

The remainder of this chapter presents basic background material on the financing of medical care in the United States. It can be skipped by readers familiar with the topic. Chapter II discusses the assumptions underlying the cost sharing and HMO strategies, and reports what the technical literature has to say about their likely success. It also briefly reviews the potential and pitfalls of increased use of consumer choice among health plans, in contrast to the current system characterized by group choice. This issue is discussed more extensively in Appendix A. Chapter III discusses major options in the tax treatment of employment-based health plans. These include limiting the exclusion from taxation, not taxing rebates paid to employees choosing low-cost plans, and requiring employers to offer a choice of plans. Both the medical care system impacts and the revenue impacts are considered. Chapter IV discusses the Medicare voucher option and alternative market-oriented changes in Medicare.

FINANCING MEDICAL CARE IN THE UNITED STATES

The purchase of medical care is distinguished from that of other goods and services by the fact that a party other than the consumer often finances it. About 82 percent of spending for hospital and physician services is financed by third parties.

Of the \$99.6 billion spent for hospital care in calendar year 1980, 91 percent was paid by third parties. Of the \$46.6 billion spent for physician services, 63 percent was paid by third parties. In contrast, third-party payment plays a much smaller role in the market for drugs and dental services.

Private Health Insurance

Private health insurance, most of it through employers, accounts for somewhat less than half of third-party payment for hospital and physician services. Significant economies of scale in group purchase of health insurance, together with important tax advantages (see Chapter III), have led most medium-sized and larger employers to offer health benefits to their full-time employees as part of the compensation package. Nevertheless, individually purchased health insurance plays a significant role in providing coverage for those not eligible for either employer-

paid health insurance or public programs. About 10 percent of those with private insurance depend entirely on an individually purchased policy.²

The health insurance market is a competitive one, although states have conferred advantages on some of the participants. Blue Cross-Blue Shield plans on the one hand, and commercial insurers on the other, have roughly equal shares of this market. Blue Cross and Blue Shield plans were developed by hospitals and physicians respectively, and in many states enjoy tax advantages based on official recognition of their providing a public service such as subsidizing premiums for individually purchased policies. With a few exceptions, the Blue plans define territories and do not compete with each other. Many of the major life insurers have developed health insurance lines and compete with the Blue plans and with each other. Health insurers are regulated at the state level, but regulation of premiums tends to apply only to individually purchased policies.

A rapidly developing trend is toward self-insurance by large employers. These employers pay claims directly for their employees, often using insurance companies only to process the claims. The trend toward self-insurance has little significance for health policy, since the premiums paid by the employers are in any case based on the claims experience of their employees. The motives underlying the trend are to improve cash management and to avoid state taxes on health insurance premiums.

Public Health Insurance

Public third-party payment became significant with the enactment of Medicare and Medicaid in 1965, and now accounts for 45 percent of all spending on hospital and physician services. The Medicare program provides hospital insurance (Medicare Part A) for about 29 million persons eligible for Social Security and railroad retirement who are 65 and older or who are disabled, and for chronic renal disease patients who have Social Security coverage either as workers, spouses, or dependents. Early retirees, survivors, and disabled persons during a two-year waiting period are not eligible for Medicare.

2. Congressional Budget Office, Profile of Health Care Coverage: The Haves and Have-Nots (March 1979), p. 40.

Medicare Part B, the Supplementary Medical Insurance program, is an optional supplement available to this same population and to all those 65 years and older. It pays, after a \$75 per year deductible, 80 percent of the cost of physicians' and other medical services.

Part A is financed by a payroll tax paid half by employees and half by employers, while Part B is financed roughly one-quarter by premiums paid by recipients and the rest through appropriations from general revenues. In fiscal year 1981, Medicare outlays were about \$42 billion.

The Medicaid program finances medical care for the needy.³ State agencies administer Medicaid under federal guidelines, while financial responsibility is shared by federal and state and sometimes by local governments. There is substantial variation from state to state both in the categories of persons covered and in the benefits to which they are entitled.

