

AN ANALYSIS OF THE
NATIONAL HEALTH CARE REFORM ACT OF 1981 (H.R. 850)

Staff Working Paper

(Background for the Statement of
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PREFACE

The Congress is now considering proposals to contain rising health care costs by encouraging the use of market forces. This report, prepared at the request of the Committee on Ways and Means, analyzes one of the most comprehensive proposals of this type, the National Health Care Reform Act of 1981 (H.R. 850). In keeping with the mandate of the Congressional Budget Office (CBO) to provide objective and impartial analyses, this study offers no recommendations.

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SUMMARY

The National Health Care Reform Act of 1981 (H.R. 850) addresses two major problems of the health care sector--rapidly rising costs and lack of access to services by some persons. It would attempt to solve the cost problem through competition--that is, increasing the role of prices in decisions made by patients and providers. At the same time, existing federal attempts to control costs through regulation would be repealed. The proposal would attempt to solve the access problem through federal financial assistance. Persons purchasing qualified health plans would all receive some federal assistance, either through the exclusion of a limited amount of employer contributions from taxation, through tax credits, or through vouchers.

The bill would reduce private spending on medical care, mostly through incentives to participants in employment-based health insurance plans to accept more cost sharing provisions such as deductibles and coinsurance, but also through encouraging enrollment in Health Maintenance Organizations (HMOs). Rates of use of medical services and prices would be somewhat lower than under current policies. Most of the impact on the federal budget would be on the revenue side, with a revenue loss amounting to \$14.5 billion in fiscal year 1984 and increasing to \$19.4 billion in 1986. Spending on Medicare and Medicaid would not change by a large amount.

Persons gaining the most would include those not currently receiving employer-paid health insurance and those who would qualify for low-income vouchers but who are currently ineligible for Medicaid. Those losing the most would include persons with large employer contributions to health plans and those receiving Medicaid who would not qualify for vouchers.

Tax Exclusion Limit

The bill would limit the amount of employer contributions for health insurance that could be excluded from employees' taxable incomes. The initial limit (in 1984) would be \$154 per month. In addition, employees choosing plans with premiums below the employer's contribution to health insurance would receive tax-free refunds from the employer.

These provisions would tend to reduce health care costs since they would effectively remove much of the incentive to purchase health insurance that is provided by the current tax system. This, in turn, would probably lead to more cost sharing provisions in health insurance plans, lower rates of use of health services, and lower medical care prices. Some small increase in enrollment in Health Maintenance Organizations (HMOs) would also result, but this would involve many fewer people than the increase in cost sharing.

These provisions alone would increase federal revenues by a significant degree--about \$4.9 billion in 1984 increasing to \$11.9 billion in 1986--but other provisions would result in a net revenue loss if the bill were enacted. The tax increases would initially affect about one-third of those with employment-based health insurance, and would be concentrated on those persons obtaining the largest tax benefits today--those with high earnings, in unions, in firms with older employees, and in areas with high medical costs.

Tax Credits

The bill would provide refundable tax credits to purchase health insurance to all persons (except for the Medicare and Medicaid populations) not receiving employer contributions and to those receiving employer contributions less than the maximum permitted.

The tax credits would encourage somewhat the purchase of health insurance, but the proposed credit's small size relative to premiums of individually purchased insurance policies would limit the magnitude of this effect. A large proportion of the credits would go to persons already insured. While this widespread eligibility would increase the uniformity of the tax benefit, a substantial revenue loss would result in the process--\$19.4 billion in 1984 and \$31.3 billion in 1986.

Open Enrollment

The bill would require qualified health plans to accept all applicants and charge identical premiums to all persons within an actuarial category, although differentials that reflect administrative savings from group purchase would be allowed.

This provision might substantially alter the way in which health services were financed, weakening the link between employment and the purchase of health insurance. Its advantages include making health insurance available to the chronically ill and assuring a wide choice of plans for most persons. Its major disadvantage would be a potentially high degree of "adverse selection," the phenomenon of persons expecting high use tending to purchase plans with extensive benefits and those expecting low use to purchase plans with limited benefits.

Medicare Vouchers

The bill would provide vouchers to Medicare beneficiaries who would enroll in qualified private health plans. This provision would increase somewhat the number of Medicare enrollees served by HMOs, but would not induce many other beneficiaries to switch to private plans. The low amounts of the vouchers (compared with the Medicare benefits per enrollee) would discourage their use, as would the disadvantages that private insurers would face in competing with Medicare. Private insurers would have to include in their premiums both selling costs, which Medicare does not have, and higher payments for hospital care than Medicare reimburses. The adverse selection associated with this provision would increase Medicare outlays by a relatively small amount, but lowered medical care prices resulting from the bill's other provisions would tend to offset this increase.

Low Income Vouchers

In 1988, the fifth year in which the major provisions would be effective, the bill would permit states to replace their Medicaid programs with a federally administered system of vouchers for the purchase of private health plans. Substantial numbers of low-income persons who are ineligible for Medicaid because of categorical requirements would be able to qualify because eligibility would be based solely on income. On the other hand, some current recipients would lose their eligibility. Many states might decline to participate because they would be given increased responsibility for the costs of nursing home care, because elderly Medicaid recipients might have less access to health services, and because low voucher amounts would severely limit the number of health plans that would be able to provide the required benefit package without losing money.

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Today, most health services are financed through private or public health insurance. Private health insurance tends to be provided through employment. Establishments accounting for about 90 percent of all U.S. employment offer their employees a health benefit plan with some contribution from the employer. A smaller amount of health insurance is purchased directly from insurers by individuals. Government provides health insurance for the elderly, the disabled, and others who are poor. The Medicare program covers 24 million aged and 3 million disabled persons, while about 29 million low-income persons are eligible for Medicaid. Nevertheless, between 5 and 8 percent of the population has no health insurance.

The bill has six major components:

1. Limit the exclusion from taxation of employer contributions to health plans, and require employers to pay refunds to employees who spend less than the contribution for a qualified plan. The limitation (approximately \$154 per month in 1984 according to CBO projections) would initially be based on the value of Medicare benefits. Beginning in 1987, the limit would vary by actuarial category (for example, age, sex, family size, and location) and be based on the mean premium of qualified plans purchased by persons in a category in an area. Refunds paid to employees would be tax free up to \$49 per month in 1984, reduced by any amount by which the premium plus refund exceeded the exclusion limit.

2. Provide refundable tax credits to those without employer contributions or with contributions less than the maximum excludable from taxation. The tax credits would be equivalent to the value of the average tax subsidy for those with employer contributions equal to the limit. In 1984, the credit for persons with no employer contributions would be approximately \$58 per month. Those persons receiving employer contributions less than the maximum would receive smaller credits. Credits could only be applied to the premiums of qualified plans. Medicare and Medicaid beneficiaries would not be eligible for the tax credits.
3. Require all health plans to open their enrollment once a year and charge all persons in a given actuarial category the same premium. This provision is intended to sever much of the link between employment and health insurance. While employers could continue to contribute to their employees' health benefits costs and operate plans, the plans would have to enroll persons other than employees, and the firms' employees could take their contributions and enroll in plans not sponsored by their own employers.
4. Give Medicare enrollees the option of using a voucher to enroll in a qualified private health plan. Enrollees choosing a plan with a premium less than the voucher would have the difference refunded by Medicare. Those choosing a plan costing more than the voucher would pay the difference. The voucher would initially be based on average Medicare benefits (net of premiums) in 1982, indexed by the gross national product (GNP) deflator. The 1984 voucher amount for the average Medicare beneficiary would be approximately \$1,845 per year. After a transition period, the voucher would be based on the average premium paid for qualified plans by those eligible for Medicare in an actuarial category and area who have enrolled in qualified private plans. Persons accepting vouchers would not be able to return to Medicare in future years, and once more than 50 percent of those eligible for Medicare have opted for vouchers, the vouchers would be mandatory.

