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Linda Bilheimer and Robert Reischauer have written a predictably first-rate description of some major estimation issues in the health care reform debate of 1993-1994. While a long list of issues could be added, I have no substantive disagreements with the paper. This should not surprise anyone, since we all grappled with the same questions and imperfect data for two years, often while trying to help each other sort out the implications of proposals and meet relentless deadlines. To their presentation and the discussion so far I add a general perspective on the role of quantitative estimates in the policy debate and a brief discussion of ways to address the data and research shortcomings that persist.

How Serious Was The Lack Of Information?

Why do we need quantitative information, or, more broadly, what is the responsibility of quantitative analysts in social policy debates? I argue that our responsibilities are three: (1) to inform public policy choices, so that decisionmakers and the public know the implications of the choices; (2) to protect the Treasury from financial ruin, that is, avoid the future consequences of rosy scenarios; and (3) to enable policy reform to have a chance by highlighting areas of analytical agreement and carefully delimiting areas of remaining uncertainty. Uncertainty is certainly large in health system reform estimates, but it should not be overstated. Since the enemies of reform and of activist presidencies always exaggerate uncertainty for their own ends, it is essential that serious analysts define precisely the contours of agreement and remaining uncertainty.

Overall, in 1993-1994 we quantitative health care reform analysts informed and protected, but we did not enable. The broad consequences of choices were made clear, at least to decisionmakers. The federal Treasury was protected by fail-safe mechanisms that all serious bills contained and, more importantly, by the reasonableness of Congressional Budget Office (CBO) cost estimates. These estimates minimized the risk of disastrous future consequences from tightly binding constraints. However, early disputes about deficit reduction created an exaggerated impression of great uncertainty and risk that was never removed and that colored the future debate.

Whatever the flaws in the Health Security Act and in the Clinton administration’s political strategy that made comprehensive health care reform a very hard sell, it is possible to construct a health plan based on reformed private insurance markets and employer mandates that will deliver universal coverage and at least rough-deficit-neutrality even without a broad-based tax increase. The Clinton administration surely thought so when it released its official estimates in November 1993. The independent firm Lewin-VHI reached the same conclusion in December 1993. Had the CBO confirmed this basic judgment of the Health Security Act...
Act in its February 1994 report, a major blow to the president’s credibility in the entire health care debate would have been averted, and the political dynamic in early 1994 surely would have been different.

If the administration had been able to work with the CBO, as major committees and the leadership routinely do, the bill could have been altered slightly to hit a modest deficit reduction target by the CBO’s scoring methods. I do not know enough to apportion blame for the fact that the CBO and the administration and its congressional allies failed to work together in this way. From what I do know about the administration’s policy development processes throughout 1993, it is not clear that the administration would or even could have supplied the CBO with sufficiently detailed legislative language within the time constraints. What is clear is that an opportunity was lost for serious and credible analysts to reach a reasonable consensus on the technical feasibility of the administration’s goals as embodied in the Health Security Act, and losing this opportunity was costly.

In any event, quantitative information of adequate quality was eventually produced, but it was very unevenly disseminated. Reischauer eloquently defined “adequate” during congressional testimony about CBO estimates of the Health Security Act. In response to a question that went something like, “Well, do you think you’re in the ballpark?” the CBO director replied, “Congressman, I believe we’re in the town the ballpark is in.”

I understand all too well that human nature and the policy process require point estimates. However, ten-year point estimates of major reforms should be rounded to the nearest $100 billion (1994 dollars). If both the administration and CBO estimates had been rounded in this way, they would easily have fallen into the same plus or minus $100 billion range. All comprehensive reform bills had subsidy cost estimates over 1996-2005 in the $1 trillion range. Plus or minus $100 billion for them is equivalent to plus or minus 10 percent. Given the inherent estimation difficulties, plus or minus $100 billion over ten years, that is, plus or minus $10 billion each year, should be good enough for major social reforms in a $7 trillion economy and with a $1.5 trillion annual federal budget. Original Social Security and Medicare predictions were nowhere near this close, and whatever their current technical problems, those programs surely must be counted among our greater political and social successes. Under current rules and laws governing the budget process, major social reforms are being held to a standard that may be impossible to reach.

In discussing the maldistribution of accurate quantitative information, I focus on the problems of three groups: the press, the people, and members of Congress. Complex and ambiguous quantitative information does not fit the preferred format of the press, and most press coverage of “numbers” issues focused on adversarial quotations and reporting conclusions without reflection or analysis. “He said, she said” in quantitative matters leads the public to the cumulative impression that “no one knows.” This is another reason that the failure to reach consensus on the feasibility of universal coverage and deficit reduction/neutrality was so critical.

By “the people” I mean both interest groups and citizens. Interest groups reduce their general credibility by acknowledging or releasing data only if the data support their current position. Most powerful interest groups manifested little ambiguity about what they stood against in this debate. This may have contributed to the general focus on the negative during the legislative struggle of 1994.

