STATEMENT OF

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Mr. Chairman, I am pleased to be here today to discuss proposals to stimulate competition in the financing and delivery of health care. My testimony will focus on the ability of these proposals to slow the rise in health care costs and their impact on the federal budget.

BACKGROUND

The rapid rise in spending for medical care is now continuing after a brief pause in the late 1970s. Per capita spending on personal health care has risen from $181 in 1965 to $941 in 1980--reflecting a 183 percent increase in prices and an 84 percent increase in the quantity of services. Moreover, under current policies, these trends are expected to continue for the foreseeable future.

This continuing increase in medical costs will have a substantial impact on the federal budget, making movement toward a balanced budget that much more difficult. Federal spending for Medicare and Medicaid will total approximately $58.3 billion in 1981 and, despite the substantial cuts just enacted, the Congressional Budget Office (CBO) projects that it will increase to $85.0 billion in 1984, almost 11 percent of total federal spending in that year. The revenue loss from the tax exclusion for employer contributions to health insurance--which amounted to about $17 billion in income taxes and about $7 billion in payroll taxes in 1981--is projected roughly to double by 1986.

The Congress has been concerned with rising medical costs for some time, with its agenda dominated up to now by proposals to contain costs through regulation--proposals such as limits on hospital revenues. Recently, attention has turned to containing medical costs through encouraging the use of market forces.

STRATEGIES AND OPTIONS

Proposals to encourage the use of market forces to contain health care costs encompass two broad strategies. One is additional use of cost sharing in the financing of health care. Under this strategy, incentives to alter health insurance policies would induce individuals to increase both deductible amounts and coinsurance rates. The resulting increased cost consciousness would, in turn, reduce the use of health services and their prices.

The second broad strategy would encourage individuals to obtain their medical care through alternative delivery systems such as Health Maintenance Organizations (HMOs). HMOs have lower medical costs, principally because of lower hospital use. Some feel that a significant presence of HMOs also makes medical markets more competitive.

A number of specific policy options are available to pursue one or both of these strategies. Those of greatest interest to the Committee today include:

- Altering the tax treatment of employer-paid health insurance, and

- o Permitting those eligible for Medicare to enroll in a qualified private health plan, using a federal voucher.

I will focus my comments today on these two options. A more detailed analysis of these and other options is included in a CBO study of H.R. 850, the National Health Care Reform Act of 1981, introduced by Representatives Gephardt and Stockman. That study, prepared at the request of the Ways and Means Committee, is also being made available at this hearing.

CHANGING THE TAX TREATMENT OF HEALTH INSURANCE

Those who propose to alter the tax treatment of employer-paid health insurance criticize current law because it encourages excessive purchases of health insurance which, in turn, result in greater use of health care services and higher prices. Since employer contributions are excluded from employees' taxable incomes, employers can provide a more attractive compensation package by favoring health insurance benefits over cash. The result has been comprehensive insurance packages with little cost sharing and a reduction in incentives to seek efficient ways of financing health care.

Moreover, the large revenue loss from this provision is distributed in a very uneven manner. Those with higher earnings get larger tax benefits, both because of their higher tax brackets and because employers with high wage scales tend to make larger contributions to health insurance. Those persons not earning wages or salaries, or in firms without health plans, get no tax benefits.

Tax Exclusion Limit

Many of the proposals to encourage market forces in health care (such as H.R. 850 and S. 433) would limit the amount of contribution that can be excluded from employees' taxable incomes. Such a ceiling would reduce spending on medical care by employed persons and their families, reduce medical care prices somewhat, and reduce the revenue loss from the exclusion. The magnitude of these effects, however, may make only a modest contribution to solving the health care cost problem.

Health insurance purchases would be reduced by removing the tax subsidy from the last dollars of contributions to health insurance. For example, if the limit were set at $120 per month for family coverage and an employee was receiving a contribution of $150 per month, $30 would be included in the employee's taxable income. Consequently, some employees would prefer to have their employer reduce the contribution to health insurance by $30 and shift this amount to cash compensation.

This reduction in employer contributions could be translated into lower health insurance premiums in one of two ways. First, the comprehensiveness of benefits could be reduced, either by reducing covered services or by increasing the deductible amount and the coinsurance rate. This could be accomplished either by altering the employer's or the union's health package or by

offering employees a choice of plans. The second way to lower health insurance premiums would be through enrollment in an HMO. Either approach would reduce the use of health services.

At least in the first few years, much more of the response to this incentive would come in the form of greater cost sharing than through increased enrollment in alternative delivery systems such as HMOs. These plans play a relatively minor role in the medical care system today, and it is unlikely that they would be able to expand rapidly. Also, HMO premiums are often not significantly lower than those of the traditional insurance plans with which they compete, because their more comprehensive benefit packages offset their lower health care costs.

Two factors would limit this approach's effectiveness in controlling health care spending. First, it would only affect persons receiving contributions in excess of the limit. Such targeting is desirable, however, since it continues the incentive for all employed persons to have some health care coverage. Second, when health insurance benefits are cut back, benefits for hospital and physician services are less likely to be reduced than coverage for other services such as dental care and prescription drugs.

Limiting the tax exclusion would reduce the revenue loss from it, with the amount depending on the level of the cap. For example, a $140 per month limit for family contributions, effective January 1, 1982, would reduce the fiscal year 1982 revenue loss by about $2 billion.

Tax Free Refunds

A second tax option would permit an employer offering a choice of health plans to pay tax-free refunds to employees choosing plans with premiums lower than the firm's contribution. This option is frequently combined with the tax exclusion cap discussed above. Reluctance of employers to expand the number of health insurance plans offered to employees would limit the impact of this approach, however, unless employees could apply their contributions to other firm's plans, as would be required under H.R. 850.

