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THE COMPETITIVE PRESCRIPTION FOR HEALTH COST INFLATION

INTRODUCTION

It appears to many people that the American health care system is in need of intensive care. Medical costs are rising rapidly, both in money terms and as a proportion of GNP, and yet there are persistent gaps in the system - people who are not adequately covered by either private or government insurance programs.

The policy of this and previous administrations has combined three approaches. First, a number of taxpayer-supported programs, such as medicaid and medicare, have been set up to reduce price barriers to the elderly and the poor. Many, including President Carter, see these as merely the first step along the road to a comprehensive national health system, where price barriers would disappear for the entire population, and health care would be funded by employers and the government. The second element in the policy has been to widen the use of private insurance by favorable changes in the tax code which encourage employers to offer health insurance as a fringe benefit. The final element, so far unsuccessful, has been the attempt to apply direct controls on the cost of medical care, in an effort to slow down cost increases.

The rationale behind these approaches has come under increasing criticism in recent years. The Administration's hospital cost control bill, for example, was emasculated on the House floor last November after a vigorous campaign showed that controls would be damaging yet ineffective.[1] Similarly, the goal of a

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1. For a short account of the objections to controls see Martin Feldstein, "Consequences of Hospital Controls," Wall Street Journal, April 12, 1979. The article is adapted from testimony given on March 15, 1979.

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

national health service has come under heavy attack by writers who have examined the results of such systems in Britain, Canada, Sweden and elsewhere, and shown that government-financed health care leads to misallocation, shortages, and a serious deterioration in quality.[2]

The growth of private insurance was welcomed by most economists and politicians, and particularly by those who saw universal private insurance as the efficient solution to the desire for a comprehensive health system. But serious objections have recently been raised by a number of academics and politicians regarding the level and type of insurance encouraged by the present tax code. They have charged that while increasing numbers of Americans are becoming insulated from the direct cost of most medical treatment by virtue of their insurance, the code has induced people to seek the wrong kind of insurance, namely first-dollar rather than adequate catastrophic cover. Furthermore, the insurance encouraged by the tax code has removed virtually all incentives for either physicians, hospitals, or patients to economize on the use of medical facilities, leading to dramatic increases in demand and costs.

These criticisms have brought about a reappraisal of the insurance market by several leading economists. These academics have sought ways of altering the law to reintroduce into the health care industry the incentive to economize while providing more effective coverage and treatment. By making these changes, they argue, certain important goals can be achieved. First, by promoting real competition within the industry, choices will become available to the consumer whereby he can select the most cost-effective form of health care to meet his needs. Second, changes in the tax code will have the effect of discouraging overinsurance, which they claim is the principal cause of hospital cost inflation. Third, by altering the requirements for a employer-sponsored health plan to be tax deductible, it will be possible to give most Americans adequate screening and catastrophic care at little, if any, increase in cost. And finally, the range and depth of medical care considered necessary for all Americans will be provided without the creation of a costly, bureaucratic and inefficient national health service.

This paper will review the economic analysis of the major authorities promoting the competitive approach to health care. It will then examine the most comprehensive bills currently before Congress which are seeking to turn the theory into legislation.

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2. See, for example, Stuart Butler, "Thirty Years of National Health Care: A Review of the British Experience," International Briefing #2 (The Heritage Foundation, Washington, D.C., 1978); Cotton Lindsay, "A Review of Canadian National Health Insurance," Backgrounder #90, (The Heritage Foundation, Washington, D.C., 1979); Ake Blomqvist, The Health Care Business, (Vancouver, Canada: The Fraser Institute, 1979); Howard Olgin, "An American Doctor in Sweden," Private Practice, June 1979.

THE PROBLEM

Medical Cost Increases

The escalation of medical costs has been substantial by any standard. In 1950, for example, the average cost per day in an American hospital was $15.62. By 1978 it has risen to $227.52, a rate of increase seven times that of general consumer prices. Estimates for fiscal 1979 indicate that the nation will have spent $206 billion in health care, up from $38.9 billion since 1965 - and representing a rise in spending over the period from 5.9 percent of GNP to 9.1 percent.

When viewing this increase it is, of course, important to bear two things in mind. The product we are comparing has clearly changed during the period. There have been significant technical advances in medicine, and these have made care more expensive, but also more effective. So part of the increase in costs can be attributed to improved equipment and skills, but these changes can hardly account for such a significant increase in costs. A second consideration is that sophisticated hospital treatment is now available to far more Americans, because of rising affluence, government programs, and wider insurance coverage. Part of the increase in costs can be explained by this development, but again the impact can only have been mariginal.

The Impact of Third Party Payments

The most important reason why health care costs are rising faster than other costs seems to be the manner in which medical expenses are paid. As Stanford economist Alain Enthoven has explained:

> The main cause of unnecessary and unjustified increase in costs is the complex of perverse incentives inherent in our dominant financing system for health care: fee-for-service for the doctor, cost-reimbursement for the hospital, and third-party insurance to protect consumers, with premiums paid entirely or largely by employers or government. This system rewards providers of health care with more revenue for providing more and more costly care, whether or not more is necessary or beneficial to the patient. It leaves insured consumers with little or no incentive to seek a less costly health care financing or delivery plan. There are many cost-increasing incentives and virtually no reward for economy.[3]

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3. Alain C. Enthoven, "Health Care Costs," National Journal, May 26, 1979, p. 885.

When the cost of medical care is paid neither by the patient nor the provider (in the form of charity), but by a third party, the economic link between the demander and supplier is weakened, since neither has to bear the cost of the treatment. Instead, the burden is spread over the population covered by the insurance company or taxed by the government. And although an expensive course of treatment received by a patient will lead to an increase in the costs of the insurer and this will have an impact on premiums, the effect on the individual is negligible compared with the benefits he has received. Thus, every insured patient has the incentive to seek as much treatment as his physician recommends, regardless of cost.

