The Administration’s proposals to reform the U.S. health care system sought to provide for universal health insurance coverage while containing the growth of health care spending. This paper focuses on the latter issue and discusses the ability of regulatory and market-oriented reforms to achieve health care cost containment from several angles: an international comparison of national cost containment measures, a review of past cost containment efforts in the United States, and a discussion of the estimated effects on health care costs of alternative proposals to reform the U.S. health care system.

JEL Classification Numbers:
I11, I18

1/ The author would like to thank colleagues in the Western Hemisphere Department for useful comments and discussion.
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Summary

The Administration's proposals to reform the U.S. health care system sought to provide for universal health insurance coverage while containing the growth of health care spending. The recent debate surrounding health care reform focused primarily on the shorter-term issues of the timing and financing of universal coverage. Less attention was paid to cost-containment measures and the role that universal coverage plays in effectively containing costs. This paper discusses the ability of regulatory and market-oriented reforms to contain health care costs from several angles: an international comparison of national cost-containment measures, a review of past cost-containment efforts in the United States, and a discussion of the estimated effects on health care costs of alternative proposals to reform the U.S. health care system.

Most industrial countries other than the United States provide universal health insurance coverage to their populations. By comparison, 15 percent of the U.S. population lacks any form of health insurance coverage. Yet, these other countries also seem to have been better able to control the rate of growth of health care spending. This paper briefly compares the health care systems in the United States and several other industrial countries and discusses the means by which other countries aim to contain health care cost-containment. It then discusses past regulatory and market-oriented reforms within the United States and their ability to contribute to health care cost containment. The effectiveness of these measures has been limited by the fragmented nature of both the reforms and the U.S. health care system in general. The paper then presents several alternative proposals that have been put forward to reform the U.S. health care system and summarizes studies that evaluate the ability of these proposals to provide universal coverage and control the growth of health care spending. The proposals discussed cover a broad range in terms of the degree of restructuring of the U.S. health care system and the mix of regulatory and market-oriented measures that they would introduce.
I. Introduction

The Administration's proposals to reform the U.S. health care system sought to provide for universal health insurance coverage while containing the growth of health care spending. The recent debate surrounding health care reform has focused primarily on the shorter-term issues of the timing and financing of universal coverage. Less attention has been paid to cost containment measures and the role that universal coverage plays in achieving effective cost containment. This paper discusses the ability of regulatory and market-oriented reforms to achieve health care cost containment from several angles: an international comparison of national cost containment measures, a review of past cost containment efforts in the United States, and a discussion of the estimated effects on health care costs of alternative proposals to reform the U.S. health care system.

Most industrial countries other than the United States provide universal health insurance coverage to their populations. By comparison, 15 percent of the U.S. population lacks any form of health insurance coverage. Yet, these countries also seem to have been better able to control the rate of growth of health care spending. Section 2 briefly compares the health care systems in the United States and several other industrial countries and discusses the means by which other countries aim to achieve health care cost containment. Section 3 then discusses past regulatory and market-oriented reforms within the United States and their ability to contribute to health care cost containment. The effectiveness of these measures has been limited by the fragmented nature of both the reforms and the U.S. health care system in general. Section 4 presents several alternative proposals that have been put forward to reform the U.S. health care system and summarizes studies that evaluate the ability of these proposals to provide universal coverage and control the growth of health care spending. The proposals discussed cover a broad range in terms of the degree to which they restructure the U.S. health care system and the mix of regulatory and market-oriented measures they would introduce. Section 5 provides some concluding remarks.

II. Health Care Financing in OECD Countries

Health care financing and delivery systems vary widely within the OECD, but can be grouped into four broad categories based on the mix of government and private sector involvement. 1/ At one end of the spectrum is the national health service model, on which the system in the United Kingdom is based. It is characterized by universal coverage, national general tax financing, and publicly-provided health care services. 2/ The Canadian health care system is an example of the national health insurance model, in which universal coverage is financed by national general taxation

2/ For example, doctors are public employees and hospitals are publicly owned.
but health care services are provided by a mix of public and private entities. The social insurance model includes some private financing as well as private provision of health care, as found in Germany \(^1\) and Japan. These systems are characterized by compulsory universal coverage financed by employer and individual contributions through nonprofit insurance funds, and a mix of public and private health care providers. Finally, the United States has what is in large part a private insurance system involving relatively little government involvement. Private health insurance is purchased voluntarily by employers or individuals and is financed by individual and/or employer contributions; health care providers are primarily in the private sector.

This section compares the U.S. health care financing and delivery system to those in several other OECD countries in terms of its ability to provide universal, comprehensive health insurance coverage and to control the rate of growth of health care spending. \(^2\) Reform proposals under consideration in the United States have included those that call for a Canadian-style national health insurance system, a compulsory employer-based system like those in west Germany or Japan, and limited reforms to what would remain a voluntary, private insurance system. A national health service system like that in the United Kingdom is not being considered and therefore is not discussed further here.

1. The U.S. private health insurance system

In contrast to most other industrial countries, the United States does not have a single nationwide system of health insurance, but relies instead on a fragmented mixture of public and private insurance. \(^3\) Most of the population (74 percent) is covered through a system of over 1,000 private health insurance companies. Over 80 percent of those with private insurance receive it through an employer, a practice that is voluntary but encouraged by tax policy. Government programs provide insurance to the elderly and disabled and some of the poor. Medicare is a national health insurance program for the aged and disabled administered by the federal government. It is the single largest health insurer, covering about 13 percent of the population, including virtually all of those aged 65 and over and certain persons with disabilities or kidney failure. Medicaid is a joint federal-state health insurance program that covers preventive, acute, and long-term care services for certain groups of the poor—about 10 percent of the popu-

---

\(^1\) All references to Germany refer to the former West Germany. The health care system of the former East Germany was publicly-owned and financed and is currently being reintegrated into the system in the west.  
\(^2\) The review of health care systems in Germany, Japan, and Canada are based on the available literature.  
\(^3\) De Lew et al. (1992).
lation who are aged, blind, disabled, or members of families with dependent children. 1/

These private and public health insurance programs all differ with respect to benefits included and payments to providers. Moreover, some persons have both public and private insurance coverage while others have neither. It is estimated that roughly 39 million persons (15 percent of the population) lack any type of health insurance coverage. Most of the uninsured are poor or near poor. In 1990, one third of the uninsured were in families with incomes below the federal poverty line ($14,800 for a family of four), while two thirds were in families with incomes below twice the poverty line. These gaps reflect the narrow designation of beneficiaries under the Medicaid program. Childless, nondisabled adults under 65 years of age, no matter how poor, are not eligible for government programs. 2/ As a result, Medicaid assisted only 45 percent of those with incomes below the poverty level in 1990. Even among the extremely poor (family incomes below 25 percent of the poverty line), nearly one quarter are not covered by Medicaid or any other program. In addition to these gaps in coverage, few are insured against the high costs of long-term care necessitated by disability, including disabilities associated with old age.

