

TABLE 2. EMPLOYER CONTRIBUTIONS TO HEALTH BENEFIT PLANS AND EMPLOYEE TAX BENEFITS, BY HOUSEHOLD, CALENDAR YEAR 1983 (In dollars)

	All Households			Households Receiving Contributions			
	Percent of Households in Category	Average Employer Contribution	Tax Benefit <sup>a</sup> Per Household	Percent of Income	Percent Receiving Employer Contribution	Average Employer Contribution	Average Tax Benefit <sup>a</sup>
<u>By Annual Household Income:<sup>b</sup></u>							
\$0-10,000	19	86	17	0.36	13	636	129
10,001-15,000	10	301	83	0.65	31	972	269
15,001-20,000	10	482	143	0.81	47	1,029	307
20,001-30,000	19	817	273	1.08	59	1,375	460
30,001-50,000	25	1,319	501	1.30	73	1,798	683
50,001-100,000	14	1,471	622	0.98	73	2,025	857
Over 100,000	4	1,092	550	0.39	62	1,761	886
<u>By Age of Head:</u>							
Under 45	50	969	362	1.13	60	1,617	606
45-64	31	1,043	398	1.00	60	1,730	661
65 or over	20	113	37	0.12	20	568	185
<u>By Region:</u>							
Northeast	21	901	340	0.95	53	1,686	639
North Central	28	1,015	381	1.09	57	1,766	633
South	31	622	230	0.70	50	1,250	462
West	20	776	297	0.85	47	1,652	633
All Households	100	823	309	0.89	52	1,578	594

SOURCE: CBO simulations based on the National Medical Care Expenditure Survey.

- a. Tax benefits include both federal income tax reductions and the employer's and employee's share of federal payroll taxes. About three-quarters of the tax benefits are income tax reductions. State and local income tax reductions are excluded. The estimates assume that taxable excess contributions are made ineligible for the medical expense deduction.
- b. Household income before taxes but including cash transfer payments, such as Social Security benefits, projected to calendar year 1983.

Persons not receiving any tax benefit tend to have lower incomes than others. Only 31 percent of households with incomes between \$10,001 and \$15,000 per year receive a tax benefit from the exclusion, while 73 percent of households with incomes between \$50,001 and \$100,000 receive a benefit. When those households receiving other federal assistance are excluded, the respective percentages receiving tax benefits are 44 and 77.

Among households benefiting from the provision, the tax benefit tends to increase with income. The average employer contribution for a household with income between \$10,001 and \$15,000 per year is \$972, while that for a household with income between \$50,001 and \$100,000 per year is \$2,025. The marginal tax rates applicable to such contributions are 28 percent and 42 percent respectively, so that the tax benefits are \$269 and \$857.

Two factors are responsible for the uneven distribution of tax benefits. First, firms whose employees have high average earnings are more likely to have a health plan, and when they do, they tend to make larger contributions. In calendar year 1977, for example, among firms with average hourly earnings between \$4.01 and \$5.00, 45 percent had health plans, with annual contributions to health, life, and accident plans averaging \$169 per employee, while among firms with hourly earnings between \$8.01 and \$10.00, 72 percent had plans, with annual contributions averaging \$435 per employee.<sup>1</sup> Second, employees in higher marginal tax brackets get larger tax benefits per dollar of excludable income.

The tax benefits also vary by region. Households in the North Central region had the highest average tax benefits, while households in the South had the lowest. When income is held constant, the differences remain.<sup>2</sup>

- 
1. CBO analysis of 1977 Expenditures for Employee Compensation Survey, U.S. Department of Labor.
  2. Household tax benefits were regressed on binary variables for age, income, and region, defined for the intervals shown in Table 2. With West the omitted category, the coefficient for North Central is 60 and that for South is -64.

Additional insight into the pattern of tax benefits is obtained by focusing on employment and the size of employer contributions (see Table 3).<sup>3</sup> Contributions vary by whether the firm has a union, by industry, and by size of establishment.