Physicians also recognize that their insured patients will bear little or no out-of-pocket expense for treatment. From purely medical considerations, therefore, the physician has no reason to avoid prescribing the most expensive tests and treatments available, even if they are only minimally superior to far less costly care. Indeed, it would be wrong to him <u>not</u> to order the best treatment available if it involved no financial hardship for his patient. In addition, he is aware that the patient will prefer luxury to basic services if his cost is the same, and so the physician has the incentive, if he wishes to retain his patients, to recommend the most pleasant and best equipped hospital available - again, regardless of the cost to the insurance company.

Hospitals, in turn, respond to the physicians' demands on behalf of their patients. It is in their interests to provide first class service and high technology in order to attract patients, and to recover the cost through maximum billings to customers - which will be reimbursed by insurance. Thus, throughout the entire health delivery system, the incentive is to generate expensive and often unnecessary costs. As economist Laurence Seidman put it in an article last year:

> The fact that third parties pass on the cost to households through insurance premiums (private insurer) or taxes (public insurer), does not affect the incentive for each physician, representing his patient, to order as though hospital care were free to his patient. An appropriate analogy is restaurant bill splitting in a large group. All persons pay a share of an inflated total bill when everyone over-orders. Yet each person knows that if he orders less, but others continue to overorder, the total group bill, and therefore his own financial burden, will remain inflated. Thus, everyone continues to order extravagantly....It remains essential to recognize...that the same wasteful cost inflation would be induced in any sector of the economy simply by having a third party pay 100 percent of the bill. Let television sets be fully paid by an "insurer," and most consumers would demand several of the finest color TVs, regardless of cost. Manufacturers of television sets

would be delighted to respond to this escalating demand. The result would be accelerating TV cost inflation.[4]

The proportion of medical costs covered by third party payments has increased considerably in the last thirty years. In 1950, half of all hospital income came from insurance. By 1965, the share provided by public or private insurance had exceeded 75 percent. Today nearly 95 percent of the nation's hospital bill is met by third party carriers, and over 85 percent of the population has public or private insurance for at least basic medical expenses. A crucial result of this trend has been explained by Professor Martin Feldstein. He has calculated that the amount of each hospital bill paid directly by the patient has remained virtually unchanged, in real terms, throughout the last 25 years. Even if we disregard government programs, Feldstein has shown, the picture is not very different. In 1950, the net cost to a private patient of a day in the average hospital was just under $10. In 1975, the same service, in 1950 dollars, had increased by only $4. Thus, while the real cost of providing a day of hospital care had risen by over 400 percent during the period, the direct cost to the patient had increased by only one-tenth of that proportion; and, of course, it is on the basis of direct costs that the physician and patient make their economic decisions.[5]

The Inflationary Tendencies in Health Insurance

It would be easy to conclude from the discussion above that in some way public and private insurance has failed as a mechanism to finance health care. But the irony is that the inflation within the health care industry has resulted from the attempt to bring quality medical care within the reach of all Americans, irrespective of their income.

There are three reasons why in the field of health the funding of the delivery system by insurance has resulted in major cost escalation:

a) Unlike, say, auto insurance, health insurance premiums are not normally adjusted on the basis of benefits claimed by the insured person. If a person has an auto accident, he can expect higher premiums, and he can always sell his car if he is unable to pay. A health premium, however, is normally unaffected by the level of claims. This situation is defended on the grounds that the patient has little flexibility regarding health care, that referral decisions are made by the physician and not the patient, and that if premiums reflected risk to the company there would be a

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4. Laurence S. Seidman, "Hospital Inflation: A Diagnosis and Prescription," Challenge, July-August, 1979, p. 18.
5. Martin Feldstein, "The High Cost of Hospitals - And What to Do About It," The Public Interest, Summer 1977.

major financial barrier to necessary treatment for very many people.

b) Reimbursement of medical bills by insurance companies is on the basis of "usual, customary and reasonable" charges made by hospitals and physicians ("UCR" in medical parlance). This gives an incentive for physicians and hospitals to charge the maximum legitimate amount, in order to establish the highest possible UCR charge. The insurance companies do try to monitor practices, in order to discourage overcharging and unnecessary testing, but other than by having fully trained inspectors examining patients and overruling physicians -an unacceptable possibility - monitoring cannot be an effective restraint on costs.

In addition, certain insurance practices also tend to drive up costs. In most plans, for example, reimbursement is only given for tests carried out in a hospital on a supposedly sick patient, and not for similar tests carried out in a doctor's office as part of a routine examination. A Houston physician explained the cost implications of this in a *Time* article last year:

> Say a man in his late 30s to early 40s complains of chest pains. I tell him he needs a thorough physical. In my office the fee would be $45, the tests $250, for a total of $295. But I have to put the patient in the hospital, so his insurance will pay for it. Everything is slow in the hospital, so figure he will be there three days. The cost increases from $295 to $900, but his insurance company will gladly pay for it.[6]

c) To some extent the inflationary factors discussed above are unavoidable, once the decision is made to remove income barriers to health care provision. But there has been another factor which is far from unavoidable, and which many economists believe is the principal cause of hospital inflation in recent years: that is the tax treatment of health insurance premiums.

The Tax Treatment of Health Insurance

Most health insurance coverage in America is now group based, usually purchased by an employer as a fringe benefit for his employees. These job-based health plans are a significant and increasing segment of most companies' labor bill. In the case of General Motors, for example, the outlay for health insurance premiums rose almost seven-fold between 1965 and 1977, from

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6. Quoted in *Time*, May 28, 1979, p. 62.