All recipients of Aid to Families with Dependent Children (AFDC) and virtually all Supplemental Security Income (SSI) recipients are eligible for Medicaid. About 30 states also cover the medically indigent: persons with large medical bills who would have qualified for AFDC or SSI but for their incomes and whose incomes less medical payments fall below state-established levels. About half of Medicaid recipients are under age 21; one-sixth are over 65, in which case Medicaid generally acts as supplemental coverage to Medicare. Large segments of the poor population--poor childless couples, single persons under age 65, the working poor, and intact families--generally do not qualify for Medicaid, however, because they do not qualify for AFDC or SSI. In fiscal year 1981, Medicaid financed medical services to over 22 million persons at a cost of \$30 billion, of which 56 percent was paid by the federal government and the rest by state and local governments.

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3. For a more detailed description of Medicaid, see Congressional Budget Office, Medicaid: Choices for 1982 and Beyond (June 1981).

While the bulk of the population is insured for health services either privately or by the public programs, a significant minority has no coverage at all. Estimates are difficult because of shortcomings of survey data and definitional problems, but between 5 and 8 percent of the population appears not to be covered.⁴

The Medical Care Market

Most medical care is provided on a fee-for-service basis. Many have criticized the practice, because those who prescribe services stand to profit from them and thus have an incentive to overprescribe.

In contrast, Health Maintenance Organizations (HMOs) charge an annual fee that covers all services considered medically necessary by the organization's medical staff. HMOs have been gaining popularity over time. While they serve only 4.5 percent of the population nationally, they play an important role in certain markets.

HMOs combine the role of insurer and provider of services. They often have physicians as owners of the organization or as salaried staff, so that decisions concerning how to provide care are made in conjunction with protecting the patient from the expense of getting sick. While such an organization eliminates the incentive under the fee-for-service system to overprescribe, some critics feel that it may replace this with an incentive to underprescribe.

HMOs have traditionally been group practices (physicians pooling income), but a looser organization called an individual practice association (IPA) has gained popularity. In an IPA, physicians practice independently; often HMO enrollees constitute only a small part of their practice. IPAs differ from traditional physician-insurer relationships in that the physicians agree in advance to subject themselves to stringent utilization controls.

The medical market is one of the least competitive markets in the U.S. economy, at least with regard to price. An important

4. Congressional Budget Office, Profile of Health Care Coverage.

reason is the extensive use of third-party payment. When someone else is paying all or most of the bill, consumers have little incentive to choose among providers on the basis of price.

Licensing has also played an important role in making the market less competitive. It prevents professionals with less extensive training than physicians from performing relatively simple medical services except under the supervision of licensed physicians. Advertising of medical services has until recently been prohibited by the American Medical Association. Most states have also prohibited insurers from restricting the payment of benefits to those using a panel of preferred medical providers.

Some feel that the medical care market is inherently noncompetitive. A person with a medical complaint has difficulty comparing prices when the complaint has not even been diagnosed. Since an important part of the service purchased is diagnosis and the prescription of treatment, a patient concerned with price is often limited to comparing charges for initial office visits. In case of hospitalization, the patient is initially limited to hospitals where the physician has admitting privileges.⁵

The presence of HMOs may make medical markets more competitive. Premiums for a year of care are much easier to compare than fees for services needed at once. In addition, consumers can exchange information on the merits of HMOs more easily than they can on individual physicians, since there is more overlap in experience.

5. But evidence is discussed in Chapter II that implies that medical markets can be competitive. It shows that prices may be affected by changes in the extent of third-party payments in a market.



CHAPTER II. MARKET-ORIENTED STRATEGIES

This chapter analyzes the cost-sharing and HMO strategies, assessing their potential for cost containment and their possible drawbacks. In addition, it examines briefly the problems (such as adverse selection) of making increased use of individual choice among health plans. While individual choice is not an essential component of the cost-sharing strategy, many advocates of "pro-competition" envision it replacing uniform health benefits within a firm, a union, or a government program such as Medicare.

