Order Code IB93030

CRS Issue Brief

Health Care Reform: Single-Payer Approaches

Updated March 16, 1994

by
Beth C. Fuchs
Education and Public Welfare Division

Congressional Research Service • The Library of Congress

Health Care Reform: Single-Payer Approaches

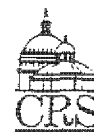
SUMMARY

Among the health reform bills introduced in the 103rd Congress are proposals to provide health insurance to most or all Americans through a "single-payer" system. Such bills are backed by many Democrats and some Republicans who claim that affordable health care for all is best achieved by ending the complexity and inefficiency resulting from our current system of multiple insurers, private and public, each with their own eligibility requirements, benefit packages, provider payment rules, and administrative expense. Single-payer bills are competing with other reform approaches (managed competition, tax approaches, etc.), each potentially producing different distributional effects on access and cost. One single-payer bill, H.R. 1200, had 90 House cosponsors as of Mar. 14, 1994. President Clinton's Health Security Act would allow a State to elect a single-payer system.

Proposals bearing the label "single payer" take a variety of forms. Most commonly, the term is used to describe a system in which the government would sponsor and pay for health care for all; often, such single-payer plans rely on broad-based taxes. Payments to providers are regulated and flow through a single pipeline; system-wide limits on spending may be imposed. Existing public insurance programs are subsumed under the new program; private insurance is eliminated or operated only to cover services not insured under the government plan. The system would be implemented at the national or State level, or through a Federal-State partnership. In the parlance of today's debate, it is the "Canadian approach." Other proposals use "single payer" to describe a system in which a framework is established for one Federal or State payer but other insuring entities distribution of program costs among consumers, employers, and governments. (such as HMOs) are available as alternatives, assuming they play by certain rules. Additional single-payer variants are found as well.

Single-payer approaches are supported by some consumer and physician groups and some employers and unions. Proponents say that moving to a single-payer, public insurance program covering all Americans would save billions of dollars in administrative expenses. In addition, they say it would end the shifting of costs from one insuring entity to another that currently impedes efforts to control spending. Assuming government subsidies of lower-income populations, such a system also would ensure universal access to adequate and affordable health insurance, without regard to ability to pay. Opponents argue that a single-payer system would lead to bureaucratic medicine in which consumer preferences would give way to government preferences in the determination of who gets what health care. They say it would reduce the innovation and diversity that has helped to bring the U.S. advances in health care delivery, technology, and financing. Opponents also claim critical medical resources would end up being rationed; millions would see their health insurance coverage deteriorate.

Major issues arising with respect to single-payer proposals include: the potential system-wide savings in administrative expenses (estimates greatly vary); the adequacy of the benefit package; methods for containing physician, hospital, and other provider costs (proposals differ in the stringency of cost controls); methods of containing system-wide expenditures; and ways to finance the system to achieve the preferred distribution of program costs among consumers, employers, and governments.



CONTENTS

SUMMARY

MOST RECENT DEVELOPMENTS

BACKGROUND AND ANALYSIS

- What is the Single-Payer Approach?
- Interest Group Views
- Arguments For and Against the Single-Payer Approach
- Administrative Cost Debate

- Major Issues Related to Single-Payer Proposals
  - Access, Benefit Coverage, and Quality
  - Cost Containment
    - Regulating provider payments
    - Limiting system-wide expenditures
  - Financing
    - Sources of financing
    - Financing the single-payer program
  - Cost Estimates

LEGISLATION

FOR ADDITIONAL READING

MOST RECENT DEVELOPMENTS

On Mar. 3, 1993, Representative McDermott and Senator Wellstone introduced the American Health Security Act of 1993 (H.R. 1200 and S. 491), a revised version of Representative Russo's 102nd Congress single-payer proposal. The McDermott-Wellstone proposal is seen by many as the major alternative to employer-based and tax-system options for expanding financial access to coverage. It is also viewed as an alternative to managed competition for achieving containment of health care costs. Single-payer proposals are among those being debated by the 103rd Congress as it considers ways to achieve health care reform. President Clinton's Health Security Act would allow a State to establish a State-wide single-payer system or to establish a single-payer system serving part of the State if it met specific requirements. A State electing this option would have to draw part of the financing of the system from employer payroll contributions.

BACKGROUND AND ANALYSIS

More discussion of health care reform is occurring today than at any time since the 1970s. This interest has been fueled by health care spending projected to reach almost 19% of the national economy by 2000 and rising numbers of uninsured (over 37.4 million in 1992). The public's concerns about unpaid medical bills, being locked in a job to maintain health benefits, and escalating insurance premiums have brought renewed attention to issues of universal coverage and cost containment. Now that President Clinton has sent to Congress his proposal -- the Health Security Act -- Congress is beginning what is likely to be a long debate over the many reform approaches.