$170 million to $1.16 billion annually.[7] And it has been calculated that the health insurance provided by the Ford Motor Company for its employees adds about $130 to the price of every car made.[8] According to the U.S. Chamber of Commerce, the typical health package now accounts for about 5 percent of an average company's payroll.[9]

The reason why employer-supported health insurance plans have become so common is primarily because existing tax law permits employers to exclude from their taxable income all contributions to an employee health plan. This situation is very attractive to both employers and employees. It means that the company can offer its workers what amounts to an increase in income, in the form of health insurance, which is tax free. As Martin Feldstein has pointed out, even for relatively low income families, a dollar spent by an employer to purchase health care for employees is worth nearly 50 percent more than if paid directly to individuals who then buy health care directly. The higher the tax bracket the greater is the tax benefit. Furthermore, the trend towards use of the standard deduction makes the employment-based plan more attractive, since the employee is not able to gain a tax write-off for a policy bought individually or for drugs and services paid for out-of-pocket. About 70 percent now take the standard deduction and it is Treasury policy to increase this proportion. The Congressional Budget Office has estimated that the tax revenue loss arising from the tax subsidy of employer health plans will be $13.6 billion for fiscal 1980.[10]

The effect of this subsidy has been to weaken even further the economic link between the patient and the cost of treatment, leading to inflationary pressures within the health care industry and wasteful distortion in the pattern of insurance coverage. In many cases employees make no contribution at all towards the premium, and thus have the incentive to press for ever-greater benefits. Also, since the employees are taken as a group, the tendency in collective bargaining is for the work force to seek coverage which is sufficient for those with greatest need, even though this leads to overinsurance for others.

Employees are thus removed from any real form of insurance market. They are not presented with a choice where they can

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7. Alain C. Enthoven, "Consumer-Centered vs. Job-Centered Health Insurance," Harvard Business Review, January-February, 1979, p. 141.
8. Time, May 28, 1979, p. 60.
9. Linda Demkovich, "Cutting Health Care Costs," National Journal, October 27, 1979, p. 1798.
10. Comprises losses due to the income tax deduction ($9.6 billion) and social security ($4 billion). Congressional Budget Office, Five Year Budget Projections, Fiscal Years 1980-1984, Tax Expenditures, Table 1. Also, E. Steuerle and R. Hoffman, "Tax Expenditures for Health Care," U.S. Treasury Department, Office of Tax Analysis, OTA Paper #38, April, 1979, p. 11.

obtain an income benefit by choosing more economical insurance coverage. Instead, it is in their interest to press for the most comprehensive insurance coverage and use it to the maximum degree possible, within the limits of total benefits available. As Al Ullman, chairman of the House Ways and Means Committee, has commented, "Our federal tax system invites almost limitless health care spending."[11]

Present tax incentives lead not only to general overinsurance, but also to "first dollar" coverage (i.e., insurance for <u>all</u> costs up to a limit) being more attractive to most employees than catastrophic coverage to protect families from severe hardship. This is due, in part, to union pressure for first dollar coverage because it has higher visibility - since more members feel a direct benefit in any year. But the chief reason is that first dollar coverage, financed largely by a tax-deductible employer contribution, enables the employee to finance regular and expected annual medical costs (for drugs and minor illnesses) out of untaxed income. The insurance is, in effect, a form of tax-free installment payment for relatively predictable costs. Catastrophic costs, on the other hand, are a very low risk for any single employee, and so a group is less likely to press for this type of protection in place of first dollar coverage.

COMPETITIVE SOLUTIONS TO THE PROBLEM

The root cause of hospital cost inflation is thus two-fold. The tax code encourages overinsurance, and first dollar rather than catastrophic coverage; and the absence of price incentives removes pressures on patients and doctors to choose appropriate but economical treatment, rather than utilizing all facilities available, irrespective of cost.

A number of economists have examined this problem in detail, and have suggested changes in the law which would lead to better insurance care at far lower cost. Each has sought ways of reintroducing genuine competition in the insurance and medical industry, and modifications to the tax code to encourage economy and better coverage. While different mechanisms have been emphasized by each, all have adopted the same broad approach to the problem. The bills to be discussed later encompass some or all of the mechanisms put forward.

I. COPAYMENTS

Professor Martin Feldstein of Harvard is the economist chiefly associated with what is known as the copayment or coinsurance approach to reform. The essence of this is the contention

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11. Congressional Quarterly, August 4, 1979, p. 1588.

that patients do respond to a requirement that they pay a percentage of medical costs, even when the copayment represents only a modest share of the bill. In testimony before a Senate Health Subcommittee last year, Feldstein argued that his research indicated that if the proportion of hospital costs paid directly by the patient were to be increased from the present 10 percent to only 14 percent, this would achieve the Administration's goal of a 13 percent reduction in hospital spending by 1984. Even if medicaid and medicare recipients were exempted from this, Feldstein pointed out, it would be necessary to increase the copayment from patients with private insurance from the present average of 18 percent to only 24 percent.[12]

The reason why copayments would achieve this saving is that both patients and physicians would become more conscious of the costs involved in medical care. The patient would have the incentive to question the need for tests and an extended hospital stay, and his physician would have to give consideration to the cost borne by his patient versus the marginal benefit resulting from another test or day in the hospital.

The necessary increase in coinsurance would be achieved, according to Feldstein, by a change in the law which would allow employers to deduct the cost of health insurance only if the plan included a minimum coinsurance rate of, say, 30 percent below some catastrophic ceiling.

