S. 491, AMERICAN HEALTH SECURITY ACT OF 1993

S. 491 would create a single-payer program of national health insurance modeled after the Canadian system. The bill was introduced by Senator Paul Wellstone in March 1993. This memorandum provides a preliminary estimate of the effects of S. 491 on government outlays and national health expenditures. It does not include an estimate of revenues, because many of the revenue-raising provisions of S. 491 were included in the Omnibus Budget Reconciliation Act of 1993.

The estimate assumes that S. 491 would be enacted in 1994 and that the program would begin in 1997. A recent CBO paper, *Estimates of Health Care Proposals from the 102nd Congress* (July 1993), summarizes CBO's methodology for estimating the effects of health reform proposals and emphasizes the uncertainty of such estimates.

SUMMARY OF THE BILL

S. 491 would make all legal residents eligible for comprehensive health benefits with no out-of-pocket payments. People would pick their own health care providers, and providers accepting payments from state programs would be prohibited from billing patients for covered services. Coinsurance or copayments would be prohibited for all items. (A similar bill, H.R. 1200, would prohibit coinsurance or copayments only for acute care or preventive services.)

The national health insurance program (called the American Health Security Program) would be financed largely by the federal government and would be administered by the states under the direction of a federal Health Security Standards Board. The board would develop most of the policies and regulations required to carry out the program. It would also establish a national health budget, which would grow no more rapidly than the economy plus the rate of growth of the population.[1] States that established a health security program would receive federal grants that would average 86 percent of their per capita share of the budget but could vary from 81 percent to 91 percent depending on their income and other factors. This estimate assumes that all states would decide to participate.

Benefits

The benefits provided by the program would include payment for hospital care, physician and other professional services, nursing home care, home health services, hospice care, prescription drugs, preventive health services, home and community-based long-term care services for people unable to perform two or more activities of daily living, durable medical items such as eyeglasses and hearing aids, routine dental care, and other services. The bill

1. As noted below, S. 491 defines the limit on the growth of health expenditures in two different ways. The alternative definition would limit the growth of health spending to the rate of increase of GDP.

requires care-management procedures for drug abuse treatment, home and community-based services, and mental health benefits over specified limits.

The new program would replace most existing public and private health insurance programs. Medicare, Medicaid, Federal Employees Health Benefits, and benefits for military personnel under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) would be terminated. Federal health programs for veterans and Native Americans would continue, however, as would the direct provision of health care by the Department of Defense to active members of the armed forces.

Administration and Cost Control

The national health insurance program would be administered by the states under the guidance of an American Health Security Standards Board, comprising the Secretary of Health and Human Services and six other members appointed by the President. The states could contract with private entities to process claims for payments, but each state could generally have no more than one processor.

The national board would set eligibility, enrollment, and benefit rules, determine provider participation standards and qualifications, review and approve state plans, and establish annual state and national budgets for health spending. The budgets would include separate amounts for capital expenditures and administration.

Hospitals and nursing homes would receive payments based on state-approved annual operating budgets, not on the volume or type of services provided. States could choose to base payment for home health services, hospice care, and facility-based outpatient services on a budget, a fee schedule, or another prospective payment method. Physicians and other professionals would be reimbursed using a fee schedule similar to Medicare's resource-based relative value scale. Payments to health maintenance organizations would be based either on budgets or set amounts per enrollee. States would be responsible for adjusting payments or budgets when HMOs contract with hospitals operating under global budgets. Payments for other items and services, including prescription drugs, would also be made on the basis of fee schedules established by the health board.

ESTIMATED FEDERAL COSTS[2]

S. 491 would, at the start, more than double federal government spending for health. Federal costs will comprise grants to the states for the universal health insurance plan, additional

2. The estimates in this section do not include the states' share of spending under the American Health Security Plan. CBO is currently reviewing the appropriate budgetary treatment of such spending.

direct spending for primary care training and public health efforts, and additional authorizations of appropriations for the Public Health Service.

Part of the federal costs of S. 491 would be offset by repealing Medicare, Medicaid, and other existing federal health programs. To avoid increasing the deficit, the remaining costs would have to be covered by additional taxes and payments by states or beneficiaries. Table 1 summarizes the effects of the bill on federal outlays.

Payments to the States

The bill provides that federal payments to the states would total 86 percent of spending for health services covered by the national health insurance program. The estimate assumes that this percentage would apply in the first year of the program. In later years, federal grants are assumed to increase by the combined rates of growth of GDP and population, as the bill specifies. To the extent that the national health budget is not fully effective in limiting the growth of health spending (as discussed below), the federal share of the total would fall below 86 percent.