One reform approach favored by some Members of Congress calls for moving away from our existing system of multiple sources of insurance to a system in which one entity serves as the insurer of all Americans. This is often called the *single-payer* approach. Single-payer bills in the 103rd Congress include, for example, H.R. 16, H.R. 1200, H.R. 2061, and S. 491. Another 103rd Congress bill, H.R. 2610, would expand Medicare to cover everyone, a clear variant of the single-payer approach. Some single-payer bills encourage managed care plans, such as health maintenance organizations (HMOs), as an alternative to the single public plan. One 103rd Congress bill, S. 1057 (Jeffords) provides for universal coverage under State programs; a State could elect a single-payer approach. Such single-payer proposals are among the options being considered by the 103rd Congress as it debates health care reform. Other options, however, including an employer mandate combined with managed competition, appear at this time to have broader support both in Congress and within the Clinton Administration. (See **FOR ADDITIONAL READING** for CRS products covering other approaches.)

What is the Single-Payer Approach?

Americans receive health insurance today from a wide variety of sources, including over 1200 commercial insurers, about 550 health maintenance organizations (HMOs), 69 Blue Cross/Blue Shield plans, self-insured plans operated by private employers, local and State governments, the Federal-State program for the poor and disabled (Medicaid) and the Federal Government (including Medicare, and the Veterans' Administration and

Defense Department programs). Each insuring entity has its own eligibility requirements, enrollment procedures, claims processing, and utilization and quality review programs, all of which add to administrative expense. For this reason, many people describe our system as multipayer or pluralistic.

Opponents of the current multipayer system say that the hundreds of different public and private insuring entities needlessly complicate the system and drive up the cost of health care. In their view, reform requires that we streamline the system, that we move towards a few entities, or a *single payer*, through which health insurance would be financed and medical services reimbursed. Such a system, they argue, would effectively contain costs because the single payer would exert monopsony power over provider payments. If a provider did not like what it was getting, it could not turn to another payer in the hopes of getting more, as it can in a multipayer system. It would also eliminate duplicate administrative costs.

Proposals bearing the label "single payer" take a variety of forms, and as such, the term can be more confusing than helpful as a tool of classification. Most commonly, the term "single payer" is used to describe an approach in which the government sponsors and pays for health care for all persons. Everyone gets their basic health insurance from the one government sponsored (i.e., public) plan. Typically, such single-payer plans are financed with revenues generated from income, payroll, and other taxes. All payments to hospitals, physicians, and other providers are regulated and originate with the government plan. System-wide controls on spending may also be in place. Existing public insurance programs, including Medicare, Medicaid, and Department of Defense and Veterans' Affairs programs are subsumed under the new, government program. Private insurance is either eliminated or maintained only to cover services not insured under the government plan. Such a single-payer approach can be implemented at the national or State level, or through a Federal-State partnership. In the parlance of today's debate, it is the "Canadian approach." It is most clearly reflected in such 103rd Congress bills as H.R. 1200 (McDermott), H.R. 2610 (Stark), and S. 491 (Wellstone).

Some proposals use the term "single payer" even though more than one entity may be authorized to play that role. These proposals set up a framework for one Federal or State payer but permit other insuring entities, such as HMOs or large employers, also to act as insurers, so long as they can meet specific requirements. While providers may receive payment from several sources, the rates of payment are typically set by the public insurer. At some point, such "single-payer" proposals begin to look more like the "all payer approach" reflected by the German health care system, and some State "all payer" rate regulation systems in which insurance companies and employer health plans are required to pay providers using predetermined uniform rates and fees, usually set through negotiation with providers. (Examples in the 102nd Congress include H.R. 3205 (Rostenkowski), H.R. 5502 (Stark), and H.R. 4889 (Cardin)). There are also proposals that channel the revenues for health insurance through a single entity, such as the Federal or a State government, but provide insurance through multiple public and public entities. The Dingell-Waxman bill in the 102nd Congress (H.R. 5514) took this approach, as does the plan proposed by California's insurance commissioner, John Garamendi.

This issue brief focuses on single-payer proposals that provide insurance coverage for all under one public program, which in turn is the main source of payment to physicians, hospitals, and other providers. It includes plans that are organized at the

national as well as State level. It also includes plans that establish the structure for a single-payer system but permit qualified health insurance arrangements, such as HMOs, to provide health insurance as well. While single-payer proposals could provide for public ownership of health care facilities and making all physicians and other providers employees of the public plan, this is not a requirement. Indeed, all but one bill in the 103rd Congress (H.R. 2061), would maintain a private delivery system.

