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Mr. Chairman and Members of the Committee;

I appreciate having the opportunity to discuss with this Subcommittee the financing and costs of national health insurance. I will talk first about medical care inflation, its causes and the effect it has on both public programs and private spending. Second, I will discuss national health insurance cost projections and compare them to current policy expenditures. Although my testimony today focuses on program costs and their budgetary impact, this should not imply that costs are the most important factor in considering national health insurance. The value of any additional expenditures must be judged by their effectiveness in improving individual financial protection and encouraging the efficient provision of high quality health services.

National expenditures for health care have been growing at a much more rapid rate than the general economy for the last two decades. In 1950, total health expenditures represented 4.6 percent of GNP. By 1975, this figure had increased to 8.3 percent. In large measure this growth is attributable to higher rates of inflation for medical care than for other services (see Table 1). Since 1964, the consumer price index has not quite doubled, but the cost per patient day in a hospital has quadrupled. While higher wages and prices have accounted for a large portion of this increase, close to 50

percent of the increase has resulted from treatments of significantly higher quality and effectiveness than were available a decade ago.

As a result of this sustained growth in inflation and service provided, public and private spending on health care and related activities will exceed \$135 billion in this fiscal year. Almost one-third, or about \$43 billion, will flow through the federal budget, largely as a result of Medicare and Medicaid. A decade ago, before the enactment of these programs, federal health expenditures were only \$6 billion. Higher costs have produced most of the growth in Medicare expenditures. Since its inception, over 80 percent of the increase in program outlays can be attributed to higher costs, and only 20 percent to increases in the numbers of beneficiaries and their utilization of services.

Inflation has had a comparable impact on spending for health care in the private sector. Per capita health expenditures increased by 12 percent from 1974 to 1975, while per capita income went up by only 8 percent in the same period. Most people are aware of--and want to hold down--the increases in medical care costs that they pay directly. The impact of the higher employer-paid health insurance premiums on wage levels and on the price of goods and services is much less visible, but equally severe. For example, Ford and General Motors now spend between \$125 and \$150 per vehicle manufactured on health insurance premiums for their employees.

Causes of Inflation in Health Sector

The higher rates of inflation in the health sector have many causes, but they are clearly related in part to growth in third-party payments through public and private insurance plans. In 1955, 38 percent of the cost of personal health care services was met by public and private insurance. By 1974, insurance covered 63 percent of these expenditures. Hospital care is the most widely insured health service--in 1974 consumers paid only about 10 percent of hospital charges as a direct out-of-pocket expense.

The growth in insurance coverage has contributed to the growth in expenditures for health services in several ways.

First, the insured consumer tends to be less price conscious, because he often pays little or nothing from his own pocket at the time care is provided;

Second, because providers realize that patients will pay only a part of the bill directly, providers may not use resources efficiently and or try to minimize the cost of treatment;

Third, the wages of health care workers have experienced substantial gains over the last ten years as a result of higher demand for wage increases and more resources available to meet those demands; and

Fourth, the increased revenues resulting from greater insurance coverage have also made possible the provision of

higher quality medical care through the acquisition of sophisticated equipment and the hiring of more and better trained personnel. These improvements add to cost.

In addition, the growth of "cost plus" reimbursement for hospitals has encouraged higher expenditures. Because a majority of hospital revenues are received on the basis of actual costs incurred, revenues rise automatically with expenses. Curtailing costs is therefore not generally a high priority.

Effect of Inflation on Public Programs

If inflation in the general economy continues at historically high levels, as seems likely, it is reasonable to assume that medical care costs will also increase at near their present rate. This means that the cost of public programs will escalate at about 15 percent annually under current policy.

CBO estimates that if present policies are continued, Medicare outlays will total approximately \$20.5 billion in FY 77 and that the cost of the federal share of Medicaid will be \$9.5 billion. These programs alone will account for 85 percent of the expected \$4.8 billion increase in federal health outlays (Budget Function 550) between FY 76 and FY 77. (This increase is for 15 months because of the transition quarter.)

By 1981 CBO estimates that under current policy Medicare expenditures will rise to \$34.5 billion and Medicaid to \$14.0.