Employees in firms with unions have much larger employer contributions than others. These employees are more likely to have a plan (99 percent versus 87 percent) and receive higher contributions where there is a plan. These differences reflect both possible higher compensation associated with collective bargaining and a tendency for unions to shift the make-up of compensation packages toward fringe benefits.<sup>4</sup>

#### PLACE A CEILING ON THE EXCLUSION

A number of proposals would place a dollar limit on the amount of employer contributions for health insurance that could be excluded from taxable income.<sup>5</sup> Limiting the exclusion would

---

3. In focusing on employment, the unit of observation used here is the employee rather than the household. Since household income is not available on the survey from which information on employers is obtained, this discussion is conducted in terms of employer contributions rather than tax benefits.
4. On the subject of the effect of unions on compensation, the classic work is H. G. Lewis, Unionism and Relative Wages in the United States: An Empirical Inquiry (University of Chicago Press, 1963). For a review of the more recent literature, see C. J. Parseley, "Labor Union Effects on Wage Gains: A Survey of Recent Literature," Journal of Economic Literature, vol. 18 (March 1980), pp. 1-31.

For a study of unionism and the proportion of compensation allocated to fringe benefits, see William T. Alpert, "An Economic Analysis of the Determinants of Private Wage Supplements," Ph.D. dissertation, Columbia University (1979).

5. Bills introduced in the 97th Congress that would do this include S. 433 (Senator Durenberger) and H.R. 850 (Representative Gephardt).

TABLE 3. EMPLOYER CONTRIBUTIONS TO HEALTH BENEFIT PLANS, 1977-78,  
BY TYPE OF FIRM, PRIVATE NONFARM SECTOR

	Percent of Employees in Firms with Group Plans <sup>a</sup>	Amount of Employer Contribution in Firms with Group Plans, Relative to Private Nonfarm Average <sup>b</sup>
<b>Union Status</b>		
Union	99	1.23
Nonunion	87	0.89
<b>Industry<sup>c</sup></b>		
Construction	66	0.74
Manufacturing	98	1.01
Transportation and other utilities	91	1.49
Wholesale Trade	91	0.95
Retail Trade	71	0.93
Finance, Insurance, and Real Estate	93	0.90
Services	90	0.95
<b>Establishment Size</b>		
2-9	56	1.00
10-99	89	0.98
100-999	100	1.00
1,000 and over	100	1.05
<b>Total Private Nonfarm Sector</b>	<b>89</b>	<b>1.00</b>

SOURCE: Employment-Related Health Benefits in Private Nonfarm Business Establishments in the United States, a survey conducted for the Department of Labor by Battelle Human Affairs Research Centers. The second column was calculated by CBO.

- a. This does not correspond to the percent of employees covered by group plans. Some employees in firms with plans do not participate. Some in firms without plans are covered through a spouse's employment.
- b. The contribution is for the firm's most common plan. All contributions have been divided by the survey average.
- c. Mining was omitted because of small sample size.

reduce the comprehensiveness of health insurance benefits, with the reduction focused on those with the most comprehensive benefits at present. This, in turn, would reduce spending on medical care. In addition, it would increase revenues.

### Medical Care Impact

Limiting the tax exclusion would affect spending for medical care by removing the subsidy to the last dollars spent on health insurance in excess of the limit. For example, if the limit was \$150 per month for family coverage and \$60 per month for individual coverage in 1983, purchases of health insurance with employer contributions in excess of these limits would no longer be subsidized through the tax system. For a family in the 40 percent tax bracket, with a contribution of \$150 per month, an extra dollar of health insurance would now cost a dollar of after-tax income, instead of 60 cents under current law. Amounts up to these limits would continue to be subsidized, however, so that such a policy would not encourage anyone to drop coverage altogether. Incentives to reduce the comprehensiveness of coverage would be focused on those with the highest contributions, and those with the highest taxable incomes.

Employers and unions with contributions over the limit would react in one of three ways. Some would adjust their compensation package by reducing their contributions to health benefits and increasing cash wages or other fringes instead. Benefits in the single health plan would be reduced to bring the premium down to the exclusion limit. Other employers would give employees a choice of health plans, with at least one of the options having a premium below the limit. Those employees choosing plans costing less than the employer's contribution would get a rebate based upon the difference. Still other employers, at least initially, would not make any changes in response to the limit; in that case, their employees would be taxed on the amount over the limit.