THE COST-SHARING STRATEGY

Increased cost sharing--through such means as deductibles and coinsurance--would lower rates of use of medical services, which in turn would lower service prices. Analysts have debated whether a reduction in rates of use would be at the expense of health levels, but the absence of good data prevents an answer to this question.

Reduced Service Use

The fact that cost sharing reduces service use is now firmly established. The conclusion is supported by the results of three types of studies: experiments, "natural" experiments, and the analysis of survey data. Indeed, the best studies of each type give similar estimates of the magnitude of the effect.

The Rand Study. Preliminary results of the Rand Health Insurance Study have recently become available.¹ Randomly selected families in a number of sites were given insurance policies

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1. See Joseph P. Newhouse and others, "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," New England Journal of Medicine 25 (December 17, 1981), pp. 1501-07, and the longer version published by the Rand Corporation (R-2847-HHS, January 1982). The results summarized below are those for predicted use.

with different degrees of cost sharing, together with annual payments to ensure that the cost sharing did not make any of the participants worse off than their present insurance.

Those with cost sharing had lower rates of service use. Families with policies requiring them to pay 25 percent of the bill spent about 19 percent less on covered services than comparable families with full coverage.²

Cost sharing that was implemented through coinsurance reduced use of both hospital and physician services. Hospital admission rates were 21 percent lower in those families having 25 percent coinsurance. There were, however, no significant differences in spending per hospital stay. Some have speculated that this could be a reflection of hospitalized persons with coinsurance being sicker than those with full coverage, but others point out how little control patients often have over what happens to them in the hospital. Coinsurance's effects on service use for those hospitalized were also reduced substantially by the ceiling on out-of-pocket liability employed in the experiment. Seventy percent of those hospitalized exceeded their limit during their hospital stay. This dilution of cost sharing would be less if higher ceilings were employed.

Spending on ambulatory care such as physician office visits was 20 percent lower in families with 25 percent coinsurance. The reduction in services was concentrated in fewer visits rather than lower prices per visit.

The Stanford Experiment. Similar results for physician services have been obtained in a study of a natural experiment. Stanford University employees receiving care at the Palo Alto Medical Clinic (a large multi-specialty group practice) decided to shift from full coverage to 25 percent coinsurance of physician services (both inpatient and outpatient). According to a careful

2. Under this 25 percent coinsurance policy, cost sharing by the patient was limited to 5, 10, or 15 percent of income, up to a maximum of \$1,000 per year.

study, physician visits declined by 24 percent.³ A second look at the group four years later showed that the lower visit rate had continued.

Econometric Studies. Numerous econometric studies of the effects of insurance also show that cost sharing reduces rates of use of services. Of those based on household surveys, the one by Newhouse and Phelps is perhaps the most reliable.⁴ Going from full coverage to 25 percent coinsurance is estimated to reduce hospital spending by 17 percent.⁵ Econometric studies using aggregate (for example, state-level) data have estimated larger effects.⁶

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3. See Anne A. Scitovsky and Nelda McCall, "Coinsurance and the Demand for Physician Services: Four Years Later," Social Security Bulletin 40 (May 1977), pp. 19-27.
 4. See J.P. Newhouse and C.E. Phelps, "New Estimates of Price and Income Elasticities of Medical Care Services," in R.N. Rosett, ed., The Role of Health Insurance in the Health Services Sector (National Bureau of Economic Research, 1976), pp. 261-312.
 5. CBO calculations based on the results of Newhouse and Phelps.
 6. See for example, Martin Feldstein, "Hospital Cost Inflation: A Study of Nonprofit Price Dynamics," American Economic Review, vol. 61 (December 1971), pp. 853-72.

In a methodological article, Newhouse argues that these results are biased upward, and that high-quality household survey studies are more accurate (Joseph P. Newhouse, Charles E. Phelps, and M. Susan Marquis, "On Having Your Cake and Eating It Too: Econometric Problems in Estimating the Demand for Health Services," Journal of Econometrics, vol. 13 (August 1980), pp. 365-90). But aggregate studies have the advantage of capturing various community effects, as when cost sharing changes the norms of medical practice in an area.

