



Testimony

**Statement of
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Expanding Health Insurance Coverage and Controlling Costs for Health Care

**before the
Committee on the Budget
United States Senate**

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Chairman Conrad, Senator Gregg, and Members of the Committee, thank you for inviting me to testify this morning about the opportunities and challenges that the Congress faces in pursuing two major policy goals: (1) expanding health insurance coverage, so that more Americans receive appropriate health care without undue financial burden, and (2) making the health care system more efficient, so that it can continue to improve Americans' health but at a lower cost in both the public and private sectors. Both are complex endeavors in their own right, and interactions and trade-offs between them may arise.

First, with respect to expanding health insurance coverage, my testimony makes the following key points:

- Without changes in policy, a substantial and growing number of people under age 65 will lack health insurance. The Congressional Budget Office (CBO) estimates that the average number of nonelderly people who are uninsured will rise from at least 45 million in 2009 to about 54 million in 2019. That projection is consistent with long-standing trends in coverage and largely reflects the expectation that health care costs and health insurance premiums will continue to rise faster than people's income—making health insurance more difficult to afford.
- Proposals could achieve near-universal health insurance coverage by combining three key features:
 - Mechanisms for pooling risks—both to ensure that people who develop health problems can find affordable coverage and to keep people from waiting until they are sick to sign up for insurance. Options include strengthening the current employment-based system, modifying the market for individually purchased insurance, and establishing a new mechanism such as an insurance exchange.
 - Subsidies to make health insurance less expensive for individuals and families, particularly those with lower income who are most likely to be uninsured today. For reasons of equity and administrative feasibility, however, it is difficult for subsidy systems to avoid “buying out the base”—that is, providing new subsidies to people who already have insurance or would have purchased it anyway.
 - Either an enforceable mandate for individuals to obtain insurance or an effective process to facilitate enrollment in a health plan. An enforceable mandate would generally have a greater effect on coverage rates, but without meaningful subsidies, it could impose a substantial burden on many people—given the cost of health insurance relative to the financial means of most uninsured individuals.

- Certain trade-offs arise in choosing how to design subsidies and mandates. To achieve near-universal coverage through subsidies alone would require that they cover a very large share of the premiums—which is an expensive proposition. But policymakers may also be reluctant to establish the penalties and enforcement mechanisms necessary to make a mandate effective. Other policies that adopted more limited versions of those three features could reduce the number of uninsured people to a lesser extent at a lower budgetary cost.

Second, with respect to controlling costs and improving efficiency—so that we get the best health for the amount we spend as a nation—some key considerations are these:

- Spending on health care has generally grown much faster than the economy as a whole, and that trend has continued for decades. In part, that growth reflects the improving capabilities of medical care—which can confer tremendous benefits by extending and improving lives. Studies attribute the bulk of cost growth to the development of new treatments and other medical technologies, but features of the health care and health insurance systems can influence how rapidly and widely new treatments are adopted.
- The high and rising costs of health care impose an increasing burden on the federal government as well as state governments and the private sector. Under current policies, CBO projects, federal spending on Medicare and Medicaid will increase from about 5 percent of gross domestic product (GDP) in 2009 to more than 6 percent in 2019 and about 12 percent by 2050. Most of that increase will result from growth in per capita costs rather than from the aging of the population. In the private sector, the growth of health care costs has contributed to slow growth in wages because workers must give up other forms of compensation to offset the rising costs of employment-based insurance.
- The available evidence also suggests that a substantial share of spending on health care contributes little if anything to the overall health of the nation, but finding ways to reduce such spending without also affecting services that improve health will be difficult. In many cases, the current system does not create incentives for doctors, hospitals, and other providers of health care—or their patients—to control costs. Significantly reducing the level or slowing the growth of health care spending below current projections would require substantial changes in incentives. Given the central role of medical technology in cost growth, reducing or slowing spending over the long term would probably require decreasing the pace of adopting new treatments and procedures or limiting the breadth of their application.

Third, controlling costs and improving efficiency present many challenges, but there are a number of approaches about which many analysts would probably concur:

- Many analysts would agree that payment systems should move away from a fee-for-service design and should instead provide stronger incentives to control costs, reward value, or both. A number of alternative approaches could be considered—including fixed payments per patient, bonuses based on performance, or penalties for substandard care—but their precise effects are uncertain. Policymakers may thus want to test various options (for example, using demonstration programs in Medicare) to see whether they work as intended or to determine which design features work best. Almost inevitably, though, reducing the amount that is spent on health care will involve some cutbacks or constraints on the number and types of services provided relative to currently projected levels.
- Many analysts would agree that the current tax exclusion for employment-based health insurance—which exempts most payments for such insurance from both income and payroll taxes—dampens incentives for cost control because it is open-ended. Those incentives could be changed by replacing the tax exclusion or restructuring it in ways that would encourage workers to join health plans with higher cost-sharing requirements and tighter management of benefits. (Given stronger incentives, the competition among health plans for enrollees could then determine the optimal mix of payment systems for providers.)
- Many analysts would agree that more information is needed about which treatments work best for which patients and about what quality of care different doctors, hospitals, and other providers deliver. The broad benefits that such information provides suggest a role for the government in funding research on the comparative effectiveness of treatments, in generating measures of quality, and in disseminating the results to doctors and patients. But absent stronger incentives to control costs and improve efficiency, the effect of information alone on spending will generally be limited.
- Many analysts would agree that controlling federal costs over the long term will be very difficult without addressing the underlying forces that are also causing private costs for health care to rise. Private insurers generally have more flexibility than Medicare’s administrators to adapt to changing circumstances—a situation that policymakers may want to remedy—but changes made in the Medicare program can also stimulate broader improvements in the health sector.

Fourth, many of the steps that analysts would recommend might not yield substantial budgetary savings or reductions in national spending on health care within a 10-year window—and others might increase federal costs or total spending—for several reasons:

- In some cases, savings may materialize slowly because an initiative is phased in. For example, Medicare could save money by reducing payments to hospitals that have a high rate of avoidable readmissions (for complications following a discharge) but would have to gather information about readmission rates and notify hospitals before such reductions could be implemented. More generally, the process of converting innovative ideas into successful programmatic changes could take several years. Of course, for proposals that would increase the budget deficit, phase-in schedules reduce the amount of the increase that is captured in a 10-year budget window.
- Even if they generate some offsetting savings, initiatives are not costless to implement. For example, expanding the use of disease management services can improve health and may well be cost-effective—that is, the value of the benefits could exceed the costs. But those efforts may still fail to generate net reductions in spending on health care because the number of people receiving the services is generally much larger than the number who would avoid expensive treatments as a result. In other cases, most of the initial costs would be incurred in the first 10 years, but little of the savings would accrue in that period.
- Moreover, the effect on the federal budget of a policy proposal to encourage certain activities often differs from the impact of those activities on total spending for health care. For example, a preventive service could be cost-reducing overall, but if the government began providing that service for free, federal costs would probably increase—largely because many of the payments would cover costs for care that would have been received anyway.
- In some cases, additional steps beyond a proposal are needed for the federal government to capture savings generated by an initiative. For example, requiring that hospitals adopt electronic health records would reduce their costs for treating Medicare patients, but the program’s payment rates would have to be reduced in order for the federal government to capture much of those savings.
- Savings from some initiatives may not materialize because incentives to reduce costs are lacking. For example, proposals to establish a “medical home” might have little impact on spending if the primary care physicians who would coordinate care were not given financial incentives to economize on their patients’ use of services. Those proposals could increase costs if they simply raised payments to those primary care physicians.

- In some cases, estimating the budgetary effects of a proposal is hampered by limited evidence. Studies generally examine the effects of discrete policy changes but typically do not address what would happen if several changes were made at the same time. Those interaction effects could mean that the savings from combining two or more initiatives will be greater than or less than the sum of their individual effects.