Interest Group Views

Among interest groups, universal, single-payer public insurance is supported by some consumer organizations (Citizen Action, Consumers Union, Public Citizen), some elderly advocates (Gray Panthers and the National Council of Senior Citizens), some provider organizations (Physicians for a National Health Program, American Public Health Association, National Association of Social Workers), and some unions, including the American Federation of State, County and Municipal Employees, the Communications Workers of America, the United Mine Workers of America, the Oil, Chemical, and Atomic Workers Union, and some affiliates of the AFL-CIO. While some representatives of large corporations have expressed private support for the single-payer approach, organized corporate and small business interests (Chamber of Commerce, ERISA Industry Committee, National Association of Manufacturers, and National Federation of Independent Businesses) are opposed. Also opposed are most provider groups, including the American Hospital Association, the Federation of American Health Care Systems, the Pharmaceutical Manufacturers Association, the American Medical Association, as well as organizations representing the insurance industry, including Blue Cross and Blue Shield and the Health Insurance Association of America.

Arguments For and Against the Single-Payer Approach

Proponents of a single-payer approach use one or more of the following arguments to support their position:

Curb cost-shifting. Current cost containment efforts have not been effective because health care is financed and delivered through a nonsystem of multiple entities, each acting on its own behalf to shift the burdens of controlling costs and ensuring access to someone else. If cost constraints are placed on any one entity, such as Medicare, providers seek higher reimbursement from other payers, such as private insurers and employers. Under a pure single-payer system, one entity would be vested with the authority to determine how much money would flow to providers and to set rates and fees paid to providers within that overall limit. Providers could not seek additional payments elsewhere because there would be nowhere else to go. (Some proposals might allow providers to bill patients directly, but many prohibit such balance billing to protect enrollees from potential cost shifts.)

Streamline administration. Under our current system, billions of dollars are spent on administration, that is, on transactions between payers, providers, and consumers that have nothing to do with the actual delivery of medical services. Duplication and overlap result from the information requirements of multiple organizations; excessive red tape results from different eligibility and coverage rules. Such costs would be substantially reduced under a single-payer system. One entity would be enrolling

beneficiaries and paying claims. The administrative costs associated with private insurance, such as marketing, risk selection (underwriting), and the payment of agent commissions, would be eliminated. Other costly administrative transactions, such as data collection for quality assurance and utilization review, could be streamlined and improved. With only one payer instead of hundreds, physicians, and other providers would be subject to more uniform standards of medical review, reducing the intrusion on their clinical decisions. In short, the single-payer approach provides for simplicity of structure and organization that no other approach under discussion can match. Employer-based options, for example, require complex arrangements to ensure that everyone retains insurance, regardless of work status. (The issue of administrative costs is discussed in more detail below.)

Ensure universal access and continuity of coverage. Today, reliance on employer-based insurance for the majority of Americans leads to gaps in coverage for millions of workers and their families. In addition to the millions of uninsured whose employers do not offer insurance are millions more who experience temporary losses of coverage as they move in and out of jobs or on and off medicaid. A single-payer system would eliminate the reliance on employment as the principal path to becoming insured. All Americans would be covered under a single insurance program, without regard to health status, medical history, linkage to employment, or -- at least in most bills -- ability to pay. This would also ensure continuity of insurance coverage because changes in job or family status would not cause interruptions in payment for ongoing services.

Provide uniform benefits. Under the current multipayer system, benefit coverage varies widely. For example, persons covered under large employer group plans typically receive comprehensive benefits, and pay low deductibles and coinsurance. Persons covered under nongroup (i.e., individual) policies typically receive less generous coverage, and pay high deductibles and coinsurance. A single-payer system would ensure that everyone would be eligible for the same set of basic benefits, provided under the same set of cost-sharing and reimbursement rules. The source of insurance would no longer be a cause of inequality in access to care.

End rationing on the basis of ability to pay. Opponents of the single-payer approach argue that it will lead to rationing of medical resources, including high technology equipment, thereby reducing access and quality of care. Single-payer proponents respond that health care is already rationed in the U.S. by ability to pay; those who are uninsured get less care and poorer quality services than those who have insurance. Under a single-payer program, rationing would be explicit, subject to public debate, and independent of a person's financial status. Also, the U.S. currently has substantial excess capacity of hospital beds, physicians (particularly specialists), technology, and unnecessary services. By managing provider payments and the distribution of technology, the single-payer system could achieve universal access and cost containment without having to ration services.

Opponents differ in their arguments against a single-payer approach depending on their perspective. Some believe that a single-payer plan is desirable but not politically feasible; others prefer an alternative approach that builds on our existing system of public and private payers, such as mandated employer-provided insurance. Still others prefer to leave the broad sweep of decisions relating to insurance entirely to the private market. In any case, opponents often suggest single-payer plans would:

Bureaucratize health care. Market competition encourages insurers to be responsive to consumer needs and to provide services as efficiently as possible. Consumers can elect a health plan that best meets their individual needs. A single-payer approach, such as one fashioned after the Canadian system, calls for one large public program controlled and administered by government, be it Federal or State. Decisions traditionally left to the market would become centralized and bureaucratic. Consumer preferences would give way to government preferences. Key decisions about benefits and the use of scarce resources would be determined by politicians. Such an approach stands in striking contrast with Americans' traditional distrust of government. The public would not accept one government entity making all coverage and payment decisions for 250 million enrollees in a fair, efficient, and accountable manner. Moreover, the administrative costs associated with the current multipayer system could be substantially reduced without adopting the drastic change required by a single-payer model. Reducing unnecessary paperwork and red tape, streamlining review and billing procedures, and reforming health insurance rating and underwriting practices could significantly reduce administrative costs without abandoning our multipayer system.