There is empirical evidence to support Professor Feldstein's contention. In 1972, for example, California undertook an experiment which introduced nominal charges for office visits to physicians under the state's medicaid program. One-quarter of the medicaid benficiaries were required to pay a dollar charge for the first two visits in any month, and a 50¢ charge for the first two prescriptions. There was no charge for hospital care. A study of the experiment indicated that office visits fell by 8 percent.[13] Similarly, a recent experiment in the New York medicaid program which involved a 75¢ charge for office visits reduced visits by 60 percent.[14]

The Feldstein approach has attracted a number of criticisms. The copayment requirement for certain categories of health care might well reduce demand for these services, but it could result

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12. Testimony presented before the Health Subcommittee of the Senate Finance Committee, March 15, 1979.
13. Jay Helms, Joseph P. Newhouse and Charles E. Phelps, "Copayments and the Demand for Medical Care: The California Medicaid Experience," Bell Journal of Economics, Volume 9, No. 1 (Spring 1978). For a review of this and other evidence see Jack A. Meyer, Health Care Cost Increases, (Washington, D.C.: American Enterpise Institute, 1979), pp. 12-13.
14. Rep. David Stockman "Can Fee-for-Service Private Practice Survive 'Competition'?," Forum on Medicine, January 1980.

either in a shift of demand to other medical services free of copayments or to the postponement of screening or necessary care. The California experiment, for instance, reduced office visits but there was a 17 percent increase in hospital days spent by those in the experiment, and a 3 percent increase in total costs - since the extra costs arising from the switch to inpatient hospital care outweighed the savings made in office visits.[15]

Another problem is that copayments plans tend to be unpopular with employees. They were, for example, a central issue in the protracted and bitter coal strike of 1977/78. One reason for this opposition is that administrative difficulties make it virtually impossible for copayments to be related to income in private health plans, and if a single copayment rate and ceiling is applied, it leads to a greater financial burden on the lower paid. But if such a plan is offered as a less expensive _alternative_ to first dollar coverage, it does seem attractive to many people. When the University of California, for example, offered a plan in 1978 with a $100 deductible and 20 percent copayment up to a ceiling of $700 in out-of-pocket costs (thereafter 100 percent of costs were met), as an alternative to first dollar coverage and an HMO, 23,000 of the university's 80,000 employees opted for it. The employees were quite willing to risk $700 in order to save $61 per month in premiums.[16]

Thus, while the Feldstein approach may attract serious objections if put forward as a mandatory alternative to full insurance coverage, it appears to be attractive to many people if offered as an option. As such it would restore cost-consciousness within the health industry and reduce unnecessary demand without presenting serious price barriers to those in need of care.

II. TAX CREDITS

A variant of the copayment idea has been suggested by Professor Laurence Seidman of Swarthmore College. Seidman has tackled the problem of relating deductibles and copayments to the income of a patient in private employment-based plans. His solution would be the use of a tax credit on federal income tax. A household would bear a deductible equal to a certain percentage of its income (he suggests 5 percent) and would then file for a tax credit equal to a percentage (80 percent) of the additional bill up to a ceiling percentage of its income (10 percent).[17]

Consider a household with an income of $30,000. Under Seidman's plan it would have to bear the first $1,500 (5 percent of annual income) of its annual medical expenses out-of-pocket as

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15. Helms _et al._, "Copayments," p. 200.
16. Statement by Senator Richard Schweiker, _Congressional Record_, June 12, 1979, p. S7419.

a deductible. For expenditure above this level it would file for a tax credit of 80 percent. The 80 percent credit would apply up to a total out-of-pocket expenditure pf $3,000 (10 percent of annual income), after which point a 100 percent credit could be taken.

Seidman points out that for normal hospital costs and physicians' fees a patient earning $30,000 would have to spend 25 days in a hospital each year before the 100 percent credit point would be reached. Since hospital stays average at 8 days only a small minority of patients would fall into the range. The tax credit would apply to all medical costs (inpatient, outpatient, office and home care), and so would remove the present bias towards expensive inpatient care. Also a tax credit, unlike a medical deduction, does not provide a tax subsidy which increases with rising income: on the contrary, the credit based on income gives most support to the low-income families. Furthermore, if the tax credit were to exceed the household's tax liability, the family would receive a payment for the difference from the IRS.

Access to medical loans would be necessary under the plan, to bridge the gap between medical expenses and the receipt of a tax credit. Seidman suggests that the government could contract with private insurance companies to provide loans using the credit as collateral.

Seidman contends that the tax credit approach avoids the reservations expressed by some regarding the Feldstein plan. Price competition would be built into the system by the copayment feature, however, and so would the incentive to economize. And yet all households would be 100 percent insulated from catastrophic medical costs. People would not be prevented in any way from taking tax deductible medical insurance, but the credit would apply only to out-of-pocket expenses, not premiums. Seidman reasons that the credit would thus provide a significant encouragement to employees to press for plans with deductibles and copayments and take the saving in premium in the form of additional cash income.

The Seidman plan would use tax money to provide catastrophic coverage for all households, and tax incentives to increase the use of copayments and deductibles. Although the tax cost of such a proposal is difficult to calculate, given the imprecision of estimating how many people would switch plans, it should be noted that the federal government would be meeting a high proportion of out-of-pocket expenses. On the other hand, assistance would be concentrated on low income earners, unlike any system based on tax deductions.

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17. Seidman, "Hospital Inflation," p. 18.

III. LEGISLATED COMPETITION

A third version of the competitive approach to health insurance reform has been advanced by Professor Alain Enthoven. Like Feldstein and Seidman, Enthoven argues that the present tax incentives constitute the principal cause of medical cost escalation in recent years, and that it is necessary to restore competition by appropriate tax changes and by reversing the trend towards employer-funded group insurance plans.