Finally, I offer some observations on the issues that arise when trying to expand coverage and reduce costs at the same time:

- By themselves, steps to substantially expand coverage would probably increase total spending on health care and would generally raise federal costs. Those federal costs would be determined primarily by the number of people receiving subsidies of their premiums and the average amount of the subsidy. Steps that reduced the costs of the health insurance policies would limit the federal costs of providing premium subsidies but could not eliminate those costs.
- An expansion of coverage could be financed in a number of ways. One option is to limit or eliminate the current tax exclusion for employment-based health insurance. The savings from taking such steps would grow steadily because the revenue losses that stem from that exclusion are rising at the same rate as health care costs. The same can generally be said about using reductions in Medicare or Medicaid spending to offset the costs of expanding insurance coverage. Those methods of financing could adversely affect some people's current coverage, however, and other financing options that would either raise revenues or reduce other spending are also available.

On a broad level, many analysts agree about the direction in which policies would have to go in order to make the health care system more cost-effective: Patients and providers both need stronger incentives to control costs as well as more information about the quality and value of the care that is provided. But much less of a consensus exists about crucial details regarding how those changes are made—and similar disagreements arise about how to expand insurance coverage. In part, those disagreements reflect different values or different assessments of the existing evidence, but often they reflect a lack of evidence about the likely impact of making significant changes to the complex system of health insurance and health care.

CBO's Recent Volumes on Health Care

Concerns about the number of people who are uninsured and about the rising costs of health insurance and health care have given rise to proposals that would substantially modify the U.S. health insurance system and that seek to reduce federal or total spending for health care. The complexities of the health insurance and health care systems pose a major challenge for the design of such proposals and inevitably raise

questions about their likely impact. To assist the Congress in its upcoming deliberations, CBO has produced two major reports that address such proposals.

The December 2008 report titled *Key Issues in Analyzing Major Health Insurance Proposals* describes the assumptions that CBO would use in estimating the effects of various elements of such proposals on federal costs, insurance coverage, and other outcomes. It also reviews the evidence upon which those assumptions are based and, if the evidence points to a range of possible effects rather than a precise prediction, the factors that would influence where a proposal falls within the range. The report does not provide a comprehensive analysis of any specific proposal; rather, it identifies and examines many of the critical factors that would affect estimates of a variety of proposals. In particular, it considers the types of issues that would arise in estimating the effects of proposals to:

- Provide tax credits or other types of subsidies to make insurance less expensive to the purchaser;
- Require individuals to purchase health insurance, typically paired with a new system of government subsidies;
- Require firms to offer health insurance to their workers or pay into a fund that subsidizes insurance purchases;
- Replace employment-based coverage with new purchasing arrangements or provide strong incentives for people to shift toward individually purchased coverage; or
- Provide individuals with coverage under, or access to, existing insurance plans such as the Medicare program, either as an additional option or under a “Medicare-for-all” single-payer arrangement.

Wherever possible, the analysis describes in quantitative terms how CBO would estimate the budgetary and other effects of such proposals. In other cases, it describes the components that a proposal would have to specify in order to permit estimation of those effects. The report reflects the current state of CBO’s analysis of and judgments about the likely response of individuals, employers, insurers, and providers to changes in the health insurance and health care systems. Certainly, the details of particular policies and the way in which they are combined, as well as new evidence or analysis related to the issues discussed here, could affect CBO’s estimates of the effects of large-scale health insurance proposals.

The December 2008 report titled *Budget Options, Volume 1: Health Care*, comprises 115 discrete options to alter federal programs, affect the private health insurance market, or both. It includes many options that would reduce the federal budget deficit and some that would increase it. Although similar to CBO’s previous reports on budget options, this volume reflects an extensive and concerted effort to substantially

expand the range of topics and types of proposals considered and includes estimates of many approaches that the agency had not previously analyzed. (Volume 2, containing budget options that are not related to health care, is forthcoming.) The report is organized thematically, rather than by program, and covers the following areas:

- The private health insurance market and the tax treatment of health insurance;
- Changing the availability of health insurance through existing federal programs;
- The quality and efficiency of health care and geographic variation in spending for Medicare;
- Paying for services in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP);
- Premiums and cost sharing in federal health programs;
- Long-term care;
- Health behavior and health promotion; and
- Closing the gap between Medicare’s spending and receipts.

The options that were included stem from a variety of sources, including extensive discussions with Congressional staff; reviews of legislative proposals, the President’s budget, and academic literature; and analyses conducted by CBO staff, other government agencies, and private groups. Although the number of health-related policy options is significantly greater than in previous *Budget Options* volumes, it is not an exhaustive list. CBO’s estimates are sensitive to the precise specifications of each option and could change in the future for a variety of reasons, including changes in economic conditions or other factors that affect projections of baseline spending or the availability of new evidence about an option’s likely effects. It should also be noted that the options’ effects may not be additive; that is, there could be important interaction effects among options that make their cumulative impact larger or smaller than the sum of the estimates. Some of the options that are particularly complex may be candidates for demonstration projects or pilot programs, which could help resolve the uncertainty about their effects.¹

The remainder of my testimony largely summarizes the conclusions reached in the *Key Issues* volume. Those conclusions—and the background information and evidence

1. Estimates of the impact on revenues of proposals to change the federal tax code are prepared by the staff of the Joint Committee on Taxation (JCT) and would be incorporated into any formal CBO estimate of a proposal’s effects on the federal budget. For its recent reports on health care, CBO consulted with JCT about the behavioral considerations that are incorporated into both agencies’ estimates, and JCT prepared the revenue estimates for several of the options.

on which they are based—are also relevant to much of CBO’s analysis for the *Budget Options* volume. Although summarizing all 115 options would not be feasible here, my testimony highlights some of the agency’s main findings.

Background on Spending and Coverage

Spending on health care and related activities will account for about 18 percent of GDP in 2009—an expected total of \$2.6 trillion—and under current law that share is projected to reach 20 percent by 2017. Annual health expenditures per capita are projected to rise from about \$8,300 to about \$13,000 over that period. Federal spending accounts for about one-third of those totals, and federal outlays for the Medicare and Medicaid programs are projected to grow from about \$720 billion in 2009 to about \$1.4 trillion in 2019. Over the longer term, rising costs for health care represent the single greatest challenge to balancing the federal budget. (For additional discussion, see the November 2007 CBO report *The Long-Term Outlook for Health Care Spending*.)

The number of people who are uninsured is also expected to increase because health insurance premiums are likely to continue rising much faster than income, which will make insurance more difficult to afford. As noted above, CBO estimates that the average number of nonelderly people who are uninsured will rise from at least 45 million in 2009 to about 54 million in 2019. The estimate for 2009 does not reflect the recent deterioration in economic conditions, which could result in a larger uninsured population, nor does it take into account recently enacted legislation.

Employment-Based Insurance

For several reasons, most nonelderly individuals obtain their insurance through an employer, and employment-based plans now cover about 160 million people, including spouses and dependents. One fundamental reason such plans are popular is that they are subsidized through the tax code—because nearly all payments for employment-based insurance are excluded from taxable compensation and thus are not subject to income and payroll taxes. Another factor is the economies of scale that larger group purchasers enjoy, which reduce the average amount of administrative costs that are embedded in premiums; partly as a result, large employers are more likely than small employers to offer insurance to their workers. Overall, about three-fourths of workers are offered employment-based insurance and are eligible to enroll in it.

Another commonly cited reason for the popularity of employment-based policies is that employers offering coverage usually pay most of the premium—a step they take partly to encourage broad enrollment in those plans, which helps keep average costs stable. Ultimately, however, the costs of those employers’ payments are passed on to employees as a group, mainly in the form of lower wages.

Other Sources of Coverage

Other significant sources of coverage for nonelderly people include the individual insurance market and various public programs. Roughly 10 million people are covered by individually purchased plans, which have some advantages for enrollees; for example, they may be portable from job to job, unlike employment-based insurance. Even so, individually purchased policies generally do not receive favorable tax treatment. In most states, premiums may vary to reflect an applicant's age or health status, and applicants with particularly high expected costs are generally denied coverage.

Another major source of coverage is the federal/state Medicaid program and the related but smaller CHIP. Both programs provide free or low-priced coverage for children in low-income families and (to a more limited degree) their parents; Medicaid also covers poor individuals who are blind or disabled. On average, Medicaid and CHIP are expected to cover about 43 million nonelderly people in 2009 (and there are also many people eligible for those programs who have not enrolled in them).² Medicare also covers about 7 million people younger than 65 who are disabled or have severe kidney disease.