Reduce innovation and diversity. The advantage of the existing system of many payers is that competitive pressures stimulate payers to seek new solutions to access, cost, and quality problems. Employers and employees demand from insurers that coverage be comprehensive and allow access to high quality of care. Under a single-payer system, much of this innovation would be lost. In addition, a single-payer system assumes that "one size fits alls," when instead, one size or, in this case, payer, may stifle innovation, concentrate too much power in one place, and become administratively rigid.

Encourage rationing of medical care. To contain costs, single-payer systems such as the Canadian system have had to resort to blunt and potentially harsh constraints on medical resource supply, including constraints on overall expenditures, limits on the availability of high technology equipment and services, and limits on physician supply. Such steps are likely to lead to shortages of technology and personnel, and delays in the replacement of out-dated hospitals and other facilities. This could mean a sacrifice in access to necessary services, long waits for nonemergency services, and reductions in quality of care.

Reduce benefit coverage and jobs. Movement to a single-payer system would result in enormous dislocations of people. First, millions of Americans who are currently satisfied with their health insurance plans would be moved to the new program. For some, the move would result in the loss of benefits they consider important (extended mental health care or comprehensive dental coverage, for example). Second, while some of the thousands of employees of private insurers might be absorbed by the new single-payer plan, many could face unemployment. Many insurance companies would go out of business; independent insurance agents would lose a major source of their income.

Administrative Cost Debate

As noted above, a principal and controversial argument in favor of moving the U.S. to a single-payer system is that the amount of money spent on administration would be reduced. Data from other countries, especially Canada, are often used to support this claim.

Administrative costs are generally defined to include: (1) public and private insurance overhead (processing claims, advertising, underwriting, billing, general operating overhead, agent commissions, premium taxes paid to States, profit, and any amounts held in reserve to cover unanticipated losses); (2) provider overhead, including that of hospitals, nursing homes and physicians (accounting, billing and collection, admitting, public relations, personnel department, data processing, etc); and (3) all other, including the administrative costs associated with running small government programs, manufacturer/supplier compliance costs, the administrative costs of research, construction, and other public health activities; the costs to employers of administering health plans; and the administrative costs of nonhealth insurance, such as auto insurance, which pays for medical care.

A true accounting of these costs is problematic given the limits of current reporting systems. For instance, reliable national level data on hospital or physician administrative costs are unavailable. Also, it is difficult to sort out those provider costs which are associated with dealing with health insurers from those that are purely necessary for patient care. The only routinely published national administrative data are those associated with the administration of private health insurance, $47 billion in 1992 (5.8% of the Nation's spending on health care), and the Federal costs of administering Medicare and Medicaid, $8 billion in 1992 (less than 1% of total health spending). (These are Congressional Budget Office -- CBO -- estimates, based on Health Care Financing Administration data.) The expenses incurred by doctors and other providers as a result of multiple claims and billing forms and the personnel to take care of them are not reflected in these estimates.

In comparing administrative costs across health systems, such as the United States with Canada, the task is more complicated. Data comparability is one problem. For example, physician overhead expenses may be reported differently in different countries. Also, analysts differ on how much to assume can be saved by transferring one nation's system to another. If the United States adopts the Canadian model, should it be assumed that it is also adopting its expenditure controls, such as hospital global budgets? And, what costs should be included in the estimate? Danzon (*Health Affairs,* Spring 1992) has argued that comparing administrative costs of alternative systems by adding up billing costs, insurance overhead, and the like is misleading because it fails to include the hidden costs and benefits associated with financing and operating different systems. In her view, a system based on multiple private insurance plans may cost more because such plans facilitate varying consumer preferences with respect to providers and delivery systems, benefit packages, and cost-sharing. On the other hand, she says, a Canadian-like system wastes valuable patient and provider resources (such as time) by requiring people to wait for nonemergency services. Also, the Canadian system's reliance on tax based financing encourages losses in productivity and investment as individuals seek to avoid taxed activities. Others dispute Danzon, saying she ignores the actual experience of Canada and other single-payer systems in favor of an ideological preference for a private insurance market.

Given these controversies, it is not surprising that a wide range of estimates have been produced on how much the U.S. could save by moving to a single-payer system like that of Canada. Woolhandler and Himmelstein have concluded that the U.S. would have saved as much as $83 billion had its health care administration been as efficient as that in Canada in 1987. Adjusted for 1991, the amount would have been $95 billion. The General Accounting Office (GAO) has estimated that a Canadian-style system

would have saved the U.S. $67 billion in 1991. A lower set of estimates include that of Lewin-ICF ($47 billion), a minority staff report of the Joint Economic Committee ($43 billion); a CBO staff study ($41 billion); and an Office of Management and Budget staff estimate of $31 to $49 billion. (Some of these studies are summarized in Gauthier et al., *Inquiry*, Fall 1992.)

