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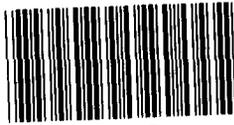
United States General Accounting Office

GAO

Transition Series

December 1992

# Health Care Reform



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GAO/OCG-93-8TR

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**Comptroller General  
of the United States**

December 1992

The Speaker of the House of Representatives  
The Majority Leader of the Senate

In response to your request, this transition series report discusses major policy, management, and program issues facing the Congress and the new administration in the area of health care reform. The issues include (1) access to health insurance for the uninsured, (2) private health insurance market reforms, (3) health care cost containment, (4) administrative simplification, (5) fraud and abuse controls, (6) diffusion and pricing of new medical technologies, and (7) medical malpractice reform.

As part of our high-risk series on program areas vulnerable to waste, fraud, abuse, and mismanagement, we are issuing a related report, Medicare Claims (GAO/HR-93-6, Dec. 1992).

The GAO products upon which this transition series report is based are listed at the end of this report.

We are also sending copies of this report to the President-elect, the Republican leadership of the Congress, the appropriate congressional committees, and the Secretary-designate of the Department of Health and Human Services.



Charles A. Bowsher

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# Health Care Reform

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A key challenge facing the new Congress and administration is finding a better way to manage and finance the U.S. health care system while preserving the high-quality, innovative medical care the United States has achieved. The United States is projected to spend 18 percent of its gross domestic product (GDP) on health care by the year 2000—far more than any other industrialized country. These growing costs are being shared by individuals and the business community as well as federal and state programs. The inexorable rise in health care costs is constraining wage increases and the financial capability of federal and state governments to address other pressing social concerns. We have emphasized that failure to control overall health care costs will stymie efforts to control outlays on Medicare and Medicaid—the fastest growing major programs in the federal budget—and will make it more difficult, if not impossible, to bring the federal budget into balance.<sup>1</sup> Individuals, business, and the government need to work together to tame the cost spiral for health care.

Despite having the highest costs in the industrialized world, our health care system is not serving large portions of our

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<sup>1</sup>See particularly app. III in Budget Deficit: Appendixes on Outlook, Implications, and Choices (GAO/OCG-90-5A, Sept. 28, 1990).

population very well. Nearly 34 million Americans are uninsured and millions more are underinsured or fear they might lose coverage if they develop a serious medical condition, lose their job, or change employers.

The Congress has asked us to review approaches developed in American communities and foreign countries that might help explain the root causes of our health care problems and suggest possible solutions. We have examined the experiences of Canada, France, Germany, and Japan as well as U.S. federal programs and state and community initiatives. If the United States is to broaden access and contain health spending, there is a need to consider adopting features common to successful systems that we have observed in other countries and within our own borders.

A reformed U.S. system must also build on the strengths of the nation's current health care system. A strong research establishment, the continuing development of technology, and the capacity to evolve more efficient service delivery mechanisms are among the strengths of the U.S. health care system that should be preserved.

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# Access to Health Insurance for the Uninsured

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Universal access to health insurance is an achievable goal. Countries like Canada, France, and Germany provide high-quality health care to all their citizens, yet spend a considerably smaller share of their nations' resources on health. Within our own borders, Hawaii is the state with the largest share of its population covered by health insurance. Rochester, New York, counts 7.1 percent of its population under the age of 65 as uninsured compared with a national average of about 15 percent. Yet both Hawaii and Rochester have achieved enviable records in terms of health cost containment and the level of insurance premiums.

Universal access to health insurance is not free. Estimates for providing the 34 million persons who are uninsured with health insurance range from \$12 billion to \$27 billion annually. These costs are not the only factor that has made it difficult to achieve universal access to health insurance in the United States. Universal access would also entail major changes in the role of government, the structure of the health finance system, and the financial responsibilities of individuals and employers. An employer mandate would compel businesses to provide or finance insurance for their employees and may add

new costs and responsibilities for many small firms. A Canadian-style system would involve a substantial increase in the share of health care costs financed through the tax mechanism.