Most citizens do not know what they are paying for health insurance now (through their employer), and little effort was devoted to this educational prerequisite for a serious public discussion about health care reform options. Given this unfortunate fact, the exaggerated uncertainties during the debate, and the complicated redistributions implicit in any comprehensive reform proposal, it is not surprising that a majority lacked faith in rhetorical claims such as “everyone’s a winner.” In the end, a majority of citizens’ lack of faith in reform and in the reformers is what killed health care reform in Congress.
Members of Congress are heterogeneous, like the press. Some are brilliant and exceptionally well informed about health care matters, and some are neither. This heterogeneity forces a “lowest common denominator” type of briefing, which, while effective in the short run, leaves any estimate vulnerable to interest groups’ counterassertions because the methodology and rationale behind the numbers never get explained.

Many members prefer credible cover to detailed analysis. Most really only want to know, “What will the CBO say?” This gives enormous power to the CBO. Thus far this has been, on balance, a good social bargain for the United States. I am not so confident about the future CBO, but I remain hopeful.

What Can Be Done About It?

Exhibit 1 presents a schematic of data on our health care delivery and financing systems. Start with household demographics at the far left-hand side and move horizontally through providers to utilization. Everything on this line and above it, with the notable exception of medical outcomes, is quite well captured in national probability surveys, usually annually, by at least one in the set of national health care surveys conducted by the National Center for Health Statistics (NCHS). We have extremely good annual information linking household demographics and utilization.

Now consider everything below that line. Much of the data represented here are captured by the National Medical Expenditure Survey (NMES) of the Agency for Health Care Policy and Research (AHCPR). This survey is the nation’s primary source linking specific households to health expenditures through their employers, insurers, and providers. Unfortunately, NMES is conducted only once a decade, the last time in 1987. So our only nationally representative data on the distribution of expenditures by demographic subgroup, crucial for premium estimation under the myriad alternative risk pools in the health care reform proposals of 1993-1994, were seven years old. This was most serious because these relative cost data were generated in a health care delivery system rather different from today’s. There would appear to be an imbalance in resource allocation for data collection, when we get expenditure data once a decade and utilization data, which do not vary nearly as much, once a year.

As Bilheimer and Reischauer point out, the biggest estimation issues affecting cost estimates were the premium and how health expenditure data on the distribution of expenditures by demographic subgroup, crucial for premium estimation under the myriad alternative risk pools in the health care reform proposals of 1993-1994, were seven years old. This was most serious because these relative cost data were generated in a health care delivery system rather different from today’s. There would appear to be an imbalance in resource allocation for data collection, when we get expenditure data once a decade and utilization data, which do not vary nearly as much, once a year.

As Bilheimer and Reischauer point out, the biggest estimation issues affecting cost estimates were the premium and how health
care costs would grow over time. The triangle in the lower left-hand corner—household demographics, employers, and insurers—represents one key set of linkages. The truth is that we know embarrassingly little about insurance markets. We have good information about the type of coverage people have, but we do not know much about how they came to make those choices. We need much better surveys on what choices employers face, what contingent choices they make, the contingent choices households then make, and how local insurance market conditions affect these offers and choices. The CBO, the Clinton administration, and Lewin-VHI all did creditable jobs of estimating the long-run equilibrium premiums for the Health Security Act, assuming mandates, complete insurance reforms, community rating, and perfect risk adjustment believed by all bidding insurers.' We need basic research to investigate the quantitative significance of relaxing any of these assumptions, to estimate proposals centered on voluntary approaches with incomplete insurance reforms.

The other area of research that would seem most fruitful to apply to future health care reform proposals would focus on the trapezoid formed by insurers, providers, utilization, and expenditures. What strategies actually reduce cost growth? The premium caps in the Health Security Act were little more than assertions of will in the face of what some analysts thought was possible. Because overall health spending may not be slowing down without reform, as much as some may have hoped, we may someday be faced with renewed policy interest in imposing arbitrary caps on spending growth. While the private sector is pursuing this question vigorously at the moment, research needs to accompany the experimentation so that systematically successful strategies spread as rapidly as possible, and so that the technology and quality policy implications of successful strategies are clearly understood. This argues for keeping a close eye on the outcomes leaking from the trapezoid on which many health economists focus exclusively.

Finally, two kinds of new surveys would greatly improve health care reform cost estimation in the future. We need to know the wage distribution within firms, to better predict how their decisions to sponsor coverage might be affected by various premium subsidies (including Medicaid expansions) and income tax changes targeted to low-income households. Second, serious thought should be given to revamping the split NCHS/AHCPR data collection efforts, consolidating surveys and coordinating updates, and finally combining the efforts into a single household panel survey that traces interactions with firms, insurers, and providers, all the way to expenditures and outcomes. Properly designed with appropriate supplements, this panel should be capable of generating insurance, utilization, and expenditure information much more often than once a decade, without sacrificing the ongoing monitoring of the evolving health care delivery system that NCHS does now.

NOTES
3. These surveys are the National Ambulatory Medical Care Survey, the National Hospital Ambulatory Medical Care Survey, the National Hospital Discharge Survey, the National Survey of Ambulatory Surgery, the National Nursing Home Survey, and the National Home and Hospice Care Survey. When coupled with the National Health Interview Survey, the items above the horizontal line are covered very well, save for managed care providers and outcomes.
4. Insurance reforms include standard benefit package; guaranteed issue, renewability, and portability; and limits on preexisting condition restrictions.