

CONTAINING MEDICAL CARE COSTS THROUGH MARKET FORCES

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PREFACE

In response to the problem of rising medical care costs in general, and their effects on the federal budget in particular, some in the Congress have proposed a change in policy that would stress greater reliance on the market to allocate resources to medical care. Its advocates believe that this would foster increased competition among the providers of services.

This report, prepared at the request of the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, analyzes the potential of this approach. Particular attention is given to options that would alter the tax treatment of employment-based health insurance and options involving the Medicare program. In keeping with CBO's mandate to provide objective and nonpartisan analyses, the study makes no recommendations.

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SUMMARY

The costs of medical care have risen steeply in recent years. After adjusting for inflation, per capita spending on personal health services in the United States increased by 124 percent between calendar years 1965 and 1980. Unless current policies change, costs will continue to increase.

These rising costs impinge heavily on the federal budget. On the outlay side, expenditures for Medicare and Medicaid totaled \$59.3 billion in fiscal year 1981, and are projected to increase to \$133.6 billion by 1987. On the revenue side, the tax exclusion for employer contributions to health benefit plans cost the Treasury \$19.8 billion in 1981 and is projected to cost \$45.8 billion in 1987.

The Administration and some members of Congress have proposed slowing these cost increases by relying to a greater extent on market forces. This is sometimes called a "pro-competitive" approach because its proponents hope that it would lead to additional competition among the providers of medical care.

MARKET-ORIENTED STRATEGIES

Two distinct market-oriented strategies are available. One would encourage increased cost sharing by users of medical care--that is, it would increase the out-of-pocket amounts that consumers pay for services, in the expectation that fewer services would be used. This in turn would exert downward pressure on prices. A second strategy would encourage people to enroll in alternative delivery systems such as health maintenance organizations (HMOs). HMOs appear to have lower costs than fee-for-service health plans, mainly because their rates of surgery and hospitalization are lower.

Cost Sharing

The impact of the first strategy, cost sharing, on rates of medical care use is well established. Early results from the Rand

Health Insurance Study showed that families required to pay 25 percent of their bills up to a maximum out-of-pocket amount spent 19 percent less on services than those with full coverage. Comparable results have been obtained in other types of studies. Cost sharing not only reduces the use of medical services; it also reduces prices. Econometric studies have shown that when patients are required to pay more out-of-pocket costs, prices tend to be lower.

Critics of cost sharing are concerned that reduced use of medical services might have serious health consequences, especially for low-income families. They fear that early diagnosis and treatment of illness might be cut back too much, since people would put off seeing their physicians. On the other hand, many feel that there is significant overuse of medical services in the United States; proponents of cost sharing believe that it could be targeted toward economizing on low-priority care. Applying incentives to increase cost sharing to those nonpoor families with the most comprehensive health insurance would minimize the risks to health associated with this strategy.

Cost sharing does not necessarily require that consumers choose among competing health plans, as proposed by many advocates of market-oriented approaches. Increased cost sharing could be brought about by changing the benefit structures of company-wide health plans and of Medicare.

HMOs

Costs in the prepaid group practice type of HMO (PPGP) have been found to be substantially lower than for comparable well-insured populations in the fee-for-service sector. Most analysts believe this is because HMO physicians have incentives to keep use of service low, in contrast to incentives in the fee-for-service system to use services extensively. But some of the cost differences may reflect a tendency of PPGPs to attract relatively healthier patients, or to attract staff physicians whose style of practice is relatively conservative. Also, much of the past research has focused on large successful PPGPs, whereas a rapid expansion of HMO enrollment would depend a great deal on the success of other types of prepaid plans such as individual practice associations (IPAs) whose ability to contain costs is not as well established. A more competitive environment induced by policy changes might induce HMOs to cut their costs more vigorously, however.

In the near term, the HMO strategy would be limited by the small size of present enrollment in those organizations. In 1981, they included only 4.5 percent of the population (although in certain areas, especially major metropolitan areas, the market share was much higher). HMOs have heavy capital and management requirements, so that a rapid increase in their market share in response to a new policy would be unlikely, especially since it would have to come on top of the 12 percent annual enrollment growth expected under present policies.

POLICY OPTIONS

Major ways in which the federal government could bring market forces to bear upon medical costs include:

- o Altering the tax treatment of employment-based health insurance;
- o Offering Medicare beneficiaries a voucher to purchase a private health plan; and
- o Other changes in the Medicare reimbursement and benefit structures.

Each option has the potential to work through both of the strategies outlined above--that is, through increased cost sharing and through increased use of HMOs and other alternative delivery systems. For example, Medicare vouchers could encourage some beneficiaries to obtain a plan with more cost sharing than Medicare, and other beneficiaries to enroll in an HMO.

