The Heritage Foundation Backgrounder

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MOBILIZING COMPETITION TO CUT HEALTH COSTS

INTRODUCTION

Consumer prices have stopped soaring. For the twelve months ending in March, they rose just 3.6 percent. But while prices throughout the economy have begun to stabilize or even fall, the cost of health care continues its inexorable climb. In the same period, the health care component of the Consumer Price Index jumped 10.5 percent. The trouble is that most Americans may not be aware of the vast and ever increasing sums they spend on medical care. Third parties, such as private health insurance companies and the government, pay most of the bill. Although medical costs may seem low to many Americans, they all pay enormous sums for health care--either as taxpayers or purchasers of insurance. The only way to restrain health costs is by a fundamental restructuring of the system to allow market forces to play more of a role in determining prices and the amount of services used.

When Ronald Reagan became president, he urged reforms aimed at creating a truly competitive health care insurance and delivery system. He appointed two of the leading advocates of the approach--David Stockman and Richard Schweiker--to top cabinet jobs. The Administration is now turning its rhetoric into a set of proposals for consideration by the Congress. In his 1983 State of the Union address, the President outlined an initiative that soon was translated into a group of bills submitted for legislative action.

The measures would put in place some of the key elements needed to create a truly competitive health industry, enabling Americans to reap the savings of market pressure on health costs. A cap would be placed on the tax exemption of employer financed insurance; this would brake cost-increasing overinsurance. Modest copayments would be required for Medicare hospitalization reimbursement; this would not only introduce greater cost sensitivity into the federal program, but would generate funds to

finance a program for catastrophic hospital cost coverage under Medicare. And a voluntary voucher program would be introduced to encourage Medicare beneficiaries to "shop around" for more economical private insurance.

These reforms are long overdue. They would change significantly the country's health care system, which now provides strong incentives for patients, physicians, and hospitals to ignore the cost of procedures and leads to ballooning medical costs. In its place would emerge the kind of system that operates effectively in virtually every other area of the economy: an industry in which price is a factor in decisions, and incentives encourage competition and economy. By moving in this direction, the U.S. would be dealing with the problem of health cost escalation in a way that uses the marketplace to restrain costs. This would be more effective and equitable than the crude policy of price controls urged by proponents of a national health program.

BACKGROUND

Expenditures on medical care rose from $41.7 billion (6 percent of GNP) in 1965 to $286.6 billion (9.8 percent of GNP) in 1981. This represents an increase of 587 percent in nominal dollars and 139 percent after adjusting for inflation. Annual per capita health expenditures also increased substantially, rising over the same period from $211 to $1,225, a rise of 481 percent, or nearly 100 percent after adjusting for inflation.[1] In 1982, health costs rose by 11 percent, while the general inflation rate dropped to less than 4 percent.

Medicare and Medicaid have become increasingly costly to maintain. Between 1967 and 1982, the combined spending on these programs grew from $3.9 billion to $64 billion; outlays are projected to exceed $100 billion annually by 1986 unless cost-saving reforms are implemented.

A number of factors contribute to soaring health care costs: inflation, an aging population, greater affluence, a rising level of medical technology, increased utilization of health facilities, and factors enhancing the quality of medical care. Nothing has fueled the surge in health costs more than the practice in America of third parties, such as insurance companies and governments, paying most medical expenses. Seldom do patients directly pay their own medical bills. These third-party payments, usually provided on a group insurance basis, artificially inflate the demand for health care because the direct cost of services to covered patients is virtually zero. This drives up the price of medical care and leads to great inefficiencies by encouraging people to use health care service options without regard to their

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1 U.S. General Accounting Office Report, "A Primer on Competitive Strategies for Containing Health Care Costs" (HRD-82-92, September 24, 1982), p. 1.

comparative cost. Moreover, many of the services are only of marginal benefit to the patient and are undertaken largely because a third party bears the expense. Because of the group nature of most insurance, heavy utilization by an individual does not directly affect his premium--the extra costs are shared by the group.

Providers of health care, meanwhile, enjoy incentives to provide excessive care because they know that such services are generally cost-free to the patient. Explains Stanford economist Alain Enthoven:

> 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 delivery plan. There are many cost-increasing incentives and virutally no reward for economy.[2]

Throughout the 1970s, the government tried to contain costs by imposing controls on prices, hospital capital expenditures, and the utilization of health care services. These were ineffective and added to the misallocation problem. Notes Jack Meyer, an economist with the American Enterprise Institute: "These policies entrench inefficiency in the health care system and foster 'cost control' at the expense of consideration of the quality and availability of services."[3] And as Milton Friedman has pointed out, a policy of price controls is like trying to stop a pot boiling by clamping down hard on the lid--rather than reducing the heat.