The private sector delivers, as well as finances, most health care in the United States. Most hospitals are owned by private non-profit institutions; the remainder are owned by governments or private for-profit corporations. Most physicians are in private practice and are paid for each service rendered (fee-for-service (FFS) basis). A relatively small number of physicians is employed by the government, corporations, hospitals, or health maintenance organizations (HMOs). HMOs are prepaid group practices that attempt to encourage physicians to practice medicine cost effectively by substituting salaries or fixed monthly payments per enrollee (capitated payments) for FFS payments.

Compared to other OECD countries, U.S. health care expenditure is by far the highest relative to GDP and in per capita terms and has grown the fastest over the past decade (see tabulation below). 3/ Chart 1 shows the shares of GDP devoted to health expenditures in the G-7 countries and highlights the divergence between the share in the United States and the shares in other countries. Chart 2 shows real per capita health expendi-

1/ The sum of the percentages of the population covered by private insurance, Medicaid, and Medicare and the percentage which is uninsured exceeds 100 because some persons have more than one type of coverage.

2/ Moreover, states can set their own eligibility requirements for Medicaid. For example, in Alabama, a family of three qualifies for Medicaid only if its income is less than 13 percent of the federal poverty guidelines (Pepper Commission (1990), pp. 30-31).

3/ See Nedde (1993) for a discussion of the special characteristics of the health care market and the factors that have contributed to the rapid growth of health spending in the United States.

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tures expressed in U.S. dollars. In addition to deviations in spending trends, other countries differ from the United States in that they finance a greater percentage of national health expenditure (NHE) with public funds and provide universal (or near-universal) health insurance coverage. The goals of U.S. health care reform are to provide universal coverage and contain the rise of health care costs while retaining quality care.

Health Statistics, 1991

<table>
<thead>
<tr>
<th></th>
<th>U.S.</th>
<th>Germany</th>
<th>Japan</th>
<th>Canada</th>
<th>OECD Average</th>
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<tbody>
<tr>
<td>National health expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As percent of GDP</td>
<td>13.4</td>
<td>8.5</td>
<td>6.6</td>
<td>10.0</td>
<td>7.9</td>
</tr>
<tr>
<td>Growth, 1980-90</td>
<td>2.7</td>
<td>-0.4</td>
<td>0.1</td>
<td>2.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Per capita, U.S. dollars</td>
<td>2,867</td>
<td>1,659</td>
<td>1,267</td>
<td>1,915</td>
<td>1,304</td>
</tr>
<tr>
<td>Growth, 1980-90</td>
<td>9.2</td>
<td>5.7</td>
<td>8.1</td>
<td>8.6</td>
<td>7.1</td>
</tr>
<tr>
<td>Percent publicly financed</td>
<td>44</td>
<td>72</td>
<td>72</td>
<td>72</td>
<td>74</td>
</tr>
<tr>
<td>Percent out-of-pocket</td>
<td>20</td>
<td>11</td>
<td>12</td>
<td>20</td>
<td>...</td>
</tr>
</tbody>
</table>

Population

| Percent uninsured | 14   | --    | --    | --     | ... |

2. Social insurance in Germany

The health insurance system in the former West Germany has been cited as a useful model on which to base a reformed health care system in the United States, in part because, like the U.S. system, it is employment-based and has multiple payers and providers. Unlike in the United States, however, the system is tightly regulated and virtually the entire population is insured. About 88 percent of the population is covered by social health insurance. Most of the rest of the population--mainly high income earners--choose to purchase private health insurance. Of the participants in the social insurance system, 85 percent are mandatorily insured--employees earning below a certain level of income (the equivalent of approximately $41,000 in the west and $30,000 in the east in 1993) are required to belong to the statutory system. The remainder have chosen the social insurance system over private insurance in part because contribution rates are usually lower and because those who chose private insurance cannot return to the statutory system unless their income falls below the eligibility level.

---

1/ The conversion to U.S. dollars uses purchasing power parities for GDP.
2/ Sources: OECD (1993) and Schieber et al. (1992).
3/ Compound annual growth rate.
4/ Using purchasing power parities for GDP.
5/ The following discussion is based on Graig (1993), Hurst (1991), OECD (1992a), Schneider (1991), and Wicks (1992).
CHART 1

UNITED STATES

HEALTH CARE EXPENDITURES IN THE G-7 COUNTRIES
(In percent of GDP)


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CHART 2

UNITED STATES

PER CAPITA HEALTH CARE EXPENDITURES IN THE G-7 COUNTRIES 1/
(In 1985 US dollars)


1/ Divided by GDP deflators (1985=100) and adjusted by purchasing power parities.
The social insurance system is made up of 1,150 sickness funds, which are private, non-profit insurance organizations. Although they are private entities, the sickness funds are subject to government regulation and are required to meet publicly established objectives, including cost containment. Competition is limited among sickness funds since only about one third of sickness fund members—mostly white-collar workers—can choose which fund to belong to. Premiums collected by the funds are income based (payroll taxes) and shared equally by employers and employees. Contribution rates vary widely among funds (between 8 percent and 16 percent) depending on the average riskiness of the fund’s membership. This variation, combined with the inability of blue-collar workers to choose among funds, has prompted calls for greater choice of insurer.

Coverage is comprehensive and includes unlimited hospital and physician services, maternity care (including household help), prescription drugs, medical supplies and devices, preventive care, family planning, rehabilitation services, dental care, attendant care, and recuperative stays in health spas. 1/ Long-term care is not covered except through a separate means-tested public program. Copayments are modest and apply to only a few services. In 1991 total out-of-pocket costs represented 11 percent of national health expenditures.