Reduced Medical Prices

Greater cost sharing appears to reduce medical prices as well as service use, although the evidence is less extensive and the results are subject to a larger degree of error.

Cost sharing can reduce prices in two ways. The first is through the normal workings of supply and demand. The second is by making the market more competitive. When differences in out-of-pocket costs are increased, patients become more sensitive to price differences among providers. This means that providers who cut prices will gain more patients, while those who increase prices will lose more.⁷

The evidence on price effects is from econometric studies.⁸ Estimates of price effects in hospital care tend to be large, but a significant delay in the working out of the full effect is

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7. For a detailed statement of this phenomenon, see H.E. Frech III and P.B. Ginsburg, Public Insurance in Private Medical Markets: Some Problems of National Health Insurance (American Enterprise Institute for Public Policy Research, 1978).

Some empirical support for this notion comes from Newhouse and Phelps, "New Estimates." Those survey respondents with more cost sharing tended to pay lower prices for hospital and physician services.

8. See, for example, David Salkever, "A Microeconomic Study of Hospital Cost Inflation," Journal of Political Economy, vol. 80 (November/December 1972), pp. 1144-66; Martin Feldstein, "Hospital Cost Inflation"; Karen Davis, "The Role of Technology, Demand and Labor Markets in the Determination of Hospital Cost," in Mark Perlman, ed., The Economics of Health and Medical Care (Wiley, 1974), pp. 283-301; and Joseph Newhouse, "The Structure of Health Insurance and the Erosion of Competition in the Medical Marketplace," in Warren Greenberg, ed., Competition in the Health Care Sector: Past, Present, and Future (Federal Trade Commission, March 1978), pp. 270-87.

observed, and some of the measured price effect is really an additional quantity change. Since price data are often hard to come by, many of the hospital studies use cost per patient day as a proxy for price. Clearly some of the effects of cost sharing reflect changes in the intensity of services per patient day, an aspect of quantity. In physician studies, price data that do not include a quantity component are more readily available (the customary fee for a routine office visit, for example), and the literature indicates sensitivity to insurance coverage. A measure combining service intensity and price (average revenues per visit) shows even larger effects of cost sharing.⁹

Effects on Health Status

Many are concerned about the effect of the reduced services associated with cost sharing on health status, particularly with respect to low-income families. Are the reduced services mainly those with little value to health or are they important ones? Unfortunately, not enough results are available to form a judgment on this issue.

Those who feel that significant effects on health status are not involved point to evidence of extensive variations in hospital and surgery use from area to area and, in particular, high rates in the United States relative to other developed countries such as Great Britain. They have confidence that physicians will advise patients concerned with out-of-pocket costs to forgo those services with the lowest value to health. They are reassured by a preliminary result from the Rand experiment, suggesting that the lower rates of hospital and physician use by those with coinsurance were to be explained by a higher proportion of episodes of illness in which no services were sought rather than by fewer

9. See Frank A. Sloan, "Effects of Health Insurance on Physicians' Fees," paper presented at the Annual Meeting of the Southern Economic Association, Washington, D. C., November 6, 1980, and Frank A. Sloan, "Physician Fee Inflation: Evidence from the Late 1960s" in Rosett, Role of Health Insurance, pp. 321-53.

services per treated episode.¹⁰ Some observers have speculated that the episodes not treated tended to be minor, self-limiting illnesses, but results from the Rand study as to the effects on health status are still some time off.¹¹

Those who are concerned that significant health effects would result from cost sharing raise the issues of early diagnosis and treatment of illness and the particular problems faced by the poor. While physicians are in a good position to advise on the best way to lower use, individuals may not make the right decision as to when to contact physicians--perhaps delaying until a health problem that could be corrected easily has become a more serious one. Those whose incomes are low may simply not have the funds to pay for services that physicians feel are important. For the cost sharing strategy to avoid the risk of impairing the health of those with low incomes, it would have to focus on those who are better off. This might involve taxing employer contributions to health benefit plans only to the extent that they exceed a limit (see Chapter III), or restricting increases in Medicare cost sharing to those who have relatively high incomes (see Chapter IV).