At least initially, most of the response to the incentives associated with limiting the exclusion would involve increased cost sharing in traditional insurance plans rather than increased enrollment in alternative delivery systems such as HMOs. Perhaps the most important reason for this outcome is the current small market share of HMOs, and the barriers to a major increase in their rapid growth under current policies (see Chapter II). Also,

the present tax subsidy to health insurance does not put high-premium HMOs at a disadvantage, so that limiting the tax exclusion would make only some of them more attractive. While HMOs often have lower overall costs than insured fee-for-service medicine, their premiums are often higher than those for the traditional health insurance plans with which they compete.<sup>6</sup> In 1981, for example, the average HMO premium for family coverage was \$132 per month, compared to an average of \$104 for all employment-based insurance.<sup>7</sup>

Some advocates of this proposal expect that limiting the tax exclusion would lead many to develop potentially less costly delivery systems such as primary care networks or preferred provider organizations. While their logic is correct, the practical outcome is less certain. Given the limited presence of such alternative systems in the health sector today, one must ask whether they are close enough to being economically viable so that a change in tax incentives would make a big difference. While new alternative delivery systems may be just around the corner, confident predictions to that effect have little empirical basis.<sup>8</sup>

The increase in cost sharing that would result from a tax exclusion limit would be significant, however. This is because decisions on the extensiveness of health insurance benefits are strictly financial ones--they do not directly involve choice of physicians for example. Less extensive insurance just means that a greater proportion of medical care is paid for at the time of

- 
6. The higher premiums are due to less cost sharing and a wider array of covered services.
  7. The average HMO premium is from U.S. Department of Health and Human Services, National HMO Census, 1981. The premium for all employment-based insurance is from CBO analysis of the National Medical Care Expenditure Survey.
  8. Another issue is whether successful alternative delivery systems would lower overall medical care costs. While a successful preferred provider plan would save money for its subscribers, system savings would require those providers outside of the plan to change their style of practice or lower their prices.

service instead of through regular premiums. Such a relatively focused financial decision is likely to be sensitive to large tax incentives.

While the timing is difficult to predict, by calendar year 1987 the tax exclusion limit described above might be expected to reduce employment-based health insurance premiums by about 13 percent relative to current policies. The decline would be concentrated among those with the highest employer contributions; no change would occur among those with contributions below the limit.<sup>9</sup>

For the population with employment-based health insurance, spending on insured medical care services would be about 9 percent lower in 1987 than under current policies. Much of the reduction would come from a 7 percent reduction in service use, but since employment-based health insurance accounts for only about one-third of national spending on hospital and physician services (and a lower proportion for other services), the percentage reduction for the nation would be substantially smaller. Medical care prices would be about 2 percent lower in 1987 than under current policies, but the reduction would continue to grow in later years.

In percentage terms, hospital care would be affected less than other medical services because of the likely pattern in which reductions in insurance benefits would take place. Hospital care is the most attractive of all medical services to insure--because the financial risks that can be insured are the largest and the administrative costs are the lowest. Those cutting back insurance benefits in response to the changed incentives would be likely to reduce coverage for other services--such as outpatient physician services, mental health services, and dental services--more extensively than they would cut coverage for hospital care.

#### Revenue Effects

A tax exclusion limit would increase federal revenues by a significant amount, with the tax burden concentrated on those who

- 
9. The decline would be greater if tax-free rebates were added to this option, but would be smaller if existing contributions were "grandfathered." See the discussion of these variations below.

are benefiting the most from the present exclusion. Limiting the exclusion to \$150 per month for family coverage and \$60 per month for individual coverage in calendar year 1983, and indexing it thereafter by the medical care component of the Consumer Price Index (CPI), would increase federal revenues by \$2.9 billion in fiscal year 1983 and \$9.4 billion in 1987 (see Table 4). Of this amount, about three-quarters would be income tax revenue while the remainder would go to the Social Security trust funds. On a calendar year basis, the additional taxes would amount to \$55 per household, or for those 17 million households affected, \$257 (see Table 5).

Revenues from this proposal would be very sensitive to the exclusion limits chosen. For example, if the limits were 10 percent lower--\$135 and \$54 per month, respectively--the 1983 revenue increase would be \$3.7 billion, or 27 percent larger.

The distribution of tax increases would mirror that of tax benefits from the present exclusion (see pp. 26-29), but the fact that the impact of the change would be concentrated on those with contributions above the limit would make the distribution more uneven. For example, the 79 percent of households with either no contributions or the lowest contributions would not be affected at all (see Table 5). Only 9 percent of those households with incomes between \$10,001 and \$15,000 would be affected by the cap, compared to 36 percent of households with incomes between \$50,001 and \$100,000. Those unaffected by the cap would be more likely to reside in the South.

The impact on households' tax bills would vary with income. For all households with incomes between \$10,001 and \$15,000, the average additional tax payment would be \$14 in 1983, or 0.11 percent of income, while households with incomes between \$50,001 and \$100,000 would pay \$116 in 1983, or 0.18 percent of income. When additional income taxes are compared to total income taxes under current law, the ratio is roughly constant over most of the income range, rising from 0.8 percent in the lowest income class to 1.3 percent for the \$30,001 to \$50,000 class, and then declining. This indicates that such a tax increase would be roughly comparable in progressivity to the rest of the income tax system.<sup>10</sup>

---

10. Alain Enthoven has suggested a modification of the exclusion limit to increase its progressivity. All employer contributions could be taxed, and a tax credit equal to the average marginal tax rate granted for all contributions up to the limit. Personal communication.