Enthoven is skeptical of proposals which would require copayments, however:

> I don't consider that to be a very good idea personally because I believe the purchase of individual units of medical care is not a very good object for a rational economic choice, especially if the patient is worried or ill. If you are sick, you put yourself in the hands of the doctor and ask him to cure you. You don't get out your pocket financial calculator and start negotiating. So, this is just not the time to inject the element of economic choice.[18]

The best time to make an economic choice, he argues:

> would be during the annual enrollment in one health plan or another that would do the medical services, in large part, for a premium payment that is fixed in advance. In the kind of world I am trying to bring about, physicians and hospital administrators would find it to their advantage to be economical. If they found ways to cut costs while improving the quality of care, they would be rewarded by receiving more business and more profit.[19]

To bring such a situation about, Enthoven favors changes in the law that would lay down the following conditions before an employer-supported health plan would qualify as a tax deduction.

a) Firms with 25 or more employees would be required to offer employees a <u>choice</u> of at least <u>three</u> competing health plans, provided by different carriers, of which at least one would have to be an HMO or similar prepaid plan (if available).

b) The employer's contribution towards the premium would have to be in the form of a <u>fixed dollar amount</u>, no matter which plan the employee selected. The present total tax write-off

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18. Federation of American Hospitals <u>Review</u>, October-November 1979, p. 17.
19. <u>Ibid</u>.

of employer-paid premiums (and the deductibility of individual premium payments) would be replaced by a tax credit equal to 60 percent of the family's actuarial cost.[20]

The Enthoven proposal, which he calls the Consumer Choice Health Plan (CCHP), would also cover medicaid and medicare. Beneficiaries under the present system are locked into the same form of inflationary cost-reimbursement structure that exists in the case of private insurance. Enthoven envisions a medicare system where each beneficiary would have the average cost to medicare for people in his actuarial group paid as a premium to the qualified insurance plan of his choice. If the person were to choose a more cost-effective plan he could pay lower premiums or receive better benefits. In the case of medicaid, CCHP would provide low income families with a voucher, based on the local average cost of comprehensive benefits for their actuarial group, usable only as a premium contribution to the qualified plan of their choice or to meet a deductible or copayment. As with medicare under the plan, the beneficiaries would have an incentive to seek the most cost-effective plan. To preserve work incentives, the value of the voucher would be related to family income, and would decline gradually on a sliding scale to the tax credit level for those not eligible for medicaid benefits.[21]

The Enthoven plan would require all health insurance plans to meet certain standards.

a) Basic Minimum Benefits

Plans would have to based on open enrollment and would need to provide a minimum and uniform set of benefits. This would make plans easier to understand and compare, and would prevent misleading exclusions.

b) Catastrophic Expense Protection

Plans would need to limit cost-sharing to a maximum amount (Enthoven has mentioned $1,500 and $2,500 on various occasions). Thus, instead of a separate federal program based on entitlements, and without cost restraint incentives, Enthoven favors catastrophic coverage as a basic element in all public and private insurance -subject to the competitive pressures that would apply to other aspects of the medical insurance industry.

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20. By actuarial cost we mean the average total cost of covered benefits (insured and out-of-pocket), adjusted for inflation each year, for each actuarial category (which would be based on size of family, age, location, etc.).

21. For a fuller exposition of Enthoven's approach, see Review, October-November 1979, pp. 16-18; Congressional Quarterly, August 4, 1979, pp. 1588-1590; Congressional Record, July 12, 1979, pp. S9267-9282; Alain Enthoven, . "Consumer-Centered vs. Job-Centered Health Insurance," Harvard Business Review, May 26, 1979, pp. 885-889.

According to Enthoven, CCHP would set in motion incentives whereby health care would become more cost-effective and reflective of consumer choice. Each year families would be given the choice of enrolling in any of the qualified plans operating in the area, rather than the single plan offered by an employer. Financial assistance from employers would be the same for all plans, which would remove a major inflationary pressure and encourage workers to seek more cost-effective plans, since the employer would not be able to give extra support for high-cost plans. Furthermore, physicians and hospitals would have the incentive to organize themselves into competing economic units to trim unnecessary costs and to innovate. Competitive management techniques would return to the health industry.

WOULD COMPETITION REALLY WORK?

While the theory behind the competitive approach has considerable support, there are many who argue that in practice the effect of introducing the changes suggested would be marginal. Consumers cannot "shop" for health care in any meaningful way, argues Robert Ball, senior scholar at the Institute of Medicine:

> It is very difficult for any but the most sophisticated purchaser to find (good medical care) or to recognize it when he does....It is difficult to envision the operation of smoothly working market forces in the American medical exchange, where quality is very hard to define, necessity is in the eye of the beholder, and the public is hostile to the queue and willing to pay to avoid it.[22]

And according to testimony given by Alice Rivlin, director of the Congressional Budget Office:

> Such responses (to the creation of a competitive structure) would take time, however, and still more time would be needed for health providers to perceive the additional pressures and then respond with changes in practice. Thus any spending reductions that come from changing the present tax treatment of health insurance are likely to develop very slowly.[23]

Supporters of the competitive approach discount these objections. They argue that there is no reason why an effective health care market would not arise, given the right tax climate. Naturally the consumer is not sufficiently well versed in the technicalities of medicine to be an expert judge of alternative plans in advance, but, as Congressman Dave Stockman's health aide

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22. Congressional Quarterly, August 4, 1979, pp. 1588, 1590.
23. Review, October-November 1979, p. 15.

Don Moran has pointed out, "At the end of the year all you really care about is, did it work? If it didn't you choose another plan."[24] Objectors also tend to overlook the fact that under a competitive system the family physician would take on the role of consumer advisor (and, indeed, independent consumer advisory groups might also appear). If his patient is paying part of the bill, he would have the incentive to examine alternative insurance and hospital facilities on behalf of the inexpert patient. If the patient was not satisfied with his advice after the event, he might lose him to another doctor.