About 12 million people have insurance coverage from various other sources, including federal health programs for military personnel. The total number of nonelderly people with health insurance at any given point in 2009 is expected to be about 216 million.

Approaches for Reducing the Number of Uninsured People

Concerns about the large number of people who lack health insurance have generated proposals that seek to increase coverage rates substantially or achieve universal or near-universal coverage. Two basic approaches could be used:

- Subsidizing health insurance premiums, either through the tax system or spending programs, which would make insurance less expensive for people who are eligible, or
- Establishing a mandate for health insurance, either by requiring individuals to obtain coverage or by requiring employers to offer health insurance to their workers.

By themselves, premium subsidies or mandates to obtain health insurance would not achieve universal coverage. Those approaches could be combined and could be implemented along with provisions to facilitate enrollment in ways that could achieve near-universal coverage. (Many of the issues and trade-offs that arise in designing such

2. That figure represents average enrollment (rather than the number of people enrolled at any time during the year) and excludes nonelderly individuals living in institutions (such as nursing homes), people living in U.S. territories, and people receiving only limited benefits under Medicaid (such as family planning services).

initiatives are also illustrated by the more incremental options to expand insurance coverage that are examined in the *Budget Options* volume.)

Subsidizing Premiums

Whether new subsidies are delivered through the tax system or a spending program, several common issues arise. Trade-offs exist between the share of the premiums that is subsidized, the number of people who enroll in insurance as a result of the subsidies, and the total costs of the subsidies. As the subsidy rate increases, more people will be inclined to take advantage of them, but the higher subsidy payments will also benefit those who would have decided to obtain insurance anyway. Beyond a certain point, therefore, the cost per newly insured person can grow sharply because a large share of the additional subsidy payments is going to otherwise insured individuals.

To hold down the costs of subsidies, the government could limit eligibility for subsidy payments to individuals who are currently uninsured. That restriction, however, would create incentives for insured individuals to drop their coverage. Some proposals might try to distinguish between people who become uninsured in response to subsidies and those who would have been uninsured in the absence of a government program (for example, by imposing waiting periods for individuals who were previously enrolled in an employment-based plan), but such proposals could be very difficult to administer. In addition, providing benefits only to the uninsured might be viewed as unfair by people with similar income and family responsibilities who purchased health insurance and would therefore be ineligible for the subsidies.

Another approach to limiting costs would target subsidies toward the lower-income groups, who are most likely to be uninsured otherwise, but such approaches can also have unintended consequences that affect the costs of a proposal. If eligibility was limited to people with income below a certain level, then those with income just above the threshold would have strong incentives to work less or hide income in order to qualify for the subsidies or maintain their eligibility. Phasing out subsidies gradually as income rises would reduce those incentives, but it would increase the amount of subsidy payments that go to individuals and families who would have had insurance in any event.

Restructuring the Existing Tax Subsidies. Tax subsidies could be restructured to expand coverage in several ways. For example, the current tax exclusion for employment-based health insurance could be replaced with a deduction or tax credit to offset the costs of insurance, and tax subsidies could be extended to include policies purchased in the individual insurance market. That step would sever the link between employment and tax subsidies for private health insurance and could give similar people the same subsidy whether or not they were offered an employment-based health plan.

Deductions and credits differ, however, in their effectiveness at reaching the uninsured. An income tax deduction might provide limited benefits to low-income

individuals because, like the existing exclusion, its value is less for those in lower tax brackets. In contrast, tax credits can be designed to provide lower- and moderate-income taxpayers with larger benefits than they would receive from tax deductions or exclusions. An important question regarding tax credits—particularly for lower-income people who pay relatively little in income taxes and are also more likely to be uninsured—is whether the credits would be refundable and therefore fully available to individuals with little or no income tax liability.

For the same budgetary costs, a refundable tax credit might be more effective at increasing insurance coverage, both because it can be designed to provide a larger benefit to low-income people than they receive under current law and because those recipients might be more responsive to a given subsidy than are people with higher income. Still, the effect on coverage rates might be limited if people do not receive refundable tax credits before their premium payments are due.

Providing Subsidies Through Spending Programs. The government could seek to increase coverage rates by spending funds to subsidize insurance premiums. New subsidies could be provided implicitly by expanding eligibility for Medicare, Medicaid, or CHIP or explicitly by creating a new program. To hold costs down, benefits could be targeted on the basis of income, assets, family responsibilities, and insurance status. Targeting benefits, however, would require program administrators to certify eligibility and enforce the program's rules, which would affect coverage and the program's costs.

The Effects of Subsidy Proposals. Proposals to subsidize insurance coverage would affect decisions by both employers and individuals. Employers' decisions to offer insurance to their workers reflect the preferences of their workers, the cost of the insurance that they can provide, and the costs of alternative sources of coverage that workers would have. Smaller firms appear to be more sensitive to changes in the cost of insurance than are larger employers. Subsidies that reduce the cost of insurance offered outside the workplace would cause some firms to drop coverage or reduce their contributions. When deciding whether to enroll in employment-based plans, workers would consider the share of the premium that they pay as well as the price and attractiveness of alternatives. The available evidence indicates that a small share of the population would be reluctant to purchase insurance even if subsidies covered nearly all of the costs.

Related Budget Options. Several of the alternatives included in CBO's *Budget Options* volume highlight the potential effects of changing the tax treatment of health insurance. For example, Option 10 would replace the current exclusion from income taxes for employment-based health insurance with a tax deduction that phases out at higher income levels. That option would increase federal revenues by approximately \$550 billion through 2018 (as estimated by the staff of the Joint Committee on Taxation). Because that option would increase the effective price of health insurance for higher-income taxpayers, it would, by CBO's estimation, increase the number of

uninsured people by about 1.5 million in 2014 (in part because some employers would decide to stop offering coverage). Those estimates are sensitive to the parameters of the deduction and particularly to the range of income over which the deduction is phased out.

Other examples illustrate the effects on federal costs and coverage that stem from targeting different populations. Allowing low-income young adults to enroll in Medicaid, as described in Option 23, would cover about 1.1 million people in 2014, at a federal cost of about \$22 billion over the 2010–2019 period, according to CBO’s estimates. Allowing low-income parents with children eligible for Medicaid to enroll in the program, as described in Option 24, would cost about \$38 billion over the same period and would expand coverage to about 1.4 million parents and 700,000 children in 2014.

Another approach is illustrated by Option 7, which would create a voucher program to subsidize the purchase of health insurance for households with income below 250 percent of the federal poverty level. Specifically, individuals would receive up to \$1,500, and families would receive up to \$3,000. According to CBO’s estimates, that approach would reduce the net number of uninsured people by about 2.2 million in 2014. Overall, approximately 4 million people would use the voucher, but about 1.7 million of those people would have had coverage in the individual health insurance market or through an employer. In addition, about 100,000 people would become newly uninsured as a result of small employers’ electing not to offer coverage because of the new voucher program. The total cost to the federal government of such a voucher program would be about \$65 billion over the next decade.

Mandating Coverage

In an effort to increase the number of people who have health insurance or to achieve universal or near-universal coverage, the government could require individuals to obtain health insurance or employers to offer insurance plans. Employer mandates could include a requirement that employers contribute a certain percentage of the premium, which would encourage their workers to purchase coverage. To the extent that the required contributions exceeded the amounts that employers would have paid under current law, offsetting reductions would ultimately be made in wages and other forms of compensation.

The impact of a mandate on the number of people covered by insurance would depend on its scope, the extent of enforcement, and the incentives to comply, as well as the benefits that enrollees received. Individual mandates, for example, could be applied broadly to the entire population of the United States or to a specific group, such as children; employer mandates might vary by the size of the firm. (Option 3 in the *Budget Options* volume is a specific requirement for large employers to offer coverage or pay a fee. Under the provisions of that option, the number of newly insured individuals would be relatively small, only about 300,000.)

Penalties would generally increase individuals' incentives to comply with mandates, but when deciding whether to obtain insurance, people would also consider the likelihood of being caught if they did not comply. Data from the tax system and from other government programs, where overall rates of compliance range from roughly 60 percent to 90 percent, indicate that mandates alone would not achieve universal coverage, largely because some people would still be unwilling or unable to purchase insurance.