TABLE 4. REVENUE INCREASES FROM VARIOUS EXCLUSION LIMITS, FISCAL YEARS 1983-87 (In billions of dollars)<sup>a</sup>

Family Coverage Limit, 1983 <sup>b</sup>	1983	1984	1985	1986	1987
<hr/>					
\$120 per month					
Income tax	3.5	6.0	7.3	8.6	10.1
Payroll tax	1.1	1.9	2.3	2.7	3.1
Total	4.6	7.9	9.6	11.4	13.2
<hr/>					
\$135 per month					
Income tax	2.8	4.9	6.0	7.2	8.6
Payroll tax	0.9	1.5	1.9	2.3	2.6
Total	3.7	6.4	7.9	9.5	11.2
<hr/>					
\$150 per month					
Income tax	2.2	3.9	4.9	6.0	7.2
Payroll tax	0.7	1.2	1.5	1.9	2.2
Total	2.9	5.1	6.5	7.9	9.4
<hr/>					
\$165 per month					
Income tax	1.8	3.1	4.0	4.9	6.0
Payroll tax	0.5	0.9	1.2	1.5	1.8
Total	2.3	4.1	5.2	6.5	7.8
<hr/>					
\$180 per month					
Income tax	1.4	2.5	3.2	4.0	5.0
Payroll tax	0.4	0.7	1.0	1.2	1.5
Total	1.8	3.2	4.2	5.3	6.5

SOURCE: CBO simulation using National Medical Care Expenditure Survey.

NOTE: Components may not add to totals due to rounding.

- a. The provision is assumed to be effective January 1, 1983. These revenue increases assume that any legislation would make contributions in excess of the limit ineligible for the medical expense deduction.
- b. The limits for employee-only coverage are 40 percent of the family limit. The limits are indexed by the medical care component of the Consumer Price Index.

TABLE 5. DISTRIBUTION OF ADDITIONAL ANNUAL TAX BURDEN OF \$150 PER MONTH EXCLUSION LIMIT IN CALENDAR YEAR 1983, BY HOUSEHOLD (In dollars)

	All Households				Households Affected		
	Average Amount by Which Annual Contributions Exceed Cap	Per Household	Per- cent of Income	Additional Taxes <sup>a</sup> Percent of Income Taxes <sup>b</sup>	Percent Affected by Limit	Average Amount by Which Annual Contributions Exceed Limit	Average Additional Taxes <sup>a</sup>
<u>By Annual Household Income:<sup>c</sup></u>							
\$0-10,000	10	3	0.05	0.8	2	557	138
10,001-15,000	50	14	0.11	1.1	9	582	168
15,001-20,000	68	21	0.12	1.0	14	479	147
20,001-30,000	128	44	0.18	1.2	23	554	191
30,001-50,000	228	88	0.22	1.3	33	690	267
50,001-100,000	279	116	0.18	0.9	36	779	323
Over 100,000	216	108	0.08	0.3	27	804	403
<u>By Age of Head:</u>							
Under 45	162	62	0.19	1.3	25	652	250
45-64	192	74	0.18	1.2	27	706	273
65 or over	11	4	0.01	0.1	3	432	157
<u>By Region:</u>							
Northeast	127	50	0.13	1.1	20	629	245
North Central	210	81	0.21	1.4	29	724	278
South	77	29	0.09	0.6	15	531	199
West	158	61	0.17	1.1	21	745	289
All Households	142	55	0.15	1.0	21	668	257

SOURCE: CBO simulations based on the National Medical Care Expenditure Survey.

- a. Tax benefits include both federal income tax reductions and the employer's and employee's share of federal payroll taxes. About three-quarters of the tax benefits are income tax reductions. State and local income tax reductions are excluded. The estimates assume that taxable excess contributions are made ineligible for the medical expense deduction.
- b. Additional income taxes as a percentage of income taxes under current law.
- c. Household income before taxes but including cash transfer payments, such as Social Security benefits, projected to calendar year 1983.

## Alternative Ceilings

The tax exclusion limit discussed above could be altered by:

- o Varying the limit on the basis of actuarial factors such as the average age of employees and location; and
- o "Grandfathering" existing contributions.