Higher costs is the principal cause for the growth in these program outlays. For example, 86 percent of the \$14 billion projected increase in Medicare outlays from FY 77 to 81 is attributable to higher costs and only 14 percent to an expansion in the number of beneficiaries or higher rates of utilization.

In a period of tight budget constraints, the additional outlays needed to finance these higher costs at current service levels will absorb most of the funds which might otherwise be available to increase the number of beneficiaries or services covered. The growth in Medicare outlays to finance higher costs, \$2.4 billion in the hospital insurance program alone from FY 76 to 77, exceeds the funding level for all categorical grant programs of the Public Health Service.

Congress could act to limit the budgetary impact of the increases in Medicare and Medicaid costs. The President has proposed such action in his FY 77 budget. Specifically, he recommends consolidating 15 categorical health service programs and Medicaid into a state block grant. Federal expenditures for Medicaid would thus be more easily controlled through the appropriations process, and by transferring the resource allocation decisions to the states.

The President also proposes three significant changes in the Medicare program. The first two changes, provider reimbursement limits and beneficiary cost-sharing, would

reduce federal expenditures while the third, maximum beneficiary cost-sharing, would add to federal outlays.

This package of proposed Medicare changes will have the effect of simultaneously reducing federal outlays and protecting Medicare recipients against "catastrophic" expenditures. The majority of Medicare recipients would pay more out-of-pocket for health services than they would under current policy. This increased cost-sharing is intended to make Medicare recipients more cost-conscious.

There is a serious question, however, as to whether overall price increases in the health sector can be moderated by a program which controls reimbursements only for public program beneficiaries.

The unreimbursed hospital costs might instead be shifted to private patients. A serious danger, particularly if hospital controls are maintained for a long period of time, will be discrimination against Medicare and Medicaid patients through the provision of lower quality care. Physicians may bill patients directly to compensate for the lower increases in Medicare reimbursement.

The higher health care expenses which have driven up the cost of public and private insurance programs have created even more severe financial problems and anxieties for people who are not insured or whose insurance is inadequate to deal with a very costly illness. The hardships faced by the uninsured, and by those for whom private

coverage is becoming prohibitively expensive, have created pressures for the extension of existing public insurance programs or for the adoption of national health insurance.

National Health Insurance Proposals

In considering whether or not to adopt national health insurance the following problem emerges. Past experience would indicate that broadening insurance coverage adds significantly to demand pressures and medical care inflation. Further improvements in individual financial protection risk more price inflation and greater inefficiencies in the use of resources.

The conflict between equally important social goals-- providing broader financial assistance for health care and efficient use of health resources--poses a serious policy dilemma. It is hard to see how further augmentation of financial assistance for health care can be accomplished without a serious inflationary impact unless some form of effective price regulation is imposed. But the desirability and form of such regulation remains extremely controversial.

Regulatory proposals which have been suggested range from hospital rate setting by states; to an extension of the type of controls used during Phase IV of the Economic Stabilization Period on all provider charges; to the imposition of global budget controls over the entire health sector. In the latter instance, hospitals would be paid on

a prospective budget basis and physicians would be reimbursed according to a government-set fee schedule or even by salary. Also, regulatory measures that assure proper utilization of hospital services could result in a reduction in expenditures.

As evidence of the fact that no consensus has yet emerged on the appropriate new role of the federal or state governments in the financing of services or regulation of the health industry, more than two dozen national health insurance bills have been introduced in this session of Congress. They have widely varying provisions with respect to population and benefit coverage, financing mechanisms and the degree of control imposed on the health care industry.

Different types of national health insurance plans would have different effects on the federal budget, on the general economy and on the health care delivery system. The key variables in assessing the probable budget impact of alternative proposals is whether the plan is primarily tax or premium financed, the range of benefits covered, the beneficiary cost-sharing requirements imposed and the plan's cost control features.

Because none of the bills has been reported out of a committee, CBO has not made formal cost estimates of specific proposals. However, in conjunction with the preparation of our annual report on the budget we have

prepared five year projections of the cost of three basic approaches to providing national health insurance in order to analyze the effect each might have on total national spending for health services and on federal outlays, including tax expenditures.

Before discussing these projections, I would like to emphasize that prospective cost estimates of any national health insurance plan will be imprecise because of the lack of hard data in a number of important areas and limited knowledge of how consumers and providers will respond to new insurance coverage. The difficulty is compounded in attempting five year estimates because of the complex and far-reaching changes which these plans could produce in both the financing and delivery of health services.