Facilitating Enrollment

Simplifying the process of enrolling in health insurance plans or applying for subsidies could yield higher coverage rates and could also increase compliance with a mandate to obtain coverage. One approach would be to enroll eligible individuals in health insurance plans automatically, giving them the option to refuse that coverage or to switch to a different plan. Automatic enrollment has been found to increase participation rates in retirement plans and government benefit programs. It requires the government, an employer, or some other entity to determine the specific plan into which people will be enrolled, however, and those choices may not always be appropriate for everyone.

Factors Affecting Insurance Premiums

Premiums for employment-based plans are expected to average about \$5,000 per year for single coverage and about \$13,000 per year for family coverage in 2009. Premiums for policies purchased in the individual insurance market are, on average, much lower—about one-third lower for single coverage and one-half lower for family policies. Those differences largely reflect the fact that policies purchased in the individual market generally cover a smaller share of enrollees' health care costs, which also encourages enrollees to use fewer services. An offsetting factor is that average administrative costs are much higher for individually purchased policies. The remainder of the difference in premiums probably arises because people who purchase individual coverage have lower expected costs for health care to begin with.

The federal costs of providing premium subsidies, and the effects of those subsidies on the number of people who are insured, would depend heavily on the premiums charged. Premiums reflect the average cost that any insurer—public or private—incur, and those costs are a function of several factors:

- The scope of benefits the coverage includes and its cost-sharing requirements,
- The degree of benefit management that is conducted,
- The administrative costs the insurer incurs, and
- The health status of the individuals who enroll.

Insurers' costs also depend on the mechanisms and rates used to pay providers and on other forces affecting the supply of health care services. Proposals could affect many of those factors directly or indirectly. For example, the government might specify a minimum level of benefits that the coverage must provide in order to qualify for a subsidy or fulfill a mandate; such a requirement could have substantial effects on the proposal's costs or its impact on coverage rates.

Design of Benefits, Cost Sharing, and Related Budget Options

Health insurance plans purchased in the private market tend to vary only modestly in the scope of their benefits—with virtually all plans covering hospital care, physicians' services, and prescription drugs—but they vary more substantially in their cost-sharing requirements. A useful summary statistic for comparing plans with different designs is their “actuarial value,” which essentially measures the share of health care spending for a given population that each plan would cover. Actuarial values for employment-based plans typically range between 65 percent and 95 percent, with an average value between 80 percent and 85 percent. Cost-sharing requirements for enrollees tend to be greater for policies purchased in the individual insurance market, where actuarial values generally range from 40 percent to 80 percent, with an average value between 55 percent and 60 percent.

Public programs also vary in the extent of the coverage they provide. Medicaid requires only limited cost sharing (reflecting the low income of its enrollees); cost sharing under CHIP may be higher but is capped as a share of family income. Medicare's cost sharing varies substantially by the type of service provided; for example, home health care is free to enrollees, but most hospital admissions incur a deductible of about \$1,000. In addition, the program does not cap the out-of-pocket costs that enrollees can incur. Overall, the actuarial value of Medicare's benefits for the nonelderly population is about 15 percent lower than that of a typical employment-based plan. Those considerations would affect CBO's analysis of proposals to expand enrollment in public programs.

In general, the more comprehensive the coverage provided by a health plan, the higher the premium or cost per enrollee. Indeed, an increase in a health plan's actuarial value would also lead enrollees to use more health care services. Reflecting the available evidence, CBO estimates that a 10 percent decrease in the out-of-pocket costs that enrollees have to pay would generally cause their use of health care to increase by about 1 percent to 2 percent. The agency would apply a similar analysis to proposals that included subsidies to reduce the cost-sharing requirements that lower-income enrollees face.

Several budget options examine the effects of changing cost-sharing requirements in the Medicare program. Option 81 would replace the program's current requirements with a unified deductible, a uniform coinsurance rate, and a limit on out-of-pocket costs. That option would reduce federal spending by about \$26 billion over 10 years—mostly because of the increase in cost sharing for some services and the resulting

reduction in their use. Option 83 would combine those changes in the Medicare program with limits on the extent to which enrollees could purchase supplemental insurance policies (known as medigap plans) that typically cover all of Medicare's cost-sharing requirements. That option would reduce federal spending by about \$73 billion over 10 years—with the added savings emerging because enrollees would be more prudent in their use of care once their medigap plans did not cover all of their cost-sharing requirements. Options 84, 85, and 86 would reduce federal outlays by imposing cost sharing for certain Medicare services that are now free to enrollees, and Option 89 would increase federal outlays by eliminating the gap in coverage (commonly called the doughnut hole) in the design of Medicare's drug benefit. Options 95 through 98 would reduce federal spending by introducing or increasing cost-sharing requirements for health care benefits provided to veterans, military retirees and their dependents, and dependents of active-duty personnel.

Management of Benefits

Another factor affecting health insurance premiums and thus the costs or effects of legislative proposals is the degree of benefit and cost management that insurers apply. Nearly all Americans with private health insurance are enrolled in some type of “managed care” plan, but the extent to which specific management techniques are used varies widely. Common techniques to constrain costs include negotiating lower fees with a network of providers, requiring that certain services be authorized in advance, monitoring the care of hospitalized patients, and varying cost-sharing requirements to encourage the use of less expensive prescription drugs. Overall, CBO estimates, premiums for plans that made extensive use of such management techniques would be 5 percent to 10 percent lower than for plans using minimal management. Conversely, proposals that restricted plans' use of those tools would result in higher health care spending than proposals that did not impose such restrictions.

Administrative Costs

Some proposals would affect the price of health insurance by changing insurers' administrative costs. Some types of administrative costs (such as those for customer service and claims processing) vary in proportion to the number of enrollees in a health plan, but others (such as those for sales and marketing efforts) are more fixed; that is, those costs are similar whether a policy covers 100 enrollees or 100,000. As a result of those economies of scale, the average share of the policy premium that covers administrative costs varies considerably—from about 7 percent for employment-based plans with 1,000 or more enrollees to nearly 30 percent for policies purchased by very small firms (those with fewer than 25 employees) and by individuals.

Some administrative costs would be incurred under any system of health insurance, but proposals that shifted enrollment away from the small-group and individual markets could avoid at least a portion of the added administrative costs per enrollee that are observed in those markets. In general, however, substantial reductions in administrative costs would probably require the role of insurance agents and brokers

in marketing and selling policies to be sharply curtailed and the services they provide to be rendered unnecessary.

Spending by Previously Uninsured People

The impact that the mix of enrollees has on health insurance premiums is also an important consideration, particularly for proposals that would reduce the number of people who are uninsured. The reason is that the use of health care by the previously uninsured will generally increase when they gain coverage. On average, the uninsured currently use about 60 percent as much care as the insured population, CBO estimates, after adjusting for differences in demographic characteristics and health status between the two groups.

On the basis of the research literature and an analysis of survey data, CBO estimates that enrolling all people who are currently uninsured in a typical employment-based plan would increase their use of services by 25 percent to 60 percent; that is, they would use between 75 percent and 95 percent as many services as a similar group of insured people. The remaining gap in the use of services reflects the expectation that, on average, people who are uninsured have a lower propensity to use health care, a tendency that would persist even after they gained coverage. For more incremental increases in coverage rates, CBO would expect that people who chose to enroll in a new program would be more likely to use medical care than those who decided not to enroll.

In addition, recent estimates indicate that about a third of the care that the uninsured receive is either uncompensated or undercompensated—that is, they either pay nothing for it or pay less than the amount that a provider would receive for treating an insured patient. To the extent that such care became compensated under a proposal to expand coverage, health care spending for the uninsured would increase, regardless of whether their use of care also rose.

Proposals Affecting the Choice of an Insurance Plan

The government could affect the options available to individuals when choosing a health insurance plan—and the incentives they face when making that choice—in a number of ways. In particular, proposals could establish or alter regulations governing insurance markets, seek to reveal more fully the relative costs of different health insurance plans, or have the federal government offer new health insurance options.