The United States is considering a commitment to universal coverage not only because of the needs of the 34 million uninsured but also because such coverage can contribute to both short- and long-term strategies for cost containment. Universal coverage contributes to lowering administrative costs for providers by relieving them of the burden of assessing insurance status before treatment and by limiting losses associated with bad debt. Changes in these two areas would be especially beneficial for institutions such as teaching hospitals and public hospitals in large cities that currently serve large numbers of uninsured patients. Universal coverage also contributes to system efficiency by reducing the need for the uninsured to use more expensive treatment settings such as the hospital emergency room because they are not covered for treatment in less expensive settings. Moreover, adequate coverage for preventive and primary care for chronic conditions can

help avoid more costly and serious treatments in the future.

Universal health insurance coverage is not ensured in all of the comprehensive reform proposals, although all proposals seek to make significant inroads to reducing the uninsured population. National health insurance plans that cover all citizens explicitly solve the problem of the uninsured. Proposals that rely on the existing employer-based insurance model require development of complementary programs to cover the uninsured who are not employed and any employed persons or family members who remain uninsured under the employer-based plans.

For example, Hawaii's mandate that employers provide insurance coverage does not require that health insurance coverage be provided to part-time workers or to family members of insured workers. To address these gaps in coverage and to include the unemployed who are not eligible for Medicaid, Hawaii developed a supplemental state-sponsored insurance plan to extend coverage to these groups. The state estimates that it has reduced the number of uninsured to about 2 percent of its population.

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# Private Health Insurance Market Reforms

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About three-fourths of uninsured Americans are workers or their dependents, and just over one-half of uninsured workers are employed by firms with fewer than 25 employees. Some underwriting and rating practices in the private insurance industry have made obtaining affordable health insurance difficult or impossible under several conditions: when an insured worker, dependent family member, or coworker in the same risk pool develops an expensive medical condition; when a worker changes jobs; or when a firm changes insurance carriers. If comprehensive reform is based on the current employer-based private insurance system, reforms of insurance practices that affect people in these situations are essential.

Two broad types of health insurance reforms would be needed—those designed to improve availability and those designed to improve affordability. Reforms related to availability guarantee that insurance will be available to all eligible members of employee groups through

- guaranteed issue of policies to all employer groups and their eligible members,

- **guaranteed renewal of policies that eliminate or restrict the capacity of insurers to cancel policies because of medical history or to introduce new policy exclusions at the time of renewal, and**
- **guaranteed continuity of coverage when employers change insurers, employees change jobs, or insurers become insolvent or discontinue offering health insurance.**

Because insurance may be available but still priced out of the reach of small businesses, affordability also needs to be addressed through

- **restricting factors used in setting rates, such as health status and previous claims experience, and**
- **limiting the range of premiums a single insurer can charge for customers with different risk characteristics.**

These types of reforms are needed to ensure that private insurance products are available to everyone under employer-mandated coverage plans. However, such reforms can be a double-edged sword. While they would increase availability and reduce insurance premiums for higher-risk groups that have

been excluded from the market, the reforms would generate higher premiums for those currently insured in lower-risk groups who would share in the costs of the extended coverage.

The net effect of insurance market reforms alone on reducing the ranks of the uninsured is unclear. States have introduced a number of these reforms in the last few years. Early experience suggests that such reforms have had a modest effect on reducing the ranks of the uninsured when coupled with limited subsidy programs and state assistance to risk pooling.

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# Health Care Cost Containment

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The call for control of health care costs is now heard throughout U.S. society. Expanding insurance coverage to the uninsured would make cost control more urgent, but even without that additional spending, the upward sweep of health care costs is threatening the financial position of businesses, individuals, and governments.

Cost control entails some force that disciplines the decisions of consumers and providers. As a result, cost control means that some segments of society will receive less. Providers (such as physicians and hospitals) will have lower revenues than if present trends continue. Consumers may face less choice among providers, and the rate of improvement in medical technology may slow.

Nonetheless, cost control is imperative. Without it, the problem of the uninsured will likely worsen as the unchecked rise in the cost of insurance puts it out of the reach of more and more people. Moreover, lack of cost control will aggravate the budgetary squeeze on the federal and state governments. How to control costs with the fewest adverse effects on the population is the challenge.