Health Care Training and Delivery

S. 491 provides that a total of up to 0.32 percent of the federal revenues dedicated to the national health insurance program shall be devoted to specified public health activities. These activities include health professional education (up to 0.06 percent), public health grants (up to 0.14 percent), grants to community health centers (up to 0.10 percent), and health outcomes research (up to 0.02 percent). The estimate assumes that spending for these activities would equal 0.32 percent of the federal payments to states.

Repeal of Existing Federal Programs

The new program would replace Medicare, Medicaid, Federal Employees Health Benefits, and CHAMPUS benefits for military service members. Of these programs, Medicare benefits, Medicaid, and health benefits for federal retirees are considered mandatory, and the rest are discretionary. The savings from eliminating these programs would equal CBO's baseline projections of spending, extrapolated through 2003. The bill also authorizes appropriations for a new Office of Primary Care and Prevention Research in the National Institutes of Health; CBO estimates that this office would cost about $200 million a year. The net reductions in discretionary programs would not be counted for pay-as-you-go scoring under the Balanced Budget Act.

TABLE 1. ESTIMATED FEDERAL OUTLAY EFFECTS OF S. 491
(By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003
Payments to the States	0	638	951	1,008	1,065	1,124	1,186	1,251
Health Care Training and Delivery	0	2	3	3	3	4	4	4
Repeal Medicare[a]	0	-147	-217	-239	-265	-292	-323	-358
Repeal Medicaid	0	-95	-141	-157	-174	-192	-212	-233
Repeal Federal Retiree Health Benefits	0	-4	-6	-7	-8	-9	-10	-11
Authorizations of Appropriations[b]	c	-15	-22	-24	-26	-28	-30	-32
Total	c	379	568	584	597	607	615	621

SOURCE: Congressional Budget Office.

NOTE: This table does not include the states' snare of spending under the American Health Security Plan. CBO is currently reviewing the appropriate budgetary treatment of such spending.

a. Includes Medicare premiums and administrative costs.

b. Includes repeal of federal employee health benefits and benefits under the Civilian Health and Medical Program of the Uniformed Services. These changes in discretionary programs would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

c. Less than $500 million.

EFFECT ON NATIONAL HEALTH EXPENDITURES

CBO estimates that enactment of S. 491 would raise national health expenditures at first but would reduce spending about 5 percent in 2003. The administrative savings from switching to a single-payer system would offset some of the cost of the additional services demanded by consumers. Over the longer run, the cap on the growth of the national health budget--assumed to be 75 percent effective, as explained below--would hold the rate of growth of spending on covered services below the baseline.

In addition to reducing national health expenditures in the long run, S. 491 would shift a large amount of health spending from the private to the public sector. The new program would assume virtually all spending now covered by private health insurance. The only health spending remaining in the private sector would be out-of-pocket spending for services not covered by the federal program, such as over-the-counter drugs, some dental care and eyeglasses, and cosmetic surgery.

CBO estimated the total cost of the national health insurance program in the following three steps:

- Estimate the amount of covered health services in 1996, the year before the new program would take effect.
- Add the estimated amount of additional health services that would be demanded under the new program in the absence of a limit on total health spending, and subtract the estimated administrative savings.
- Estimate total spending for 1997 through 2003 based on the expenditure limit set in the bill and its likely effectiveness.

Covered Services

The program would cover virtually all spending for hospital care, physician and other professional services, nursing home care, and home health services. For these items, the estimate excludes only other private funding (including nonpatient revenues and philanthropic contributions), 20 percent of current out-of-pocket spending (representing an estimate of services that the new program would not cover), and spending by the Veterans Administration and Indian Health Service. All spending on prescription drugs is assumed to be covered.

State plans would have to cover routine dental care for all beneficiaries. CBO estimates that this represents approximately 50 percent of baseline dental spending from all sources of payment in 1996, initially about $100 per person each year. The bill authorizes the

board to place limits on the cost and frequency of benefits for eyeglasses and durable medical equipment. The estimate assumes that all baseline third-party payments and half of baseline out-of-pocket expenditures for durable medical equipment would be covered.

Additional Demand for Services

Under S. 491, spending on health care would no longer be limited by a person's income, wealth, or insurance coverage. Providing health insurance to people who currently lack insurance and eliminating copayments for those who have insurance would increase the demand for health services. Expanding the coverage of health care to include home and community-based services for the disabled would also greatly increase their use.

