STATEMENT BY

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Medical expenditures have grown rapidly and probably will continue to do so. From 1968 to 1978, personal health expenditures grew at an average annual rate of 13 percent. During this same period, the proportion of Gross National Product accounted for by these expenditures increased from 6 percent to 8 percent. If current policies are continued, there is little reason to project a change in this trend.

One reason why spending for medical care has grown so rapidly is the extensive use of health insurance to finance medical expenditures. Roughly two-thirds of personal health expenditures are paid for by public and private health insurers. This high rate of third-party financing reduces the incentives for patients and health-care providers to limit expenditures.

Federal tax policy is partly responsible for the extensive use of health insurance. Employer contributions to health benefit plans are excluded from taxable income without limit. This lowers the cost of insurance to employees, inducing more extensive coverage. Furthermore, Internal Revenue Service rulings have forbidden employers who offer a choice of plans from giving rebates to employees who choose the lower-cost plans. Limiting tax-free employer contributions, or mandating that employers offer a choice of plans with fixed contributions, are ways to reduce the use of insurance and contain medical expenditures.

While the Health Cost Restraint Act of 1979 (H.R. 5740) includes reforms of Medicare, Medicaid, and the Health Maintenance Organization (HMO) program, its most important provisions would alter the tax treatment of employer-provided health benefits. Title I of the bill would place a ceiling on the amount of employer contributions that could be excluded from the employee's gross income subject to income taxes and Social Security taxes (FICA). H.R. 5740 would also require that employers making contributions to plans whose premiums exceed a certain threshold offer their employees a choice of either membership in a federally qualified HMO or a low-option insurance plan. Each plan would have to protect against "catastrophic" medical expenses. Employees who choose a plan with a premium lower than the employer's contribution to a more expensive plan would have to receive a taxable rebate of at least 90 percent of the difference. For example, if an employer offered both a $70 and a $100 per month plan at no cost to the employee, employees choosing the less expensive plan would receive a rebate of at least $27 per month.

In order to assist the Committee in evaluating Title I of H.R. 5740, my testimony today will concentrate on the following points:

- The effect of H.R. 5740 on federal revenues and outlays and on medical spending;

- Possible modifications of H.R. 5740 and their effects; and
- The interaction of H.R. 5740 with other cost containment and health insurance proposals.

IMPACT OF H.R. 5740

The major effect of the Health Cost Restraint Act of 1979 on health care costs would be to encourage conventional health insurance policies with less extensive benefits. In response to the altered tax treatment of employer contributions, employees would be likely to prefer less costly insurance with larger deductibles and higher coinsurance rates for hospital and physician services. Most of the employees' added cost sharing or out-of-pocket payments would probably be for physician services rather than hospital services. They would tend to reduce their coverage for dental services, mental health services, and routine eye care. The bill would also encourage increased use of HMOs and other prepaid health plans. These changes would probably take place over a period of several years.

The change would probably cause consumers to use fewer health care services, and thus their health expenditures would be lower--by $5 to $8 billion in fiscal year 1985. Most of the reduction would come in lower payments for nonhospital services.

The bill would also increase federal revenues by $4 to $6 billion in fiscal year 1985. By 1985, the ceiling on tax-free employer health insurance payments would affect about 42 percent of persons with employment-related health benefits. Tax receipts from employer contributions to plans that remained above the ceiling and from the taxable rebates to employees who chose lower-cost plans would increase by $5 to $7 billion above those collected under current policies; whereas, federal tax receipts from persons whose employers coatribute less than the ceiling amount would be $1 to $2 billion lower under H.R. 5740 than if current tax policies were continued.

Federal revenues are expected to fall because of increased tax-free contributions by some employers. Currently most employers offer only one plan, presumably one reflecting the preferences of the average employee for tax-free health benefits rather than taxable wages. H.R. 5740, however, would allow employers to provide more insurance for those preferring it without hurting those employees who prefer less. Because the bill would permit rebates to employees choosing low-option plans without jeopardizing the tax-free status of contributions to high-option plans, it would encourage employers to offer employees increased contributions to health benefit plans as an alternative to future wage increases. Those employees desiring more health insurance would benefit from the additional, tax-subsidized coverage. In addition, those preferring less insur-

ance could choose the low-option plan, receiving the taxable rebate, and be about as well off as if the compensation increase had been entirely in wages. Because wages and rebates would be taxed and the employer health insurance contributions would not, tax revenues from the employees who chose to keep the higher-cost health insurance would be lower than if the increase in compensation had been in wages. This revenue loss would equal $1 to $2 billion in fiscal year 1985.

On balance, some employees would lose, while others would gain under the proposal. Those currently receiving employer contributions above the ceiling would lose because a portion of their compensation would be taxed for the first time. Employees now receiving contributions below the ceiling could benefit in a variety of ways. Some would obtain increased tax-free health insurance benefits. Others would benefit from opportunities to save money on medical care, either by joining a prepaid plan or by choosing a conventional insurance policy with more cost sharing and getting a rebate reflecting the lower premium.