Among the many proposals for achieving cost discipline in U.S. health care, two broad strategies are currently most prominent: managed competition and direct controls. Both would use government regulation, although in quite different ways. The two strategies differ in the extent to which they rely on market forces and in the extent to which they have been tested in practice. Managed competition would give regulation a competition-enhancing slant by establishing a complex set of rules within which competition can occur. After restructuring the marketplace, the government would play umpire for insurers, providers, and beneficiaries while letting competition exert discipline and rein in health care costs. The second strategy, direct controls, would require public (or quasi-public) authorities to set health care prices, limit overall spending, and regulate the spread of new technology.

The strategy of managed competition is evolving, and its various proponents sometimes define it in different ways. Nonetheless, they agree on blending federal regulation with incentives and private initiative to create a cost-conscious discipline for hospitals and physicians. Also, current proposals assume heavy reliance on

managed care health plans, such as health maintenance organizations (HMO) and preferred provider organizations (PPO), that try to encourage efficiency by placing providers at risk for health costs, using administrative processes to attempt to control services, or both.

In designing a practical system of managed competition, two questions are pivotal:

- First, can rates for health care plans be set so that insurers are not rewarded for “cream-skimming”?

Under current arrangements, a company offering health insurance makes more money by attracting people who are healthier than average and by not insuring bad health risks. Whether a system of managed competition could prevent cream-skimming—which would undermine the system—is much debated. Our work on Medicare’s rate-setting for HMOs illustrates the difficulty of the task.

- Second, would managed competition achieve cost savings at the expense of quality?

To prevent this, the proponents of managed competition stress the need to create new sources of information about the quality of health care. How quickly such information could be generated and how consumers would use it are, however, open questions. Our work on HMOs for Medicare enrollees shows that quality assurance is needed to avoid abuses due to cost-cutting.

The strategy of managed competition is appealing to many. The Netherlands, for example, is in the early stages of implementing a particular version of the strategy. But evaluating the likely effectiveness of managed competition is hampered by lack of a real test, abroad or within an American state, in which a system of managed competition could be observed. Some research on states with relatively strong competition among HMOs and other managed care providers is mildly encouraging. Nonetheless, these states have not implemented managed competition, so it is difficult to draw conclusions from them about how much a managed competition system would flatten the trend in costs.

The alternative approach, direct controls, uses fee schedules and other price controls,

spending targets and caps (sometimes called “global budgets”), and controls on the dispersal of new technology. Our analysis of these controls also reveals both strengths and weaknesses.

Direct controls have been employed in many different settings and have been implemented in a variety of ways. For example, direct controls are used systemwide in countries with many insurers (such as Germany) and with a single insurer (Canada). In the United States, direct controls are used at the federal level (Medicare uses a fee schedule and has introduced a spending target for physicians’ services), at the state level (Maryland sets hospital rates), and at the local level (Rochester, New York, has used global budgets for hospitals).

In addition, direct controls have, with different degrees of success, restrained health care costs. Our studies of American and foreign health care provide evidence on the effectiveness, in particular, of spending controls and price controls. Thus, we found that the cost containment strategy used in Rochester, New York—which included global budgets—seemed to have slowed the rise in hospital costs. For France and

Germany, our analysis showed that targets and caps slowed the rate of spending increases compared with what would have happened without these policies. Our analysis also confirmed that the strength of enforcement is important: In Germany, spending caps have replaced targets, which were more weakly enforced, and the caps have proved more effective in limiting spending.

Direct controls on prices also have been relatively effective in containing costs. As our analysis showed, U.S. states that have set rates for hospital services to which all insurers in the state must adhere have slowed the growth in their per capita health spending. In addition, Medicare, which uses a variant of price controls in reimbursing hospitals, has slowed the rise in its costs for hospital services. Other countries' experience with price controls is generally consistent with these findings for the United States.

Direct controls are not a panacea, however. Even viewed just in terms of cost containment, they do not eliminate all spending pressures. Moreover, direct controls can hamper efficiency and retard innovation. Budgeting procedures may not

reward efficient providers and insurers and may not penalize inefficient ones. Spending caps and targets may freeze the prevailing system of delivering health care and discourage innovations like managed care. Budgets may adapt too slowly to changes in technology, the demographic mix of patients, and methods of delivering care. Price controls can slow or block a needed shift of resources, say from one specialty to another, when demand or supply conditions change. To some extent these difficulties can be mitigated, but still they must be weighed when the choice of a spending control strategy is made.