THE HMO STRATEGY

Increased enrollment in HMOs would lower spending on medical care through lower rates of use of hospital services by those persons who leave the fee-for-service (FFS) component of the medical care system, but the number of potential transfers is

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10. These results are based on only three site-years and are subject to change when the data base is expanded. See Emmett Keeler et al., "The Demand for Episodes of Medical Services: Interim Results from the Health Insurance Study," paper presented at the Annual Meeting of the Association of Public Policy Analysis and Management, Washington, D. C., October 1981.
 11. When available, results from the Rand experiment should significantly increase knowledge about these effects. Sophisticated measures of health status have been developed, and careful measurements have been taken over time on a large sample of the participants.

limited in the short run by capacity constraints. The notion of some that increased HMO enrollment would reduce costs in the FFS system through competitive pressure is not at this point supported by data.

Lower Costs per Enrollee

An extensive literature supports the conclusion that per enrollee costs are lower in HMOs that are prepaid group practices (PPGPs), largely because of lower rates of surgery and of hospitalization. A number of factors suggest caution, however, in projecting similar rates of savings for a substantial expansion of enrollment.

In an exhaustive review of the HMO experience to date, one analyst concludes that:

the total cost of medical care (premiums plus out of pocket costs) for HMO enrollees is lower than for comparable people with conventional insurance coverage. The lower costs are clearest for enrollees in prepaid group practices, where total costs range from 10 to 40 percent below costs for conventional insurance enrollees.¹²

Most analysts attribute these results to the incentives for HMO physicians to keep costs down. In contrast to the FFS system, where more services mean higher incomes for physicians, HMO physicians earn more when fewer services are used. Physician incentives to prescribe less care appear to outweigh patient incentives to use more. As one might expect, the lower rates of use are confined to inpatient care, which is prescribed by physicians--whereas use of outpatient care, which is more under patient control, is somewhat higher.

A number of factors lead one to be cautious in projecting the results of an increase in HMO enrollment from this experience. First, some of the cost difference could reflect a tendency of

12. Harold S. Luft, "Assessing the Evidence on HMO Performance," Milbank Memorial Fund Quarterly: Health and Society, vol. 58 (Fall 1980), p. 508.

HMOs to enroll persons less prone to use medical services. All HMO patients have chosen their plan over a traditional health insurance plan, but as a group they may differ from those who instead chose the traditional plans.

Knowledge about the selection process is scanty at present, but it appears that those joining PPGPs tend to be low users relative to those in traditional plans, while those joining IPAs with high premiums tend to be relatively high users.¹³ In mature HMOs, which tend to have stable enrollments, these tendencies may account for very little, since differences between those who chose the HMO and those who did not would tend to erode over time. Indeed, an analysis of survey data from large SMSAs in California indicated that PPGP enrollees were in somewhat poorer health than those with other private health coverage.¹⁴

Second, the experience studied to date has been highly varied. Luft's reporting of costs as 10 to 40 percent lower rather than 25 percent lower (the mean of the range) emphasizes the extensive variation from one organization to another, as well as the lack of precision in each study's results. Would enrollment growth tend to be in organizations closest to the 10 percent end of the range or closest to the 40 percent end? On the other hand, the established HMOs that have been studied so extensively have not been subject to much competitive pressure, so that future performance under a more competitive health system could be better than past experience.

Third, most of the research has focused on the experience of large, successful PPGPs such as the various Kaiser Foundation plans. But other forms of HMOs such as Individual Practice Associations (IPAs) may not be as successful. According to Luft:

Although the evidence is scanty, costs for enrollees in individual practice associations appear no lower than for enrollees in conventional plans. (p. 508)

13. These results are discussed in more detail in the Appendix.

14. Mark S. Blumberg, "Health Status and Health Care Use by Type of Private Health Coverage," Milbank Memorial Fund Quarterly: Health and Society, vol. 58 (Fall 1980), pp. 633-55.

Rapid increases in HMO enrollment would be more difficult without IPA growth, the potential of which depends on their ability to reduce costs.