Studies have revealed that cost-sharing by the consumer through deductibles and copayments significantly reduces the use of medical services and promotes more economical use of resources.[4] In one test group, for instance, a copayment of 25 percent, in

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

3 Jack A. Meyer, "Health," in Eugene J. McAllister, ed., Agenda for Progress: Examining Federal Spending (Washington, D.C.: The Heritage Foundation, 1981), p. 242.

4 For a review of some of these studies, see GAO, op. cit., pp. 8-21, and Congressional Budget Office, "Containing Medical Care Costs Through Market Forces," May 1982, pp. 11-16.

place of 100 percent insurance coverage for hospital and physician services, cut total health care expenditures by 19 percent; hospital admission rates were 21 percent lower and spending on physician care was 20 percent lower, thanks mainly to a reduction in the number of office visits. In another experiment, a copayment of 25 percent for all physician services resulted in a 24 percent decline in visits to physicians. Econometric studies yield similar results. One such study showed that 25 percent coinsurance, rather than full coverage, was estimated to reduce hospital spending by 17 percent.

The evidence suggests strongly that wider application of cost-sharing by the patient, leading to the more efficient utilization of services, would result in lower expenditures and a downward pressure on medical prices. Consumers would be more sensitive to the prices of services they use, and this would force greater price competition between providers.

Encouraging competition would also stimulate development of alternative health care financing and delivery systems to match the desires of the public, such as Health Maintenance Organizations (HMOs). HMOs avoid the perverse incentives associated with the fee-for-service and cost based reimbursement mechanisms by operating as prepaid group plans. Because these groups are paid in advance, they have financial incentives to minimize costs by curtailing unnecessary services, thereby rewarding efficient providers and penalizing inefficient ones.[5] There is considerable evidence that shows these prepaid groups provide services of high quality at costs significantly lower than those of conventional insurance plans.[6]

THE REAGAN PROPOSALS

Much of the Administration's health care budget focuses on encouraging competition. With greater coinsurance, the patient, together with his physician, determines the amount of care he receives; with the HMO, it is the physician, rather than the patient, who makes the determination. Either approach promotes the competitive forces necessary to insure that resources are used efficiently. Four bills have been sent to the House (H.R. 2574, H.R. 2575, H.R. 2576, and H.R. 2577) and four to the Senate (S. 640, S. 641, S. 642, and S. 643)--all incorporating the Administration's proposals. Representative Barber Conable (R-N.Y.) introduced the House bills, and Senator Robert Dole (R-Kan.) the Senate measures.

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5 See GAO, op. cit., pp. 22-31, and CBO, op. cit., pp. 16-21.

6 Ibid.

CHANGING THE TAX TREATMENT OF HEALTH BENEFITS
(H.R. 2754, S. 640)

The tax treatment of employer sponsored health insurance has been a major factor in discouraging competition. Although the tax code does not subsidize individual medical expenses, except in cases where the costs exceed a threshold based on adjusted gross income, it does subsidize employee health insurance benefits paid on their behalf by their employers.[7] The current law encourages the purchase of excessive health insurance coverage because it allows employers who offer employee health insurance plans to deduct their contributions as business expenses. Employees, meanwhile, receive these benefits tax free.

Consequently, the more of his income an employee can take in the form of health insurance benefits, the more of it is sheltered from taxation. This explains the growth of dental plans, family insurance and, above all, first dollar coverage. This growth of tax-sheltered group plans blinds the health consumer to the true cost of the services.

The Administration proposes to limit the tax-free treatment of employer health insurance premium contributions to $2,100 annually for family plans and $840 annually for individual plans. Any contribution exceeding this would be treated as taxable income for the employee. This change would raise an additional $2.3 billion in federal revenues in 1984 and a total of $31 billion from 1984-1988.[8]

This proposed reform would promote a competitive environment in the health care industry by making both employers and employees more cost conscious when purchasing health insurance and medical care. The original rationale for tax relief for employee plans was to help people purchase insurance to protect themselves and their families from large, unexpected medical expenses--not to provide tax exemption for income spent on very routine and inexpensive services.

Under the Reagan proposal, those with insurance premiums above the tax-free limit would have to choose a less costly alternative or pay tax on the amount over the limit. Those choosing the former course might select plans that have more deductibles and coinsurance, while still providing full coverage of catastrophic expenses. The evidence suggests that even modest deductibles and copayments could reduce dramatically excessive

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7 The Tax Equity and Fiscal Responsibility Act raised the floor under the itemized deduction for medical expenses for calendar year 1983 from 3 percent to 5 percent of adjusted gross income.