5. Give low-income persons vouchers to purchase health plans with no cost sharing for covered services. This provision, which would not take effect until 1988, would make vouchers available to all low-income persons, regardless of family status, but only in states agreeing to participate. States participating would lose federal matching grants for Medicaid in return for federal underwriting of the full cost of vouchers for low-income persons. These states would be required to maintain Medicaid services that would not be covered by the voucher such as long-term care--about half of the current program.

6. Repeal various provisions of federal laws and preempt state laws thought to impede competition. The bill would repeal Medicare limits on reimbursements to providers, the PSRO program (which reviews the appropriateness of service use by Medicare and Medicaid patients), the federal health planning program, and much of the HMO Act. Any state law that impedes the reforms of the health care delivery system implemented under this bill would be preempted. Specifically preempted would be prohibitions against the corporate practice of medicine, discriminatory premium taxes, requirements that health plans provide certain services, regulation of premiums charged, and regulations on facilities that can be purchased or used or services that may be provided by hospitals or physicians.

This study analyzes each of these six major components of H.R. 850. Questions considered will include:

- impact on the medical care system,
- impact on the federal budget and the economy, and
- impact on the distribution of income.

The request for this study also asked about the impact of components of this proposal on the quality of care. Unfortunately, so little is currently known about the determinants of the quality of care that informed statements about the effects of components of this proposal are not possible.

The following section of this study discusses some basic issues about how increased competition might lead to lower health care costs. Then, each of the six major components of the proposal are analyzed.

COMPETITION AND COST CONTAINMENT

Use of private incentives can contain health care costs through at least two mechanisms. One mechanism is cost sharing, where the insurance contract requires the patient to pay part of the cost of medical care. If persons were induced to change the provisions of their health insurance plans to incorporate more cost sharing, they would reduce their use of health services.¹ Evidence also links cost sharing to lower medical prices.

A second mechanism is inducing persons to enroll in Health Maintenance Organizations (HMOs) or other alternative delivery systems. The research literature indicates that at least the prepaid group practice (PPGP) model of HMO achieves lower medical costs than insured fee-for-service practice. Some contend that increased enrollment in HMOs also reduces costs in the fee-for-service sector, once a substantial market share is obtained, but others disagree.

Some analysts envision increased use of market forces spurring the development of health plans which borrow some characteristics from HMOs but are less structured. These range from plans that place physicians who deliver primary care partially at risk for all services used by a patient, to plans that limit choice of providers to those who are low cost, to plans that give the patient financial incentives to choose low-cost providers. Whether the present limited use of these alternative plans reflects an absence of incentives to contain costs or serious drawbacks of the plans is a difficult question to answer.

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1. The Rand National Health Insurance Experiment indicates that going from full coverage to 25 percent payment by the patient reduces service use by 15-20 percent. See Paul B. Ginsburg, "Altering the Tax Treatment of Employment-Based Health Plans," Milbank Memorial Fund Quarterly/Health and Society, vol. 59, no. 2 (Spring 1981), pp. 224-255, for a discussion of the evidence on this relationship and others that are discussed below.

incentives can contain health care costs. The bill focuses on competition between providers on the basis of price, quality, and method of delivery. It calls for

health care deliverers to compete with each other for members based on cost, quality, and method of delivering care, thereby introducing incentives for the development of cost-effective, quality systems of health care delivery (Section 4(4)).

This view of competition appears to exclude some of the potential of the cost sharing mechanism, which does not need to be combined with competition to work. For example, an employer, responding to incentives from changes in the tax law, could increase cost sharing in the firm's single health plan. This additional cost sharing would induce employees and their families to reduce use, and might in turn induce providers to lower their fees (or raise them more slowly) even though they were not facing competition from other providers. Competition among providers might increase these price effects, however. While the authors of the bill appear to place great emphasis on incentives for the development of alternative delivery systems such as HMOs, the CBO expects that a major part of cost containment resulting from this bill would come through increases in cost sharing. The basis of this contention is explained in the following section.

TAX EXCLUSION LIMIT AND TAX-FREE REBATES

These provisions would induce individuals and/or their employers to spend less on health insurance. Most of those altering their health plans would probably increase the degree of cost sharing in their traditional health insurance plans. A smaller number would switch to HMOs or HMO-like plans that limit choice of providers.

Impact on the Medical Care System

The CBO has attempted to estimate the magnitude of the decrease in health service use and medical care prices that would occur as a result of the exclusion cap and tax-free refunds. In

1988, the fifth year that these provisions would be effective, health service use for the population covered by employment-based health plans is estimated to be about 10 to 15 percent lower than under current policies. Medical care prices would be about 1 to 2 percent lower than under current policies.²

Basis for Impact. The tax exclusion limit and tax-free rebates would remove most of the incentives to purchase comprehensive health insurance that are associated with federal tax subsidies.³ Under current law, all employer contributions to employee health plans are excluded from taxation. In other words, compensation in the form of health insurance benefits is not taxed, while cash compensation is taxed, so it has been in the interests of both employers and employees to shift some compensation toward health insurance.

The exclusion cap would eliminate these incentives to shift compensation to health insurance for persons with contributions exceeding the cap. An additional dollar of compensation would be taxed regardless of whether it purchased health insurance or was in cash.

For employees receiving contributions below the cap, tax-free refunds would remove the subsidy to additional health insurance purchases. An employee deciding to purchase a health plan with a premium that is \$10 per month less than the current plan, would have \$10 per month more in after-tax income to be spent on other goods and services.

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2. The medical care price estimate relates only to the exclusion cap and tax-free refund provisions of H.R. 850. Other parts of the bill, such as tax credits and vouchers for low-income persons would tend to increase medical prices by increasing the demand for medical care services. CBO has not estimated the net impact of the entire bill, although it is expected that the direction of the impact would not change.
 3. The bill would also deny to purchasers of qualified plans the subsidy to individual purchases of health insurance that is part of the medical expense deduction.

The research literature indicates that insurance purchases are moderately sensitive to subsidies, although deficiencies in the data limit the reliability of the results. Preliminary results from recent studies by the CBO and the Department of Health and Human Services (HHS) indicate that a 10 percent increase in the price of health insurance (the ratio of premiums to benefits) would, over time, decrease the amount of health insurance purchased by about 6 percent. Such a result is obtained from studies of variations in premiums for health insurance among employee benefit plans in firms of different sizes. The price of health insurance varies by firm size, permitting inferences about the effect of price on the purchase of insurance.

Inferences from these results are subject to error for three major reasons, however. First, the survey data used in the studies do not include information on the premium-to-benefit ratios faced by each firm--these ratios must be inferred from external data compiled by actuaries. Second, the research concerns decisions made by firms, either unilaterally or through collective bargaining, whereas the bill would rely more on the actions of individual employees to adjust health insurance purchases to new incentives. While it is reasonable to assume that firms and unions have made decisions concerning health insurance versus cash compensation that reflect employee preferences, their actions are only a rough guide to decisions that employees would make on their own. Finally, the methods employed in these studies do not permit any inferences about timing. Little is available to indicate how long it would take employees to adjust their health insurance purchases to the new incentives associated with this bill.

Specifics of Impacts. Employees increasing their cost sharing probably would not do so uniformly since coverage of some health services is more valuable to people than coverage of other services. The economics literature indicates that services that are expensive, nonelective, and not predictable are most likely to be insured.⁴ Hospital care is the most likely service to be insured under this criterion, and in fact it is. Dental care and prescription drugs are much less likely to be insured.

4. See Paul J. Feldstein, Health Care Economics (Wiley, 1979), Chapter 6.

Those employees who increase their cost sharing are likely to concentrate the increase on those services where insurance is least valuable. This means that dental service and prescription drug coverage are likely to be reduced by the greatest proportion and hospital coverage the least. Such a pattern would tend to focus the effects of the bill on the health services where concern with spiraling costs is least intense.