In sum, neither managed competition nor direct controls is without drawbacks. Indeed, some analysts and policymakers are crafting proposals that combine the market-oriented advantages of managed competition with the extra cost discipline of direct controls—specifically, a cap on overall health spending. These hybrid plans are too sketchy as yet for observers to determine whether the two strategies can be blended, or how effective such a hybrid system might be.

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# Administrative Simplification

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In the United States, nearly 6 percent of total health expenditures in 1989 were accounted for by the administration of government health programs and private insurers. In sharp contrast, Canada spends about one-fifth as much proportionately on these insurance overhead functions. In addition, U.S. providers spend billions of dollars each year for billing and other administrative activities directly attributable to our system of financing health care. Providers in Canada, Germany, France, and Japan incur lower costs, in part because they deal with a more unified payment mechanism. While considerable debate continues about the precise magnitude of the potential savings in administrative overhead and providers' administrative burdens associated with specific reform proposals, there is general agreement that significant savings can be achieved in this area.

Administrative expenses for private insurance plans average about 12 percent, but they can be as high as 40 percent of claims costs for individual and small group plans. When multiple insurers market a range of plans differing in scope of coverage, the result is significant overhead costs to cover claims processing and marketing. While a wide range of insurers and plans

may create greater consumer choice and greater responsiveness to consumers' needs, this wide range is part of the reason for higher administrative costs. Physicians, hospitals, and other providers must expend resources on billing and administrative procedures to deal with the fragmented payment system.

Almost all reform proposals attempt to achieve cost savings by reducing administrative costs through one or more of the following approaches:

- combining large numbers of employers into large insurance-buying cooperatives to achieve administrative economies,
- defining a single or limited number of basic insurance plans to reduce marketing costs and the burden on providers,
- developing standardized claims forms and billing procedures for all insurance plans and providers,
- eliminating insurance underwriting activities,
- eliminating deductibles and copayments to eliminate the need for providers to issue bills,

- using more inclusive methods for reimbursing providers, such as global budgets, and
- using a single payer with uniform payment rules and procedures in each market area.

Canada, for example, achieves substantial administrative savings through a combination of a single payer with uniform payment rules and elimination of all deductibles and copayments. The United States might achieve a similar level of administrative savings if it adopted a Canadian-type reform, but the savings could be largely offset by the additional use of services associated with the elimination of deductibles and copayments. Alternatively, the United States could retain deductibles, copayments, and utilization review activities. This approach would reduce potential administrative savings but result in greater control over potential costs associated with increased use of health services. If the United States should choose a system that depends on employer-based private insurance, some level of administrative savings could still be achieved through a combination of the other approaches described above.

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# Fraud and Abuse Controls

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The United States may want to invest more, rather than less, in the administrative resources required for detection of fraudulent and abusive practices by health care providers. Estimates vary widely on the losses resulting from fraud and abuse, but the most common is about 10 percent of total health care spending or about \$80 billion annually. Only a token amount of administrative resources are devoted to detection and elimination of fraudulent and abusive practices.

Both public and private health insurance programs are subject to fraud and abuse but separately appear unable to combat it successfully. Our work suggests that fraud and abuse may be even more prevalent in privately insured programs, in which control efforts have not been as prominent and data systems are more fragmented. Indeed, federal health care programs have taken the leadership role in prevention of such practices. While a simpler and more uniform payment and administrative system may make it easier to detect potential fraud and abuse, we believe that investing the needed resources in designing the administrative structure and continuing surveillance to limit the potential for such practices is essential. These issues are discussed more fully in our

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related report, Medicare Claims (GAO/HR-93-6,  
Dec. 1992).

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# Diffusion and Pricing of New Medical Technologies

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The rapid spread and increased use of new medical technologies has been relatively unrestrained in recent years and has given health spending added momentum.