Health services are provided by a mix of public and private providers, among which individuals may choose freely. Public and private hospitals each account for about one half of total hospital beds. Most of the private hospitals are non-profit and account for about 35 percent of total hospital beds; private for-profit hospitals account for 15 percent of total hospital beds. Hospitals are paid on the basis of per diem payments which are negotiated by individual hospitals with regional sickness fund associations. Capital budgets, even for private for-profit hospitals, are provided by state governments. German hospitals do not generally have outpatient departments, as ambulatory and inpatient care are provided by different segments of the health care market. Ambulatory care physicians (about half of all physicians) are usually self-employed and cannot provide care in hospitals. They are paid on the basis of fee schedules that are negotiated by physician organizations and regional sickness fund associations (see below). The remainder of physicians are employed by hospitals and are paid salaries.

Faced with rapidly rising health care costs in the 1970s, Germany passed the Health Care Cost Containment Act of 1977. The goal of this Act and subsequent cost containment acts has been to bring the growth of health care expenditures in line with the growth of wages and salaries of sickness fund members, on which health revenues are based. At the same time, cost containment efforts have sought to preserve free access to health care, independent of income, and without reductions in benefits. 2/ Consequently, cost containment policy has focused on containing prices, with

utilization control designed to play only a complementary role. In particular, copayments are thought to impede access and to have negative distributional effects. Thus, although copayments have been increased for some services, they remain modest as noted above. 1/

The principal achievement of the Cost Containment Act of 1977 was the creation of the Concerted Action for Health Affairs (CAHA), which twice a year brings together sickness funds, private health insurance companies, physicians and other providers, hospitals, trade unions, and employers to discuss and agree upon recommendations for spending increases for ambulatory and dental care and drugs. Several additional cost containment acts have been passed since 1977, and in 1982 regulation of hospital care was included in the CAHA. The decisions by the CAHA are not binding but have a strong influence on negotiations at lower levels. Germany's cost containment efforts have been relatively successful at stabilizing the share of GDP devoted to health care. In fact, Germany is one of the few countries that has experienced declines in health care spending relative to GDP over the past decade. Health spending fell from 8.4 percent of GDP in 1980 to 8.1 percent in 1990, but rose again to 8.5 percent of GDP in 1991.

The German health care cost containment strategy in the area of physician payments is based on negotiations between physician organizations and sickness fund associations. A fee schedule of relative values is negotiated periodically by the two groups at the national level. The schedule assigns a point value or weight, but not a monetary value, to each physician procedure to reflect the worth of the procedure relative to others. A monetary equivalent which determines average prices is determined at the regional level, resulting in differing average prices among regions and among mandatory and voluntary funds. The Government is not directly involved in these negotiations, unless required to act as final arbiter in the case of a deadlock. Spending targets for physician expenditures were created, but were consistently exceeded and were replaced with spending caps in 1986. Increases in the caps are tied to the growth rate of sickness fund members' wages and are enforced by adjusting fees downward when the volume of health services exceeds the level consistent with the spending limit. 2/ These adjustments are made by the regional physician associations which receive a prospective lump sum from the sickness funds and in turn monitor the quality and volume of service of each physician. 3/

Less cost control has been exercised in the areas of hospital services and pharmaceuticals. Hospitals have been required to adopt global budgets since 1986, but the budgets are not strictly enforced. Pharmaceutical prices in Germany are twice as high as those in any other industrialized country and expenditures on drugs account for 20 percent of national health

2/ Physicians have lobbied heavily against the expenditure caps and, as of late 1991, some voluntary (substitute) funds had tentatively agreed to return to straight fee-for-service payment (Wicks (1992), pp. 10-11)).
expenditures (compared to 8 percent in the United States). 1/ The Health Reform Act of 1988 sought to control spending on drugs by requiring that sickness funds not reimburse beyond the price of generic equivalents of pharmaceuticals. Drug companies have since significantly reduced the prices of brand names to avoid losing market share.

3. **The Japanese social insurance system**

Japan also has an employment-based, multipayer health care system in which patients have their choice of physician, and health care services are delivered in the private sector. Employers are required to provide health insurance coverage to their employees and dependents, either through contributions to a government-managed plan or by financing an independent health insurance plan. Employer-sponsored plans numbered over 1,800 in 1991. Payroll taxes vary from 3.5 percent to 13 percent, depending on the plan, and employers are required to pay at least one half of the total. Governments pay most of the administrative costs of the private plans and use general revenues to offer subsidies (up to 50 percent) to certain insurers. The National Health Insurance program guarantees universal health insurance coverage by covering all those not enrolled in an employer plan—about 35 percent of the population that is self-employed, unemployed, or elderly.

Services covered by the social insurance system include physician and hospital services, long-term care, dental care, and prescription drugs. Since the coverage is comprehensive, the role of private insurance is limited to offering supplemental benefits to cover amenities such as private hospital rooms. 2/ Significant copayments were introduced in 1984 with a view to controlling the demand for health services. Employees insured by employer-sponsored plans pay 10 percent of covered health care costs, while their dependents pay 20 percent of in-patient costs and 30 percent of out-patient costs. Persons covered by the National Health Insurance plan face copayments of 30 percent of both in-patient and out-patient costs. 3/ Although this level of cost sharing appears much higher than in Germany, total out-of-pocket payments represent 12 percent of NHE (about the same share as in Germany), in part because of upper limits placed on monthly copayments in Japan.

In-patient medical care is provided in both hospitals and clinics. Clinics are medical facilities with fewer than 20 beds and are linked closely with physicians' private practices; clinics numbered 80,000 in 1986. 4/ Hospitals are prohibited by law from operating on a for-profit basis, but most are privately owned; about 80 percent of hospitals and 94 percent of clinics are privately owned and operated, mostly by physicians.

Hospitals are paid a per diem rate based on a national negotiated fee schedule. Japan has the highest number of hospital beds per capita among industrialized countries and legislation was passed in 1985 aimed at regulating hospital capacity, and thus controlling the volume, as well as price, of services provided. In general, however, the Government seems to place few restrictions on the overall level of hospital expenditures. Although the Government sets a desired growth rate for total health care spending, Japan does not set budgets for in-patient hospital care or services.