Some recipients of employment-based health insurance would not have their incentives changed by the exclusion cap and tax-free refunds. Employees who are required to contribute to their firm's single health plan do not have the last dollars of their health insurance costs subsidized under current law. Since the employees' contribution is paid from after-tax income, the current tax system would not encourage purchase of a more expensive plan. Current law does not prevent the employer from offering a low option plan that would require a smaller contribution from the employee--equivalent to a tax-free refund.

Effects on HMOs. While removal of the tax subsidy would induce more cost sharing in health insurance, the impact on enrollment in HMOs or HMO-like plans is more difficult to predict. At present, many HMOs' premiums are higher than the premiums of the traditional insurance plans that they compete with, frequently the result of HMOs' more comprehensive benefit packages. Removing tax subsidies to the purchase of health insurance would not induce a switch to those HMOs that have premiums higher than the traditional plans that they compete with.

The relative premiums between HMOs and traditional plans could be changed by the bill, however. The bill would repeal sections of the Health Maintenance Organization Act that some feel have impeded the growth of federally qualified HMOs. Also, removing the incentives of the tax subsidy and requiring that the employer's contribution be invariant to the plan chosen by the employee would make it more attractive for HMOs to take steps to lower their premiums, either through efficiencies or by reducing the comprehensiveness of the benefit package.

Supply-side constraints might limit increases in HMO enrollment in the short run, however. Current HMO enrollment amounts to only 4 percent of the population. The research literature has established that prepaid group practice (PPGP) HMOs have lower

costs than fee-for-service practice, though it is unclear whether independent practice association (IPA) HMOs have lower costs. But PPGPs cannot grow very rapidly. Some experts feel internal enrollment growth in established PPGPs cannot exceed 10 percent per year. Since enrollment growth under current policies (which includes new plans as well) has been about 10 percent per year, the margin for increases in growth induced by the bill is not very large. An immediate acceleration of enrollment growth to 14 percent per year that might be induced by the bill would amount to 10 percent of the population by 1988, the fifth year that these provisions would be effective, as opposed to 8 percent under current policies.

The bill could encourage the development of new types of plans, such as those limiting choice of providers to ones with low fees or ones that are frugal in ordering services. To the extent such plans are economical, elimination of subsidies to health insurance might make them more attractive. It is unlikely that the bill would produce a boom in such plans, however. Health insurance policies that reward the insured for using low-priced providers have been available for a long time and have declined in popularity. Commercial insurance policies in the past often paid a fixed dollar amount per hospital day or per physician visit. Now policies typically pay the full cost of hospital care and "usual, customary, and reasonable" physician charges. Limiting choice of physicians or hospitals to relatively low-priced ones would not be very different than these "indemnity" policies. While changes in the tax laws might reverse these trends, rapid shifts are unlikely.

Impact on the Federal Budget and the Economy

These provisions would increase federal revenues by a significant amount (see Table 1) but would have only a minor effect on outlays. In 1984, the first year that these provisions would be effective, revenues would be \$4.9 billion higher than under current policies, with approximately two-thirds in income taxes and one-third in payroll taxes.⁵ The combined revenue increase

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5. The provision would be effective January 1, 1984. If in effect for the full fiscal year, revenues would be \$7.0 billion higher than under current policies. Also increased payroll tax revenues tend to increase future Social Security benefit obligations.

TABLE 1. ESTIMATED IMPACTS OF MAJOR PROVISIONS OF H.R. 850 ON FEDERAL REVENUES (In billions of dollars)^a

	1984	1985	1986	1987	1988
Tax Exclusion Cap (Revenue Increase)	4.9	9.3	11.9	10-15	13-18
Tax Credits for Those with Employer Contributions (Revenue Decrease)	8.3	12.5	12.9	7-10	6-9
Tax Credits for Others ^b (Revenue Decrease)	11.1	17.1	18.4	16-19	17-20
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Net Revenue Impact (Revenue Decrease)	14.5	20.3	19.4	12-15	9-12

a. Excludes budget impact of Medicare vouchers, subsidies for graduate medical education, changes in Federal Employees Health Benefits Program, repeal of various provisions of Social Security Act and the Public Health Service Act. The net impact of these provisions which affect outlays rather than revenues is unlikely to be large compared to the impact of the provisions estimated. Low-income vouchers are excluded because the outlays are approximately equal in size to reductions in federal grants to the states for Medicaid.

b. Includes repeal of deduction for health insurance premiums.

would grow to \$11.9 billion in 1986. Revenues in 1987 and 1988 are far more difficult to estimate, because the cap would be based upon average premiums for different actuarial categories and would vary by area. In 1988, federal revenues would be \$13-18 billion higher than under current policies.⁶

Any effects of these provisions on federal outlays would come from indirect impacts on federal health programs such as Medicare and Medicaid. Reductions in medical care prices would lower outlays. On the other hand, increases in service use by those remaining in Medicare could occur as a result of reductions in use by the employed population. The freed-up hospital beds and physician time would increase rates of use by those whose care is financed by these programs. Many economists have documented how increases in medical resources tend to increase use of services.⁷ Whether the price decreases or utilization increases would have a larger effect on outlays is difficult to predict.

While these provisions would lower medical care prices, the reduction would not be large enough to have a significant effect on the Consumer Price Index (CPI) for all items. In 1988, the CPI would be 0.1 percent lower than under current policies. This would be offset to some extent by the increase in the federal deficit and increased health spending from other provisions in the bill.

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6. These revenue estimates assume that whatever shifts in the structure of compensation are induced by the bill will tend toward taxable rather than nontaxable compensation. (Specifically, 15 percent of health insurance contributions newly subject to tax would ultimately be shifted to nontaxable fringes while the rest would be taxed.) The reasoning behind this assumption is that capping the tax exclusion does not change the incentives to shelter earnings through contributions to pension plans or other tax-free fringes. Compensation shifted out of health insurance would be distributed to taxable and nontaxable components of compensation in the general proportions that they currently account for.
 7. For an estimate of the magnitude of the effects specific to Medicare, see Paul B. Ginsburg and Daniel M. Koretz, "Bed Availability and Hospital Utilization: Estimates of the 'Roemer Effect,'" August 1981.

One reason for this result is the relatively low weight that medical care has in the CPI. Since much medical care is paid for by employers and by the federal government through Medicare and Medicaid, rather than directly by consumers, its weight in the CPI is substantially lower than the proportion of personal consumption it accounts for.

Distributional Impact

During the transition period, when the cap on the exclusion would be uniform, it would have very uneven effects on taxpayers. Much of the unevenness would end with the transition period, however.

In 1984, the exclusion cap would affect about 32 percent of families with employment-based health coverage. The median increase in taxes for those affected would be about \$25 per month. Those employees receiving the largest employer contributions would be affected the most. Also, those employees in the highest tax brackets would pay the most additional dollars in higher taxes.

Receipt of a large employer contribution can reflect one or more of the following:

- a rich benefit package,
- the employer contributing a high proportion of the premium, and
- actuarial factors causing the premium to be relatively high for a given degree of coverage.

A major issue of controversy is what proportion of the variation in employer contributions is associated with actuarial factors, such as the age of employees and local medical care prices, as opposed to the richness of the benefit package and the proportion contributed by employers. To the extent that actuarial factors are important, some would criticize a uniform cap.

The CBO has been analyzing this issue, and has found evidence that actuarial factors are important. Using a Bureau of Labor Statistics survey of employment 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 ranged from \$57 to \$170 per month.