Alter the Tax Treatment of Employment-Based Health Insurance

Under current law, employer contributions for health benefit plans are excluded from employees' taxable income and from the earnings to which payroll taxes are applied. The revenue loss from this will amount to \$25.4 billion in fiscal year 1983.

The tax benefits from this provision are distributed unevenly, varying by income and region. For households with incomes between \$10,000 and \$15,000 per year, the tax benefit is worth \$83

on average, or 0.65 percent of income. In contrast, for households with incomes between \$50,000 and \$100,000, the tax benefit is worth \$622, or 0.98 percent of income. The difference is explained by higher rates of eligibility for employment-based health plans, higher employer contributions for those in firms with higher wage and salary scales, and marginal tax rates that increase with income. Average tax benefits for households residing in the South are 26 percent below the national average of \$309. The current tax treatment could be changed in several ways.

Limit the Exclusion. If employer contributions in excess of a certain amount were included in the employee's taxable income, medical care spending would be reduced and federal revenues increased.¹ Most of the impact would come through the cost sharing strategy.

Limiting the special tax treatment of employer contributions would reduce present incentives to shift employee compensation from cash to health insurance, and lead employers to make health insurance benefits less comprehensive. This, in turn, would induce some employees to use fewer medical services, thereby slowing medical care price increases. It might encourage enrollment in HMOs, but only to a limited degree, since HMO premiums often exceed those of the traditional plans with which they compete, and their present market share is small.

If the exclusion was limited to \$150 per month for family coverage (and \$60 per month for employee-only coverage) in calendar year 1983, and indexed by medical care prices thereafter, employment-based health insurance benefits would be about 13 percent less by calendar year 1987 than if current policies were continued. For the population covered by these plans, spending on insured medical services would be about 9 percent lower.

The exclusion would increase federal revenues by \$2.9 billion in fiscal year 1983 and \$9.4 billion in 1987. The distribution of the tax increases would mirror that of the tax benefits under current law, but would be more pronounced. For example, almost four-fifths of households would not be affected at all, either because they have no contribution from an employer or because the contribution is below the limit.

1. Bills containing such limits include H.R. 850, introduced by Congressman Gephardt, and S. 433, introduced by Senator Durenberger.

Opponents of this option object to its heavy dependence on cost sharing and are concerned that it might reduce health care use by those with lower incomes. People who would be affected by the ceiling tend to have above-average incomes, however. Other objections to the option are that it does not focus on the hospital cost problem--most of the increased cost sharing would likely be for nonhospital care--and that a uniform ceiling would have the strongest impact on households in areas with high medical costs.

Permit Tax-Free Rebates. This option would permit employers to pay tax-free rebates to employees choosing a health plan with a premium lower than the employer's maximum contribution. It might or might not be combined with an exclusion limit.²

Tax-free rebates would have the advantage, in theory, of altering the incentives in the purchase of health insurance for all those participating in employer-paid plans. In contrast, the exclusion limit would affect only those receiving contributions in excess of the ceiling. Tax-free rebates would reduce federal revenues somewhat, however.

In practice, the impact of this option would be limited by employers' willingness to offer a choice of plans. Employers might resist offering choices because of the risk that their outlays for health benefits might increase. (This could happen if adverse selection among plans led to an increase in average premiums, or if employees covered under their spouses' plans chose to take rebates.) The impact of the option would also be limited by the fact that many employees already pay part of the premiums of their health benefit plans, so that tax-free rebates would not increase their incentives to purchase an optional plan with a lower premium. When combined with an exclusion limit, rebates would not affect more than one-fifth of those participating in employment-based health plans.

Require Multiple Choices. The federal government could require employers wishing to qualify for the tax exclusion to offer choices of plans and to pay rebates to employees choosing

2. H.R. 850 would combine tax-free rebates with an exclusion limit. S. 139, introduced by Senator Hatch, does not include an exclusion limit.

plans with low premiums.³ This option would not increase cost sharing to a significant degree, but it might encourage increased HMO enrollment by getting more employers to offer them as options. Regulation would be necessary to ensure that the choices were meaningful, however, and small employers might face significantly more administrative costs.

Offer Medicare Vouchers

Because Medicare plays such an important role in financing health services, changing its provisions would be an important part of any policy to expose health care to market forces. Some members of Congress have proposed offering vouchers to Medicare beneficiaries that they could use to purchase qualified private health plans.⁴ Since beneficiaries would be responsible for any amounts by which a plan's premium exceeded the voucher amount, and get cash for amounts by which the plan's premium was lower, they would have stronger incentives than at present to economize on medical care.