About one-third of physicians are in private practice and have no access to hospitals, 40 percent are in nonteaching hospitals, and the rest are in teaching hospitals. Physicians employed by public hospitals are paid a salary. The rest are paid on a fee-for-service basis according to a national rate schedule, which is set by the Government in consultation with providers, payers, and consumers. Billing beyond the set fees is not permitted.

Despite the absence of strict budgets for hospital or physician services, health expenditures in Japan have grown roughly in line with nominal GDP during the last decade. After rising from initial low levels during 1960-80 (from 2.9 percent of GDP in 1960 to 4.4 percent in 1970 and 6.4 percent in 1980), Japanese national health expenditure stabilized at below 7 percent of GDP.

4. The Canadian national health insurance system

Canada's national health insurance system provides a useful comparison to the U.S. system since, until its introduction in the early 1970s, the United States and Canada had similar health care systems and spent roughly equal shares of GDP on health care. The Canadian health care system is typically referred to as a single-payer system, but the system actually consists of twelve separate provincial and territorial plans which are jointly financed by federal and provincial governments and administered by the provinces. Federal funding for provincial plans is contingent on satisfying the following conditions: plans must be comprehensive; publicly financed; universal and provided on uniform terms and conditions; and portable across provinces.

All provincial health plans cover all medically necessary physician services, in-patient hospital services, in-patient drugs, and both in-patient and out-patient mental health services. Some provincial plans cover podiatry, physical therapy, chiropractic treatments, prescription drugs for the elderly, and dental care for children. Long-term care is covered if the person requires it in order to function. Private insurance is available for benefits not covered by the public plans, such as prescription drugs, dental care, vision care, and private hospital rooms. About 80 percent of the

population has such additional coverage, with most of it financed by employers.

Federal guidelines permit provinces to impose copayments for services provided under the public plans, but none do so because federal funding would be reduced in direct proportion to the charges. Both deductibles and copayments are charged for services covered by private plans and have been increased in recent years in an attempt to control strong growth in some expenditure categories, such as prescription drugs. In 1991, total out-of-pocket costs in Canada were 20 percent of national health expenditures, the same share as in the United States.

Although the system is publicly financed, health care itself is provided privately and patients can choose their own health care providers. Physicians own private practices and are paid on a fee-for-service basis and hospitals are largely private, nonprofit organizations. Payment for services is regulated however—physicians are paid according to a fee schedule that is negotiated between provincial governments and medical associations and hospitals operate within defined budgets. Private insurance is prohibited from covering any services covered by the provincial plans and physicians are not permitted to bill patients directly for such services—thus ruling out balance billing and preventing physicians from practicing both within and outside of the system.

In 1970, Canada spent 7.1 percent of its GDP on health care while the United States spent 7.4 percent of GDP. By 1980, these ratios had risen to 7.4 percent of GDP in Canada and 9.2 percent of GDP in the United States. The most recent data for 1991 show a continued divergence, with spending rising to 10.0 percent of GDP in Canada and 13.4 percent of GDP in the United States. However, health care spending has grown faster in Canada than in the OECD on average. Part of the strong growth has been attributed to increased utilization since balance billing was banned in 1984. In more recent years, provinces have taken steps to penalize providers for excess utilization, for example by scaling back fees for a specified period of time and these efforts appear to have helped slow the rise in health care spending.

5. Assessment

Germany, Japan, and Canada all provide universal, comprehensive health insurance coverage to their populations while spending significantly smaller shares of their GDP than the United States. Social factors in the United States, including the heterogeneity of the population, probably contribute to the higher share of GDP devoted to health expenditures than in other OECD countries. 1/ But the fragmented U.S. health system and the cost-increasing incentives inherent in its financing also contribute to the high level and rate of growth of NHE. The experience of other countries suggests that fee schedules and/or expenditure limits can be used to control costs.

1/ See, for example, Graig (1993) p. 144.
The health care systems of all three countries are affected by the extent to which they rely on regulatory, rather than competitive, methods of cost control. For example, long hospital stays are encouraged in Germany and Japan by per diem hospital payments and both have relatively large expenditures for prescription drugs. Global budgets for hospitals in Canada have resulted in waiting times for certain procedures and tests. Consequently, all three continue to search for improved incentives for the efficient delivery of services and cost control, including more market-oriented measures.

III. The Experience with Cost Containment Measures in the United States

In the past, various measures have been introduced in the United States in an attempt to control the rate of growth of health care spending. The federal and state governments have introduced a number of regulatory changes to the Medicare and Medicaid programs, with a focus on hospital and physician reimbursement. In addition, the proliferation of health maintenance organizations and other types of managed care represent more competitive kinds of changes designed to control health care costs. While both the regulatory and competitive measures discussed below have shown some success in reducing health care costs, their effects on the rate of growth of national health expenditure has necessarily been limited by their piecemeal approach and the absence of more fundamental changes to the incentives inherent in the U.S. health care financing system.

1. Regulatory approach: prospective payment and fee schedules
   a. Medicare

In 1983, Medicare changed its payment methods for hospitals from one based on days of stay and services provided (retrospective payment) to one based on the number and type of admissions (Prospective Payment System or PPS), with reimbursement rates divided into 470 diagnosis-related groups (DRGs). Under PPS, hospitals face much greater incentives to control costs since they experience a financial loss or gain depending on whether their costs exceed or fall short of the prospective payment.

During the first five years of the PPS, the average length of stay for Medicare enrollees declined by 10 percent and admissions declined by

---

1/ Hospital and physician services together accounted for 57 percent of NHE in 1990. Medicare, Medicaid, and other public health programs financed 42 percent of NHE in 1990.

2/ CBO (1991a), Davis et al. (1990), and Starr (1994), among others, make this point.