8 Office of Managment and Budget, "Major Themes and Additional Budget Details Fiscal Year 1984," p. 67.

demand for health care services by increasing consumer awareness of costs. Or they might choose some of the less expensive alternative delivery systems that provide quality care more cost-effectively.

Objections to the Tax Cap

The Poor: Opponents of the tax cap proposal argue that additional cost-sharing may be difficult for low income families and that they may delay or forget the routine medical services that keep them healthy and out of expensive hospitals. Among the cost effective services they fear would be dropped are outpatient and preventive care services, early diagnosis and treatment, dental, vision, mental, and home health services.

This argument would have some merit, were the cap were set at a very low level. In fact, the Administration's ceiling is high enough to leave unaffected the coverage of most low income employees.

Administration: Some critics point out that a tax on health insurance premiums would be difficult and costly to administer. These regulatory burdens, they argue, would be particularly onerous for small businesses, which cannot afford to hire the experts needed to monitor regulatory and tax changes. David Winston, a consultant to the White House on health issues, however, points out that the proposal only sets a limit on the amount of health insurance that is tax deductible and that it should not impose an unreasonable accounting burden.

High Cost Areas: Others claim that a uniform limit would penalize people living in areas with exceptionally high medical costs. These critics propose that the limit vary by location and actuarial group. But this would complicate administration and establish a precedent for regional variations in the tax code based on differences in costs of living. If the cap, moreover, introduces the greatest price constraint in high-cost areas, it is precisely there that downward pressure on prices is most needed.

Tax Revenue: Other critics argue that the tax cap will not have the anticipated effect on tax revenues because employers will merely shift money spent on excess health insurance into other nontaxed fringe benefits. While this may be true, it ignores that primary purpose of the cap is to restrain the growth of health care costs due to inappropriate demand. The aim is not to raise tax revenues.

MEDICARE

The present Medicare program has two parts. Part A is a hospital insurance (HI) program, which is financed from payroll taxes and covers inpatient hospital services, skilled nursing care, and home health services. It provides full coverage after

an annual deductible, which represents the average daily cost of one day in a hospital ($350 in 1984). For the next 59 days, it neither requires cost-sharing by the beneficiary nor limits the total costs incurred. Coinsurance charges are not made until the 61st day, and in 1984 would be increased to $87.50 per day through the 90th day. Beyond 90 days, an individual can draw on a nonrenewable lifetime reserve of 60 days, at a cost of $175 a day in 1984. Beyond this point, the patient is responsible for the full cost of hospitalization. As only 0.6 percent of Medicare patients remain longer than 60 days, Part A coinsurance rarely applies.[9]

Part B of Medicare, the Supplementary Medical Insurance (SMI) program, is an optional supplement to those eligible for Part A, as well as for everyone over the age of 65. It is 75 percent financed from general revenues, with the rest coming from premium payments of beneficiaries. It includes coverage for all other Medicare services, primarily physician services. There is an annual $75 deductible, after which the program reimburses 80 percent of Medicare approved charges for covered services leaving the patient to pay 20 percent (though this share is largely offset by private insurance purchased by about half of all Medicare beneficiaries).

The Medicare program faces serious financial difficulties. This February, the Congressional Budget Office projected that under current law the HI trust fund would be depleted by 1988 and run a $400 billion deficit by 1995.[10]

Catastrophic Hospital Costs Protection and Cost Sharing (H.R. 2575, S. 642)

Under the present cost-sharing structure, individuals have little incentive to avoid unnecessary hospital services once they are admitted to a hospital and pay the deductible, since cost sharing only begins on the 61st day. In addition, patients have no incentives to seek hospitals with lower costs, because the deductible remains the same regardless of hospital costs. Assuming a cost-per-day price equal to the $350 deductible in 1984, Medicare would pay $3,500 for the average stay of eleven days, and $20,650 for the maximum 60-day stay, before the consumer begins to share any costs. Based on these figures, the Medicare patient's share of the cost would be less than $32 per day for the average stay in the hospital, and less than $6 per day for a 60-day hospitalization. On the other hand, Medicare patients face virtually unlimited liability for the cost of their care after they use up their lifetime reserve days. Severely ill people requiring long hospitalization can face extremely high personal expenses. A five-month hospital stay in 1984, for

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9 See Linda E. Demkovitch, "The Medicare Tradeoff--Many Would Pay More So That a Few Could Save," National Journal, p. 545.