Though the ability to separate variation in employer contributions into these three components is limited, data are available to analyze who would be affected most by uniform ceilings. Employees in firms with high average wages tend to receive larger contributions. A univariate analysis of data on firms paying the full cost of health insurance (about 60 percent of firms with plans) indicated that for each 10 percent increase in average wages, health insurance contributions per employee increased 18 percent. Data also indicate that employees in firms with collective bargaining agreements have higher employer contributions, as do employees in firms in the Western and North Central regions. Employees in metropolitan areas also have higher employer contributions.

A distributional effect unique to this proposal is a much heavier impact on families than on single persons. Unlike other proposed tax exclusion caps, the one in this bill would be the same for single persons and families. Since single employees generally have much lower employer contributions than employees with families, they would be affected much less by the cap in this proposal. This uneven impact would not continue past the transition period because of the subsequent use of actuarial categories.

Such an effect could be eliminated by varying the cap by family size. If the uniform cap in the bill became a family cap, and a cap for singles were set at 40 percent of that level (a typical ratio between single and family coverage), the revenue increase would be about 18 percent greater. Health system impacts would be slightly larger.

When both husband and wife have employer contributions, the exclusion cap would be applied to the sum of the contributions. This would affect such families more than the exclusion caps in other proposals which treat each policy separately. Some would favor this, arguing that all families should be subject to the same cap, regardless of the number of earners. Others note that coordination of benefits provisions in health insurance policies make contributions received by dual earners worth less to them than contributions received by others, so that taxing the sum would be harsh.

After the three-year transition period, the cap would become nonuniform and would thus have a very different distributional impact. Each family's cap would be based on the average premium paid for qualified plans by families within the same actuarial category in an area. As a result, factors such as age, family status, and local medical care prices would not have much of an impact on the pattern of who would pay most in additional taxes. Those paying the most additional taxes would still be those in high tax brackets, with rich benefit packages, and whose employers contribute large proportions of the premiums, but would no longer include those in groups with high rates of spending on medical care for a given health benefit package.

TAX CREDITS

The tax credits in the bill would encourage those not now covered by health insurance to obtain coverage through a qualified plan. (Qualified plans are those that limit cost sharing for a defined set of services to \$2,900 in 1982 and meet other conditions--see Title II of the bill.) This would reduce somewhat the problem of lack of access to the medical care system caused by the inability of some to afford health insurance. A large proportion of the credits would go to persons already covered by private health insurance, however, thereby substantially increasing the losses in tax revenues.

Impact on the Medical Care System

The tax credits would increase medical care spending and, along with the open enrollment provisions discussed in the next section, work toward severing the link between employment and

health insurance coverage. A large proportion of the 5 to 8 percent of the population that is currently uninsured would purchase a qualified health plan with this tax credit. This increase in health insurance coverage would lead to higher medical spending, but would make the distribution of medical care spending more even.

The amount of health insurance that could be purchased with the tax credit would be modest. In 1984, the credit would amount to about \$59 per month (38 percent of the cap). In that year, the average family premium for employment-related insurance is projected to be about \$175 per month. Moreover, the size of the credit would decline relative to average health insurance premiums after the transition period. How much coverage such a currently uninsured person could purchase with the credit is difficult to determine, but cost sharing would have to be much more extensive than is commonly found today. The possibility exists that the tax credit would not be large enough to purchase the minimum benefit package specified for a qualified plan. This would be especially likely in high-cost areas during the transition period.

Not all of the currently uninsured would buy a qualified health plan with the tax credit. If the only plans available for the amount of the credit would have very high deductibles, persons who have low incomes and are currently making use of public clinics or hospital emergency rooms for care would have little motivation to purchase a health plan, lay out the money, and file for a tax credit. CBO studies of the Earned Income Tax Credit, which does not require purchasing something, estimate that only 63 percent of those eligible have filed for it. On the other hand, sales efforts by insurers and the proposal's requirement that recipients of Supplemental Security Income (SSI) and Food Stamps purchase a qualified health plan would work against these factors.

For those persons already insured, whether through employment or through individual policies, the opportunity to receive a tax credit would in most cases not have a large effect on the amount of insurance purchased. As long as the premium paid for a qualified plan already exceeds the tax credit amount, likely to be a very frequent case, no additional purchase of insurance would be necessary to receive the full amount of the credit that one is eligible for. The requirements for qualified plans would often mean a change in the benefit structure, however, reducing "first-dollar" coverage and increasing protection against catastrophic expenses.

The tax credit provision would remove one of the major rationales for associating health insurance with employment--the tax advantage. Since those families not receiving employer contributions would receive a tax credit roughly equivalent to the maximum tax subsidy for the average person through employment-related insurance that is permitted under the bill, the tax shelter motivation for employer contributions to health insurance would, for the most part, be removed. Only firms with employees in relatively high marginal tax brackets would find that the tax savings to their employees from an employer contribution would exceed the value of the alternative tax credit. For firms where the average marginal tax rate of their employees is lower than the national average, contributions to health plans would yield average tax benefits lower than what would be available from the credit.

Budget Impacts

The tax credit provision would result in a large revenue loss because so many would be eligible. With the exception of those families receiving employer contributions at or above the ceiling, the entire population not eligible for Medicare or Medicaid would be eligible for some credit. The revenue loss from tax credits would amount to \$19.4 billion in 1984, and increase to \$31.3 billion in 1986, the last year of the transition period (see Table 1).⁸ Netting out the revenue increases from the tax exclusion cap, these provisions would result in an overall revenue loss of \$14.5 billion in 1984 and \$19.4 billion in 1986.

As discussed earlier, it is much more difficult to estimate the effects of H.R. 850 after the transition period. In 1987, the revenue loss from tax credits would be in the \$24-28 billion

8. These estimates include the revenue gains from the proposal's repeal of the health insurance deduction. They incorporate an assumption that 75 percent of those with no insurance coverage and 95 percent of those with individual insurance (not employer-based) would claim the tax credit. The estimate assumes that all persons with employment-based insurance who are eligible for a tax credit without changing the premium of their policy would claim the credit.

range. The revenue loss is smaller than in the transition period because the tax credits would be smaller. This would be the case especially for single persons, as the average premium for their actuarial categories would be much less than the uniform amount upon which all tax credits would be based during the transition period. Combining the tax credit and the tax exclusion cap yields a net revenue loss in the \$12-15 billion range. In 1988, the revenue loss from tax credits would be in the \$9-12 billion range.

The large budget impact during the transition period could be reduced by differentiating credits between single persons and families. If the amount in the bill became the family credit, and a credit for single individuals were established at 40 percent of that, the revenue loss from the tax credits would be reduced to \$12.0 billion in 1984 and to \$19.0 billion in 1986. Differentiating both the tax exclusion cap and the tax credit in this way would reduce the net revenue loss to \$6.2 billion in 1984 and \$4.9 billion in 1986. The alternative would not have a substantial impact on the revenue loss after the transition period, however.

Distributional Impact

The distributional effects of the tax credit provision of this proposal would be similar to those of the tax exclusion cap in the sense that those who lose the least from the exclusion cap tend to gain the most from the credit. Among persons with employer contributions to their health insurance, those receiving the smallest contributions would get the largest credits. Persons without employer contributions, who receive virtually no tax subsidies under current law, would gain the largest credits of all.

OPEN ENROLLMENT AND COMMUNITY RATING

The open enrollment and community rating provisions might cause a substantial change in the way health services are financed, largely by weakening the link between employment and health care financing. While the provision would make health insurance available to those "uninsurable" today because of chronic illness, adverse selection could pose a serious obstacle to full achievement of the proponents' goal of having a wide choice of health plans available to all.

The bill would require qualified plans to accept all applicants who pay the premium.⁹ Premiums charged by plans could not vary among persons within an actuarial category except to reflect "any administrative savings effected by group purchases, or continuous membership in the plan over a specified period of years" (Section 204(c)). Employers would have to permit employees to apply contributions to health benefits to any qualified plan, even plans not sponsored by the employer.