Actuarial Variation in Ceiling. Among group health insurance plans, premiums do not track closely with the level of benefits. Factors such as the size of the group, the average age of its members, and local medical prices and style of practice play major roles in determining group insurance premiums. As an example, one major insurer charges \$120 per month in Raleigh-Durham, North Carolina, and \$240 per month in Los Angeles for the same family coverage.<sup>11</sup>

Many see this variability as a drawback to a uniform ceiling, since it would not target the incentives to reduce insurance coverage on those with the most comprehensive benefits. Some also object to taxing more heavily those whose premiums are high due to actuarial factors. They say that if subsidizing a moderate amount of health insurance is a federal goal, then the subsidy should take these actuarial factors into account.

---

### 11. Personal communication.

Additional evidence on this point comes from analysis of survey data. Using a Bureau of Labor Statistics survey of employment-based plans, CBO constructed a premium index that reflected only variation in the comprehensiveness of coverage (including projected induced variation in use of care). This index deliberately excluded factors such as age, sex, and local medical care prices.

Approximately 70 percent of these plans (weighted by the number of participants) had index values between 85 and 98. But family premiums, which include the other factors, had a much wider range. The comparable percentile range of family premiums was from \$57 to \$170 per month.

Others, however, object to higher subsidies going to those in areas with higher medical prices, and find the uniform nature of the proposed ceiling to be desirable. Indeed, some of the area price differences reflect long-standing differences in the extent of insurance. Moreover, many oppose varying exclusion ceilings because of reluctance to set a precedent of introducing explicit regional variation into the tax code. Arguments for varying the exclusion ceiling are similar to those for varying the size of the standard deduction and exemptions by area to reflect cost-of-living differences. Many would rather not open up the tax code to explicit area variation.

One could vary the exclusion limit in an attempt to approximate more closely the degree of extensiveness of health insurance benefits. H.R. 850, for example, would do this after a transition period by basing a family's limit on the average premium paid for qualified plans in an area by persons of similar age and sex. Such a method would automatically incorporate the actuarial factors used for the groupings. A drawback would be the extensive data collection required to determine average premiums, and the difficulty of calculating taxes due when so many limits are involved.

An alternative with more modest data requirements would be to use Medicare data to adjust for geographic differences in medical care use and prices. For example, if Medicare beneficiaries in an area spent 20 percent more than the national average (after adjusting for age and sex), the tax exclusion limit for persons in that area would be set 20 percent higher than the average ceiling. Additional actuarial factors such as age could be introduced through standard tables, but this would add substantially to the complexity of calculating taxes.

Grandfathering. Some have suggested taxing only those portions of employer contributions exceeding both the set limit and the firm's rate of contribution in effect at the time of its enactment.<sup>12</sup> By "grandfathering" current contributions, this would avoid sudden tax increases. During the early years of such a provision, some regional and actuarial variation would therefore be introduced implicitly.

---

12. The National Governors' Association's position on medical care financing adopted at its 1982 Winter Meetings supported a tax exclusion limit with a grandfathering provision.

Such grandfathering would not provide substantial relief to many persons. For one thing, the initial additional tax liabilities would be relatively small. A family receiving a \$200 per month contribution in 1983 and with a taxable income of \$25,000 per year, for example, would pay about \$230 per year in additional taxes.<sup>13</sup> Also, the effectiveness of the provision would diminish quickly. Since insurance premiums per employee are expected to increase by about 14 percent per year under current policies, most of the effects of such a provision would be gone within three years.

A major drawback to grandfathering would be the delay in realizing the effects of tax exclusion limits on the medical care system. Two or three years would have to pass before incentives to alter health insurance would become substantial. Moreover, administering such a provision would be very difficult.

Opportunities to raise revenues would also be forgone. For example, grandfathering 1982 contributions would result in fiscal year 1983 revenue gains of only \$1.2 billion rather than \$2.9 billion, while 1984 gains would be reduced from \$5.1 billion to \$3.0 billion.

#### PERMIT TAX-FREE REBATES

Some proposals would allow employers to pay rebates to employees choosing health plans with premiums lower than the employer's contribution and would make these payments tax free. Under current law, payment of rebates other than as part of a "cafeteria" plan meeting IRS regulations may jeopardize the tax-free status of part of the benefits received by those employees not choosing the lower-cost plan. Such proposals often require employers to make fixed contributions--that is, the same contribution whichever plan the employee chooses. They also require a minimum benefit package in order to maintain encouragements for individuals to have health insurance.