The Congressional Budget Office argument that competition would take time to work through the system can only really be tested empirically, but the existing evidence does suggest that the public response to price regarding health insurance is fairly rapid. But even if the process occurred slowly, it would at least be in the right direction, leading to economies and a reduction in total costs. And it would not have the damaging side effects of controls, such as resource misallocation and bureaucratization.

The evidence available does indicate that if consumers were given an incentive to seek alternative forms of health insurance there would be a significant impact on the industry. So far, most studies have concentrated on HMOs or similar pre-paid systems, although there are many other health delivery systems in existence (such as Individual Practice Associations),[25] and other innovations could be expected to develop within a competitive framework.

In Minneapolis-St. Paul, where there are several HMOs competing both with traditional health facilities and among themselves, enrollment in HMOs has grown at 27 percent per year since 1971; and as of 1978, 12.4 percent of the Twin Cities' population had joined an HMO.[26] Studies of Minneapolis-St. Paul suggest strongly that the public responds quickly when alternatives are offered, and that it is sensitive to price incentives. The HMOs in the area vary widely in the premiums they offer to different groups, occasioned by competitive forces, and considerable switching has taken place as a result.[27] The need to be competitive has also

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24. Congressional Quarterly, August 4, 1979, p. 1591.
25. An IPA is a grouping of physicians who render services on the basis of mutually agreed fees, but bill the IPA, not the patient. The patient enrolls with the IPA and pays a fixed periodic charge, as he would in an HMO. The IPA pays hospital costs directly or contracts with an insurer to its members. For a discussion of this and other alternatives see article by Alain Enthoven, Congressional Record, July 12, 1979, pp. S9268-9269.
26. Minnesota Department of Health, Statistical Report on Minnesota Health Maintenancy Organizations (1974-1978 editions, Minneapolis, Minnesota).
27. Article by Jon Christianson and Walter McClure, Congressional Record pp. S16337-16338.

forced the HMOs to be very cost conscious. Premiums have been kept low, and substantial reductions in hospitalization have been achieved.[28]

Similar consequences of competition can be seen in Hawaii, another area with pre-paid plans as an alternative. In the state the premiums for comprehensive protection are among the lowest in the country, despite the consumer price level above the national average. Figures for 1976 indicate that hospital expenses per resident were only 68 percent of the national average.[29]

It does appear that the predictions made by supporters of a competitive approach are borne out when a genuinely competitive situation exists. It must be remembered, moreover, that the successes so far have occurred within a tax structure which provided little encouragement to innovation and economy. If the tax climate were to be altered in the manner suggested by Enthoven and others there is every reason to believe that competitive systems would develop rapidly and that the present cost escalation would be halted.

PRO-COMPETITIVE HEALTH LEGISLATION BEFORE CONGRESSS

A number of bills currently before Congress aim to create a competitive health care industry. Some are comprehensive bills, while others concentrate more on specific problems and seek to solve them through competitive mechanisms. Each bill uses some element of the theoretical models discussed above, and they may be said to adopt all or part of the following strategy.

a) Requiring employers to offer more than one group insurance plan, but giving the same contribution whichever is chosen by the employee.

b) Giving employees an incentive to choose economical coverage by altering the tax code.

c) Reversing the present trend towards job-based coverage and instead encouraging an insurance system based on individuals and small groups.

d) Requiring all tax-deductible plans to provide certain basic benefits, including catastrophic care.

e) Encouraging the use of copayments and deductibles in increase price consciousness.

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28. <u>Ibid.</u>, p. 16339.
29. Jon Christianson, "Do HMOs Stimulate Beneficial Competition?," <u>Interstudy</u>, April 1978.

The following are the principle bills before Congress which seek, as their primary purpose, to promote competition within the health industry as a means of restraining costs and improving efficiency.

S. 1590 (SENATOR RICHARD SCHWEIKER, R-PA) THE COMPREHENSIVE HEALTH CARE REFORM ACT

Summary

a) Multiple Choice of Plans

In order for their health plans to remain tax-deductible, all employers of more than 200 full-time persons must offer the employees at least three plans operated by different carriers. All employers, regardless of size, must offer at least one plan including a copayment of 25 percent of hospital costs up to a limit of 20 percent of family income. The employer must make the same dollar contribution towards the employee's health premium, whichever plan he selects. If this contribution exceeds the cost to the employer of the premium chosen, the difference is rebated to the employee, tax free. While there is no dollar ceiling on the contribution that can be made by the employer, it must not be more than the most costly plan offered and chosen by at least 10 percent of the workforce.

b) Catastrophic Coverage

All plans offered by employers of more than 50 full-time persons must contain a minimum level of catastrophic protection for the employees and their families. The minimum would have to include full payment of all expenses incurred annually in excess of 20 percent of the family's income.

c) Ineligible Groups

In the case of employees of small firms, "uninsurable risks," the self-employed, and those without public or private insurance for some reason, the states would be encouraged to assign such individuals and their families to private insurance companies in proportion to each company's business within the state. Companies would have to provide assigned individuals with at least catastrophic and preventive health benefits at premiums not exceeding 125 percent of the premium cost of comparable group plans offered in the same area.

d) Medicare

The present 150 day limit on hospital days covered by medicare is eliminated, having the effect of building catastrophic coverage into medicare. The copayment requirement is amended such that patients would have to contribute 20 percent of hospital costs and physicians' fees, up to a maximum of 20 percent of income in any year.