Impact on the Medical Care System

The major impact on the medical care system would occur through changes in the financing of health care. The magnitude of change from these provisions would depend upon the extent to which employers are able to use the administrative savings clause to maintain current arrangements. Administrative savings associated with group purchase of insurance are substantial today. In very large groups, only 4 percent of premiums go toward administrative expenses, compared to about 35 percent for individual policies.¹⁰ If employers that run plans give their own employees a substantial discount based on these savings, a substantial disincentive to joining outside plans would be established. Each firm's employees would tend to stay with the firm's own plan because of a much more attractive price. Indeed, in the absence of detailed regulation, employers might exaggerate the administrative savings in order to prevent high-risk persons from joining the plan. The extent of effective choice available to employees of large firms would thus depend on employer initiatives to make group purchases from a variety of plans.

An advantage of these provisions would be an improvement in access to health insurance by those who are uninsurable today. Persons who do not have access to an employer-sponsored group health insurance plan who have chronic health problems may not be able to purchase health insurance at any price. Most individual

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9. If a plan reached its capacity, existing enrollees would be given preference. New applicants would be accommodated on a first-come, first-served basis.
 10. Unpublished tabulations from the Health Insurance Association of America.

insurance policies exclude from coverage pre-existing conditions. Under the bill, such persons could purchase any health plan in their area, and pay the same premium as others (except for the adjustments for administrative savings).

A second advantage of these provisions is that they open the way for a large choice of plans for many employees. Except for the potential barrier of the administrative discounts, each person would have a wider variety of plans to choose from than if restricted to choices offered by their own employer. This would increase competition among health care plans.

Impact on Budget

The open enrollment provisions in H.R. 850 would have only minor impacts on the federal budget.

Distributional Impact

The most important disadvantage of these provisions is the additional exposure of health care financing to adverse selection. Adverse selection in health insurance is the phenomenon of persons who are relatively low users of services choosing those plans with less extensive benefits. When this occurs, the premiums of the "low option" plans are lower than would be the case if their enrollment were randomly selected from the population, and the premiums of the "high option" plans higher. This expanded premium difference encourages shifts out of high option plans, which may exacerbate the problem.

If adverse selection were severe, high option plans could not survive. The result would be a tendency to have only plans with benefits close to minimum requirements.

If adverse selection were less severe, the result would be a shift of income from the high users to the low users. Looked at in a different manner, choice with adverse selection reduces the extent of transfers from the low users to the high users by having expected utilization a factor influencing which experience pool persons go into. Many consider this redistribution a disadvantage of adverse selection. It appears to be a price that must be paid for the advantages of employing a choice of plans to further the use of market forces.

In situations where the choice is between a traditional insurance plan and an HMO, adverse selection is a different phenomenon. Here, the benefit structures are often similar, so the pattern of selection is more likely to be dominated by the differences between persons willing to change their physician and those who are not. As a result, PPGP model HMOs tend to attract a population of relatively low users. Since HMO enrollees tend not to switch back and forth, however, the phenomenon decays over time and thus is more important for new HMOs than for established HMOs.

Experience with Adverse Selection. Our limited experience with multiple choice in health insurance makes inferences about the gravity of the problem difficult. The Federal Employees Health Benefits Program (FEHBP) has offered a choice of plans for years. While it has not been studied extensively, the program appears to experience adverse selection. For example, the premium difference between the high and low options offered by Blue Cross and Blue Shield far exceed what would be expected on the basis of the benefit differences and the effects of those differences on use of services. A CBO analysis of plan switching in FEHBP indicates that those persons leaving the Blue Cross-Blue Shield high option plan are lower users than those remaining, although persons joining the plan have used services during their first year in amounts that are comparable to those already enrolled. Despite this adverse selection, however, the Blue Cross-Blue Shield high option plan is still the dominant plan, with 69 percent of the enrollment in the four government-wide plans and 50 percent of enrollment in all FEHBP plans other than HMOs. Inference from this experience is nevertheless difficult for two reasons:

- Possibly as a result of the formula for federal contributions, the range of choice available is quite limited. None of the options, for example, involve extensive cost sharing. Further, the federal contribution formula dilutes incentives to choose some of the low option plans that are offered, which in turn dilutes incentives for adverse selection.
- Simple tools to reduce adverse selection have not been employed in FEHBP. For example, premium differences among plans are not based on actuarial categories or location.

It is also difficult to make inferences from experience with multiple choice related to the underwriting of health insurance for individuals (as opposed to groups) because insurers often refuse to insure pre-existing conditions, a practice that would be illegal for qualified plans under this bill.

Adverse Selection under H.R. 850. Adverse selection could be extensive under this proposal because of the incentives to insurers to enroll low-risk persons. Insurers that are successful in enrolling low-risk persons would stand to make substantial underwriting profits, while those who enroll high-risk persons would experience substantial losses. Indeed, these profits and losses would probably be much greater in magnitude than the potential gains from innovation in the organization of the health plans to reduce the cost of medical care.

Despite the requirements in the bill that attempt to prevent it, insurers would have many ways to enroll relatively low users of services. The benefit structure could be tailored to attract healthy people. Examples include adding preventive dental benefits and excluding alcoholism and mental health benefits. In addition, marketing could be selective. Through selection of media and use of census tract data, insurers could direct their marketing to the relatively young persons in an actuarial category, or to people in types of occupations known to have low rates of medical care use. Vast creative energies might be channeled into ways to get an attractive pool of risks, energies that the sponsors hope to channel into finding ways to reduce the cost of medical care.

The adverse selection that might occur under this proposal would tend to reduce the extensiveness of health insurance benefits further than would be predicted from the change in tax incentives. While this might increase the extent of cost containment, it would have the negative side of increasing exposure to financial risk beyond what is desired and constraining too greatly peoples' use of medical services.

The extent of adverse selection would be much less under a system where employers would offer their employees a choice of plans. Under such an alternative, employers could use the same insurer to underwrite all of the plans offered, thus neutralizing the incentives described above to "skim the cream." Indeed, since

employers would be hurt by adverse selection, through its raising the premium of the firm's basic plan, they would have strong incentives to innovate to reduce it. Innovations might include use of finer actuarial categories on which to base premium differences.

Other disadvantages of open enrollment include increased resources devoted to the administration of health insurance. Some of the extensive economies of scale associated with employment-related group health insurance would be lost. While insurance might be distributed to individuals at lower cost than the present 35 percent of premiums, the increase in administrative costs over those under current law would nevertheless be substantial.

VOUCHERS FOR MEDICARE ENROLLEES

Providing vouchers for persons eligible for Medicare to enroll in a private health plan would encourage some increase in enrollment in HMOs or other nontraditional plans that had lower costs than Medicare. The low amounts of the vouchers and the risk that they could be substantially less than the cost of Medicare benefits in the future would hold down the number who would take advantage of them, however, since few persons eligible for Medicare considering traditional private health insurance policies would find the vouchers attractive. Moreover, adverse selection against Medicare would cause increased federal outlays.

The Provisions

The bill would make vouchers available to all persons eligible for Medicare who wanted to join a qualified health plan. Eligible persons could apply the voucher toward a plan with a premium higher than the voucher and pay the difference, or get cash by purchasing a plan with a premium lower than the voucher. Persons opting for a voucher could not return to Medicare in the future. Once 50 percent of those eligible for Medicare had opted for vouchers, they would become mandatory.

During the transition period of 1984-1986, voucher amounts would be based on expenditures from the Medicare trust funds in calendar 1982, net of premiums, divided by the number of enrollees. The amounts would be indexed by the GNP deflator. Separate

amounts would be established for the disabled and four actuarial categories of aged persons. The amounts would not vary by region, however.

After the transition period, the voucher amount would be based on the previous year's average premium paid by those using vouchers in an actuarial category in an area, indexed for one year by the GNP deflator.