3/ PPS is categorized as a regulatory cost containment measure since it is a form of price control. But to some extent, it is also a competitive approach to cost containment since, like payment methods used by HMOs, it increases the cost-reducing incentives facing providers.
12 percent. The latter development is somewhat surprising—the expectation was that hospitals would attempt to maintain their revenues by increasing the number of admissions. The concurrent introduction of the Medicare hospital utilization review process probably assisted in this respect. With these declines in use of service, the average annual rate of increase of real Medicare spending for hospital services per enrollee was about 1.3 percent during the period 1983-88, compared with 6.9 percent during the previous 3 years. 1/

However, the overall cost-reducing effects of PPS are thought to have been limited by the ability of hospitals to shift costs to other payers and to shift services to outpatient settings which are not subject to the PPS (although some of this shift to outpatient settings may be viewed as appropriate). The CBO (1993b) estimates that, in response to cost controls in Medicare and Medicaid and the costs of uncompensated care, hospitals charged private patients a 15 percent average markup over the costs of treatment in 1989 (up from an estimated markup of 6 percent in 1980). The effects of PPS are also thought to have been limited by the unchanged incentives facing physicians as they continued to be reimbursed for "usual, customary, and reasonable charges." In an attempt to address this latter problem, a new reimbursement system for physicians under Medicare was introduced in 1992 (to be fully phased in by 1996). The new system is based on a resource-based relative value scale (RBRVS), where fees are set centrally according to relative resource use and complexity of the task. This fee schedule is to be buttressed by annual expenditure targets designed to prevent doctors from arbitrarily increasing the volume of their services. 2/

b. Medicaid

Until 1981 states were required to reimburse hospitals according to Medicare rules (cost-based reimbursement). Federal legislation in 1981 permitted states to pay hospitals an amount that would cover only the costs of efficiently and economically operated hospitals. In 1989, the average Medicaid hospital payment per day was about 80 percent of the average per diem cost for Medicaid patients. States also restrict their payments to physicians, with payments averaging less than 70 percent of Medicare rates in 1989.

Davis (1990) reviews the early experience with these changes to hospital reimbursement under Medicaid and concludes that state policy changes appear to have been effective in reducing the growth in expenditures per beneficiary. However, most states have payment systems that apply only to Medicaid and appear to experience only temporary savings. Those states with all-payer rate setting are able to force down hospital prices for all payers and have been more successful in achieving sustained savings (see below). Moreover, there is general agreement that the low relative reimbursement rates for Medicaid beneficiaries cited above have reduced

their access to care. According to CBO (1991a), only about 75 percent of physicians were willing to treat Medicaid beneficiaries in 1989, whereas nearly all physicians were willing to treat Medicare enrollees.

c. All-payer rate setting

An all-payer rate setting program is one in which all payers (public and private insurers and direct consumer payments) pay health care providers based on a single fee schedule. During the 1970s and 1980s, the majority of states adopted some form of hospital rate-setting and four states (Massachusetts, Maryland, New York, New Jersey) implemented statewide all-payer hospital reimbursement programs. Currently, Maryland is the only state that continues to operate an all-payer system that includes Medicare. The other three states have a form of all-payer rate setting when the state program and the Medicare PPS are combined.

Virtually all studies of these systems have found that all-payer rate setting is associated with lower costs (2 to 13 percent) and reduced rates of increase in hospital costs over time compared to increases projected in the absence of an all-payer system (CBO (1991a)). Anderson (1991) cites a number of specific studies, one of which found that during the period 1982 to 1986, all-payer rate setting reduced hospital expenditures by 16 percent in Massachusetts, 15 percent in Maryland, 6 percent in New York, and 2 percent in New Jersey. 1/ The trends in hospital costs per admission (adjusted for outpatient volume) in Maryland are striking: in 1976, before the Maryland program was fully implemented, costs per adjusted admission were 25 percent above the national average. Costs steadily approached the national average during the next decade and by 1990 costs were 8 percent below the national average. 2/ Davis et al. (1990) concludes that successful rate-setting programs tend to be those that change incentives for the practice of medicine, for example by setting rates per admission, rather than those that regulate the costs of individual services.

Critics of rate setting argue that access to and quality of care may be compromised. However, Davis et al. (1990) argues that part of the appeal of all-payer rate setting is that hospitals are not discouraged from providing services such as uncompensated care and graduate medical education since these costs tend to be apportioned among all payers. Overall quality of care is difficult to measure, but there is little evidence that regulated hospitals have compromised quality in an attempt to reduce costs. 3/ Finally, another concern is that hospital profitability will be reduced, thereby curtailing hospitals’ access to capital. There is some evidence that the stringent rate-setting program in New York during the 1970s reduced hospital profitability. Studies of other state programs have found

conflicting results, but there is no empirical evidence that access to or acquisition of capital has been impeded. 1/

2. Competitive approach: health maintenance organizations and other managed care

Health maintenance organizations (HMOs) have proliferated in the United States since the early 1970s when federal legislation was enacted to provide funding and qualification guidelines for HMOs in an attempt to encourage their development and assist in slowing the rate of growth of national health care expenditures. Unlike fee-for-service payment systems in which health insurance companies pay health care providers for each service rendered (or reimburse patients for fees paid), HMOs attempt to integrate the provision and financing of health care.

HMOs vary in organizational structure, the financial risk faced by health care providers to encourage cost savings, and their resulting effectiveness in controlling health care costs. The staff or group model HMO provides physicians with their entire patient load and pays them a salary or fixed capitation fee to provide an agreed range of health care services for the enrolled population. A looser organizational structure is found in individual practice associations (IPAs) which involve contracts between an HMO and a number of health care providers with payments based on agreed fee schedules or capitation payments (fixed monthly payments per enrollee). IPA physicians may contract with a number of HMOs and HMO enrollees may represent only a small share of their practice, so these arrangements tend to be less effective at controlling costs. Fifteen percent of the U.S. population was enrolled in HMOs in 1990, about two thirds of which were enrolled in IPAs.

A review of the literature by the CBO (1994b) concluded that HMOs can provide lower-cost health care than the traditional fee-for-service (FFS) sector, largely through a reduction in hospital inpatient services. However, once one takes into account the relatively healthy enrollees in HMOs, the recent shift away from inpatient to outpatient care throughout the health care sector, and the increased use of some form of managed care within the FFS sector, potential savings associated with shifting more of the population to HMOs may be relatively small. The CBO estimates that the most effective HMOs can reduce use of health care services by about 12 percent compared with unmanaged care, or by 9 percent compared with the FFS sector, which is a mix of managed and unmanaged care. When account is taken of the effectiveness of the average HMO, these estimated reductions in use decline to 7 percent compared to unmanaged care and only 4 percent compared to the current FFS sector. Moreover, declines in use do not necessarily translate into declines in premiums because benefits or plan profits may increase.