10 Ibid., p. 544.

example, would cost a Medicare patient over $13,000 according to the Administration, increasing by about $10,000 for each additional month.[11]

Some cost-sharing is needed to provide an incentive to minimize routine hospitalization. The elderly, however, must be protected from catastrophic hospital costs. To achieve these two goals, the Administration has proposed adding a copayment equal to 8 percent of the hospital deductible ($28 in 1984) for the 2nd through 15th day and 5 percent ($17.50 in 1984) for the 16th through the 60th day of care. Beyond this, however, the beneficiary would not be liable for any hospitalization costs.

The Administration's plan, in other words, is to replace a system that provides practically free hospitalization for short stays--but provides no catastophic coverage--with one that requires a modest copayment and covers catastrophic hospital charges. In addition, beneficiaries would be liable for no more than two hospital deductibles a year, while daily coinsurance charges for the 21st through 100th day in a skilled nursing facility would be reduced from 12.5 percent to 5 percent of the inpatient hospital deductible. The proposal is expected to save $710 million in fiscal 1984 and $6.7 billion through fiscal year 1988.[12] For 1984, the anticipated savings due to increased cost-sharing are actually $1.6 billion, but these are partially offset by increased costs of $910 million for catastrophic coverage.

Not only does the Administration's proposal provide self-financing catastrophic care within Medicare, but by introducing cost-sharing immediately after payment of the deductible, it provides greater incentives to restrain consumption and therefore hospital prices.[13] Advancing the coinsurance rates would not impose an unduly large burden on most beneficiaries--it would raise the copayment for an average stay to just $280. On the other hand, patients requiring a five-month hospital stay would pay a maximum of $1,530 in 1984, a saving of $11,945 over present law.[14]

Increased copayments in the early stages of hospitalization, of course, would mean an extra financial burden on most of those requiring hospitalization, since only a very small proportion of Medicare beneficiaries need catastrophic protection. Only those requiring hospitalization for 74 or more days would come out ahead under the Administration's proposals. Of Medicare's 29

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11 OMB, op. cit., p. 57.

12 Ibid.

13 While coinsurance would foster the more efficient use of hospital care, the Administration's proposal would not do anything to encourage patients to look for less expensive hospitals, since the coinsurance rates are based on a percentage of the deductible rather than a particular hospital's average daily costs. Basing coinsurance rates on each hospital's own costs may provide even greater incentives to seek out low-cost hospitals as well as stimulating competition among hospitals.

14 OMB, op. cit., p. 57.

million eligibles, about 170,000 actually spend that amount of time in a hospital annually. But as pointed out by Robert J. Rubin, Assistant HHS Secretary for Planning and Evaluation, the additional $280 in costs faced by the average beneficiary "will buy the peace of mind of having unlimited hospital coverage."[15] And, of course, the downward pressure on prices resulting from copayments will reduce the possibility of a major disruption of Medicare the cause of runaway costs.

VOLUNTARY VOUCHERS
(H.R. 2577, S. 641)

Medicare beneficiaries today cannot use their entitlement to purchase coverage under alternative delivery systems, even if an alternative provides a superior package at a reduced rate. To remedy this, the Administration proposes establishing a voluntary Medicare voucher that beneficiaries could use to enroll in private health insurance plans. The federal government would pay 95 percent of Medicare's average adjusted per capita cost (AAPCC) to individuals choosing private plans that offer coverage at least as full as that provided by Medicare.

The AAPCC would be adjusted actuarially to take into account Medicare's true costs according to such personal characteristics as age, sex, and health status, and regional medical cost differences. Beneficiaries choosing plans costing less than the voucher would be entitled to a cash rebate. In addition, anyone becoming dissatisfied with their private coverage would be permitted to rejoin the Medicare system.

This voluntary voucher system would encourage Medicare beneficiaries to shop for alternatives to fee-for-service medicine, such as prepaid groups like HMOs. Currently there is no such incentive.

Vouchers have several advantages. They could reduce the cost of the Medicare program by effectively setting a limit on the government's financial responsibility for those accepting the voucher, since it would replace a system of open-ended reimbursements with fixed premium payments. Savings would occur if the value of the voucher is less than would otherwise have been spent on the Medicare recipient. Total savings would depend on the number and health status of Medicare beneficiaries selecting the voucher.

A Medicare voucher also would allow Americans to shop for plans in the private sector they feel are better suited to their needs and desires. Enrollees may accept greater cost-sharing in return for the cash refund. Others may wish more comprehensive coverage than is available under Medicare and use the voucher to purchase private insurance. The voucher expands opportunities.

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15 See Demkovitch, op. cit., p. 545.