In April 1993, CBO issued revised estimates based on somewhat different assumptions that show the U.S. saving about $27 billion in administrative costs by going to a single-payer system with no enrollee copayments and $24 billion if enrollee copayments were required. Assuming the use of Medicare rates to pay providers, CBO estimates that movement to a single-payer system without enrollee copayments would have raised national health expenditures by 5%, or $38 billion in 1991. If copayments typical of those used in employment-based plans were required, then a single-payer system would have produced a net savings of about 2%, or $14 billion in 1991. While CBO says that movement to a single-payer system might produce additional savings by slowing year-to-year increases in health care costs, these potential savings are not estimated in this document. (See CBO, *Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates,* Staff Memorandum, April 1993. See also below under "Cost Estimates.")

Whatever the magnitude of the savings, most analysts agree that movement to a universal, single-payer system would not eliminate all administrative costs. It would reduce the direct and indirect costs associated with insurance, such as those associated with eligibility determinations, marketing, and processing the large assortment of claims and billing forms. It would not eliminate the need for maintaining patient records, complying with government regulations, and other administrative tasks that play a role in and add to the costs of health care delivery.

Major Issues Relating to Single-Payer Proposals

The debate with respect to single-payer approaches to health system reform raises questions about access, benefit coverage, and quality; cost containment; and financing. The wide variation in treatment of these issues in the various proposals reflects different objectives and philosophies and would produce substantially different distributional effects.

Access, Benefit Coverage, and Quality

Single-payer proposals generally provide access to insurance coverage to all legal residents. Some bills phase in access, typically starting with children and sometimes early (pre-Medicare) retirees. Others provide for a one-time move to universal access. Effective dates for coverage of specific populations are generally linked to financing. As the pool of available revenues grows (either through taxation or savings from cost containment measures), new populations are made eligible for coverage under the program.

Single-payer proposals usually provide for coverage of comprehensive acute care services, including inpatient and outpatient hospital care, physician, laboratory and x-ray services, and post hospital care. To this extent, single-payer and "Medicare-for-all" bills are similar. They tend to diverge with the increasing generosity of the benefit

package and declining reliance on enrollee cost sharing. Some single-payer bills also include prescription drugs, and/or long-term care services. Some provide all covered services free to the patient at the time of service, while others require enrollees to share in the cost of the insurance (see **Financing**, below).

Another benefit design issue is whether a proposal allows consumers to buy private insurance duplicating the benefits of the public insurance program. Some believe that such a provision would encourage two-tier health care because those with an ability to pay would opt for private insurance. Accordingly, some proposals explicitly prohibit private insurers from selling coverage duplicating public program benefits. A related issue is whether physicians and other providers can receive payment for services from other than the single-payer entity. Under the Canadian system, for example, physicians must decide whether or not they want to participate in the provincial health plan. They cannot accept payment from private insurers if they receive provincial plan reimbursement. Those few that do not participate in the provincial plans tend to be in specialties providing services not covered by the plans (e.g., cosmetic plastic surgery). In England, specialists that are salaried under the National Health Service (NHS) are permitted also to take patients on a fee-for-service basis. As a result, patients with the ability to pay (or who are privately insured) sometimes pay privately for elective procedures rather than wait for them under the NHS. Critics claim that this leads to inequitable access to nonemergency care.

Most proposals do allow private insurers to sell policies that supplement the benefits provided under the public program. This would enable consumers to purchase policies, for instance, that cover so-called amenities, such as private hospital rooms, as well as services that exceed public program limits (e.g. extended treatment for mental illness) or are not covered by the public program. The effects of supplemental coverage on total system spending and equity then have to be considered.

Quality assurance under the single-payer proposals is inherently linked to the method of paying providers (see **Cost Containment**, below). But most proposals also include mechanisms aimed at regulating the quality of services provided to program enrollees. Several 102nd Congress bills incorporated Medicare quality assurance standards and procedures. Some bills would have increased Federal funding for outcomes research and the development of clinical practice guidelines to make medical services more appropriate and effective. Some charged the States with implementing quality assurance measures.

Cost Containment

In addition to savings on administration achieved by eliminating multiple payers, single-payer proposals generally include other measures aimed at controlling costs. These include: constraints on medical resource supply (e.g., planning and regulation of the distribution of high cost technology, expanded Federal technology assessment, and/or increased Federal funds for outcomes research and clinical practice guideline development); and incentives to encourage more primary care. Potentially most important to cost containment, however, is the manner in which the proposals seek to regulate payments to providers and/or control system-wide health expenditures.