e) Preventive Benefits

All tax-deductible plans would have to include comprehensive maternal care, baby clinic services, childhood immunizations, regular hypertension screening and pap smears, and periodic physical examinations.

f) Finance

Senator Schweiker estimates that the annual cost impact of his bill would be as follows, given assumptions regarding the load on each program. The calculations do not include estimates on savings due to preventive care. The figures are based on 1979 costs.

i) Federal Government:

Savings from hospital cost restraint achieved by competition.	$2.5 billion
Cost of medicare improvements and reductions in tax revenue to deductions to cover catastrophic and preventive benefits.	+$2.3 billion
Net saving to the Federal Government	$0.2 billion

ii) State and Local Government:

Savings from hospital cost restraint.	$0.7 billion
Reduction in tax revenue.	+$0.2 billion
Net saving to State and Local	$0.5 billion

iii) Private Sector:

Savings from hospital cost restraint	$4.3 billion
Reduction in taxes.	$1.7 billion
Cost of preventive health programs	+$2.0 billion
Cost of catastrophic protection.	+$1.0 billion
Net saving to the Private Sector.	$3.0 billion

TOTAL NET SAVING TO ALL SECTORS PER YEAR	$3.7 billion

By assuming a growth in enrollment in plans with a 25 percent copayment from 18 percent of employees in 1980 to 65 percent in 1984, Senator Schweiker estimates that a $37.8 billion saving in hospital costs between 1980 and 1984 could be achieved by his bill (current dollars).

Comment

The Schweiker bill embodies much of the Enthoven approach in requiring employers to encourage competition. But rather than giving a special place to pre-paid HMO-type systems within the alternatives which must be offered, as Enthoven does, the bill incorporates the Feldstein emphasis on copayments. By allowing employees to choose low premium plans and take the difference between the premium and the equal employer contribution as a tax-free increment to income, the bill would provide a powerful incentive for workers to seek less expensive plans with copayments and deductibles, and yet the minimum benefits required by the bill would mean that if the lower cost plan were selected the employee would probably still have a better balance of protection than is currently the case in most plans. The incentive to opt for a low cost plan would be strongest for the high income employee who does not itemize, since he gains most from a tax free increment to his income (such an employee has the incentive to push for the most comprehensive coverage under the present tax law).

By requiring all plans, including medicare, to include catastrophic and preventive provisions, and by encouraging states to enact pooling arrangements, the bill would remove the problem of catastrophic health costs for virtually all Americans. This can be achieved without a net increase in costs because catastrophic protection is less expensive than first-dollar coverage, does not result so much in an overdemand for hospital services, and because the bill stimulates economy through the creation of competitive forces.

S. 1968 (SENATOR DAVID DURENBERGER, R-MINN), THE HEALTH INCENTIVES REFORM ACT

Summary

a) Multiple Choice of Plans

In order for their health plans to be tax-deductible, all employers of more than 100 persons must offer at least three health benefit plans operated by different carriers. No particular type of plan (such as an HMO or copayment plan) would be required as one of the options.

The employer's contribution must be the same for each plan, whichever is selected by the employee. If the employee chooses a plan with a premium cost to the employer below that of the employer's contribution, the difference is rebated to the employee as a taxable increment to his income (but the rebate would not be subject to social security tax). A limit is placed on the tax-deductible contribution that an employer can make; if this limit is exceeded, the excess is taxable. For the calendar year 1980 the limit is set at:

$ 50 per month for plans covering the employee only.

$100 per month for plans covering the employee and his spouse.

$125 per month for plans covering the employee and his family.

Higher limits would apply in future years, according to the rate of inflation.

b) Catastrophic Coverage

All plans offered by employers must include a premium for catastrophic coverage, which would pay 100 percent of medical services to a family when out-of-pocket costs exceeded $3,500 in any year.

c) Minimum Benefits

Each health plan offered must provide benefits at least equal to those available under medicare, but the plans may have different provisions regarding copayments, deductibles, etc.

d) Finance

Senator Durenberger argues that in terms of tax receipts and expenditures, the bill would be at least neutral, and that a saving in the federal budget could be expected. This is because of the limit on tax-deductible employer contributions and because the employee's rebate is taxable.

Comment

In broad terms, the Durenberger bill is very similar to the Schweiker proposal, but there are some important differences which should be noted.

Unlike the Schweiker bill, no encouragement is given to any particular type of low-cost delivery system (an earlier version of the bill did require two of the three alternatives to be HMOs, but this was subsequently dropped). If one envisages market forces operating effectively as a result of the tax changes in the bill, then it is reasonable to suppose that the competitive market will innovate many alternatives and that the most appropriate will be selected by each group of employees. Thus, it could be argued that requiring a specific type of plan as one of the alternatives would pre-judge the market and could distort it. If HMOs are superior systems, then their market share will increase without any requirement that they be offered. On the other hand, if it is to be a central aim of public policy to bring about a significant reduction in the amount of money people spend on health care then the requirement in the Schweiker bill is reasonable.

Another difference between the two bills is that Durenberger places a limit on the tax-deductible contribution an employer can make. This is a direct way of discouraging employers from agreeing to provide first dollar coverage. This might well be a more effective downward pressure on medical costs than Schweiker's tax break for employees who choose a low option, and it would not involve a revenue loss.

The Durenberger bill differs again by making any rebate to the employee, as a result of his choosing a low-cost plan, a taxable part of income. This would certainly reduce the incentive to choose a low option, but to what degree could only be assessed by experimentation. If the rebate is taxable, of course, there is no loss to the Treasury.

Under the Durenberger bill, the threshold for 100 percent insurance benefits is not related to income, unlike the same provision in Schweiker's bill. A fixed dollar threshold would be easier to administer, and would not require an investigation of the family's means by an insurance company, but it would result in a relatively heavier health cost burden on the lower paid.