Technological advances have sometimes led hospitals to participate in a medical “arms race,” as they acquire expensive technology and seek to keep patients and doctors from shifting to rival hospitals.

Once declared eligible for reimbursement, third-party payers—business, government, and private insurers—have primarily shouldered the financial burden of these technological advances. However, insurers’ payment policies have not always encouraged efficient and prudent use of these medical services. Instead, insurers have left themselves vulnerable to excessive spending by giving providers incentives to be wasteful or abusive in offering medical services. In particular, our work has shown that in some cases, insurers have not adjusted payment rates to reflect the effect of maturing technology on costs.

The challenge for policymakers is to find ways to encourage development of new technologies while ensuring their efficient use. This can be accomplished through

payment policies that reflect the costs  
incurred by high-volume, efficient providers.

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# Medical Malpractice Reform

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Savings in addition to those stemming from comprehensive health care reform can be achieved through fundamental changes in the U.S. medical malpractice system. The United States faces higher costs for medical malpractice insurance and associated defensive medicine costs than other nations.

U.S. medical malpractice premiums are estimated to be only about 1 percent of total U.S. health care costs. There is considerably wider variation in estimates of the potential additional costs of defensive medicine—diagnostic tests and procedures performed solely to protect physicians in the event a malpractice claim is filed. The American Medical Association estimated the costs of defensive medicine at \$20 billion in 1991. Moreover, physicians want relief, not only from the financial burdens of malpractice, but also from its emotional burdens.

Cost reduction should not be the sole basis for malpractice reform. Malpractice reform also should be directed toward providing better access to compensation for those who are injured. Arbitration and no-fault programs have been implemented in various states as an alternative to a complex and expensive court process. Many of these

programs also incorporate local practice guidelines that, although not an absolute defense, provide evidence in a judicial process that accepted medical protocols were followed. Furthermore, hospitals and other medical settings are adopting risk-management programs that are expected to improve the quality of care. We believe these efforts should continue to be studied and, when positive effects are demonstrated, should be considered in conjunction with comprehensive health care reform.

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# Observations About Health Care Reform

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Reform of U.S. financing of health insurance and payment of health care providers is a daunting task. U.S. health care is an \$800 billion enterprise that is diverse, complicated, and dynamic. Achieving reform will be particularly difficult because, to many people, reform seems to threaten a good situation. People whose health insurance is adequate and whose health care is good may fear that reform will result in diminished care or higher costs for them. For providers as well as consumers, reform of the health care marketplace will cause a considerable reshuffling and generate losers as well as winners.

Moreover, reform will not produce a structure that is perfect. Our reviews of the health systems of other countries shows that after putting major reforms in place, these countries continue to seek ways to improve their systems. We believe that the imperfections of any reform—and the dynamic character of the health care industry—make a stream of further changes inevitable in the years ahead. However, there may be greater risks in not undertaking comprehensive health care reform. Without reform, costs will continue to escalate while a substantial number of Americans lack access to health insurance.

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## Related GAO Products

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### Alternative Health Care Systems

Health Care: Rochester's Community Approach Yields Better Access, Lower Costs (GAO/HRD-93-44, forthcoming).

Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992).

Health Care Spending Control: The Experience of France, Germany, and Japan (GAO/HRD-92-9, Nov. 15, 1991).

Canadian Health Insurance: Lessons for the United States (GAO/HRD-91-90, June 4, 1991).

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### Health Care Costs

Hospital Costs: Adoption of Technologies Drives Cost Growth (GAO/HRD-92-120, Sept. 9, 1992).

Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

Health Care Spending: Nonpolicy Factors Account for Most State Differences (GAO/HRD-92-36, Feb. 13, 1992).

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (GAO/HRD-91-102, June 10, 1991).

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Health Insurance

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992).

Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992).

Private Health Insurance: Problems Caused by a Segmented Market (GAO/HRD-91-114, July 2, 1991).

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Fraud and Abuse

Medicare Claims (GAO/HR-93-6, Dec. 1992).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (GAO/T-HRD-92-49, July 28, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

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Medical  
Malpractice

Medical Malpractice: Alternatives to  
Litigation (GAO/HRD-92-28, Jan. 10, 1992).

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