A final caveat concerns the possibility that some of the savings achieved by PPGPs could reflect the effects of group practice rather than of prepayment. A recent study found that Stanford University employees enrolled on a prepaid basis in a large fee-for-service group practice that was not at risk for hospital expenses had rates of use strikingly similar to those employees enrolled in Kaiser.¹⁵ The author suggests that the conservative use of services in the fee-for-service group practice was due to control over the supply of physicians exercised by the group. This implies that the conversion of physician groups from fee-for-service to prepayment (HMO) would not have large effects on medical costs.

Limits to Rapid Growth

Policy changes to speed the development of HMOs would not greatly affect the proportion of the population served by these organizations in the near term. One reason is that HMO enrollment is expected to grow rapidly (in percentage terms) under current policies. Any policy-induced growth must come on top of the 12 percent per year that is now projected.

Second, because HMOs have such a small market share today, their market share late in this decade would still be small, even with an acceleration in growth. Under current policies, the 4.5 percent market share in 1981 would increase to 11 percent by 1990. An increase in the annual growth rate to 20 percent, beginning in 1984, would increase the 1990 market share to only 17 percent.

15. Anne A. Scitovsky, "The Use of Medical Services Under Prepaid and Fee-for-Service Group Practice," Social Science and Medicine, 15C (1981), pp. 107-16. Prepaid plans were a minor part of the practice of this group, and most of the physicians were not aware of whether a patient was prepaid or fee-for-service.

The third factor limiting enrollment gains is management requirements. HMOs tend to be complex organizations that are difficult to manage well. As a result, growth must be carefully planned and proceed in an orderly fashion to prevent serious losses in efficiency. Rapid growth of the industry would require the entry of many new HMOs, dependent on the availability of entrepreneurial talent and of venture or philanthropic capital. The federal government has provided grants for start-up expenses, but funding for that program has been terminated. Some major health insurers are said to be positioning themselves to enter the HMO business in a significant way.

Effects on the Fee-for-Service System

Whether increased enrollment in HMOs would lower medical care costs in the FFS sector is an open question. The experience with HMOs that have a substantial market share is so limited that inference is extremely difficult.

Some argue that increased enrollment in HMOs would affect both insurers and FFS providers, causing both to change their behavior. Insurers, when faced with decreased sales of policies, might develop HMOs themselves, or innovative plans such as those that limit choice of provider. Alternatively, they might focus their sales efforts on traditional plans with more cost sharing.

Providers might respond to competition by practicing less costly medicine, and in that event reduced demand for their services could cause prices to decline. For example, primary care physicians, whose services tend not to be completely paid for by insurance, might order fewer services in order to keep their patients' annual costs more in line with HMO premiums.

On the other hand, some factors could limit the magnitude of such a competitive response, or even cause it to work in the other direction, as long as the level of third-party payment in the FFS system remains high. Those providers that derive almost all of their revenues from third-party payment, such as hospitals and surgeons, would have little incentive to compete. When services are fully insured, individual providers do not gain increased business by cutting prices or prescribing services more judiciously. Indeed, they might react to lower demand for their services

by inducing increased rates of use among their remaining patients. A 10 percent increase in the surgeon-to-population ratio in the FFS sector could increase surgery rates by 3 percent, for example, and a 10 percent increase in the hospital bed-to-population ratio could increase days of care by 4 percent.¹⁶ Such responses would tend to be self-limiting, however, as they would increase incentives for consumers to shift to HMOs.

Empirical studies of the effects of HMOs on the FFS sector do not, at this point, support the hypothesis of reduction in per capita medical costs or hospital use. Some have identified a slowing of medical care cost increases or reductions in hospital use in areas that have experienced growth in HMO enrollment. But a recent study of three of these areas--Minneapolis-St. Paul, Hawaii, and Rochester, New York--has raised doubts about the linkage between HMO growth and cost reduction by suggesting alternative explanations.¹⁷

THE NEED FOR INDIVIDUAL CHOICE

Many proponents of increased use of the market in medical care envision a process of "fair economic competition" through which consumers would make choices among health plans.¹⁸ Employers contributing to health plans, and Medicare (through a voucher program), would pay the same amount regardless of the plan selected, so that individuals would be rewarded for selecting plans with low premiums.