Making any rebates tax free, when coupled with an exclusion ceiling, would augment the ceiling's impact on the medical care

---

13. This includes the additional payroll taxes paid by the employer.

system but would reduce additions to revenue. Where employers offer a choice of plans, tax-free rebates would remove tax incentives for purchasing additional health insurance, even for employees with contributions below the ceiling. For example, an employee receiving a \$140-per-month contribution for family coverage might choose a \$100-per-month plan and get a \$40 rebate tax free. Since the employee would have the opportunity to receive \$40 in additional after-tax income in return for a \$40 reduction in health benefits, the tax incentive to choose health benefits would no longer exist. Since only about one-third of employees receiving contributions would be affected by an exclusion cap, at least initially, tax-free rebates have the potential of increasing the effectiveness of the cap.<sup>14</sup>

The impact of tax-free rebates would be limited in that a significant proportion of employees would not have their incentives changed by the provision, and by employers' reluctance to set up choice mechanisms. Today, roughly half of employees in firms with health benefits sponsored by employers must contribute toward premiums. Under these financing arrangements, however, the equivalent of permitting tax-free rebates is already in place. Since the employee is already contributing out of after-tax income, the full savings of any optional plan with a lower premium would already go to the employee through a reduction in the required contribution. Between those in plans where employees contribute, and those receiving employer contributions exceeding a \$150 limit, only 21 percent of employees with health plans would have their incentives altered by tax-free rebates.

Employers might be reluctant to set up the choice mechanisms to make use of the tax-free rebate because this approach would raise some serious short-term problems involving duplicate coverage and adverse selection. First, roughly 23 percent of families covered by employer-paid health insurance have some overlap in

---

14. Tax-free rebates would, for the most part, not affect choice for those with contributions above the cap, since taxes would be paid on the excess contributions in any case. That is, the addition of the rebate feature would alter incentives only in situations where plans with premiums below the ceiling were offered.

that one or more members are covered by two employer-paid plans.<sup>15</sup> As long as coordination of benefits is effective, employees with duplicate coverage draw fewer benefits than other employees. Rebates would enable such employees to collect cash without significantly reducing the benefits they draw from the health plan. While this might be desirable from the perspective of equal pay for equal work, it would cost employers money.<sup>16</sup>

The second problem for employers would be pressure to raise contributions to health plans because of adverse selection. If the result of employee choice was adverse selection against the original plan (in other words, if employees choosing new plans were lower than average users), the premium of the original plan would increase. Employers would then have to decide whether to continue long-standing policies of paying a fixed proportion (often 100 percent) of the plan's premium, which would increase their costs, or cutting back on the proportion contributed.

In fact, the experience with contributory health plans suggests that employers would probably not initiate choices if tax-free rebates were enacted. Despite the current favorable tax climate for choice of plans in firms requiring the employee to contribute to the health benefit plan, such arrangements are not common. This record casts doubt on the likelihood that employers who pay the entire premium would offer choices if tax-free rebates were permitted.

Tax-free rebates would lead to a revenue loss, by inducing employers to increase their contributions to health plans, unless steps were taken to prevent it. A firm's response to the rebates

- 
15. This estimate was obtained from an analysis by CBO of the March 1980 Current Population Survey. Harold Luft, using a different technique, obtained a similar estimate. See his "Diverging Trends in Hospitalization: Fact or Artifact?" Medical Care, vol. XIX (October 1981), pp. 979-94.
  16. Over time, employers could avoid an increase in costs by reducing cash compensation or their contribution to health benefits for all employees. The net result would be that the compensation package would be more attractive to dual-earner couples than before, and less attractive to others.

might range from raising the contribution to the premium for a new "super-high" option plan that few employees would choose, to not changing the plan but increasing the proportion of the premium paid by the employer.<sup>17</sup>

Each of the Congressional proposals that includes a tax-free rebate has incorporated provisions to reduce this revenue loss. For example, Senator Hatch's bill (S. 139) limits tax-free contributions to the premium of the highest-cost plan chosen by at least 10 percent of the firm's employees. Representative Gephardt's bill (H.R. 850) has an exclusion limit, and also would place a \$42 per-month limit on the size of the rebate that would be tax free. While each provision would reduce the revenue loss significantly, neither would prevent the loss that would result if employers raised contributions toward the premium of the basic plan.