The estimated additional demand for health services under the bill is based on the methodology detailed in the CBO memorandum, *Behavioral Assumptions for Estimating the Effects of Health Care Proposals* (November 1993). Under those assumptions, hospital utilization would grow by 12 percent if not constrained by the national health budget; the estimate assumes that this increase would occur gradually over the first three years of the plan. The unconstrained demand for physician and other professional services and covered dental care is assumed to increase by 30 percent, and spending on prescription drugs would increase by 35 percent, also building up over three years. CBO assumes that spending for vision care and durable medical equipment would increase by 30 percent over three years. The demand for home health care and nursing home care is assumed to grow by 50 percent; these latter increases are assumed to be experienced over five years because of their size and the need to expand the capacity of the industries. All of the figures in this paragraph represent weighted averages of the estimated increases in demand on the part of the currently uninsured, Medicare beneficiaries, Medicaid recipients, and people with private health insurance coverage. The estimates of unconstrained demand assume that spending would increase in proportion to the growth in the use of health care services.

In the absence of cost-control, CBO assumes that spending for drug abuse treatment would triple over baseline expenditures, adding $16 billion a year to the cost of these benefits by the third year of the plan. The benefit for home and community-based services and the unlimited mental health benefit would add over $50 billion a year to uncapped health spending after three years.

Administrative Savings

Replacing a variety of private insurers, government programs, and individual out-of-pocket payments with a single payer in each state would reduce the costs of administering the health care system. The national health expenditure accounts, developed by the Health Care Financing Administration, record administrative expenses in several places. The category labeled "administration" includes only the direct costs of administering government programs

as well as profits, overhead costs, and additions to the reserves of private health insurers. The costs of billing for services, filing claims forms, complying with utilization review, and other administrative requirements are included in hospital and physician expenditures and other specific categories of personal health spending.

The estimate assumes that the national health insurance program would operate with direct administrative costs equal to 5.0 percent of spending for covered services in 1997, 4.0 percent in 1998, 3.5 percent in 1999, and 3.0 percent thereafter. In comparison, administrative costs of all insurers (public and private) are currently about 7 percent of spending for covered services, Medicare's administrative cost rate is about 2 percent, and the administrative cost of Canada's single-payer system is less than 2 percent of spending. Although the administrative costs of the national health insurance program might eventually fall closer to the Canadian level, the estimate assumes that this level would not be reached within the first seven years.

The estimate also assumes that hospitals, physicians, other health professionals, home health agencies, and nursing homes could save 6 percent of revenues by dealing with only one payer and eliminating copayments and other billing. These savings would be phased in over two years. No administrative savings are assumed for prescription drugs, dental and vision care, and other categories of personal health expenditures.

Efficacy of Expenditure Limits

S. 491 would limit the rate of growth of spending for the national health insurance program to the rate of increase of GDP for the previous year plus population growth. The present estimate assumes that this limit, after allowing for the increase in demand for health care services and the reduction in administrative costs, would be 75 percent effective. The estimated savings from the limit equals the difference between the unconstrained demand created by the bill and the bill's expenditure limit, multiplied by its effectiveness rating of 75 percent.

S. 491 contains many of the elements that, CBO has concluded, would make its expenditure limit reasonably likely to succeed. The bill establishes a single payment mechanism and a uniform system of reporting by all providers of health care. It sets up global prospective budgets for hospitals and nursing homes. And, by prohibiting participating providers from billing for covered services, it makes it unlikely that people would purchase health care outside the regulated system.

Under S. 491 the states, not the federal government, are at risk if the expenditure caps are not completely effective. If a state exceeds its budget in a given year, it must fund from its own revenues any health spending above the limit. If a state provides all covered health services for less than the budgeted amount, it may retain the full federal payment. Because states generally cannot run deficits to finance current services, and because resistance to tax

increases is strong, states would have a strong incentive to stay within their share of the national health budget. No penalties would apply, however, if a state failed to live within the budget, and some states may therefore opt to spend more on health care services than the budget provides. As a result, the expenditure limit is unlikely to be fully effective in controlling the growth of national health expenditures.

S. 491 defines the limit on national health expenditures in two different ways. Section 601(a)(l) states that the national health budget "shall not exceed the budget for the preceding year increased by the percentage increase in gross domestic product." Section 602(a)(2), however, would allow per capita spending to rise by the rate of increase in GDP; under this specification, the health budget would increase by the rate of growth of population plus GDP.

Because of this ambiguity, Table 2 shows two different estimates of the effect of S. 491 on national health expenditures. The base estimate assumes the less stringent expenditure cap (rate of growth of GDP plus population) and 75 percent effectiveness at achieving the cap. The alternative estimate assumes the tighter cap (rate of growth of GDP alone) and 75 percent effectiveness.

In the base estimate, the additional demand for health services raises national health expenditures in the early years, but the expenditure limit eventually causes spending to fall below the baseline level. National health expenditures fall more rapidly in the alternative, which features a more stringent cap. In both cases, federal grants to the states would grow at the budgeted rate, and any spending above the budgeted amounts would be funded by the states. Health spending by state and local governments would be about 16 percent above baseline levels initially and about 35 percent higher by 2003. Such increases in state spending could create pressure on the federal government to increase its share of payments under the national health insurance program.