H.R. 5740 (CONGRESSMAN AL ULLMAN, D-ORE), THE HEALTH COST RESTRAINT ACT

Summary

a) Multiple Choice of Plans

If the premium cost of an employer-sponsored medical plan exceeds a "trigger point" (more than $75 per month for family protection - including the employee's contribution), the plan must offer as an alternative either an HMO or a low-cost option. A low cost option is defined as one whose premium is below the trigger point. An HMO alternative can have a pre-payment of more than the trigger point: the bill also amends the HMO act to allow other pre-paid plans to be classed as HMO alternatives. The provisions of the bill apply only in cases where one option in a plan exceeds the trigger point (which would be adjusted annually in line with medical cost increases). If any of the requirements of the bill are not met by an employer, the full contribution he makes to any plan will be considered as part of the employee's taxable income.

A limit of $120 per month (for calendar year 1980) is placed on employer contributions to a family plan which may be deducted from tax. Anything in excess of this limit will be included in the employee's taxable income. Lower contribution limits apply to insurance coverage for the employee only, and for the employee and his spouse.

The employer contribution to a health plan must be "approximately equal" whichever option the employee chooses. In the case

of two options, the contribution will be considered approximately equal if it is no less than the employer contribution to the higher cost option, less 10 percent of the difference in cost between the two options. If the employee chooses a low option, the employer must rebate to him the excess of the contribution made to that option over the cost to the employer of the option. This rebate is considered a taxable increment to the employee's income (but is not subject to social security tax).

b) Catastrophic Coverage

If any option of a plan exceeds the trigger point, all options must provide catastrophic coverage. This requirement would limit out-of-pocket expenses by an employee to $2,000 in any year (adjusted annually for inflation).

c) Minimum Benefits

If the trigger point is exceeded, all options must provide certain basic benefits. These must include ambulance services, home health visits, x-ray and laboratory services, but not preventive services.

d) Medicare and Medicaid Provisions

Under the bill, medicare will pay on a prospective capitation basis 95 percent of the per capita cost medicare would otherwise expect to incur for a person in the same actuarial group within the local area. The bill also requires HEW to conduct demonstration projects to determine the effect of a competitive marketplace model on medicaid reimbursement.

Comment

Unlike the Schweiker or Durenberger bills, Congressman Ullman's proposal specifically encourages HMOs (especially since they may be offered with prepayments above the trigger point). Thus, a low cost option would not necessarily have to be provided, although the prospect of a (taxable) rebate would produce at least some employee pressure for such an alternative.

The limit on tax-deductible employer contributions would give employers the incentive to provide more economical plans. Furthermore, the "approximate" basis for judging equality of contributions would mean that employers would have an incentive to offer low cost options and to encourage their employees to choose them: in the other bills examined, the employer has no financial incentive to recommend a low cost plan.

Like the other bills discussed, Ullman's measure would deal with the issue of catastrophic coverage by requiring all plans with one option above the trigger point to provide it for all the options. The Treasury cost would be confined to the tax loss arising from any increase in average premiums up to the $120

limit. The trigger point was chosen as the average cost of a premium with reasonable deductibles and copayments. It has been the provision of fuller coverage than this, according to Ullman, which has led to hospital cost inflation. His bill aims to reduce demand for such coverage.

H.R. 3943 (CONGRESSMAN JAMES JONES, D-OK, AND JAMES MARTIN R-NC) TO AMEND THE INTERNAL REVENUE CODE OF 1954 TO LIMIT THE BUSINESS DEDUCTION FOR HEALTH INSURANCE PREMIUMS

Summary

This short bill requires copayment provision to be included in any plan offered by an employer and deducted from tax. Plans must require the beneficiary to pay or personally obtain insurance for 25 percent of insured inpatient hospital care. The total beneficiary copayments for hospital care insured under a plan are limited to $2,000, or 15 percent of the beneficiary's average income during the previous three years, whichever is the lower. Employer contributions to HMOs would not be covered by these requirements.

Comment

The Jones-Martin bill embodies the Feldstein copayment approach in a direct form. Unlike the Schweiker bill, it does not encourage plans to offer a copayment feature as an option, but requires it for all plans. Undoubtedly, it would lead to a reduction in hospital cost pressures, but it does little to stimulate the creation of new forms of insurance.

CONCLUSION

The health bills now before Congress may be broken down into three broad categories. There are the measures which would seek to create a national health service, such as the Kennedy "Health Care for All Americans Act," and to a lesser extent the Administration bill. These would expand the government role in order to cover groups currently lacking adequate medical care. Government expenditure would increase substantially, but there would be no real attempt to improve efficiency or to develop a responsive health care market. Instead, the blunt instrument of price and fee controls would be used in a vain attempt to hold down costs.

The second group of bills concentrates on providing catastrophic health care for Americans, by requiring all employers to provide catastrophic coverage as part of their health plans, and by making appropriate adjustments to medicare. This category would include the measures introduced by Senator Long and by Senators Dole, Danforth, and Domenici. Again, federal expenditures and the total demand for health services would increase -

though not by as much as in the case of the national health service bills. But little would be done to improve the operation of the health care market.

Finally, there are the competition bills discussed in this paper. Unlike the other two groups, they would seek to restructure radically the incentives involved in the demand for health, by making the consumer and his physician more sensitive to costs, and by reintroducing real competition into the health care market. And they would require catastrophic protection to be a part of all health plans. Thus, without erecting serious price barriers to the consumer, they would reduce the demand for unnecessary tests and treatments and channel demand into more appropriate services. They would do this while reducing costs throughout the industry and _without_ unleashing yet another flow of federal dollars.

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