The effects of proposals on insurance markets would depend on more than the impact they have on the premiums charged or on the share of the premium that enrollees have to pay; those effects would also reflect the market dynamics that arise as individuals shift among coverage options and as policy premiums adjust to those shifts. In particular, the risk that some plans would experience “adverse selection”—that is, that their enrollees will have above-average or higher-than-expected costs for health care—

has important implications for the operation of insurance markets and for proposals that would regulate those markets or introduce new insurance options.

Insurance Market Regulations and Related Budget Options

Proposals could seek to establish or alter regulations governing the range of premiums that insurers may charge or the terms under which individuals and groups purchase coverage. Purchases in the individual insurance market and most policies for small employers are governed primarily by state regulations. Those regulations differ in the extent to which they limit variation in premiums, require insurers to offer coverage to applicants, permit exclusions for preexisting health conditions, or mandate coverage of certain benefits. Roughly 20 percent of applicants for coverage in the individual market have health problems that raise their expected costs for health care substantially, and in most states they may be charged a higher premium or have their application denied; as a result, premiums are correspondingly lower in those states for the majority of applicants.

Proposals might seek to modify the regulation of health insurance markets in order to make insurance more affordable for people with health problems or to give consumers more choices, but those goals might conflict with each other. For example, limiting the extent to which premiums for people in poor health can exceed those for people in better health (as some states currently do) would reduce premiums for those who have higher expected costs for health care, but it would also raise premiums for healthier individuals and thus could reduce their coverage rates. Other proposals might counteract such limits on variations in premiums—for example, by allowing people to buy insurance in other states. That approach would enable younger and relatively healthy individuals living in states with tight limits to purchase a cheaper policy in another state. Older and less healthy residents who continued to purchase individual coverage in the tightly regulated states, however, would probably face higher premiums as a result.

By themselves, changes in the regulation of the small-group and individual insurance markets would generally have modest effects on the federal budget and on the total number of people who are insured. Those budgetary effects would primarily reflect modest shifts into or out of Medicaid, CHIP, or employment-based coverage as those options became more or less attractive relative to coverage in the individual market. Proposals to require insurers to cover all applicants or to guarantee coverage of preexisting health conditions would benefit people whose health care would not be covered otherwise, but insurers would generally raise premiums to reflect the added costs.

Another approach that has attracted attention recently involves so-called high-risk pools. Most states have established such pools to subsidize insurance for people who have high expected medical costs and have either been denied coverage in the individual insurance market or been quoted a very high premium. Overall participation in high-risk pools is limited—there are currently about 200,000 enrollees nationwide—but proposals could seek to expand the use of those pools by providing new federal

subsidies. The costs of such subsidies would depend primarily on the average health care costs of enrollees, the share of those costs covered by the pool, and the number of people who enrolled as a result.

CBO analyzed several specific options related to the regulation of insurance markets in its *Budget Options* volume. For example, Option 2 would allow insurers licensed in one state to sell policies to individuals living in any other state and to be exempt from the regulations of those other states. Under that option, premiums would tend to rise for people with higher expected costs for health care living in states that tightly regulate insurance markets, and premiums would fall correspondingly for low-cost individuals in those states because some of them would find insurance policies with lower premiums sold in other states with looser regulations. As a result, according to CBO's estimates, by 2014 about 600,000 people with relatively low expected health care spending would gain coverage and about 100,000 people with higher expected costs would drop their coverage. In addition, some firms would stop offering health insurance plans altogether, resulting in an additional loss of coverage for about 100,000 employees and their dependents. Those changes in coverage would generate nearly \$8 billion in additional federal revenues over 10 years, as some compensation shifted from untaxed health benefits to taxable wages. Among those who were no longer offered employment-based coverage, a small number would enroll in Medicaid causing roughly a \$400 million increase in federal outlays over the 2010–2019 period.

Option 6 would require states to use “community rating” of premiums for small employers who purchase coverage from an insurer—meaning that insurers would have to charge all applicants the same per-enrollee premium for a given policy. Under that option, total enrollment in the small-group health insurance market would fall by about 400,000 (or roughly 1 percent of current enrollment) in 2014, reflecting the net effect of both increased enrollment by people with high expected costs and decreased enrollment by people with low expected costs. The budget deficit would be reduced by about \$5 billion over the next decade, largely as a result of higher tax revenues. Option 4 would require all states to establish high-risk pools and provide federal subsidies toward enrollees' premiums. Enrollees would be responsible for paying premiums up to 150 percent of the standard rate for people of similar age. That option would increase the deficit by about \$16 billion over the 2010–2019 period; on net, about 175,000 individuals who would have been uninsured otherwise would gain insurance coverage in 2014.

Steps to Reveal Relative Costs

Some proposals would seek to restructure the choices that individuals face—and expose more clearly the relative costs of their health insurance options—either by reducing or eliminating the current tax subsidy for employment-based insurance or by encouraging or requiring the establishment of managed competition systems. Both approaches would provide stronger incentives for enrollees to weigh the expected benefits and costs of policies when making decisions about purchasing insurance. As a

result, many enrollees would choose health insurance policies that were less extensive, more tightly managed, or both, compared with the choices made under current law.

The current tax exclusion for the premiums of employment-based health plans provides a subsidy of about 30 percent, on average, if both the income and payroll taxes that are avoided are taken into account. Eliminating that exclusion, or replacing it with a fixed-dollar tax credit or deduction, would effectively require employees to pay a larger share of the added costs of joining a more expensive plan; conversely, employees would capture more of the savings from choosing a cheaper plan. As a result, according to CBO's estimates, people would ultimately select plans with premiums that were between 15 percent and 20 percent lower than the premiums they would pay under current law. Less extensive changes, such as capping the amount that may be excluded at a certain dollar value, would have proportionally smaller effects on average premiums.

The key features of a managed competition system involve a sponsor, such as an employer or government agency, offering a structured choice of health plans and making a fixed-dollar contribution toward the cost of that insurance. Enrollees would thus bear the cost of any difference in premiums across plans. In CBO's estimation, a proposal requiring that approach would yield average premiums for health insurance that were about 5 percent lower than those chosen under current law. Proposals that also adopted other features of managed competition, such as standardization of benefits across plans and adjustments of sponsors' payments to those plans to reflect the health risk of each enrollee, might yield more intense competition among plans and help avoid problems of adverse selection.

Federally Administered Options and Related Budget Options

Under some proposals, the federal government would make available additional options for insurance—for example, by providing access to the private health plans that are offered through the Federal Employees Health Benefits (FEHB) program. The effects of that approach would depend critically on how the premiums for non-federal enrollees were set. If insurers could charge different premiums to different applicants on the basis of their expected costs for health care, the option would resemble the current small-group and individual markets and thus would have little impact. Alternatively, if new enrollees were all charged the same premium, the FEHB plans would be most attractive to people who expected to have above-average costs for health care. If no subsidies were provided, the total premiums charged to nonfederal enrollees would probably be much higher than those observed in the program today—so the number of new enrollees would probably be limited. Depending on the specific features of such proposals, providing access to FEHB plans might not prove to be financially viable because of adverse selection into those plans.

The government could also design an insurance option based on Medicare that would be made more broadly available, on a voluntary basis, to the nonelderly population. The federal costs per enrollee would depend primarily on the benefits that system pro-

vided; the rates used to pay doctors, hospitals, and other providers of health care; and the extent of any premium subsidies that were offered to enrollees—all of which could differ from Medicare's current design. As for whether such a plan would be more or less costly than a private health insurance plan that provided the same benefits to a representative group of enrollees, the answer would vary geographically. Assuming that Medicare's current rules applied, those costs would be comparable in many urban areas, but in other areas, the cost of the government-run plan would be lower (as is evident in the current program through which Medicare beneficiaries may enroll in a private health plan). At the same time, because Medicare currently provides broad access to doctors and hospitals and employs little benefit management, a Medicare-based option might attract relatively unhealthy enrollees, which could drive up its premiums, federal costs, or both.