If Medicare vouchers were voluntary, as in the proposals made so far, they would increase enrollment in HMOs somewhat, but would have little effect on cost sharing. Vouchers would increase the financial reward to beneficiaries from enrolling in HMOs that have low costs. But cost sharing would not increase much since sellers of traditional insurance would have a difficult time competing with Medicare due to their selling costs and Medicare's hospital discount. It is likely that a relatively small proportion of Medicare beneficiaries would choose to take advantage of a voucher option.

Medicare vouchers could reduce federal outlays significantly only if they were made mandatory for everyone. In that case, they would reduce Medicare outlays by the difference between the

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3. S. 433 would require firms with more than 100 employees to offer a choice of three options, each offered by a separate carrier. The amount of the employer's contribution would have to be the same, regardless of the option chosen.
 4. H.R. 850 and H.R. 4666, the latter introduced by Congressman Gradison, include provisions for Medicare vouchers.

voucher amount and the average cost of current benefits. Voluntary vouchers could not achieve significant savings because, to induce much participation, the voucher amount would have to be close to current benefit costs. Federal outlays might actually increase under voluntary vouchers because those using the voucher would tend to have lower claims than the average. The costs of their vouchers to the federal government would thus exceed what their benefits would have cost if they had remained in Medicare.

Change Medicare Reimbursement or Benefit Structures

The role of the market in financing medical services could be increased by other changes in Medicare. For example, modifying the reimbursement of HMOs by Medicare could enable them to achieve enrollment gains similar to those from using vouchers, while avoiding some of the problems mentioned above.⁵

Cost sharing could also be increased in several ways--for example, by applying a tax to the premiums of insurance policies that supplement Medicare, by directly altering the Medicare benefit structure, or by offering a choice of "plans" within Medicare. Unlike the voucher proposal, these options would reduce Medicare outlays substantially. A premium tax of about 35 percent would reduce the federal budget deficit by \$2.5 billion in fiscal year 1983 and by \$4.7 billion in 1987 through a combination of increased revenues and the reductions in Medicare outlays that would result from some dropping their supplemental policies. Requiring beneficiaries to pay 10 percent of the cost of the current Medicare first-day hospital deductible for the second through thirty-first days of hospital stays would reduce outlays by \$1.1 billion in 1983 and \$1.9 billion in 1987. Finally, a choice of benefit "plans" could also be offered within Medicare. Those choosing less comprehensive benefits, for example, could be given a rebate.

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5. H.R. 3399, introduced by Congressman Waxman and reported by the Committee on Energy and Commerce, and S. 1509, introduced by Senator Heinz, would have Medicare reimburse HMOs on a per-enrollee basis.

CONCLUSION

Changes in economic incentives can potentially slow the rise in medical costs and reduce federal outlays on medical care. In the short run, the most effective approach would be through the cost-sharing mechanism, though in the long run HMOs might play an increasing role. Some may not regard the magnitude of the effects of market-oriented options to be large enough in the short run, however, especially with regard to hospital costs. Prospective payment of hospitals—a regulatory approach in which third parties set rates for hospital payment in advance—might be considered as a complement to market-oriented options.⁶

6. For a brief discussion of prospective payment, see Paul B. Ginsburg, "Issues in Medicare Hospital Reimbursement," National Journal, vol. 14 (May 22, 1982), pp. 934-37.

CONTAINING MEDICAL CARE COSTS THROUGH MARKET FORCES

In response to a number of concerns, some in the Congress have proposed a change in federal policy toward medical care that would stress greater reliance on the market. This approach is often labeled "pro-competitive," because one of the results of a shift toward market mechanisms would be increased competition among the providers of medical care.

THE MEDICAL CARE COST PROBLEM

Spending on medical care has increased rapidly since the mid-1960s. For instance, the share of the gross national product (GNP) devoted to medical care increased from 6.0 percent in calendar year 1965 to 9.4 percent in 1980. Per capita spending on personal health services increased from \$181 in 1965 to \$941 in 1980, an increase of 420 percent, or 124 percent after adjusting for inflation. These increases are projected to continue.

An important component of the increase in medical care spending is increased rates of use of services. The quantity of services per capita more than doubled between 1965 and 1980. Rates of hospitalization have increased somewhat, and, for those hospitalized, use of diagnostic and therapeutic procedures has increased dramatically.¹

Many regard this substantial shift of resources to medical care from other sectors of the economy as a serious problem. While such shifts among sectors are common in a dynamic economy, the shift toward medical care is different in that it may not reflect the preferences of consumers, either individually or

1. For evidence on this last point, see Anne A. Scitovsky, "Changes in the Use of Ancillary Services for 'Common' Illness," in Stuart H. Altman and Robert Blendon, editors, Medical Technology: The Culprit Behind Health Care Costs? (U.S. Department of Health, Education, and Welfare, 1979), pp. 39-56.

collectively. As a result of extensive third-party payment, the medical care system may induce consumers to devote more resources to it than they would really like to. Procedures which have only marginal value to the patient's health may often be prescribed only because a third party--a private insurer or government--will bear the cost.