Regulating provider payments. Most single-payer proposals include controls on the rates (prices) charged by providers. These take a variety of forms. Some

proposals call for the use of Medicare's prospective payment system for hospitals and its resource-based relative value scale (RBRVS) method of setting fees for physicians. Others call for the use of negotiation processes to set hospital and physician payment rates. Still others would leave decisions on rate setting to an independent board or to the States. If the bill allows HMOs to operate as an alternative to the public program, capitation payments are permitted. (Capitation is a method of paying for an individual's medical care through a per capita payment that is independent of the number of services received or the costs incurred by providers in furnishing those services. Capitation rates are typically set in advance of payment.)

While rate regulation may help control prices paid to providers, it could encourage providers to offset price limits by providing an increased quantity and intensity of services. If a physician, for instance, cannot charge more than $100 for a procedure, then he or she may be encouraged to provide more of that procedure or substitute procedures for which the unit fee is higher in order to maintain his/her expected income. In response, some proposals would establish an expenditure target for all physicians in a State (or other geographical area). If physicians in the aggregate were to exceed the ceiling, then all physicians would be penalized by receiving a lower than scheduled annual update in their fees.

Some analysts believe that expenditure limits designed in this fashion would not be very effective in controlling the growth in volume and intensity of services because individual physicians would not see their individual actions directly influencing future fee schedule adjustments. They believe potentially more effective alternative would be to place an expenditure target or limit on smaller subsets of physicians, such as all physicians in an area, specialty, or group practice. More effective still might be limits on the fees of individual physicians. In this case, once a physician reached his or her preset expenditure limit, reimbursement for additional services provided during the remainder of the payment period would be substantially reduced. One concern with this approach is that it could reduce patient access if physicians responded to reaching their expenditure cap by going on vacation or refusing to accept patients requiring a lot of time and/or resources.

A related cost containment measure is often referred to as global budgeting, and is usually applied to hospitals or other large providers of services. Global budgets define the total resources available for treating all patients and place the responsibility for cost containment on the actual providers of care. Accordingly, each hospital, nursing home, clinic, etc. is placed in a position of operating within predetermined limits which affects its decisions regarding treatment and resource allocations.

System-wide (global) expenditure limits. The most expansive cost controls are those that establish targets or limits on total system-wide health care spending. Under this system-wide target or limit, spending is then limited within each health care sector (usually within each State or geographic region) to an annual amount. Spending in excess of the limit is penalized by offsetting adjustments in subsequent periods. Important issues then arise with respect to determining how to define and allocate spending within each sector and determining allowable rates of growth. Should, for example, all physician services be bundled together or separated in some way? Should the expenditure limit take into account general inflation, demographic changes, and changes in medical practice and technology, or should it be linked to overall economic measures, such as the growth in wages or the growth in the economy?

Proponents of system-wide expenditure limits say that limits would help discipline spending and facilitate predictability and planning in public and private budgeting for health care. Resource allocation decisions would necessarily become explicit political questions, which would encourage the Nation to debate priorities and assess tradeoffs. Opponents say that expenditure limits could lock in existing inefficiencies in the system. Besides, they say, we do not have the data to determine how to allocate spending limits. They also argue that it is unrealistic to expect the limits to be enforced, especially if such decisions lead to rationing of services. Some opponents also oppose expenditure limits because they would, in their view, replace marketplace decisions with government controls.

Financing

Sources of Financing. Under the current mixture of public and private financing, individuals, governments, and employers share in the burden. Individuals directly finance health care costs through premium contributions and out-of-pocket payments. The insured generally contribute all or a share of the premiums and pay out-of-pocket for deductibles, coinsurance, and uncovered services. The uninsured may bear significant out-of-pocket costs for received services.

Federal, State and local governments today contribute a major share of the total dollars spent on health care. The burden of government financing is distributed among taxpayers through a mixture of tax levies, including individual and corporate income taxes, the Medicare payroll tax, excise taxes, and at the State level, property, income, sales and excise taxes. Government also indirectly helps to finance (and thus encourage) employer-provided health insurance through various tax expenditure provisions of the Internal Revenue Code.

Businesses account for the remaining share of total health care expenditures. Much of that cost is incurred providing health benefits for employees and their families, and paying the employer share of the Medicare payroll tax and other payroll taxes that support the medical portion of State-mandated workers' compensation and temporary disability insurance programs. Some economists assert that employer contributions are really costs to employees since they are likely to reflect foregone wages. From this perspective, it could be said that individuals ultimately finance all of health care in the form of taxes, reductions in wages, increases in prices, and out-of-pocket payments.

Proponents of single-payer plans generally believe that we need to move away from what they say is a complex, sometimes hidden, and often regressive way of financing health care to a system that is largely financed on broad-based and progressive taxation that is decided in the open political arena. Opponents tend to argue that such a system would lead to highly politicized decision making about how much money to raise and how the money should be spent. They say that politicians would be unwilling to risk voter anger to fully finance the system and scarcity of health care resources would result.