#### REQUIRE A CHOICE OF PLANS

Since multiple choice is so important to the HMO strategy, some have proposed requiring employers to offer a choice of plans with a fixed contribution by employers in order to be eligible for

- 
17. Employers might increase the proportion of the premium they pay because tax-free rebates would permit them additional options to deal with divergent preferences for health insurance relative to cash among their employees. Secondary earners covered under their spouses' health insurance would rather have cash than health insurance. In order to make the compensation package attractive to both the secondary earners and the primary earners who want coverage, employers often pay only part of the premium and pay higher cash wages than they otherwise would. In this way, the secondary earners who decline the coverage get more cash while the primary earners get health insurance coverage and some tax sheltering. Under tax-free rebates, the employer could shelter more of its compensation from taxes by raising its health benefits contribution while not forcing the secondary workers to take a lot of health insurance (they would take a minimal plan and a rebate).

the tax exclusion.<sup>18</sup> Senator Durenberger's bill (S. 433), for example, would require a choice of at least three plans from different carriers for firms with 100 employees or more participating in health plans.

Since employers do not have much experience with multiple choice and face possible short-term costs in conjunction with it (see above), a mandate would increase the number of employees offered a choice. Such a mandate would assist HMOs and other alternative delivery systems in their marketing efforts by encouraging employers to seek them out. The extent of cost sharing in traditional insurance policies would not change much on average, however, and small employers might experience significant administrative cost increases.

This section begins with a discussion of the need for regulation to make choices meaningful--in other words, ensuring that the plans made available to employees differ appreciably and are attractive. Assuming that the choices are indeed meaningful, the section then turns to the likely impacts of a mandate. It ends by examining the possibility of divorcing health insurance from employment, an alternative that would make a wide range of choices available to employees.

#### Making Choices Meaningful

Ensuring that the choices offered were meaningful would require some rules about characteristics of the plans offered. The simplest requirement would be that at least one PGP and one IPA be offered when available, as is required of firms with 25 or more employees under current law.<sup>19</sup> Additional HMOs could be required when available, to encourage competition among such organizations.

---

18. A fixed contribution is the same for an employee no matter which plan is chosen. If the plan's premium is lower than the employer's contribution, the employee receives a rebate for the difference. It does not mean that all employees get the same contribution.

19. Section 1310 of the Public Health Service Act.

Requiring choices among traditional plans is more difficult, but probably less important because individual choice is not necessary for increased cost sharing. The Ullman bill in the 96th Congress (H.R. 5740) would have required employers to offer either an HMO or a plan with a premium below \$75 per month, but the latter might have little cost sharing in low-cost areas and too much cost sharing to be attractive to many in high-cost areas. Requiring each firm to offer a plan with 20 percent coinsurance would be more effective than a premium limit but might preclude plans with a configuration of cost sharing that is more attractive to employees--for example, a large deductible but no coinsurance once it is met. Requiring different carriers (S. 433) would not ensure substantial differences among plans.

#### Effects of Requiring Choice

A mandate for choice among traditional plans would be most important in conjunction with permitting or requiring tax-free rebates, since choice is a prerequisite for tax-free rebates to be effective. But if an exclusion limit that was not combined with tax-free rebates was enacted, changes in an employer's single traditional plan combined with employer-initiated multiple choice would be sufficient to respond substantially to the new incentives.<sup>20</sup>

The fact that employers with health plans are already required to offer HMOs to their employees under current law would reduce the effectiveness of a multiple choice mandate somewhat. Requiring multiple choice would strengthen this to a degree--by putting the onus on the employer rather than on the HMO and by requiring that employees get the benefit of any lower premiums--but the effect might not be very great.

Administrative costs would increase somewhat under a mandate of multiple choice. The most expensive mandate would be one

---

20. A choice mandate would have a much smaller effect on the extent of cost sharing if rebates were taxed. Multiple choice would offer some the option to increase their coverage. Without changes in tax incentives, coverage increases by some would roughly balance coverage decreases by others.

requiring different carriers. Administrative costs vary substantially with group size. If a small or medium-sized firm was required to deal with several carriers, some of the scale economies would be lost. Asking one carrier to offer both a low and a high option would be less costly than seeking two different carriers.

Variation: Permit Employees to Apply Their Employer Contribution to Any Qualified Plan

An alternative to requiring choice would be to allow employees to apply the contribution to plans not sponsored by the employer. H.R. 850 includes such a provision, and would obligate health plans to accept all applicants on an equal basis, with premiums varying only by actuarial category.