CBO asserts that, in theory, IPAs could be as effective as group or staff model HMOs in controlling costs if they placed providers at financial risk and generated a significant portion of each provider's patient load. In practice, however, IPAs tend not to satisfy these conditions and therefore are estimated to reduce the use of services by about 3 percent relative to unmanaged care and by less than 1 percent relative to the FFS sector. Similar effects would result from a FFS plan with effective utilization review. Given the current distribution of the population enrolled in effective HMOs, other managed care plans, and unmanaged care, CBO estimates that national health expenditures in 1990 would have been reduced by 4 percent if 70 percent of the population had been enrolled in effective HMOs and the remaining 30 percent of the population (who reside in sparsely populated regions where HMOs would not be viable) had been enrolled in FFS plans with effective utilization review.

While HMOs appear able to reduce the level of health care spending, there is no evidence that they can reduce the rate of growth of spending. In recent years, HMOs appear to have contained the rise in their premiums by increasing enrollees' out-of-pocket expenses, resulting in little effect on the growth of total expenditures. On the other hand, HMOs and other forms of managed care could be more successful at containing the rate of increase in costs if they were part of a reformed health care system that encouraged insurers to compete on the basis of price and quality and encouraged consumers to choose cost effective plans. 1/ Under the current system, HMOs must compete with the larger FFS sector for provider services and, like traditional insurance companies, have incentives to compete by attracting relatively healthy enrollees. At the same time, consumers face little financial incentive and often have inadequate information to choose low-cost, high-quality plans.

IV. Alternative Reform Proposals for the U.S. Health Care System

This section reviews four alternative proposals to reform the U.S. health care system. Although some of these proposals may no longer be viable given the current state of the political debate, they cover a broad range of reform options and provide a framework for evaluating more recent proposals. The descriptions provided are not meant to be exhaustive, but to highlight the key features of the proposals and differences in terms of providing universal, comprehensive coverage and containing health care costs. The cost estimates are those of the Congressional Budget Office (CBO) which is responsible, among other things, for evaluating the cost and economic impact of legislative proposals. Although a key part of CBO's responsibilities is evaluating the possible fiscal consequences of legislative proposals, no attempt is made to rank the following proposals.

1/ CBO (1994b), Wallack (1991), and Starr (1994) are among those who make this point.
based on their fiscal effect. 1/ According to CBO, ranking alternative proposals on this basis is not meaningful since cost estimates were not available to the authors of each bill at the time they were written--any of them could have been made deficit neutral by reducing spending or raising additional revenues.

Following a review of the Administration’s proposal, three alternative reform proposals are discussed in the order that they are estimated by the CBO to have the greatest impact on reducing the uninsured population and controlling health care costs. In CBO’s view, both the Administration’s plan and one for a Canadian-style single-payer system would provide for universal health insurance coverage and would have the potential to reduce significantly the rate of growth of health care spending. A third proposal relies relatively more on market incentives than the first two proposals and according to CBO would be less successful at expanding health care coverage or reducing health care spending over time. The final proposal considered is quite limited, focusing on insurance market reforms, and is estimated to result in only negligible effects on the number of uninsured and the level and growth of health care spending.

1. The Administration’s health care reform proposal: managed competition under a budget

The Administration’s Health Security Act would provide universal health insurance coverage while using a combination of market forces and government regulation to control the rate of growth of health care spending. Universal health insurance coverage would be achieved by requiring that all employers pay on behalf of their employees 80 percent of the average health insurance premium in that region. Subsidies would be available to small businesses and low-income individuals to ensure that health insurance would be affordable as well as accessible. The major change in the market for health care would come about through the creation of regional purchasing alliances (health alliances) that would monitor the quality of health insurance plans and offer a choice of health plans to most individuals under age 65 at community rates (i.e. based on the risk characteristics of the entire region rather than those of small groups or individuals). Medicare would remain separate from the health alliance system, as would large firms (over 5,000 employees) which could choose to act as their own alliance (corporate alliance) by offering a choice of health plans directly to their employees. Medicaid beneficiaries would participate in the health alliance system. Participating health plans would offer a standard, comprehensive benefit package and would be prohibited from denying coverage or excluding pre-

1/ The Budget Enforcement Act of 1990 set up pay-as-you-go requirements to ensure that legislative changes to revenues or mandatory spending programs (such as health care) that would otherwise tend to increase the deficit would be matched by equivalent offsetting changes in revenues or spending. The Congress and the Administration are required by law to use the cost estimates provided by CBO for purposes of satisfying the BEA requirements.
existing medical conditions. These changes are expected to encourage consumers to choose lower-cost health plans, provide incentives for insurers to compete on the basis of price and quality, and in turn, encourage health care providers to practice cost-effective medicine. 1/

To supplement the effects that market forces might have on the level and growth of health care spending, the proposal includes limits on the rate of increase of the average premium for the standard benefit package. Average premiums would be permitted to increase by the rate of CPI inflation plus 1.5 percent in 1996, 1.0 percent in 1997, 0.5 percent in 1998, and zero percent in 1999 and 2000. After 2000, if the Congress did not specify new inflation factors, premiums would increase with the CPI plus per capita GDP.

The projections assume that 15 percent of the population would participate in health alliances in 1996, 40 percent would participate in 1997, and 100 percent would participate in 1998--thus achieving universal health insurance coverage. Health care coverage would also become more comprehensive by creating a standard benefit package as well as by adding prescription drug benefits for Medicare beneficiaries and long-term care benefits.

The federal share of spending on health would rise throughout the projection period as the cost of subsidies, the prescription drug benefit for Medicare beneficiaries, and the new long-term care benefit would exceed savings from the Medicaid and Medicare programs. The CBO projects federal health expenditure to increase by roughly 9 percent of baseline in 1997 and 7 percent of baseline in 2004.