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16. The surgery estimate is from Victor R. Fuchs, "The Supply of Surgeons and the Demand for Operations," Journal of Human Resources, vol. 13, Supplement (1978), pp. 35-56. The hospital estimate is from Paul B. Ginsburg and Daniel M. Koretz, "Bed Availability and Hospital Utilization: Estimates of the 'Roemer Effect'," Health Care Financing Review, in press.
 17. Harold Luft, presentation to National Health Policy Forum, Washington, D. C., November 1981.
 18. See for example, Alain C. Enthoven, Health Plan (Addison-Wesley, 1980).

The HMO strategy clearly requires increased use of such individual choice mechanisms, but the cost-sharing strategy does not. Employers could increase cost sharing by changing the provisions of their single health benefits plan and shifting compensation to cash or other fringe benefits, and the Medicare benefit structure could be changed to increase cost sharing.

While individual choice has the potential to stimulate competition among health plans, a number of problems could seriously impair its effectiveness. These include:

- o Adverse and preferred-risk selection;
- o Administrative costs; and
- o Contract complexity.

These problems tend to be most severe when the choice is between plans with different degrees of cost sharing. The Appendix reviews the issues in more detail.

Adverse and Preferred-Risk Selection

When persons choose among health plans, the result is unlikely to approximate that of a random sorting. Consumers are likely to take into account their expected rate of use of services when choosing a plan, while insurers are likely to focus their efforts on persons who are expected to be low users of services. The former process is often referred to as adverse selection, while the latter is called preferred-risk selection, both terms reflecting the perspective of insurers.

Such selection results in a shift of resources from those expecting to be high users to those expecting to be low users. Persons choosing plans comprised of those who use less than average medical care gain from a low premium reflecting that pattern of use, while those choosing the alternative plan lose by paying a higher premium than otherwise (see Appendix Table 1).

In situations where the choice is between a traditional insurance plan and an HMO, adverse selection is a different phenomenon, since the benefit structures often differ less.

Selection is more likely to be dominated by the differences between persons willing to change their physicians and those who are not, since enrolling in a PPGP-model HMO generally requires such a change. But those willing to change tend to be relatively low users. Once the PPGP enrollments have stabilized, the phenomenon may decay--that is, it is probably more important for new PPGPs than for established ones.

Many consider adverse selection undesirable because of these transfers, but others feel differently. The former group champions the current internal subsidy of high users by low users as socially useful, spreading the burden of high medical costs among a larger population. The internal subsidy represents a type of insurance against chronic poor health, a spreading of risks that are long-term as well as those occurring during the policy year. Others object to internal subsidies that are not directly a result of government policy, maintaining that only through explicit government action should resources be directly transferred from one individual to another.

Preferred-risk selection has effects that are very similar to those of adverse selection. In marketing to consumers thought to be the lowest users, insurers segment the market in the same way that adverse selection does, so that the internal subsidy between high and low users is reduced. The opportunities for preferred-risk selection that could arise when individual choice of plans is permitted could lead insurers to channel their energies into marketing schemes designed to select good risks rather than into reducing the cost of medical care.

Adverse selection and preferred-risk selection in health plans would be present under any scheme of individual choice. Their magnitude is difficult to estimate, however, since there has been only limited experience with individual choice, and methods of limiting selection have, for the most part, not been employed.

The Federal Employees Health Benefits Program (FEHBP) exhibits adverse selection, but not to a degree to make individual choice untenable (see the Appendix). It is difficult to generalize from this example, however, since the program deviates from the consumer choice model in some important respects. Also much depends on the experience of consumers in making their choices. As they become more competent in comparing plans, they are more likely to take into account their expected service use.