Impact on the Medical Care System

Medicare vouchers would encourage the development of health plans which can achieve lower costs than Medicare. Under current law, enrollees gain little financial benefit from joining an HMO, and cannot receive credit for purchasing private insurance. Most HMOs are reimbursed by Medicare on a fee-for-service basis, so that most of the savings from their lower rates of hospital use accrues to Medicare. In contrast, under a voucher system, those enrolling in low cost plans would benefit from a portion of the savings. Such incentives would permit such plans to increase their enrollments. The shift to lower cost plans would contain medical costs.

While vouchers are attractive in theory, a number of problems--some specific to this bill and some general--would hold down the number of persons who would take advantage of such an opportunity. The problem specific to this bill is the manner in which the voucher amount is determined. The general problems involve the limited number of places in HMOs and the cost disadvantage faced by traditional insurers competing with Medicare.

Problems Specific to H.R. 850. Because the GNP deflator is expected to rise at a much lower rate than Medicare trust fund expenditures, the voucher specified in H.R. 850 would soon be worth much less than Medicare. Over the next five years, growth in Medicare benefits per enrollee are expected to increase at 6 percentage points per year in excess of the GNP deflator. This means that in 1984, the first year that this provision would be effective, the voucher would be worth 11 percent less than Medicare benefits. By 1986, the voucher would be worth 21 percent less. With savings from efficient HMOs thought to average about 20 percent, few financial incentives to enroll in HMOs would remain. In 1987 and thereafter, the voucher would be set equal to

the average premiums for plans purchased by those eligible for Medicare. What this level would be is difficult to predict, but it is likely to be substantially below Medicare expenditures. As discussed below, those who opt out of Medicare are likely to do so in search of lower premiums, a tendency exacerbated by the low voucher levels during the transition period. Consequently, those persons contemplating the voucher, who cannot return to Medicare once they leave, would be dissuaded by both the initial low voucher amounts and by the risk of future voucher amounts being even lower.

This problem could be resolved either by more generous indexing during the transition period, or by tying the voucher to future Medicare expenditures. The medical care component of the CPI would come closer to reflecting increases in medical care spending, but still would not reflect the growth in spending associated with service increases from new technology as opposed to price increases. An additional allowance might be added to reflect this.

Alternatively, the voucher amount could be set at some percentage (for example, 95 percent) of Medicare expenditures per enrollee. This would limit the financial risk to those opting out. Once those taking vouchers reached a certain percentage of the Medicare eligible population, the voucher could then be based on the average premium for qualified plans. This approach would avoid the phenomenon of a sharply diminished Medicare program dictating the size of vouchers.

Other Problems. One of the more general obstacles to this approach involves the difficulty that private insurers would have in competing with Medicare. Private insurers have selling costs while Medicare does not, and selling insurance to individual aged and disabled persons could be very expensive. The active role prescribed for the Department of Health and Human Services in informing eligible individuals of the plans available to them would certainly reduce selling costs, but it would not eliminate them.

Private insurers costs would also be higher because they often must pay providers at higher rates than Medicare does. The problem is most serious in hospitals, where Medicare does not permit additional charges to the patients. Data from the Health Care Financing Administration indicate that, in 1976, Medicare reimbursements to hospitals were 16 percent less than charges. Recent calculations by insurance company actuaries indicate that the differential has since grown.

The problem of private insurers competing with Medicare is particularly acute with respect to those interested in a richer benefit package than Medicare provides. Today, such persons may purchase private policies to supplement Medicare. These purchases of supplemental policies are implicitly subsidized by Medicare, however. The reduction in cost sharing that results from such purchases induces higher rates of use of medical services, but Medicare pays a large proportion of the costs of the additional use.¹¹ If a private insurer were to offer a richer benefit package as a substitute for Medicare and the supplemental plan, it would have to include in its premium the entire cost of the additional utilization induced by the richer benefits.

These competitive disadvantages of private insurers would tend to rule out use of vouchers to purchase traditional health insurance plans, but might still permit purchase of other types of plans. Plans that might be purchased would include HMOs and other plans that have cost advantages over traditional health insurance or plans with very extensive cost sharing. HMOs are available to some of those who are eligible for Medicare but, as was discussed above, their present small market share would limit the number of persons who would be able to take advantage of these opportunities.

Some persons could opt for traditional health insurance policies with extensive cost sharing. Premiums for such policies could probably be substantially below Medicare expenditures per enrollee, although an important part of the saving might be absorbed by selling costs and higher reimbursements. With almost no data on the demand for health insurance by the elderly, forecasting the demand for such policies is very difficult.

Use of vouchers to purchase insurance policies with extensive cost sharing would have two effects on the health care delivery system. First, use of health services would be lowered in a

11. As an example, the supplemental plan might pay the 20 percent coinsurance for physician services. But if physician visits increase by 20 percent, Medicare would pay 80 percent of the fees for the additional visits. In this example, Medicare would pay 40 percent of the full costs of additional coverage.

manner similar to that described in the section on exclusion caps. Second, bad debts might increase. Those eligible for Medicare could purchase a plan with the minimum coverage required by the bill (a plan with a \$2,900 deductible) and be unable to pay their medical bills should they get sick. To the extent that care is delivered anyway, its cost would tend to be borne by other payers or local governments operating public hospitals.

Budget Impact

While these provisions would result in some containment of health care costs, federal outlays would more likely be higher than lower. Two reasons for this are

- Current Medicare savings from HMO enrollment, and
- Adverse selection.

Since the Medicare program currently benefits from lower costs its enrollees experience in HMOs, use of vouchers by those enrollees could increase Medicare outlays. Despite the lack of incentives to join HMOs under current law, about 540,000, or 2 percent, of all those eligible for Medicare are members. Most of these persons joined HMOs through employment and maintained their membership upon reaching age 65. But most of this care is currently reimbursed on a fee-for-service basis, so Medicare outlays for any voucher that would be attractive to these persons would necessarily exceed current Medicare reimbursements on their behalf.

Adverse selection would increase Medicare costs as well because those who would choose to use vouchers would likely be relatively low users of services. Since Medicare vouchers would be more attractive to those seeking plans with lower premiums than Medicare than to those seeking plans with high premiums (and more extensive benefits), Medicare would lose more of its low users than its high users. This tendency could be exaggerated during the transition period by enrollees in low cost areas being more likely to seek (and find) plans with premiums below the uniform voucher amount than those in high cost areas.

Evidence from demonstration projects indicates that those Medicare enrollees switching to HMOs had lower expenditures during the years before enrollment than other Medicare enrollees of similar age and sex in their area. The most recent analyses of a carefully supervised enrollment process indicate a 20 percent difference in prior expenditures for those joining HMOs that required a change in physician.¹² Analysts explain this pattern as one of persons with less recent contact with the medical system being more willing to change physicians.

Alternatives

A number of alternatives to the vouchers proposed in H.R. 850 would increase the attractiveness of more cost sharing and avoid the potential increase in Medicare outlays. They include:

- reimbursing HMOs on a capitation basis;
- applying a surcharge to supplemental premiums;
- restructuring Medicare benefits to increase both cost sharing and catastrophic protection;
- offering a choice of plans within Medicare; and
- making vouchers mandatory.

Reimburse HMOs on a Capitation Basis. This option would establish incentives to enroll in HMOs comparable to the voucher proposal, but would reduce the extent of adverse selection. Under H.R. 3399, for example, Medicare would pay HMOs 95 percent of the per capita cost of Medicare benefits. If HMOs were able to provide the service for less, they would either reduce their premium to the enrollee or increase services. If most persons who would find vouchers attractive would enroll in HMOs, then most of the potential of vouchers would be accomplished by a much more

12. Paul W. Eggers, "Pre-Enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in 'At-Risk' HMOs," Preliminary Findings, June 26, 1981.

limited policy change. Moreover, Medicare would not be exposed to increased costs from insurers selectively marketing traditional plans with more cost sharing, leaving the high users to be served by Medicare. A disadvantage to this approach is the need to define "HMO" and the possible exclusion of innovative plans not qualifying under that definition.