Rising medical care costs have a substantial impact on the federal budget, making movement toward a balanced budget that much more difficult. Federal spending for Medicare and Medicaid totaled \$59.3 billion in fiscal year 1981 and, despite the substantial cuts just enacted, the Congressional Budget Office (CBO) projects that it will increase to \$133.6 billion in fiscal year 1987, about 12 percent of total federal spending in that year. The revenue loss from the tax exclusion for employer contributions to health insurance--which amounted to \$14.5 billion in income taxes and \$5.3 billion in payroll taxes in fiscal year 1981--is projected to increase 131 percent by 1987.

The federal government has two broad options to contain health costs--expanding the economic regulation of medical care providers or encouraging a greater role for the market. Some steps were taken during the 1970s to regulate the medical sector. A health planning system was created, for example, to review the appropriateness of hospital capital projects and a number of states began regulating hospital revenues. Federal regulation of hospital revenues was debated extensively in the Congress, but ultimately was defeated.

Many of the most active opponents of further regulation of medical care agreed with the proponents that medical care costs were too high. They turned their attention to the potential of a market-oriented solution to the problem. While they were skeptical about the ability of regulatory tools to contain costs, they thought that competition on the basis of price would have such potential.

MARKET STRATEGIES

Two distinct strategies to increase the role of market forces in medical care are available. One calls for an increase in cost sharing by consumers of medical care. This would require consumers to pay a larger fraction of the prices charged by providers,

with less being paid by insurance plans. As a result, consumers would be induced to use fewer services and become more sensitive to price differences between providers. These changes in consumer behavior would also put downward pressure on medical prices.

A second strategy envisions greater use of prepaid health plans such as health maintenance organizations (HMOs). HMOs are thought to encourage a more economical use of medical services. They may also encourage price competition, since consumers are in a better position to consider price in choosing a health plan that covers a year's services than they are in choosing a provider for a specialized service needed immediately.

The distinction between the two strategies is not always clear-cut. For example, insurance plans might offer policyholders reduced cost sharing if they restrict themselves to a list of preferred medical service providers--providers thought to be relatively low-cost. Proposals such as these combine elements of both strategies.

FEDERAL OPTIONS

Two major policy options that are market-oriented are available to the federal government. They would:

- o Alter the tax treatment of employment-based health insurance; or
- o Offer vouchers to Medicare beneficiaries permitting them to enroll in private health plans.

Each of these policy options could work through both strategies--that is, each could increase both the number of people choosing insurance policies with substantial cost sharing and the number enrolling in HMOs.

Alter Tax Treatment

The current tax treatment of employer-paid health insurance favors the purchase of more comprehensive policies. Not only are employer contributions to employee health insurance deductible by

the firm for income tax purposes as business expenses and exempt from employer payroll taxes, but they are also excluded from the employees' incomes when federal, state, and local taxes and payroll taxes are assessed. This means that shifting compensation from cash to health insurance contributions reduces employees' tax liabilities, and reduces them by substantial amounts. Average marginal federal tax rates that would apply to such contributions if they were taxed will total 38 percent in calendar year 1983--28 percent for individual income taxes, and 9 percent for the combined employer and employee shares of payroll taxes.

This tax treatment could be altered to reduce the incentive to purchase extensive employment-based health insurance. For example, limiting the amount of the contribution that could be excluded from taxation would end the subsidy for the purchase of insurance in amounts exceeding the limit, while leaving intact the subsidy for purchasing some insurance. Encouraging employers to offer a lower-cost plan as an option, with tax-free rebates to employees choosing such a plan, would encourage some to choose less extensive insurance.

Offer Medicare Vouchers

The second policy option--vouchers for Medicare beneficiaries--would reward those choosing a qualified private plan having lower costs than Medicare. Voucher amounts could be based on per capita Medicare benefits (net of Medicare premiums), adjusted for factors such as the age, sex, and location of the beneficiary. Those paying less than the voucher amount for a health plan meeting certain qualifications would receive the difference in cash. Vouchers could lead to lower medical costs by allowing beneficiaries to choose private plans with more cost sharing than Medicare and by encouraging them to enroll in HMOs or other alternative delivery systems that have lower costs than Medicare.

The Medicare benefit structure could also be changed to encourage increased cost sharing. This could be done either in conjunction with vouchers or as an alternative.

PLAN OF THE PAPER

The paper discusses the potential of these two market strategies, and evaluates the federal policy options in pursuing them.