Many of the same considerations would arise in designing a single-payer, Medicare-for-all system, but that approach might raise some unique issues as well—and the scale of its impact on federal costs could obviously be much larger if nearly all of the population was covered. Enrollees could be offered a choice of plans under a single-payer system (as happens in Medicare). If, instead, only one design option was offered and all residents were required to enroll in it, then concerns about adverse selection would not arise. That approach could also reduce the administrative costs that doctors and hospitals currently incur when dealing with multiple insurers. The lack of alternatives with which to compare that program, however, could make it more difficult to assess the system's performance. More generally, that approach would raise important questions about the role of the government in managing the delivery of health care.

Under the provisions of Option 27 in the *Budget Options* volume—which would allow individuals and employers to buy into the FEHB program—CBO estimates that about 2.3 million people would enroll in 2014, of whom about 1.3 million would have been uninsured otherwise. The new program would constitute a separate insurance risk pool for nonfederal enrollees, and their premiums would not be the same as those for federal employees. However, premiums would be the same for all nonfederal enrollees within each plan in a particular geographic area and would be structured so that they did not lead to any new outlays by the federal government. The estimate reflects an assessment that the individuals who enrolled in the program would have greater-than-average health risks, which would lead to higher premiums than if the entire eligible population had enrolled in the program. Although considerable uncertainty exists about the financial viability of FEHB plans in such a program, CBO estimated that features such as an annual open-enrollment period, limited exclusions of coverage for preexisting health conditions, and participation by small employers would limit adverse selection and yield a stable pool of enrollees. The buy-in option would increase the deficit by almost \$3 billion from 2010 to 2019, reflecting the net effect of reduced revenues (from a shift in employers' compensation to nontaxable health insurance) and reduced outlays from lower enrollment in Medicaid.

Option 18 would establish a Medicare buy-in program for individuals ages 62 to 64. CBO's analysis reflects an assessment that the government could set a premium at a level such that the program was self-financing; that is, the premium would not be subsidized (and a mechanism would be established to ensure that outcome). As with the option to buy into the FEHB program, CBO would expect the buy-in program to attract individuals with higher-than-average health risks. Although the program would be structured so that enrollees paid its full costs through their premiums, federal spending would increase by about \$1 billion over 10 years because some people would choose to retire—and thus receive Social Security benefits—earlier than they would have otherwise. In a typical year of the buy-in program, CBO estimates, about 300,000 people would participate, of whom 200,000 would otherwise have purchased individual coverage, 80,000 would have been uninsured, and 20,000 would have remained employed and had employment-based coverage.

Factors Affecting the Supply and Prices of Health Care Services

The ultimate effects of proposals on the use of and spending for health care depend not only on factors that affect the demand for health care services, such as the number of people who are insured and the scope of their coverage, but also on factors that affect the supply and prices of those services. The various methods used for setting prices and paying for services, and the resulting payment rates, affect the supply of health care services by influencing the decisions that doctors, hospitals, and other providers of care make about how many patients to serve and which treatments their patients will receive. Average payment rates for Medicare, Medicaid, and private insurers also differ, which would affect the budgetary impact of proposals that shifted enrollees—and their costs—from one source of coverage to another. Changes in payment rates for public programs or in the amount of uncompensated care provided to the uninsured could also affect private payment rates.

Payment Methods, Incentives for Providers, and Related Budget Options

Most care provided by physicians in the United States is paid for on a fee-for-service basis, meaning that a separate payment is made for each procedure, each office visit, and each ancillary service (such as a laboratory test). Hospitals are generally paid a fixed amount per admission (a bundled payment to cover all of the services that the hospital provides during a stay) or an amount per day. Such payments may encourage doctors and hospitals to limit their own costs when delivering a given service or bundle, but they can also create an incentive to provide more services or more expensive bundles if the additional payments exceed the added costs.

Other arrangements, such as salaries for doctors or periodic capitation payments (fixed amounts per patient), do not provide financial incentives to deliver additional services. Those approaches raise concerns, however, about providers' incentives to stint on care or avoid treating sicker patients. One study randomly assigned enrollees to different health plans and found that those in an integrated plan (which owns the hospitals used by enrollees and pays providers a salary) used 30 percent fewer services

than enrollees in a fee-for-service plan, but whether those results could be replicated more broadly is unclear.

Proposals could seek to change payment methods either indirectly or directly. They could change the payment methods used by private health plans indirectly by encouraging shifts in enrollment toward plans that have lower-cost payment systems. For public programs, such as Medicare and Medicaid, federal policymakers could directly change payment methods. In either case, making those changes could prove to be very difficult.

Chapter 5 of CBO's *Budget Options* volume examines a number of policies that could change the way that providers are paid and thus the incentives they have. Most of those options focus on Medicare, but other options address Medicaid or the larger health care system. Some options would involve relatively modest changes in payment methods, but others would make more dramatic changes to those methods and thus to incentives for providers. Given the significant uncertainty surrounding the effects of some approaches, a series of pilot projects or demonstration programs might provide valuable insights into how to design new payment systems to achieve lower spending while maintaining or improving the quality of care.

Option 30, for example, would bundle Medicare's payments for hospital and post-acute care. Under the specifications of that option, federal spending would be reduced by about \$19 billion over the 2010–2019 period, CBO estimates. That approach would constitute a significant change in the way Medicare pays for post-acute care (which includes services provided by skilled nursing facilities and home health agencies). Medicare would no longer make separate payments for post-acute care services following an acute care inpatient hospital stay. Instead, the unit of payment for acute care provided in hospitals would be redefined and expanded to include post-acute care provided both there and in nonhospital settings. Hospitals would have incentives to reduce the cost of post-acute care for Medicare beneficiaries by lessening its volume and intensity or by contracting with lower-cost providers.

Option 38 illustrates how Medicare could move away from fee-for-service payments to physicians in favor of a blend of capitated and per-service payments. That option would require the Centers for Medicare and Medicaid Services (CMS) to assign each beneficiary who participates in fee-for-service Medicare to a primary care physician. Those physicians would receive approximately three-fourths of their Medicare payments on a per-service basis and approximately one-fourth under a capitated arrangement; they would also receive bonuses or face penalties, depending on the total spending for all Medicare services incurred by their panel of beneficiaries. In response to the incentives created by that payment approach, physicians would probably try to reduce spending among their panel of patients in several ways—for example, by limiting referrals to specialists, increasing their prescribing of generic medications, and reducing hospitalizations for discretionary procedures. According to CBO's estimates, this option would increase payments to physicians and decrease

payments to all other Medicare providers, with a net federal savings of about \$5 billion between 2010 and 2019.

Payment Rates and Related Budget Options

The financial incentives created by different payment systems—and the spending amounts they yield—also depend on the level at which payment rates, or prices, are set. Those rates depend partly on the methods that are used to set them. Private-sector payment rates are set by negotiation, reflecting the underlying costs of the services and the relative bargaining power of providers and health plans; in turn, bargaining power depends on factors such as the number of competing providers or provider groups within a local market area. Fee-for-service payment rates in Medicare and Medicaid are generally set administratively. That method poses a number of challenges, including how to determine providers' costs—particularly for services that require substantial training or that become cheaper to provide when they are performed more frequently. Additional issues include how to account for the quality of those services and their value to patients, and what impact rate setting might have on the development of new medical technology.

On average, payment rates under Medicare and Medicaid are lower than private payment rates. Specifically, Medicare's payment rates for physicians in 2006 were nearly 20 percent lower than private rates, on average, and its average payment rates for hospitals were as much as 30 percent lower. As for Medicaid, recent studies indicate that its payment rates for physicians and hospitals were about 40 percent and 35 percent lower, respectively, than private rates. Within Medicare, and probably within Medicaid as well, those differentials vary geographically and tend to be larger in rural areas and smaller in urban areas (where competition among providers is generally greater). Given those differences, proposals that shifted enrollment between private and public plans could have a large impact on payments to providers and on spending for health care. Depending on how providers responded to those changes, enrollees' access to care could be affected.

Chapters 7 and 8 of the *Budget Options* volume examine a wide variety of ways in which payment rates for medical services and supplies could be changed under both the Medicare and Medicaid programs. In particular, Option 55 would reduce (by 1 percentage point) the annual update factor under Medicare for inpatient hospital services; by CBO's estimates, that change would yield \$93 billion in savings over 10 years. Option 59 includes several alternatives for increasing payment rates for physicians under Medicare, which (under current law) are scheduled to fall by about 21 percent in 2010 and by about 5 percent annually for several years thereafter. The 10-year cost of those alternatives ranges from \$318 billion to \$556 billion.