The CBO estimates that national health expenditure (NHE) would rise in the initial years of the Administration’s proposal as health insurance coverage was expanded to the uninsured and the average level of benefits was broadened. Beginning in 2000, however, the combined effects of reductions in the Medicare program and caps on health insurance premiums would reduce NHE relative to baseline projections. By 2004 (9 years after the first phases of implementation), NHE would be $150 billion (6.8 percent) below baseline.

1/ CBO (1994a) contains the assessment of the Administration’s plan; see CBO (1993a) for a thorough discussion of managed competition in general. One aspect of the managed competition model that is missing from the Administration's proposal is a significant limitation on the exclusion for tax purposes of employer-paid premiums from employees' income. In the Administration plan, the exclusion would be limited beginning in 2004, but only for supplementary insurance; the plan would not limit the exclusion of premiums for the standard benefit package, regardless of the cost of the health plan chosen.
2. **Single-payer proposal**

The American Health Security Act of 1993 (H.R. 1200 sponsored by Representative McDermott) would create a national health insurance system financed largely by the federal government in the form of tax revenues instead of health insurance premiums. Like the system in Canada, this single-payer plan would be administered largely by the states. All legal residents would be eligible for comprehensive health benefits with no out-of-pocket payments for acute care or preventive services. People would pick their own health care providers; providers accepting payments from state programs would be prohibited from billing patients for covered services (CBO (1993f)).

The federal government would set a national health budget, with its growth limited to the rate of growth of the economy plus that of the population. States that established so-called health security programs would receive federal grants equivalent to 81-91 percent of their per capita share of the national budget (depending on state income and other factors). Hospitals and nursing homes would receive payments based on state-approved annual operating budgets, while physicians and other professionals would be reimbursed using a fee schedule similar to Medicare’s resource-based relative value scale.

CBO’s analysis assumes that the bill would be enacted in 1994 and that the program would begin in 1997, thus achieving universal health insurance coverage in that year. Federal spending on health care would more than double initially as public financing substituted for private financing of the bulk of national health expenditures. Medicare, Medicaid, and other federal health programs would be repealed. The role of private insurers would be limited to offering coinsurance for out-of-pocket expenses.

CBO estimates that the proposal would raise NHE initially because of increased demand for health services stemming from providing the currently uninsured with comprehensive health insurance and eliminating most copayments for those who have insurance. Coverage would also be expanded for home and community-based services. The additional expenditure arising from this increased demand would be offset somewhat by administrative savings: CBO predicts that direct administrative costs would decline from the current (public and private combined) 7 percent of spending for covered services to 3.5 percent of covered services by the end of the projection period. Moreover, health care providers are assumed to save 6 percent of their revenues by dealing with one payer (rather than 1,500 nationwide) and by eliminating most copayments and other billing.

Health care cost containment under this proposal is obtained through an annual health budget, which CBO has concluded would be reasonably likely to control spending. The uncertainties stem from the states' ability to exceed their budgets as long as they fund the excess expenditure from their own revenues. On the other hand, according to CBO, states would have strong incentives to stay within budget given the resistance to state tax increases and states' general inability to run deficits to finance current services.
Assuming that a limit tied to the growth rate of GDP plus the population is 75 percent effective, CBO estimates that NHE would be reduced by 5.5 percent relative to baseline in 2003 (7 years after implementation). 1/

3. The Managed Competition Act

The Managed Competition Act of 1993 (sponsored by Representative Cooper) proposes to reduce the rate of growth of health care spending by strengthening market forces and expanding affordable health insurance coverage. The principal features of the reformed system would include health plan purchasing cooperatives (HPPCs—equivalent to the health alliances in the Administration’s proposal), changes in the tax code to limit the size but broaden the availability of the tax deduction for health insurance premiums, and subsidies to low-income individuals to assist in the purchase of health insurance. The proposal would provide for universal access to health insurance, but not universal coverage as it contains no employer or individual mandate to purchase insurance. Nonetheless, insurance reforms and subsidies to low-income individuals would reduce the share of the uninsured in the population from 15 percent to 9 percent in 1996 (and beyond). 2/

The system of health plan purchasing cooperatives would allow employees of small firms (less than 100 employees) and those persons with no attachment to the labor force to purchase a standard health insurance package from a choice of accountable health plans (AHPs) through an HPPC. AHPs would be required to accept anyone for enrollment, regardless of health status, and could vary the premiums charged only on the basis of age and type of enrollment (individual, family, etc.). 3/ Unlike under the Administration’s proposal, larger firms could not participate in the HPPCs unless the state in which they were located raised the maximum size of firms that are required to participate in that system. Otherwise, larger firms would be required to offer (but not pay for) the standard benefit package either by self-insuring (creating their own AHP) or by purchasing insurance from an AHP in the non-HPPC marketplace.

The proposal would also change the rules for the deductibility of health insurance premiums in order to make insurance more affordable for some and discourage the purchase of generous policies (relative to the

1/ CBO also projects NHE under a tighter expenditure cap in which health spending is allowed to increase at the rate of growth of GDP since the Act is unclear on this point. Under that assumption, NHE would be 8.5 percent below baseline by 2003.

2/ See CBO (1994c). The proposal does not specify the benefits to be included in the standard package of benefits. In order to prepare cost estimates, CBO assumed two alternative benefit packages. The cost estimates discussed here are based on a comprehensive benefit package like that in the Administration’s proposal.

3/ This is considered limited community rating since age can be used as a factor in determining premiums.
standard package) by others. Premiums paid to AHPs would be tax deductible up to a low cost reference premium for the area. This tax deduction would be made available to the self-employed and individuals and would no longer be unlimited for businesses, encouraging employers to limit their contributions for health insurance benefits and making employees and others purchasing coverage more conscious of the cost of health insurance and more likely to purchase lower-cost plans.

Finally, the proposal would eliminate the Medicaid program and would offer subsidies to low income individuals in order to increase access to health insurance. Those with incomes at or below 100 percent of the poverty line (currently $14,800 for a family of four) would be fully subsidized for the reference premium. Premium subsidies would be phased out between 100 percent and 200 percent of the poverty level. Subsidies for cost-sharing would be available to those with incomes up to 200 percent of the poverty line and would be eliminated abruptly at that point. The design of this subsidy system has the effect of raising effective marginal tax rates significantly in this income range. This problem is also present, but less pronounced, in the Administration's plan.