However, as the projection problems are more or less common to all of the plans, useful comparisons can still be made among them. To assist in these comparisons, the cost estimates were made for all plans assuming full operation for the entire 1977 fiscal year. This does not mean we think it would be feasible to fully implement these plans in fiscal year 1977. Because some assumptions, such as the probable effectiveness of cost controls, are so uncertain, we felt it necessary to develop a "high" and "low" estimate series.

First Full-Year Cost Estimates for
Prototype National Health Insurance Plans

Targeted Approach

The first of the three prototype plans might be labeled as a "targeted approach," since it would be aimed at providing coverage for all low-income families and universal protection against catastrophically high medical expenditures.

This prototype plan assumes that low-income families would be protected by a "federalized Medicaid" program with uniform national entitlement and benefit levels. We assumed income entitlement limits of \$4,800 for a family of four, with "spend down" eligibility for families at higher income levels and state contributions to continue at their present level. The net additional cost of this part of the plan would be \$6 to \$7 billion in FY 77.

A number of plans have been proposed to provide protection against catastrophic medical costs. We assumed a fixed-benefit deductible plan which pays hospital costs after the first 60 days and medical expenses over the first \$2,000. If a majority of employers choose to provide catastrophic protection through private insurance, the net new budget cost would be from \$4 to \$4.5 billion if the program were fully operational in FY 77.

Because of the possible reduction in categorical programs, the total additional costs of a catastrophic plan in which half the costs are borne by the federal government

plus a uniform Medicaid program would be between \$8.5 to \$10.5 billion in FY 77 (see Table 2).

Comprehensive Premium Financed

The second prototype we examined was a comprehensive national health insurance plan with mixed public and private financing. We assumed that most of the population would be covered through employment-based private health insurance and that there would be public programs with comparable benefits for the poor and for high-risk individuals who could not purchase private insurance at acceptable rates. Medicare would be continued for the aged. If such a plan were fully operative in FY 77, it would result in additional federal outlays for health services of \$13.5 to \$15.5 billion (see Table 2).

Comprehensive Tax Financed

The third type of proposal for which we developed estimates is a tax-financed, publicly-administered health insurance plan with comprehensive benefits and no cost-sharing. Such a plan would absorb Medicare, Medicaid and most categorical health care programs. If fully operative in FY 77, a plan of this nature would result in additional federal outlays for health services of \$74.5 to \$77.5 billion (see Table 2).

Estimates for FY 81 of Total National Spending
and Federal Budget Costs Under Three National
Health Insurance Plans

Each of the national health insurance plans I have described would have markedly different effects on federal outlays. While total national spending for health care would be roughly comparable in the first year under any of the proposals, it could vary substantially over time.

The similarity in the first year is because the existing health system is operating at close to capacity. Therefore, the greater potential demand generated by increased insurance coverage cannot be met initially. Furthermore, it is unlikely that prices will rise high enough to eliminate the shortage. However, as the capacity of the health system will adjust to the increased demand for services over time substantial differences in expenditures could be realized within five years.

Specifically, the increased demand for inpatient services produced by the targeted and premium-financed plans could probably be met in the first year of program operation and that of the tax-financed plan by the end of the second year. Physician shortages would be more serious in the early years and would be insufficient to meet full demand under all the plans for at least one year. Even after five years the availability of physicians might be insufficient to meet all demands generated by the tax-financed plan although the shortage will have been substantially reduced.

Because the impact of increased demand cannot be fully realized in "first year" projections and, similarly, because cost-containment provisions could not be assumed to have any substantial effect in the first year, we have estimated the cost of the three plans in 1981. This projection assumes five full years of program operation.

For each plan we have developed both "high" and "low" estimates. The "low series" assumes that cost control features proposed in a plan will be very effective in restraining inflation. The "high series" assumes that these measures will not be fully effective.

Two important points emerge from the five year projections which are not apparent in comparing initial-year program costs. First, strong cost controls, if they are effective, will yield substantially lower federal spending for these programs over time. Second, adoption of a national health insurance plan with rigid adherence to cost controls could actually reduce national spending on personal health services below the levels projected under current policy.

