and the new long-term care program are "capped entitlements." The long-term care program is an entitlement to States, not to individuals. The amount of money that States may receive is specified explicitly. Federal liability is limited to that amount, even if demand is greater than predicted. Similarly, there is no authority to pay for premium discounts beyond what is provided in the Health Security Act. In the event that spending is projected to exceed the amount in the legislation, the President must submit to the Congress a plan for addressing the issue. The Congress will then act on this plan through an expedited process.

The notion of a capped entitlement is not new. A number of Federal entitlement programs operate under a budget limit, including the social services block grant and payments to States for AFDC work programs. The legislated appropriation sets a limit on how much can be spent in total. Then, if spending is expected to be above projections, the government must change the eligibility requirements, change the benefits, or pass a supplementary appropriation.

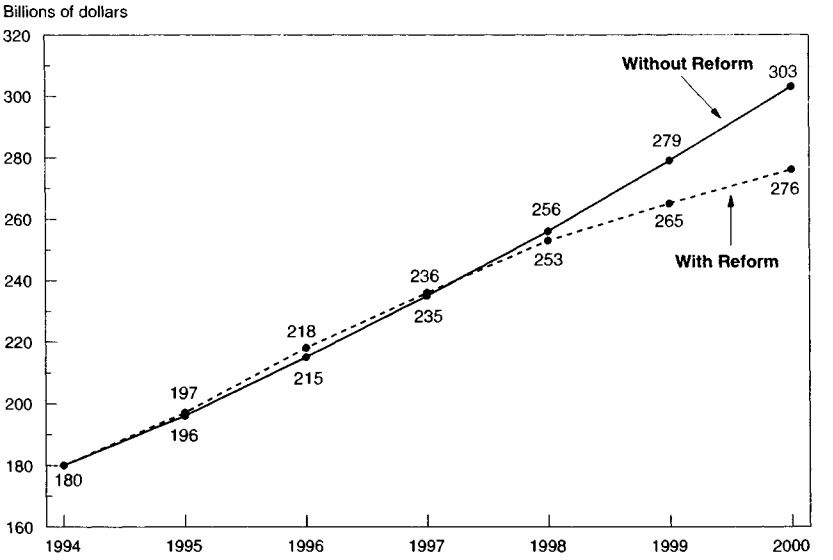
are underproviding insurance, fears have arisen that labor demand might decline as a consequence of reform.

In fact, however, changes in employer-paid health insurance costs can have several effects on workers other than changes in employment. As noted earlier, the dominant effect of increases in health care costs in the past has been a reduction in the real wages received by employees.

Chart 4–9 shows projections of total employer health insurance payments with and without health reform. While reform will have different effects on different firms, total employer spending is essentially unchanged through 1998 and then declines relative to the baseline. This pattern reflects the balance of spending increases from the employer mandate and spending reductions from cost savings. Through 1998 these effects are roughly equal, resulting in little additional business spending. Between 1998 and 2000, the savings increase but there is no increase in spending. The result is a net savings in employer payments.

There are many things employers can do with the savings from reform: They can hire more workers, pay higher returns to shareholders, or increase employee compensation. Empirical evidence suggests, however, that as total employer payments fall over time, the likely result will be a corresponding increase in workers' wages. By the year 2000, wage and salary compensation could therefore

Chart 4-9 **Business Spending on Health Insurance**
Business spending will increase slightly after reform but will fall below baseline by the end of the decade.



Note: Business spending is for services and populations that will be in regional or corporate health alliances.
Source: Administration estimates.

increase by $20 billion to $30 billion, or about 0.6 percent of payroll.

Although reform is unlikely to lead to a large reduction in the demand for labor, it could affect the supply. Some individuals who work mainly to obtain health insurance may voluntarily leave the labor force after health reform is passed. Evidence from continuation of coverage (COBRA) laws passed by the Federal Government and many State governments suggests that the number of people deciding to retire is about 1 percent higher when they have the option to purchase coverage through their former employer after retirement. These estimates must be raised to account for the lower price of insurance under reform; with this adjustment, it is estimated that about 350,000 to 600,000 additional people will be retired as a result of the provisions in the Health Security Act.

On the other hand, some welfare recipients are likely to decide to enter the labor force when health benefits become universal. A welfare recipient currently receiving medicaid benefits who then takes a job incurs a "tax" of two-thirds or more on earnings because of the resulting reduction in AFDC benefits, food stamps, and medicaid benefits. Once health care is guaranteed universally, the loss

of income associated with leaving welfare should fall by up to 10 percentage points. A number of studies suggest that many more welfare recipients will decide to work in response to these lower implicit tax rates.

Weighing all this evidence, several private sector economists have concluded, as has this Council, that the net effect of health reform on employment is likely to be small: at most plus or minus one-half of 1 percent of total employment. The reason is that a number of offsetting factors are in the plan, some of which will increase employment and some of which will reduce it. On net, these factors are likely to cancel out.

SECTORAL EFFECTS

Health reform will affect different firms differently (Table 4–10). Firms that are not now providing insurance will face increased costs after reform. Firms that are currently offering coverage, however, will on average enjoy cost reductions. These gains come from spreading the cost of universal coverage over everyone in the population, from premium discounts, and from slower growth of costs over time. Putting these two groups together, the average firm will experience cost reductions of about $230 per worker in 2000. There will also be changes in the distribution of spending across industries. Industries that have traditionally provided generous benefits to much of their work force, such as manufacturing, will see expenditure reductions compared with industries in which most firms do not currently provide insurance.

TABLE 4–10.—*Employer Payments for Health Care: Baseline and Reform, 2000*

Insurance status of firm	Number of workers (millions)	Average spending per worker (dollars)		
		Baseline	Reform	Change
All	122.7	2,478	2,245	–233
Currently offers insurance	96.3	3,092	2,482	–610
Does not offer insurance	24.4	0	1,292	1,292

Source: Urban Institute.

Employment is expected to increase in the health sector in the short run, because of increased spending on the uninsured and underinsured. Universal coverage by itself will increase health-related employment by more than 400,000 jobs, although employment will not increase uniformly throughout the sector. Resources are likely to shift from administration to providing care. As the growth rate of health spending falls, employment in health care will grow less rapidly than without reform. The number of employees will still increase over time, however.

Health care reform should set the stage for increased productivity growth. As administrative expense and inappropriate care decrease and the health care industry becomes more productive, the economy should be able to produce more output than it would have without reform. As a result, Americans will be able to consume health services of the same or better quality as before, as well as more of other goods and services. This productivity increase will raise living standards, which is the principal objective of this Administration's economic policies.

CONCLUSION

Reforming the Nation's health care system is integral to the health of both our citizens and our economy. One-seventh of the Nation's economy is currently characterized by weak competition, inadequate information, and inappropriate incentives. The Administration's health care reform proposal builds on the strengths of the current system while correcting its shortcomings. It preserves consumer choice and our employer-based private insurance system. It relies on enhanced market competition and improved incentives to provide health security for all Americans, slow rising health care costs, and address our long-run budget deficit problem.