This approach would extend the incentives for lower health care premiums to a wider population than would a limit on the tax exclusion. First, persons with contributions less than the exclusion limit--who would be unaffected by it--would be able to gain financially from choosing lower-cost health insurance plans. Second, alternative delivery systems such as HMOs would have additional markets opened to them.

The available evidence suggests that employers would be reluctant to offer a choice of plans. Even under present law, employers that require a contribution from their employees can offer a choice of health plans and reward those selecting plans with lower premiums. Yet these firms seldom take advantage of this opportunity.

Employers' reluctance to offer a choice of plans is likely to be related to concerns about adverse selection. Adverse selection in health insurance is the phenomenon of those likely to be low users tending to choose the low option plan and those likely to be high users tending to choose the high option plan. When premiums are based on claims experience, the result is a transfer of funds from those choosing the high option plan to those choosing the low option plan. Employers could find their health benefit costs increasing if the high option plan was their original plan and they felt compelled by tradition to contribute a fixed percentage of the premium of that plan. Adverse selection is a much smaller problem when the choice is between an HMO and a traditional plan because benefit differences are usually small and consumers' preferences for types of delivery systems play a significant role.

Unrestricted tax-free refunds could reduce federal revenues substantially. If the stricture that employees cannot take part of the employers' health benefit contributions in cash were

removed, employers might increase their contributions, thereby sheltering more of their employees' compensation from taxation. Each of the bills discussed here has provisions to limit this revenue loss, however.

MEDICARE VOUCHERS

Given the substantial proportion of health care costs paid by Medicare, a policy to encourage the use of market forces to contain costs might be more successful if Medicare beneficiaries were included. One approach that has been proposed would give those eligible for Medicare the choice between remaining under Medicare and receiving a federal voucher to pay for qualified private health plans. Those who purchased a qualified plan that cost less than the voucher would get a refund from Medicare.

This option would increase enrollment in HMOs somewhat, by rewarding financially Medicare beneficiaries who enroll in HMOs that have lower costs than Medicare. Under current law, most HMOs are reimbursed by Medicare on a fee-for-service basis, so that most of the savings from lower rates of hospital use accrue to Medicare. In contrast, a voucher tied to average Medicare costs would allow enrollees to share in the savings.

Vouchers would not, however, induce many Medicare beneficiaries to opt for traditional private insurance plans, because insurers would face disadvantages in competing with Medicare and

would have to provide less coverage for the same cost. In particular, private insurers would have to include selling costs in their premiums, a cost that Medicare does not have. These selling costs could be quite high, since the purchasers would be individuals, most of whom would not be reachable through employers. Also, Medicare pays less to hospitals than do most private insurers--on average, 16 percent less than hospital charges.

Finally, insurers offering a more extensive benefit package than Medicare would be at a particular disadvantage because of inadvertent subsidies currently provided by Medicare to those purchasing policies that supplement Medicare coverage. These supplemental policies often reduce cost sharing, for example, by reimbursing the 20 percent of physician fees now not paid by Medicare. This reduction in cost sharing induces more use of medical services, but the supplemental policy does not pay the full cost of these services. Instead, Medicare pays a large proportion of them--80 percent in the case of additional physician visits. A private insurer offering a substitute for Medicare plus the supplemental plan would have to pay the entire cost of the expanded use of services.

Two factors--adverse selection and the use of vouchers by those currently enrolled in HMOs--might actually cause Medicare outlays to increase if the voucher approach were adopted. Adverse

selection could result in increased Medicare outlays, because persons opting out of Medicare would tend to be low users seeking plans with more cost sharing than Medicare. This phenomenon might be aggravated by incentives to insurers to market selectively to attract the best risks. Greater use of HMOs would increase Medicare costs since Medicare would no longer reap the benefits of the HMOs' lower costs.

A number of other "market-oriented" alternatives might be more successful than vouchers in containing health costs for those eligible for Medicare. 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; and
- Making vouchers mandatory.

Reimbursing HMOs on a capitation basis would establish incentives to enroll in HMOs comparable to the voucher proposal, but would reduce the extent of adverse selection. H.R. 3399, for example, would have Medicare pay HMOs 95 percent of the per capita cost of Medicare benefits, and would require HMOs to pass along to Medicare enrollees the difference between the actual cost of services and the Medicare payment to the HMO. Since most persons who would find vouchers attractive would enroll in HMOs, most of the potential of vouchers would be accomplished by this more

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.

An alternative would be to discourage supplemental plans that effectively eliminate cost sharing under Medicare by applying a surcharge to their premiums. This change would offset the additional cost such plans create for Medicare by inducing increased service use.

A more direct approach to increasing cost sharing would be to change 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.

Finally, the voucher approach would have a larger impact if it were mandatory. Private plans would no longer be at a disadvantage in competing with Medicare, and Medicare outlays could be reduced, depending on the level at which the voucher was set. This option would have a number of disadvantages, however. First, adverse selection might be substantial--especially given the potential underwriting profits from favorable risk selection--resulting in large transfers among the elderly. Second, high selling expenses could increase the cost of financing health care for the Medicare population. Third, the inherent complexity of health insurance plans leads to questions about the efficiency of requiring large numbers of people to make individual choices.

CONCLUSION

In summary, changes in economic incentives can potentially slow the rise in medical costs and reduce federal expenditures for health care. Of the available options, limiting the tax exclusion for employer contributions to employee health plans and incorporating greater cost sharing into Medicare seem to be more efficient and direct than providing consumers with additional choices of health insurance plans. Such policy changes would result in lower use of medical care services and greater sensitivity to their prices, thereby leading to lower health care prices. Both private individuals and the federal government--through reduced expenditures for Medicare and Medicaid--would benefit.