Administrative Costs

Systems permitting consumers to choose among health plans are bound to have higher administrative costs, but the costs would vary substantially according to the approach used. For example, if an employer has its regular insurer offer a low-option plan or offers an HMO, administrative costs will probably be very small, at least if the firm is large. FEHBP has low administrative costs despite a relatively large number of plans available to each employee. But in a less structured situation, selling insurance to employees could be very expensive. Administrative costs for individual policies are on the order of 35 percent of premiums, as compared to less than 5 percent for very large group policies and 10 percent for all group insurance. The more "open" the competition among insurers, the higher the administrative costs are likely to be. In assessing the merits of greater use of individual choice, the additional administrative costs must be subtracted from the gains in medical care efficiency.

Contract Complexity

Insurance contracts tend to be complex documents. Group insurance relieves purchasers of some of the burden of studying their health insurance contracts because a professional does the buying.

Under individual choice, the purchaser must have a greater understanding of the plans. If intelligent choices are not made, individual choice loses its value as a means of stimulating competition.

As in the case of administrative costs, a highly structured organization of choice can avoid an important part of the problem. To the extent that the employer or union standardizes benefits so that HMOs and high-option plans have the same benefits, and high- and low-option plans differ only in the size of the deduction or coinsurance, complexity would not be a problem.

CHAPTER III. OPTIONS IN THE TAX TREATMENT OF EMPLOYMENT-BASED
HEALTH INSURANCE

The federal government could foster increased use of the market in medical care by changing the tax treatment of health insurance provided through employment. Current policy subsidizes the purchase of health insurance through employment by excluding employer contributions from the taxable incomes of employers and employees. Limiting the subsidy could spur a reduction in the comprehensiveness of insurance without reducing the number of persons covered. This would cause both consumers and providers of medical care to be more conscious of its costs.

This chapter reviews three options for changing the tax treatment of employment-based health insurance:

- o Place a ceiling on the exclusion of employer payments from employees' taxable income;
- o Permit tax-free rebates by employers to employees choosing low-cost plans; and
- o Require employers to offer a choice of plans.

These options could be adopted either singly or in combination.

BACKGROUND

Under current law, employer contributions for employees' health insurance are excluded from employees' taxable incomes. They also are excluded from the earnings on which both employers and employees pay payroll taxes.

With rising medical care costs and increased use of health insurance to finance them, the effect of this exclusion on revenues has become very large. Without the exclusion, the federal government would receive \$16.5 billion more in income tax revenue

and \$6.5 billion in payroll tax revenue during the current fiscal year (see Table 1). In 1970, these revenue losses totalled only \$2.4 billion and \$0.8 billion respectively. By 1987, they will increase to \$31.1 billion and \$14.7 billion.

TABLE 1. ESTIMATES OF REVENUE LOSS FROM EXCLUSION FROM EMPLOYEES' TAXABLE INCOME OF EMPLOYER CONTRIBUTIONS TO HEALTH INSURANCE, BY FISCAL YEAR (In billions of dollars)

	1970	1975	1981	1982	1983	1987
Income Tax	2.4	5.0	14.5	16.5	18.1	31.1
Payroll Tax	<u>0.8</u>	<u>1.9</u>	<u>5.3</u>	<u>6.5</u>	<u>7.6</u>	<u>14.7</u>
Total	3.2	6.9	19.8	23.0	25.7	45.8

SOURCE: CBO calculations based on data from Health Care Financing Administration and the National Medical Care Expenditure Survey.

The tax benefits from this provision are distributed unevenly (see Table 2). The average tax benefit for all households with incomes between \$10,000 and \$15,000 per year is \$83, while that for all households with incomes between \$50,001 and \$100,000 is \$622. As a percentage of household income, the tax benefits are 0.65 percent and 0.98 percent, respectively. This uneven pattern combines several uneven distributions: higher-income households are more likely to receive an employer contribution; they tend to receive a larger contribution; and they are likely to get a larger tax benefit per dollar of contribution.

About 48 percent of households receive no employer contribution and thus no tax benefits from this provision. Some of these households receive federal assistance through Medicare, Medicaid, or programs for military retirees and dependents, but 26 percent of all households receive neither assistance from these programs nor a federally subsidized employer contribution.