Responses to Changes in Demand or Payment Rates

Changes in payment rates could also have an indirect effect on spending by altering the number of services that providers would be willing to supply. Similarly, the budgetary effects of covering previously uninsured individuals would depend not only on

the resulting increase in their demand for care but also on how that increase affected the supply and prices of services. Because the number of U.S.-trained physicians that will be available to work over the next 10 years is largely fixed, supply adjustments in the short run would have to occur in other areas—which could include changes in the number of hours doctors worked or in their productivity, inflows of foreign-trained physicians, or changes in doctors’ fees and patients’ waiting times.

Whether and to what extent the supply of physicians and other providers would become constrained also depends on the size of the increase in demand for their services and the amount of time available for adjustments to occur. CBO’s analysis indicates that providing the uninsured population with coverage that is similar to a typical employment-based plan would increase total demand for physicians’ services and hospital care by between 2 percent and 5 percent. If payment rates rose in response to that increase in demand, the impact on spending could be larger. Spending on behalf of previously uninsured people would also increase to the extent that the uncompensated care they had received became compensated.

Uncompensated Care and Cost Shifting

Another issue that arises when analyzing payment rates is whether relatively low rates for public programs or the costs of providing uncompensated or undercompensated care to the uninsured lead to higher payment rates for private insurers—a process known as cost shifting. To the extent that such cost shifting occurs now, proposals that reduced the uninsured population or that switched enrollees from public to private insurance plans could affect private payment rates and thus alter insurance premiums. For that to occur, however, doctors and hospitals would have to lower the fees they charged private health plans in response to a decline in uncompensated care or an increase in their revenues from insured patients.

Overall, the effect of uncompensated care on private-sector payment rates appears to be limited. According to one recent set of estimates, hospitals provided about \$35 billion in uncompensated care in 2008, representing roughly 5 percent of their total revenues.³ Roughly half of those costs may be offset, however, by payments under Medicare and Medicaid to hospitals that treat a disproportionate share of low-income patients. Estimates of uncompensated care provided by doctors are considerably smaller, amounting to a few billion dollars, so the costs of providing such care do not appear to have a substantial effect on private payment rates for physicians.

Whether and to what extent payments to hospitals under Medicare and Medicaid fall below the costs of treating those patients is more difficult to determine. Recent studies indicate, however, that when payment rates change under those programs, hospitals shift only a small share of the savings or costs to private insurers (the same logic would apply for uncompensated care). Instead, lower payment rates from public programs or

3. Jack Hadley and others, “Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs,” *Health Affairs*, Web Exclusive (August 25, 2008), pp. W399–W415.

large amounts of uncompensated care may lead hospitals to reduce their costs, possibly by providing care that is less intensive or of lower quality than would have been offered had payments per patient been larger.

Administrative Issues and Effects on Other Programs

The extent to which proposals would affect health insurance coverage or federal budgetary costs, and the timing of those effects, would depend partly on the administrative responsibilities and costs that those proposals entailed and partly on their interactions with other government programs. Other factors would also affect coverage and costs, including the impact of any maintenance-of-effort provisions that might be applied to states or employers and the treatment of various segments of the population, including people who are ineligible for current government health programs and those who—although eligible—are generally difficult to reach and enroll.

Administrative Issues

Proposals could require both federal and state governments to assume new administrative responsibilities and could allocate those responsibilities to new or existing agencies. How well agencies fulfilled new missions—and how long it would take them to do so—would depend on the scope of the new responsibilities and the funding provided. Even with adequate funding, implementing a major initiative might take several years, as illustrated by the experience with the new Medicare drug benefit. One way to ease the implementation of a new federal program would be to build on existing programs; CHIP, for example, was implemented relatively rapidly because it largely built on the existing infrastructure of the state-operated Medicaid program.

Maintenance-of-Effort Requirements

A proposal that created new subsidies for health insurance could lead employers or states to scale back the coverage that they sponsor, particularly if a new federally funded program provided similar or more generous benefits. To prevent such responses or offset their effects on federal spending, proposals could include maintenance-of-effort provisions. Monitoring and enforcing such requirements for private firms would be difficult, however, unless proposals specified effective reporting mechanisms and sufficient penalties for violations.

States' maintenance-of-effort provisions are generally structured in two ways: requiring states to maintain existing programs at historical eligibility or benefit levels (as is done under CHIP), or requiring states to continue spending funds at certain historical or projected levels or to return some of their savings to the federal government (as is done for the Medicare drug benefit). The effectiveness of such requirements would depend on how they were defined, the enforcement mechanisms that were specified, and the incentives for states to comply. The provisions for CHIP and the Medicare drug benefit are examples of effective approaches.

Effects on Other Federal Programs

Proposals could also have unintended effects on eligibility for other federal programs that are not directly related to health care. New subsidies for health insurance might be counted as income or assets when determining eligibility for benefits in means-tested programs (such as the Supplemental Nutrition Assistance Program, formerly known as the Food Stamp program) unless explicitly excluded by law. Proposals that changed the employment-based health insurance system could shift compensation between wages and fringe benefits, thus affecting eligibility for government benefits (including Social Security) or tax credits (such as the earned income tax credit) that are based on cash earnings. Temporary or aggregate adjustments could be made to benefit formulas in order to minimize any adverse effects, but some recipients might still be made worse off.

Treatment of Certain Populations

The treatment of certain populations would present various administrative challenges for proposals to expand coverage. Some individuals, including military personnel and veterans, already receive health benefits from the federal government, and issues might arise regarding the coordination of their current benefits with new federal subsidies. In other cases, federal health programs currently deny benefits to certain populations, such as unauthorized immigrants or prison inmates, and proposals would have to specify whether and how those restrictions would apply to new programs. Other populations, such as the homeless, face challenges enrolling in existing programs, and similar issues might arise in designing new subsidies for health insurance. Those considerations would affect both the costs of proposals and their overall impact on rates of insurance coverage.

Changes in Health Habits and Medical Practices

In addition to any broader changes they make in the health insurance and payment systems, proposals could include specific elements designed to induce individuals to improve their own health or to encourage changes in how diseases are treated. Through a combination of approaches, proposals could try to change the behavior of both patients and providers by:

- Promoting healthy behavior, including measures aimed at reducing rates of obesity and smoking;
- Expanding the use of preventive medical care, which can either impede the development or spread of a disease or detect its presence at an early stage;
- Establishing a “medical home” for each enrollee, typically involving a primary care physician who would coordinate all of his or her care;

- Adopting “disease management” programs that seek to coordinate care for and apply evidence-based treatments to certain diseases, such as diabetes or coronary artery disease;
- Funding research comparing the effectiveness of different treatment options, the results of which could help discourage the use of less clinically effective or less cost-effective treatments;
- Expanding the use of health information technology, such as electronic medical records, which would make it easier to share information about patients’ conditions and treatments; and
- Modifying the system for determining and penalizing medical malpractice.

Some of those initiatives could improve individuals’ health or enhance the quality of the care that they receive, but it is not clear that they also would reduce overall health care spending or federal costs. In its analysis of such initiatives, CBO considers the available studies that have assessed the particular approaches. In many cases, those studies do not support claims of reductions in health care spending or budgetary savings.

Challenges in Demonstrating Savings

For several reasons, it may be difficult to generate reductions in health care spending from such initiatives. In some cases, the problem is largely one of identifying and targeting the people whose participation would cause health care spending to decline. Broad programs aimed at preventive medical care and disease management could reduce the need for expensive care for a portion of the recipients but could also provide additional services—and incur added costs—for many individuals who would not have needed costly treatments anyway. To generate net reductions in spending, the savings that such interventions generated for people who would have needed expensive care would therefore have to be large enough to offset the costs of serving much larger populations.