Financing the Single-Payer Program. Any single-payer initiative will draw on revenues from individuals, government, and/or business, and in so doing, is likely to alter the current distribution of the financing responsibility. Most single-payer proposals are explicitly designed to spread the responsibility of providing universal coverage broadly among taxpayers by providing for government financing. Such

proposals generally rely on broad-based taxes, such as personal and corporate income taxes, as well as payroll taxes, with some financing responsibility left to enrollees through premiums and coinsurance. A consumption tax, such as a value added tax (VAT), is also sometimes accorded a role in such proposals. Some proposals raise part of the revenues through excise taxes on alcohol and tobacco products. Still another source of revenues may be State contributions, often set at an amount approximating the State's Medicaid payments for acute care services.

The income tax is generally viewed as the most progressive revenue source because it is designed on the basis of ability to pay. Financing health care through a progressively structured income tax is assumed by many to be the most equitable way to spread the cost of health care across the entire population; most single-payer bills therefore rely to some extent on increases in Federal income taxes (usually by raising rates on higher-income taxpayers). Others believe that higher users of health care should have to pay more, especially those with high risk behaviors, such as smokers and drinkers. Opponents of an income tax-supported system argue it would lose out in competition with other government programs for needed funding, especially if the revenues were not dedicated to a health insurance trust fund. In another vein, some say that financing health insurance through increases in Federal income taxes is politically unfeasible because of general voter opposition to tax increases. Proponents respond that voters would accept tax increases to finance a universal health insurance program if they were persuaded that other financing options were less desirable.

Payroll taxes also are used to finance many of the single-payer proposals. Such taxes are typically levied at a flat rate on wage income, usually up to some dollar ceiling, and are thought to be more regressive for workers because wage income is a smaller fraction of total income at higher income levels. Payroll taxes may also penalize labor intensive industries in favor of capital intensive ones. A variety of measures can be used to reduce the regressivity of payroll taxes, such as basing a portion of the employer contribution on profits instead of payroll. Consumption taxes are usually considered to be neutral with respect to labor or capital intensity of firms. Because they are levied at a flat rate and because lower-income people use more of their income for consumption than savings, they are regarded by many as regressive. They can be made less regressive depending on which items are exempted from the tax and whether other tax mechanisms are used to offset their effects on income.

Direct consumer financing in the form of enrollee premiums and/or cost sharing also is used in most of the single-payer proposals. Premiums tend to be scaled to income to limit their potential regressivity. Some bills use premiums to finance specific benefits, such as long-term care. Cost-sharing is included in some bills but is generally waived for certain services, such as prenatal and well-baby care. Proponents of consumer cost-sharing say that it is important to sensitize consumers to the cost of services and to discourage unnecessary utilization. Opponents say that it mostly discourages low-income enrollees from seeking services but has little effect on those of greater means, that it may deter necessary as well as unnecessary care, and that it does little to alter the course of care once treatment has begun because the decision-making has shifted to the physician.

Cost Estimates

In December 1993, CBO issued preliminary estimates of the effects on government outlays and national health expenditures of S. 491 and H.R. 1200 (103rd Congress). It did not contain an estimate of revenues, because many of the revenue raising provisions of these bills were included in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66). According to CBO, the bills would increase total national health expenditures by less than 1% in the first year (1997) but would reduce spending by about 5%-6% in 2003. Federal spending would increase substantially since most of the financing of covered services would be channeled through the Federal Government. However, spending by the private sector (individuals and employers) would fall dramatically.

The House sponsors have since introduced a new financing package, which has been included in a revised version of the bill (H.R. 3960) introduced by Representatives Miller and McDermott (see LEGISLATION). New CBO estimates have not yet been issued.

Readers interested in cost estimates by other organizations as well as recent studies of the economic impact of single-payer (and other) health reform proposals may wish to consult a recent compilation produced by the Office of Technology Assessment (OTA). (See: OTA. *An Inconsistent Picture. A compilation of analyses of competing approaches to health care reform by experts and stakeholders.* OTA-H-540, June 1993.)

LEGISLATION

H.R. 16 (Dingell)

National Health Insurance Act. Provides health insurance coverage for most U.S. residents; replaces all insurance except Medicare. States and localities would administer plans with Federal assistance. Introduced Jan. 5, 1993; referred to Committees on Energy and Commerce and Ways and Means.