Under the proposal, federal spending on health would increase by roughly 11 percent of baseline in the second year (FY 1997); this increase would decline to about 2 percent of baseline spending in 2004 as health care spending slowed overall relative to the baseline projections. This scenario is in contrast to the design of the proposal in which subsidies are to be paid for out of health care cost savings, implying no net effect on federal health outlays. CBO concludes that financing for the subsidies would fall far short of the necessary funding—the annual average shortfall would be 30 percent of subsidies between 1996 and 2000. In order to assess the effect of the plan on national health expenditures and health insurance coverage, CBO assumes that alternative financing would be found so that the subsidies would be fully funded. According to the CBO, the estimated impact on national health expenditures would be smaller than under the Administration's proposal. After an increase in spending of 2.8 percent of baseline in the first year, the rate of growth of NHE would slow by 0.6 percentage points a year and the level would be $30 billion (1.4 percent) below baseline by 2004.

Enthoven and Singer (1994) argue that these projected savings are small compared to those estimated for the Administration's proposal (and other proposals which use national health budgets to control spending) because CBO cost estimates are biased in favor of regulatory reforms relative to more competitive reforms. Simulating the effects of budgets on NHE are straightforward, while the cost-saving potential of competitive measures is more difficult to measure. Enthoven and Singer also maintain that the cost containment measures contained in the Administration's proposal are overly ambitious—the premium caps would allow a 1 1/2 percent increase in real per capita NHE in 1996 compared to an average increase during 1980-90 of 4 1/2 percent in the United States and 3 1/4 percent in OECD countries as a whole. The CBO itself recognizes problems in this regard, emphasizing that its analysis assumes that the premium caps will be sustained even though
"they are likely to create immense pressure and considerable tension." The CBO concludes, however, that "other methods of restraining the rapid growth of health care spending would be likely to generate similar stresses." 1/

4. **Private insurance reform**

Several proposals have been put forth that would introduce limited insurance market reforms. One such proposal for which CBO cost estimates are available is the Comprehensive Health Reform Act of 1992 (H.R. 5919 introduced by House Republican Leader Robert Michel). 2/ That bill would allow the self-employed to deduct the full cost of their health insurance from taxable income, would regulate the current system of voluntary employment-based health insurance to improve its availability and affordability, would standardize claim forms and improve consumers' access to medical and health insurance information, and would reform the system of liability for medical malpractice by limiting awards and requiring nonbinding arbitration of most claims. These features are largely included in the proposals discussed above (or would be made superfluous by more fundamental reforms.)

Enhanced regulation of private health insurance would limit insurers' ability to refuse or cancel any employment-based health insurance coverage on the basis of an individual's health or to exclude coverage for pre-existing medical conditions. The access of small businesses to affordable health insurance policies would be enhanced by requiring that each insurer offering health insurance to any small business make that plan available to every small business in the state and not cancel or refuse to renew the plan. Over the longer-term, states would be required to pool the risks of providing health insurance to small businesses.

CBO estimates that this proposal would have a negligible effect on the number of uninsured, reducing it by 0.2 million people by 2000, compared to the 39.2 million uninsured that CBO projected at the time the estimates were prepared. According to CBO, the proposed changes would probably raise NHE by a small amount (0.1 percent of baseline), primarily because of expanded coverage of the self-employed and an associated increase in their demand for health care services. In general, CBO does not attribute any increase in private health insurance coverage to insurance market reforms. Rather the mix of those people with insurance coverage would shift toward higher-risk individuals as some firms employing above-average risks would be encouraged to purchase insurance, but some firms with below-average risks might drop coverage as average insurance costs rose.

A proposal, such as that approved by the Senate Finance Committee, that would supplement these features with subsidies to help lower-income people pay for insurance would probably be somewhat more successful in expanding insurance coverage. But without a mechanism to control health care costs,

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2/ CBO (1993d).
the subsidies would likely prove to be inadequate to reduce the number of uninsured significantly or the subsidy bill to the federal government would be very large. By only guaranteeing access to health insurance through a combination of subsidies and the requirement that insurance companies accept all applicants, such reform plans run the risk of raising private health care costs. Free access to health insurance without a requirement for universal coverage could prompt many to drop insurance coverage until they need it, resulting in higher insurance costs for the covered population. At the same time, cost controls aimed only at public programs are likely to cause providers to shift costs to private patients (and thus to private insurance premiums).

V. Concluding Remarks

Universal health insurance coverage and health care cost containment are often described as conflicting public policy goals. However, most other industrial countries seem to provide universal access to quality health care at lower cost than the United States. They achieve this largely through negotiated fee schedules and global budgets. The health care systems in west Germany and Japan seem to be relatively effective in controlling health care costs without compromising the quantity or quality of health care services. Canada has been less successful at containing health care costs than the average OECD country, but recently has implemented reforms aimed at controlling overutilization that seem to have met with some success.

Within the United States, the experience with cost containment efforts to date has shown that the effectiveness of both regulatory and competitive changes in controlling the overall growth in health care costs is limited when they are implemented in segments of a larger health care market that continues to have cost-increasing incentives. In particular, cost control efforts in public health insurance programs have been shown to shift costs to the private segments of the market for health care. Within the existing private market, consumers have little incentive and inadequate information to choose cost-effective, high-quality health plans. Both types of cost-containment efforts are likely to be more effective if they are broadly based and implemented in a restructured health care market that encourages cost-consciousness decision making.

Among proposals for reform of the U.S. health care system, those that provide for universal health insurance coverage also seem to include the elements needed to control the rate of growth of health care spending. The Administration's proposal for reform of the health care system would provide for universal health insurance coverage and combine enhanced market incentives with global budgets to achieve cost control. The single-payer proposal would rely relatively more on the fee schedules and global budgets that have been used in other countries. Comprehensive market-oriented...
reforms (such as managed competition without global budgets) also have the potential to contribute to cost containment if they ensure universal coverage. However, such an assessment is necessarily more difficult to make because of the lack of experience in other countries and the greater degree of uncertainty surrounding the effects of changes in market incentives.
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