A related issue is that many individuals or health plans might already be taking the steps involved (or will in the future) even in the absence of a new requirement or incentive. The effect of any proposal would have to be measured against that trend, and a large share of any subsidies involved might go to people who (or health plans that) would have taken those steps even if there were no requirements or incentives to do so. For example, some doctors and hospitals are already using electronic medical records, and more will adopt that technology in the future under current law, so new subsidy payments would go to many providers who would have purchased such systems anyway, and savings would accrue only for those providers who accelerated their purchases as a result of the subsidy.

In other cases, the effect on health care spending depends crucially on whether doctors and patients have incentives to change the use of health care services. For example, studies may find that a given treatment has fewer clinical benefits or is less cost-effective (meaning that added costs are high relative to the incremental health benefits) for certain types of patients—but those results may not have a substantial effect on the use of that treatment unless the financial incentives facing doctors (through their payments) or patients (through their cost sharing) are aligned with the findings. Similarly, proposals to establish a medical home may have little impact on spending if the primary care physicians who would coordinate care were not given financial incentives to limit their patients' use of other health services.

Other types of initiatives might ultimately yield substantial long-term health benefits but might not generate much savings, at least in the short term. Even if successful, measures to reduce smoking and obesity—two factors linked to the development of chronic and acute health problems—might not have a substantial impact on health care spending for some time. In the long term, spending on diseases caused by poor health habits could decline substantially, but the impact on federal costs would also have to account for people living longer and receiving more in Medicare benefits (for the treatment of other diseases and age-related ailments) as well as other government benefits that are not directly related to health care (including Social Security benefits). Similarly, investments in health information technology might require substantial start-up costs that would be difficult to recapture in the typical 5- and 10-year budgetary time frames used to evaluate legislative proposals.

Demonstrating savings might also be difficult because of data limitations and methodological concerns. For example, studies have found that tort limits, by reducing malpractice awards, cause premiums for malpractice insurance to fall and thus could have a very modest impact on doctors' fees and health care spending. Some observers argue that tort limits would yield larger reductions in that spending because doctors would stop ordering unnecessary tests and taking other steps to reduce the risk of being sued. CBO has not found consistent evidence of such broader effects, but that may reflect the difficulty of disentangling the impact of changes to the medical malpractice system from other factors affecting medical costs.

Related Budget Options

In its *Budget Options* volume, CBO estimated the effect of several approaches aimed at changing health habits or medical practice. For example, Option 106 would impose a new excise tax on sugar-sweetened beverages (equal to 3 cents per 12 ounces of beverage), which would raise about \$50 billion in revenues from 2010 to 2019. CBO did not, however, estimate that spending on health care would be reduced under that option. After evaluating the available evidence, CBO could not establish causal links between lower consumption of sugar-sweetened beverages (which would occur under the option) and the use of health care. Studies indicate, for example, that people would offset the reduction in their consumption of such beverages with increases in consumption of other unhealthy foods—so the impact on obesity rates is not clear. In

addition, even though obesity is associated with higher spending on health care, the effect of losing weight on spending for health care is more difficult to determine.

CBO also analyzed the effects of establishing a “medical home” for chronically ill enrollees in the Medicare fee-for-service program (see Option 39). As designed, that option would increase Medicare spending by about \$6 billion over 10 years because of the fees provided to practitioners who elected to become medical homes. Alternatively, approaches that would give primary care physicians a financial incentive to limit their patients’ use of expensive specialty care—such as the option imposing partial capitation, discussed above—could reduce Medicare spending (depending on the specific features of their design). In the realm of preventive medical care, CBO analyzed the impact of basing Medicare’s coverage of such services on evidence about their effectiveness (see Option 110). That option would save nearly \$1 billion over 10 years because it would lead the Medicare program to drop coverage for services that are currently covered even though an independent task force has recommended against their use (reflecting evidence that the preventive services are either ineffective or do more harm than good).

Under Option 45, the federal government would fund research that compares the effectiveness of different medical treatments. The results of that research would gradually generate modest changes in medical practice as providers responded to evidence on the effectiveness of alternative treatments, the net effect of which would be to reduce total spending on health care in the United States; the resulting reductions in spending for federal health programs would partly offset the federal costs of conducting that research. Option 8 would impose specific limits on medical malpractice awards; the resulting reduction in premiums for malpractice insurance would yield reductions in the federal budget deficit of nearly \$6 billion over 10 years. (CBO did not conclude that the option would have broader effects on the use of health care services.)

Finally, Options 46 through 49 provide various approaches to increase the adoption of health information technology and electronic medical records. Option 46 would create incentives under the Medicare program to adopt that technology; the primary effects on federal outlays would stem from the payment of bonuses for adopting it or the collection of penalties for not doing so. Option 47 would require doctors and hospitals to use electronic health records in order to participate in Medicare. CBO judged that virtually all doctors and hospitals would adopt electronic health records as a result, reducing the federal budget deficit by about \$34 billion over 10 years (or by a larger amount if Medicare’s payments to doctors and hospitals were also reduced to capture the resulting gains in their productivity).

Effects on Total Health Care Spending, the Scope of the Federal Budget, and the Economy

Proposals that would substantially change the health insurance market could affect total spending on health care, the flow of payments between various sectors of the economy, and the operation of the U.S. economy. CBO will consider those effects in its analyses of major health care proposals.

Effects on Total Spending and the Scope of the Federal Budget

Many health insurance proposals would have an impact on total spending for health care, and some might contain provisions that explicitly limit the level or rate of growth in health care spending; such proposals might impose a global budget or budgetary cap on all or a part of that spending. The effectiveness of such strategies would depend on several factors, including the scope of the global budget, the targets selected for different categories of spending, and the mechanisms used to enforce the caps.

In addition to their overall effects on federal spending and revenues, proposals that made substantial changes to the health insurance system or its financing methods could raise a number of budgetary issues. Such proposals could have substantial effects on the flows of payments among households, employers, and federal and state governments—even if the proposals were budget neutral from a federal perspective. Some proposals might assign the federal government a more active role in the health insurance market; for example, the government could be required to disburse subsidies covering the cost of health insurance, collect health insurance premiums from policyholders, or make payments to insurers. Any of those changes might raise questions regarding who—the government, the insured, or the insurer—would bear financial responsibility for any shortfalls in payments that might occur.

Other proposals might require that individuals or businesses make payments directly to nongovernmental entities. Depending on the specific provisions of such proposals, CBO might judge that payments resulting from federal mandates should be recorded as part of the federal budget even if the funds did not flow through the Treasury. The extent of federal control and compulsion is a critical element in determining budgetary treatment. In general, CBO believes that federally mandated payments—those resulting from the exercise of sovereign power—and the disbursement of those payments should be recorded in the budget as federal transactions.

Effects on the Economy

Proposals that made large-scale changes affecting the provision and financing of health insurance could also have an impact on the broader economy. Because most health insurance is currently provided through employers, proposals could affect labor markets by changing individuals' decisions about whether and how much to work and employers' decisions to hire workers. Such effects could arise in several ways:

- Proposals that decreased the return from an additional hour of work, by imposing new taxes or phasing out subsidies or credits for health insurance as earnings rise, could cause some people to work fewer hours or leave the labor force.
- Proposals that made health insurance less dependent on employment status could induce some people to retire earlier and others to change jobs more often.
- Proposals that treated firms differently on the basis of such characteristics as the number of employees or average wages could affect the allocation of workers among firms.
- Proposals that required employers to provide health insurance could adversely affect the hiring of employees earning at or near the minimum wage, because the total compensation of those workers could exceed their value to the firm.

Some observers have asserted that domestic firms providing health insurance to their workers incur higher costs for compensation than do competitors based in countries where insurance is not employment based and that fundamental changes to the health insurance system could reduce or eliminate that disadvantage. Although U.S. employers may appear to pay most of the costs of their workers' health insurance, economists generally agree that workers ultimately bear those costs. That is, when firms provide health insurance, wages and other forms of compensation are lower (by a corresponding amount) than they otherwise would be. As a result, the costs of providing health insurance to their workers are not a competitive disadvantage for U.S.-based firms.

In addition to their effects on the labor market, proposals could also affect the size of the nation's stock of productive capital, especially through their effects on government budgets. Those effects would depend partly on how the costs of any insurance expansions or other changes were financed. The net effect on the economy of a broad proposal to restructure the health insurance system would, not surprisingly, depend crucially on the details.