Targeted Approach

This plan offers only a limited opportunity to institute cost controls other than those which currently operate in the Medicare program. Therefore, the five-year estimates for the targeted approach show a small range between the

"high series" and "low series" estimates by 1981. Our projection for total national spending on personal health services under the targeted approach range from \$249 to \$256 billion in FY 81. Federal budget costs for health services in that same year would range from \$74.5 to \$79.5 billion. This compares with our current policy estimates of \$238 billion for total national spending and \$52 billion for federal budget costs for personal health services in 1981 (see Tables 2 and 3).

Comprehensive Premium Financed

Effective control of health prices through insurance reimbursement is difficult when there are multiple sources of funding as our present rate of inflation in the health sector would suggest. Therefore our "high series" estimates for the premium-financed comprehensive plan assume that present levels of inflation continue and are slightly accelerated in the early years by the increased demand new insurance coverage will generate. The low series projections for this plan assume that federal and/or state regulatory programs will reduce inflation in health services costs by 20 percent below expected inflation levels under current policy.

These assumptions produce estimates of total national spending ranging from \$235 to \$256 billion in FY 81. The federal budget costs for health services would range from \$71 to \$81 billion in the same year (see Tables 2 and 3).

Comprehensive Tax Financed

Insurance financed directly through the tax system has the potential to provide the most effective means for controlling health costs through mechanisms such as prospective budgeting for hospitals and fee schedules for physicians. But if that potential is not fully realized, a tax-financed public plan could be far more inflationary than the present mixed system or than any of the other prototypes discussed.

Experience in other countries, most notably Canada, indicates that even a government-controlled tax-financed plan will have difficulty in controlling inflation. Alternatively in Great Britain, where controls have been successfully applied, under investment problems seem to have resulted because of the stringency of the controls.

In constructing the low-series estimate for this plan we assumed that a maximum federal budget would be adhered to and that spending would be limited to the amount of revenue generated by the payroll tax. The high series increased the expected inflation rates above the level anticipated for current policy. Under these widely varying assumptions the FY 81 budget cost for health care services of a tax-financed comprehensive plan could range from \$157 to \$192 billion. Total national spending in the same year could range from \$217 to \$273 billion (see Tables 2 and 3).

You will note that our low series estimate on total national spending under the tax-financed approach is about \$20 billion less than our 1981 estimate for current policy. This reduction in projected expenditures could occur only if very severe controls are imposed on the health sector and are adhered to over the five year period. There is little in the history of public or private health insurance administration in this country to suggest that such a policy would be followed.

CONCLUSION

As I noted in opening this testimony, program costs will be only one aspect Congress considers when legislating national health insurance. Although my testimony has concentrated on the question of costs and their budgetary impact, I would repeat that it is equally important to take into account the benefits to be derived from each of the plans. It is not total costs alone that are important, but the value that we receive for those expenditures.

Table 1

Average Annual Increases in Overall and
Health Care Prices for Selected Years,
1955 to 1975
and for Economic Stabilization Period (ESP)

Year	CPI All Items	Medical Care	Semi-Private Room Charge
1955	2.2	3.8	6.9
1960	2.0	4.0	6.5
1965	1.3	2.5	5.8
1967	2.9	7.1	19.8
1970	5.9	6.5	12.9
1975	8.5	10.0	19.1
ESP (Aug '71 - April 1974)	6.4	4.5	5.7

Table 2

Federal Outlays for Health Services, 1977 and 1981
(\$ in billions)

	<u>1977</u>	<u>1981</u>
Current Policy	\$ 32.5	\$ 52.0
Changes From Current Policy		
Targeted Approach	8.5 to 10.5	22.5 to 27.5
Premium Financed	13.5 to 15.5	19.0 to 29.0
Tax Financed	74.5 to 77.5	105.5 to 140.0

Table 3

Total National Spending (Private and Public)
for Personal Health Services, 1977 and 1981
(\$ in billions)

	<u>1977</u>	<u>1981</u>
Current Policy	\$ 142	\$ 238
Targeted Approach	148 to 149	249 to 256
Premium Financed Comprehensive National Health Insurance	152 to 153	235 to 256
Tax Financed Comprehensive National Health Plan	152 to 154	217 to 273