Apply a Surcharge to Supplemental Premiums. Applying a surcharge--a fee to offset additional costs to Medicare--to premiums for supplemental plans would eliminate the current subsidy to them. While somewhat difficult to estimate, the magnitude of this subsidy is probably substantial. A user charge would compensate Medicare for the amount of this subsidy through two mechanisms--transferring amounts collected from those continuing their supplemental policies and reducing claims by those terminating them through an effective increase in the amount of cost sharing.

Restructure Medicare Benefits. A more direct approach to increasing cost sharing would be a change in the Medicare benefit structure. Cost sharing for the second through thirtieth day of a hospital stay could be introduced, for example, possibly in a form that would vary with individual hospital charges so that those choosing less expensive hospitals would pay less. Some of the savings to Medicare could be applied toward increasing catastrophic protection, perhaps by adding an annual limit to cost sharing. Such an option would reduce the use of hospital care and increase the degree of price competition among hospitals. Those desiring more extensive coverage could still purchase supplemental plans. Its disadvantage would be the financial burden experienced by some beneficiaries, and the possibility that some would go without valuable care.

Choice of Plans Within Medicare. Medicare could, alongside of its present plan, offer a series of plans with different benefit structures. Refunds or extra premiums would be based on actuarial categories and reflect the experience of the alternative plans. Since Medicare cannot run HMOs, a provision for paying HMOs on an incentive basis, such as would be provided for in H.R. 3399, would be a useful component of this option. The surcharge on premiums for supplemental policies discussed above would also be a useful component of this option. Choice of plans within Medicare would, relative to the voucher proposal, increase the attractiveness of cost sharing and reduce adverse selection and its effects on Medicare outlays.

This option would make cost sharing attractive because the advantages of Medicare in lower reimbursements to providers and the absence of selling costs could be retained in the process of choosing a different benefit structure. Indeed, the moderate adverse selection likely to be experienced would make a plan with higher cost sharing particularly attractive to many Medicare beneficiaries.

A second advantage over the voucher proposal would be a reduction in adverse selection, since Medicare would design and market the alternative plans. The situation of private insurers profiting or losing money according to their ability to select the best risks would be avoided. While some adverse selection would nevertheless remain, it would have no financial consequences to Medicare. Those persons choosing plans with more cost sharing would tend to gain, while those choosing more comprehensive plans would tend to lose.

A disadvantage of this option is that opportunities for innovative health plans might be lost. While HMOs would still be encouraged, a line would have to be drawn between plans eligible for such reimbursement and those that were not. Innovative plans that were not eligible would not be able to market to the Medicare population.

Mandatory Vouchers

Making vouchers mandatory would avoid the problems of private insurers competing with Medicare, but would suffer from other problems inherent to Medicare vouchers. It would permit reductions in Medicare outlays, however. Vouchers could be phased in by making them mandatory only for those newly eligible for Medicare.

Mandatory vouchers would permit broad competition among private health plans for Medicare enrollees, but would suffer from a number of problems. First, adverse selection might be substantial, given the potential underwriting profits from favorable risk selection. While such adverse selection would not affect the federal budget, large shifts of income from the high users to the low users might occur. Second, the significant costs required to distribute the private plans to the Medicare population would tend to increase the cost of health care for them. Third, the inherent complexity of health insurance plans leads to questions about the efficacy of requiring large numbers of people to make individual choices.

Mandatory vouchers would reduce Medicare outlays as long as the voucher amounts did not grow as rapidly as Medicare benefit payments would under current policies. On the other hand, the vouchers could be increased rapidly enough to avoid such a reduction in what is now an entitlement to services.

VOUCHERS FOR LOW-INCOME PERSONS

The bill would permit states to replace their current Medicaid programs with a federally administered system of vouchers for the purchase of private health plans. The amount of the voucher would probably be less than the cost to most insurers of financing the health care use of low-income participants and, thus, the choices of low-income persons would be limited to a few plans. On the other hand, substantial numbers of low-income persons who are ineligible for Medicaid would be able to qualify for vouchers because eligibility would be based solely on income. Many states, however, would probably elect not to participate in this system of vouchers because states would be required to continue to support a portion of the cost of covered services and would also be given increased responsibility for nursing home care, which would not be covered by vouchers.

The Provisions

Beginning in 1988, the bill would provide a voucher to persons whose incomes fell below the federal poverty guideline to enable them to purchase coverage from a qualified private health plan.¹³ Qualified plans for low-income persons would have to cover the same services as those required for Medicare vouchers (hospital and physicians' services, prescription drugs, and medical supplies), but could not have cost sharing provisions. The low-income elderly and disabled would be required to give up Medicare in order to receive a low-income voucher because receipt of benefits from both Medicare and Medicaid would no longer be possible in those states participating in the program. The amount of the voucher would be an average of the premiums for all persons in an actuarial category within a specific area purchasing a qualified plan, plus the average of out-of-pocket expenditures incurred by plan members in that area.

13. Persons with incomes between the poverty level and the poverty level plus twice the value of the voucher would be eligible for a reduced voucher.

States electing to participate would be responsible for their current (1981) Medicaid costs adjusted for inflation, although the voucher plan itself would be financed directly by the federal government. After 1988, the portion of federal Medicaid grants that states now receive for services not covered by the proposed vouchers (most notably nursing home care) and for persons now eligible for Medicaid who would not qualify for a voucher would be reduced by an amount equivalent to what states now expend for acute care under Medicaid adjusted for increases in the GNP deflator. The proposal's maintenance of effort provision would also transfer to the states the sole responsibility for increases in excess of the GNP deflator in expenditures for long-term care costs, and other services excluded from the health care proposal. States would become solely responsible for administration of long term care and other excluded services.

Impact on the Medical Care System

The effect of the provision of these vouchers on demand for medical care is uncertain, because the proposal would extend coverage to many who currently have no health insurance but it would also reduce coverage for some who are now eligible for Medicaid. The total number of persons estimated to be eligible for vouchers, about 30 million, would not be significantly different from the number of persons projected to be eligible for Medicaid.

About 8.4 million single persons and 1.8 million childless couples who are now ineligible for Medicaid would receive vouchers. These persons could be expected to demand greater quantities of medical care than under current policies.

On the other hand, others who would have their coverage reduced as a result of this proposal could be expected to demand less medical care. For example, the low-income elderly and disabled who are currently covered by both Medicare and Medicaid would receive less coverage because they would be required to choose either a low-income voucher or Medicare only. Also, because eligibility for vouchers would be based upon income received over a period of at least three months, many current Medicaid recipients would lose eligibility.¹⁴ The proposal would not readily permit persons to qualify for periods of less than three months.

By basing the amount of the low-income voucher on the average of premiums for all plans in a geographic area and the average out-of-pocket expenditures of plan members, the proposed vouchers could be inadequate to purchase from most plans the full coverage that is required. In most instances, premiums would reflect the lower rates of use of medical services that would be found in insurance plans that have cost-sharing provisions for most members. In contrast, vouchers could be used only to purchase plans with no cost sharing. The difference in rates of use would be exacerbated by the greater health care needs of the poor.¹⁵ In addition, the reports by plans of average out-of-pocket costs that would be used to determine the voucher amount would probably underestimate the costs because many out-of-pocket costs are not claimed by insured individuals. The relatively small size of the voucher could make many insurers unable to meet the minimum requirements at the cost paid by the voucher.