H.R. 1200 (McDermott)

American Health Security Act. Establishes a universal comprehensive health insurance program to replace all other private and public coverage (with the exception of Veterans' Administration services). State administered, single-payer system. Global budgets would be established for hospitals; physicians would be paid negotiated fees; other services also would be subject to cost controls. Nationally, the growth in expenditures would be limited to the growth in the gross domestic product. A national board would allocate funds in the national budget to the States, based on average national per capita costs adjusted for differences in costs and health status. Providers could not balance bill; private insurers could not sell insurance covering those services insured under the public program. Financing would come from funds currently received by Medicare (other than premiums), Medicaid, and other specified Federal health programs; increases in corporate and individual income tax rates; a new Health Security premium; a surtax on individuals with incomes over $1 million; payroll taxes; and from funds generated from a variety of other tax changes. Introduced Mar. 3, 1993; referred to Committees on Ways and Means, Energy and Commerce, Armed Services, Post Office and Civil Service, and Veterans' Affairs.

H.R. 2061 (Dellums)

U.S. Health Service Act. Establishes a national health service to provide free health care directly to all individuals in the U.S. through regional and community health service facilities and employees and to conduct medical education and research. Introduced May 11, 1993; referred to Committees on Energy and Commerce; Banking, Finance, and Urban Affairs; the District of Columbia; Education and Labor; Judiciary; Post Office and Civil Service; Veterans' Affairs; and Ways and Means.

H.R. 2610 (Stark)

MediPlan Act of 1993. Establishes universal insurance under an expanded Medicare program called MediPlan. Finances Mediplan through an employer payroll tax and an income tax-based premium, with lower-income individuals, children and Medicare beneficiaries generally exempt from the premium. Providers would be paid using Medicare reimbursement methodologies. A MediPlan budget would be set annually by statute. States could obtain a waiver to opt out of MediPlan for non-Medicare beneficiaries if they provide universal coverage and meet other budget and administrative requirements. Coverage to supplement MediPlan would be Federally regulated. Introduced July 1, 1993; referred to Committees on Ways and Means and Energy and Commerce.

H.R. 2624 (C. Peterson)

Comprehensive Health Care and Cost Containment Act of 1993. Establishes federally funded, State and locally administered public plan; retains private insurance for physician and other practitioner services. Finances public plan by increasing taxes on cigarettes and distilled spirits. Introduced July 13, 1992; referred to Committees on Energy and Commerce, Ways and Means, Education and Labor, Judiciary, Armed-Services, and Post Office and Civil Service.

H.R. 3960 (Miller)

American Health Security Act of 1994. Similar to H.R. 1200, but with new financing package and other revisions. Financing would come from funds currently received by Medicare (other than premiums), Medicaid, and other specified Federal health programs; a new payroll tax on employers; a 2.1% health care income tax; and increased taxes on tobacco, firearms, and ammunition. Introduced Mar. 3, 1994; referred to Committees on Energy and Commerce, Ways and Means, Armed Services, Post Office and Civil Service, Natural Resources, and Education and Labor.

S. 491 (Wellstone)

American Health Security Act. See H.R. 1200. Introduced Mar. 3, 1992; referred to Committee on Finance.

S. 1057 (Jeffords)

MediCORE Health Act of 1993. Provides for universal coverage of all legal residents for CORE services under a State program, overseen by an independent Federal MediCORE board. The Board would be responsible for developing the package of CORE services as well, Federal guidelines for State programs, a model State administration manual, and a national MediCORE budget. Each State program would be run by a single agency, but the State could include two or more plans under its program. (Self-insurance for large firms would also be allowed.) Sale of private insurance duplicating CORE services would be prohibited. To be an approved program, a State would have to show that it has a process for establishing a budget and

containing costs. MediCORE would be financed using dollars now going to Federal health programs, a new "MediCORE" payroll premium tax paid by employers and employees, repeal of the exclusion for employer contributions for health insurance, and additional measures. Introduced May 27, 1993; referred to Committee on Finance

FOR ADDITIONAL READING

U.S. Library of Congress. Congressional Research Service. *Health Care Reform: Tax System Approaches*, by Beth C. Fuchs and Mark Merlis. [Washington] (Regularly updated)
CRS Issue Brief 93002.

-----*Health Care Reform: Managed Competition*, by Mark Merlis. [Washington] (Regularly updated)
CRS Issue Brief 93008.

----- *Health Care Reform: President Clinton's Health Security Act*, by Beth C. Fuchs and Mark Merlis. [Washington] Nov. 22, 1993
CRS Report 93-1011 EPW.

----- *Health Insurance*, by Mark Merlis. [Washington] (Regularly updated)
CRS Issue Brief 91093.

----- *Health Insurance Legislation in the 102d Congress*, by Beth C. Fuchs, Janet Lundy, and Joan Sokolovsky. [Washington] July 1991.
CRS Report 91-564 EPW.

-----*Health Insurance Legislation in the 102d Congress,* Part II, coordinated by Beth C Fuchs. [Washington] Oct. 4, 1993.
CRS Report 93-952 EPW.

----- *Mandated Employer-Provided Health Insurance*, by Beth C. Fuchs. [Washington] (Regularly updated)
CRS Issue Brief 87168.

-----*Summary Comparison of Selected Health Care Reform Bills*, by Health Section. [Washington], Mar. 2, 1994.
CRS Report 94-185.