Finally, an important part of the Administration's proposals is to stimulate competitive forces in Medicare and the entire health care system. By encouraging more competition among new kinds of delivery systems, the voucher should lead to downward pressure on costs and to private sector innovation in health care coverage and delivery.

The voucher concept, however, may create a few problems. Private plans may have a difficult time competing with Medicare because of various cost advantages enjoyed by the federal system. The Medicare program, for instance, is not subject to premium taxes, and it generally reimburses providers at a lower rate than most private insurers. These cost disadvantages can be considerable, and could explain the relatively little interest expressed by private insurers in Medicare vouchers.

A second common criticism of vouchers is that they could lead to adverse selection, i.e., that those people who are relatively low users of health care might opt for the vouchers, leaving heavier users in the system. This could drive up Medicare costs, rather than reduce them as intended. The Administration partially addresses this problem by adjusting the value of the voucher to actuarial classes.

OTHER REFORMS
(H.R. 2576, S. 643)

The Administration also proposes other reforms in the Medicare and Medicaid programs. The major provisions include a freeze on physician fees for Medicare and changes in the Supplementary Medical Insurance program and modest copayments for the Medicaid program.

Premiums and Deductibles for Supplementary Medical Insurance (SMI)

The elderly participating in the SMI program now pay a monthly premium of $12.20 and a deductible of $75. The Administration proposes to delay the next annual Part B premium increase for six months until January 1, 1984, and then begin annual adjustments to raise it from the current level of 23 percent of program costs to 33 percent by January 1, 1988. The deductible would also be indexed to the annual increase in the price of physician services. These reforms would actually raise outlays by about $100 million in fiscal 1984 but would save over $9 billion through fiscal 1988.[16]

When the SMI program originally was introduced in 1966, it was to be funded only half by general revenues, with beneficiary premiums paying the other half. While this was the case for the

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[16] OMB, op. cit., p. 60.

program's first five years, beneficiary premiums in the past decade have declined to just 23 percent of program costs. The Administration's proposal should be a first step to raising the premium back to the full 50 percent.

Physician Payment Freeze

Medicare currently reimburses physicians on a "reasonable charge" basis. These are updated annually to reflect changes in physician charges. The Administration proposes freezing physician charges paid by Medicare during 1984 at the 1983 levels. The measure is expected to save $100 million in fiscal year 1984 and $5.2 billion over a five-year period.[17]

The physician freeze does not freeze what physicians can charge, only what Medicare pays. If physicians feel that the market will bear a higher price, they can charge more. They risk, of course, losing patients to other physicians who offer services at a lower rate.

Medicaid Copayments

Medicaid is an open-ended entitlement program that provides medical care for needy persons, such as families with dependent children, and the aged, blind, and disabled. It is a federal-state matching program, with states administering the program subject to federal guidelines. The federal government's contribution is determined by a formula that is inversely related to the per capita income of a state. Federal contribution rates range from 50 to 78 percent. There is, however, considerable variation among states with respect to eligibility requirements and benefit levels.

Medicaid offers a number of services, such as inpatient hospital care, outpatient care, skilled nursing and physician services. The program is heavily weighted in favor of providing long-term institutional care (in contrast to Medicare, which aims at providing for acute illnesses).

The Administration proposes to require that Medicaid recipients share the cost of the services they receive. Copayments of $1 and $1.50 would be required for physician visits and $1 to $2 for each day spent in a hospital. There is evidence that even modest copayments can curtail significantly unnecessary health care utilization. While a $1 copayment for Medicaid is not so onerous as to prompt beneficiaries to delay essential care, it may cause them to think twice before using services unnecessarily.[18]

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17 Ibid., p. 59.

18 The higher copayments would apply to the "medically needy" beneficiaries of the program.

CONCLUSION

Public health care policy has long been based on a variety of regulations and cost controls. These methods have failed to stem health care inflation and have caused the misallocation of resources. The Reagan Administration is proposing a pragmatic attack on this problem. It is trying to promote market forces to reduce unnecessary use of and inappropriate demand for health care. The President's plan is designed to expand consumer choice in government programs and promote more selective use of private insurance plans. It would increase consumer awareness of health costs and stimulate competition among health care providers. While some people would bear additional costs, all Americans would benefit from a restructured health care sector that lowers medical care costs by limiting excessive demand. In addition, Medicare beneficiaries would be protected from the disastrously high expenses associated with prolonged illness.

While stronger measures may be needed, those offered by the Administration are an important reversal in the direction of federal health sector involvement. They leave more room for a competitive market to push down costs and ensure economical use of resources. The result: A reduction in the use of unnecessary health care services and lower costs to both taxpayers and patients.

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