Alternative Scenarios. The assumption about how effectively the states restrain the growth of health spending has a significant impact on the estimate of national health expenditures. Because the United States has no experience with a program like the one envisioned in S. 491, the assumption about the effectiveness of the spending caps is highly uncertain. Table 3 illustrates the sensitivity of the estimate to this assumption. The table provides five alternative estimates, in which the effectiveness of the spending limit ranges from zero to 100 percent. If the spending limit were fully effective, national health expenditures in 2003 would be some $250 billion below the baseline. If the spending limit were 50 percent effective or less, however, national health expenditures would exceed the baseline in each year. Under these latter scenarios, even more than in the base estimate, state government spending on health would be substantially above the baseline.

TABLE 2. PROJECTIONS OF NATIONAL HEALTH EXPENDITURES, BY SOURCE OF FUNDS (By calendar year, in billions of dollars)

Source of Funds	19%	1997	1998	1999	2000	2001	2002	2003
Baseline								
Private	614	661	712	766	824	886	952	1,022
Public								
Federal	379	418	460	505	555	610	670	735
State and local	169	184	200	216	234	253	273	295
Total	**1,163**	1,263	1,372	1,488	1,613	1,748	1,894	2,052
Changes from Baseline								
Base Estimate: S. 491 (Higher Expenditure Cap, 75 Percent Effective)								
Private	0	-512	-553	-597	-644	-694	-748	-805
Public								
Federal	a	542	558	571	580	587	592	594
State and local	0	30	54	61	67	78	89	101
Total	a	60	59	35	4	-29	-67	-110
Alternative Estimate: S. 491 (Lower Expenditure Cap, 75 Percent Effective)								
Private	0	-512	-553	-597	-644	-694	-748	-805
Public								
Federal	a	534	541	546	545	541	535	525
State and local	0	31	57	64	71	82	94	107
Total	a	53	45	13	-27	-70	-118	-173

SOURCE: Congressional Budget Office.

a. Less than $500 million.

TABLE 3. PROJECTIONS OF NATIONAL HEALTH EXPENDITURES UNDER ALTERNATIVE ASSUMPTIONS ABOUT THE EFFECTIVENESS OF THE SPENDING LIMITS IN S. 491
(By calendar year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003
Baseline								
National Health Spending	1,163	1,263	1,372	1,488	1,613	1,748	1,894	2,052
Changes from Baseline								
5. *491* 100 Percent Effectiveness Rating	a	35	-1	-41	-91	-140	-196	-258
S. 491 75 Percent Effectiveness Rating	a	60	59	35	4	-29	-67	-110
S. 491 50 Percent Effectiveness Rating	a	84	120	114	104	90	73	52
S. 491 25 Percent Effectiveness Rating	a	109	183	197	212	218	224	229
S. 491 0 Percent Effectiveness Rating	a	133	248	283	325	355	387	422

SOURCE: Congressional Budget Office.

a. Less than $500 million.

COMPARISON WITH PREVIOUS ESTIMATE

CBO has previously analyzed H.R. 1200, the House version of S. 491. H.R. 1200 differs from the Senate bill primarily by allowing the states to charge coinsurance or copayments except for acute care or preventive services. H.R. 1200 also has more limited dental benefits than S. 491 and therefore subjects slightly less health spending to the expenditure limit.

S. 491 and H.R. 1200 would have similar effects on national health expenditures. Compared to H.R. 1200, the absence of coinsurance in S. 491 would increase the demand for nursing home care, drugs, and durable medical products but would reduce administrative costs. In the absence of a limit on expenditures, the net effect would be an increase of about 1 percent in national health spending. If the expenditure limit were completely effective, national health expenditures would be virtually identical under the two bills.

As a result of the lack of coinsurance or copayments, the states' share of health spending would be substantially higher under S. 491 than under H.R. 1200, and the private share would be correspondingly lower. In 1997, for example, state spending would be $30 billion above the baseline under S. 491 and $29 billion below the baseline under H.R. 1200. The increase in federal costs would be greater under S. 491 than under H.R. 1200 on account of the larger dental benefits.

OTHER CONSIDERATIONS

This memorandum deals only with the costs of this bill. Any major reform of the health care system, however, would have many other significant effects. Providing universal health insurance coverage would increase the demand for health care services. At the same time, the imposition of a limit on health expenditures would reduce the resources available. These changes could affect the incomes of providers, access to certain types of care, accessibility of some providers, the pace of technological change, and other important aspects of the health care system.