Such a provision would make a wide array of plans available to many employees, but not all of the choices would be attractive ones. In theory, all health plans in a local area would be available to all persons willing to pay the premiums. But H.R. 850, for example, would permit discounts to reflect administrative savings from group purchase. Since these administrative savings are often large, employees of a large firm might find the company's single health plan much more attractive than other plans in the locality because of the discount. Even though each employee would technically have a wide choice, outside plans would be at a substantial disadvantage.

Besides potentially expanding the range of choices, this option might improve access to insurance for those not employed, or employed by a firm without a health plan. Many persons not in a group insurance plan have difficulties obtaining individual coverage because they are presumed by insurance companies to be in poor health. Even those who are demonstrably in good health often face very high premiums reflecting the high claims experience of individual insurance policyholders. H.R. 850 would give these persons access to insurance through its open enrollment requirement.

The disadvantages of the proposal are potentially extensive adverse and preferred-risk selection, and high administrative costs. By severing the link between employment and health plans,

the employer's ability to prevent preferred-risk selection would be lost. If employees were able to apply the employer contribution to any plan, employers would have no control over the marketing practices of insurers. Moreover, some of the economies of marketing to groups would be lost. Since administrative costs for individual plans are high relative to those in large groups, substantial additional resources might be involved.

---

## CHAPTER IV. MEDICARE OPTIONS

---

Medicare is the primary insurer for 29 million persons. Because the use of medical services is so high among elderly and disabled persons, the program affects a substantial proportion of hospital and physician spending. For example, Medicare beneficiaries account for over one-third of expenditures in community hospitals. Because Medicare plays such an important role in the financing of health services, many consider changing its provisions as essential to encouraging greater use of the market.

In order to include Medicare in a market-oriented policy, some have suggested creating a system of Medicare vouchers. Medicare beneficiaries could use vouchers to purchase any qualified private health plan operating in their locality. (Plans would qualify by providing minimum benefit packages and meeting other requirements such as annual open enrollment periods.) Those choosing plans with premiums lower than the voucher amount would receive the difference in cash from Medicare, while those choosing plans with higher premiums would pay the extra amounts from their own funds. Voucher amounts could vary according to the age and sex of the enrollee and relative medical spending in the locality. Beneficiaries would have stronger incentives than at present to economize on medical care.

This chapter analyzes the Medicare voucher idea, and considers some alternative Medicare options to encourage greater use of the market. First, it discusses how vouchers fit into the two strategies of containing health care costs through the market, and then considers certain difficulties in the voucher approach. Alternatives discussed include other ways to encourage greater use of HMOs by Medicare beneficiaries, and ways to expand the amount of cost sharing by Medicare beneficiaries.

### THE VOUCHER OPTION

The main effect of Medicare vouchers would be to increase enrollment in HMOs, which would become much more attractive to

Medicare beneficiaries than at present. If vouchers were voluntary (the case in all legislative proposals thus far), they would increase cost sharing by only a limited amount because of the problems private insurers would face in competing with Medicare. Vouchers would have a relatively minor impact on Medicare outlays unless they were mandatory, in which case savings could be substantial.

### The Potential of Voluntary Vouchers

Vouchers would further the HMO strategy by establishing incentives to join HMOs having lower costs than fee-for-service medicine. Under current law, Medicare enrollees have little financial incentive to join such HMOs since most of them are reimbursed by Medicare on a fee-for-service basis; much of the savings from lower rates of hospital use therefore accrues directly to Medicare, not to the beneficiary. Under a voucher system, the Medicare payment would not be based on the experience of the particular HMO, but on Medicare's experience in the fee-for-service system in the same locality. To the extent that an HMO's premium was lower than the voucher amount, the beneficiary would keep the difference.

Vouchers would encourage enrollment in HMOs by easing their marketing problems as well. In any locality, an annual listing of the HMOs that qualify for vouchers, their benefits, and their premiums, would reduce their costs of marketing to the Medicare population in that area--costs that might otherwise preclude substantial efforts to enroll this population. Other alternative delivery system health plans would also benefit from this marketing opportunity.

Cost sharing might be further increased if enrollees were given a cash refund in return for accepting additional cost sharing. Under current law, Medicare beneficiaries willing to pay additional premiums to reduce their cost sharing can do so by purchasing private health insurance that supplements Medicare--but those wanting to convert some of their Medicare benefits to cash cannot do so. The voucher proposal would provide such an outlet.<sup>1</sup>

- 
1. Some voucher proposals, such as H.R. 4666, introduced by Congressmen Gradison and Gephardt, would permit vouchers to be used to purchase health plans with benefits at least equivalent to Medicare's. Proposals such as these would work only through the HMO strategy.