The low voucher amount might also cause many people eligible for Medicare to decline the voucher in order to remain in Medicare. Since the amount of the voucher for this group would be based upon the average premium of plans selected by those who have opted out of Medicare, even with an allowance for out-of-pocket expenditures, the voucher amount might not enable the recipients to purchase better coverage than that provided by Medicare.

14. A consequence of Medicaid's use of a monthly accounting period for most persons is that many recipients, about 20 percent in 1977, had coverage for three months or less. Gail Wilensky, Daniel C. Walden, and Judith A. Kasper, "The Changing Medicaid Population." Paper presented at the 1980 annual meeting of the American Statistical Association, August 11, 1980.

15. By many measures, low-income persons use more medical care than do those with higher incomes; however, many of these differences appear to be due to differences in health status. Much of the difference in health status between those with low income and other persons is due to a greater prevalence of chronic conditions among low-income persons than among the general population.

Finally, the low voucher amount could restrict the choices of recipients to practices specializing in low-income patients. This could perpetuate the different health care system now used by many poor individuals because of the current reluctance of physicians to accept Medicaid patients at the program's low reimbursement levels. As a result, almost 60 percent of all Medicaid patients currently receive care in practices where Medicaid patients account for at least 30 percent of all patients.

The problem of low voucher amounts could be overcome by basing the size of the voucher on the expected cost of providing care to persons with low income. The value of vouchers could be set at different levels for the disabled, and for other types of low-income families, to reflect their different medical needs. Increasing the size of the voucher would raise the cost to the federal government, however. For example, the voucher would have to be increased by about 15 percent just to compensate for the greater demand for services that would result from the absence of cost sharing for recipients of vouchers. An additional increase would be required to reflect the greater health needs of this population.¹⁶

On the other hand, increasing the voucher amount to encourage more plans to enroll persons receiving low-income vouchers would reduce incentives to select efficient low-cost health care plans. Persons enrolling in a low-cost plan who present a voucher worth more than the plan's premium would not be given a rebate of the difference. The plan would be reimbursed only its premium amount and the federal government would receive the full benefit of the recipient's prudent choice.

Budget Impact

If all states participated, federal expenditures for low-income health care under the proposal would be roughly equal to projected outlays for Medicaid which would be replaced, so that

16. Although adequate data are currently unavailable to permit adjustment of the voucher amount to reflect the greater use of medical services due to the lower health status of recipients, estimates of this adjustment could be developed by surveying the potential eligible population prior to implementation of the proposed voucher plan.

there would be no net budget impact.¹⁷ The cost of providing health insurance vouchers would be about \$25 billion. In addition, federal grants to states for noncovered services, after applying the state maintenance of effort provisions, would amount to \$2 billion.

In spite of the extension of federally assisted health care to many previously ineligible persons, the proposal's cost does not significantly exceed projected Medicaid costs because of eligibility reductions and reductions in covered services. To a large extent, growth in eligibility would be offset by elimination of coverage for many current Medicaid recipients. Services covered by the proposal do not include one of the most costly of Medicaid's covered services, nursing home care. The low amount of the vouchers relative to the cost of providing medical care to low-income persons also limits the cost of this proposal.

Distributional Impact

The proposal would affect both states and individuals.

Impact on States. A large number of states would probably elect continued participation in Medicaid rather than the low-income voucher plan because their financial responsibility for providing medical care to low-income persons would not necessarily be reduced and could significantly increase under the voucher. The proposed voucher plan would relieve states of some of the financial responsibility of providing acute medical care to low-income persons. States would not be responsible for acute care costs that exceed their 1981 level adjusted for increases in the GNP deflator. For many states, this relief would be smaller than the costs of their increased responsibility for nursing home care and other services not covered by qualified health insurance plans.

17. The estimate of the bill's effect upon outlays assumes participation by all states in low-income vouchers. This assumption was necessary because of the uncertainty of state choices to participate and the unreliability of estimates of individual state expenditures seven years in advance.

The rising cost of noncovered services, especially nursing home care, would be a particularly severe problem for states choosing to participate. Between 1973 and 1978, Medicaid expenditures for services that would be covered by the health care vouchers rose at an average annual rate of 13 percent, compared with an average annual rate of 19 percent for services that would not be covered by the voucher. This rapid increase in expenditures for services that the vouchers would not cover was due largely to their increased use, and the population most likely to use them--the elderly--will continue to grow during the 1980s. Moreover, prices for these noncovered services would not be directly affected by enhanced competition in the provision of covered services.

States might experience an increase of \$1 billion to \$2 billion over expected Medicaid costs because of their expanded responsibility for nursing home costs. Because states would have full responsibility for the provision of nursing home care and other noncovered services, they might be able to restrain the cost of these services by developing more efficient alternative methods of providing care. For example, states could expand the range of noninstitutional services to reduce the need for more costly nursing home care.¹⁸ The extent to which home care and other alternatives to nursing home care could reduce long term care costs may be limited, however.

Impact on Individuals. Among those who would lose Medicaid eligibility are the working near-poor and the medically needy. At present in states with a high payment standard for Aid to Families with Dependent Children (AFDC), families may qualify for public assistance and thus for Medicaid even though a household head worked full-time for much of the year. Many of these families would no longer be able to meet the income eligibility standard for vouchers. In addition, persons would no longer be able to qualify for medical assistance if their income after deducting medical expenses were below income eligibility standards. All of these persons, however, would receive either employer contributions for health care coverage or refundable tax credits to purchase coverage. Persons who receive a tax credit in place of Medicaid coverage would probably have much less extensive health insurance than the coverage provided by Medicaid or low-income vouchers.

18. The Omnibus Budget Reconciliation Act of 1981 contains provisions that permit states to apply for waivers to offer many alternatives to institutional care.

The proposal's eligibility requirements would reduce the number of persons who are eligible for federally subsidized health care and who have annual incomes significantly above the federal poverty standard. Eligibility for a year beginning in January would be based upon annual income received in the 12-month period ending the previous June. Alternatively, an individual could establish eligibility at any time during a year, if income for the previous 3-month period were below one-quarter of the yearly income eligibility standard and if income for the next 3-month period was expected to continue to be below the income eligibility standard. Although normal fluctuations in earnings could boost annual incomes of some persons above the income eligibility standard, this is less likely to occur under the voucher proposal than under current Medicaid rules that use a monthly accounting period. To reduce costs to the government of vouchers received by people with incomes above poverty guidelines, the proposal provides for recovery of voucher amounts paid to plans on behalf of individuals who are also covered by employer health care contributions. Administration of this provision could be cumbersome, however.

REPEAL OF REGULATORY PROVISIONS OF FEDERAL HEALTH LEGISLATION AND PREEMPTION OF STATE LAWS

The proposal would dismantle some of the federal apparatus that attempts to contain costs through regulation. It would also preempt some state activities in this area, as well as many state laws that, though not intended to contain costs, might impede competition.

While such repeals and preemptions would certainly reduce regulation, they are probably not critical to the success or failure of the rest of the bill. For the most part, these provisions have impacts on the medical care system that are less important than the likely impacts of the provisions of H.R. 850 discussed above. While repealing each of these provisions might or might not be desirable, failure to do so would not jeopardize the ability of the rest of the bill to contain health care costs.

Analysis of these changes should proceed on a case-by-case basis, although such a task is beyond the scope of this report. The CBO has studied one of the programs slated for repeal--the Professional Standards Review Organization (PSRO) program--at the

request of this Committee's Subcommittee on Oversight.¹⁹ The CBO is also in the process of studying the federal health planning program at the request of the Senate Labor and Human Resources Committee. These studies are designed to assist the Congress in its consideration of these specific repeals.

19. See Congressional Budget Office, The Effect of PSROs on Health Care Costs: Current Findings and Future Evaluations, June 1979, and The Impact of PSROs on Health-Care Costs: Update of CBO's 1979 Evaluation, January 1981.