The bill would not affect employers to a significant degree. They would benefit from their ability to retain up to 10 percent of premium differences from those employees choosing low-cost plans, and they could exclude some of the rebated amounts from payroll taxes. Such gains, however, might be

offset if most of the employees choosing low-option plans were healthier than the average worker in the firm. If less healthy employees were to dominate the enrollment in the high-option plan, the premium for this plan would increase. Should the employer be constrained by contract or by tradition to contribute all or a certain proportion of the high-option premium, the employer's costs for health benefits could increase.

These increased employer costs could be avoided, however. Employers could choose to differentiate contributions (and thus rebates) on the basis of the actual claims experience of different groups of employees. Such a differentiation (for example, by age) would remove much of the incentive for healthier employees to select the low-option plan. Further, employers would have the option to reduce increases in cash wages to offset increases in fringe benefit costs.

Title I of H.R. 5740 would have only a minor impact on federal outlays because it affects only employment-related insurance plans. The proposal could slow the rate of increase in physician prices, and thus Medicare and Medicaid outlays could fall slightly. But this could be offset for the most part by increased use of physician services by beneficiaries of these programs as the reduction in physician use by the employed population made doctors more available.

POSSIBLE MODIFICATIONS IN H.R. 5740 AND THEIR IMPACTS

H.R. 5740 could be modified in several different ways, including eliminating the ceiling on tax-free employer contributions, making rebates below the ceiling tax free, and freezing the present level of tax-free contributions.

Eliminate Ceiling on Tax-Free Employer Contributions

The bill could be modified by eliminating the ceiling on the level of employer contributions that could be excluded from employees' taxable income, while leaving intact the provisions mandating choice of plans. This change would virtually eliminate medical expenditure savings and change the revenue increase projected under H.R. 5740 to a substantial revenue loss.

Eliminating the ceiling would remove the provision responsible for most of the savings. Most of the projected savings resulting from the bill as introduced would come from employees choosing low-option plans because of the changed tax treatment of their employers' contributions to high-option plans. Removing the ceiling on tax-free contributions would end these savings. Furthermore, eliminating the ceiling would not alter the tax incentives for those employees with employer-paid contributions below the ceiling. While some would choose lower-cost plans, others would want more extensive plans than those they have at present. To the extent that current group health

insurance plans reflect the preferences of the average employee in the firm, increases and decreases in insurance coverage should approximately balance.

Removing the ceiling would cause a substantial loss in federal revenues compared with current policies. Relative to the bill, the revenue loss would be even larger.

Make Rebates Tax Free

An option that would increase incentives for employees to choose low-cost health plans would be to make a portion of the rebate tax free. For example, the portion of rebates between the ceiling and the maximum premium specified for low-option plans could be excluded from taxable income. This change would increase the savings resulting from H.R. 5740, but it would not generate increased tax revenues.

Medical expenditures would be $10 to $15 billion lower than under current policy. This option would effectively remove the incentives now in the tax system to take compensation in the form of health insurance. Therefore, more people would choose less insurance coverage and, in turn, reduce their health expenditures.

This option would not significantly affect federal revenues in 1985. While substantial revenues would be gained due to the ceiling on tax-free employer contributions, revenues would be lost due to increased incentives for employers to increase their contribution to the ceiling. All employees would benefit from this substitution of health benefit contributions for cash wages--both those accepting the more extensive insurance and those choosing a low-cost plan and obtaining a tax-free rebate. Furthermore, the revenues gained from the rebates would be lost.

Freeze Tax Exclusion

An alternative that would eliminate the ceiling but maintain the large expenditure reductions obtained under the tax-free rebate option would be to freeze employer contributions excludable from employees' taxable incomes at their present levels. The freeze could be indexed for medical expenditure increases.

Expenditures under this option would fall by roughly the same amount as under the tax-free rebate option--$10 to $15 billion in 1985. Revenues, however, would increase slightly from current policy levels because employer contributions have been increasing more rapidly than medical expenditure growth.

RELATIONSHIPS OF H.R. 5740 TO HOSPITAL COST CONTAINMENT AND NATIONAL HEALTH INSURANCE

H.R. 5740 is not a substitute for either mandatory controls on hospital revenues or proposals to increase health insurance coverage. Indeed, the bill could be complementary to both of these other types of legisative proposals.

Hospital Cost Containment

H.R. 5740 would probably have quite different effects from legislation to place limits on hospital revenues--such as the Hospital Cost Containment Act of 1979 (H.R. 2626) as reported by the Committee on Ways and Means.

First, H.R. 5740 would take longer to affect the health system than would a strict regulatory approach. Most people have no experience in choosing among health plans, so changes in consumer insurance choices would occur slowly. Once people did change insurance plans, physicians and hospitals would take some additional time to adjust to the new, more cost-conscious environment. Hospital cost containment legislation would have a more immediate impact on health costs, but the long-term effectiveness of an incentive-based, pro-competition approach such as H.R. 5740 could be larger.

Second, H.R. 5740 would affect mainly outpatient, nonhospital service use, while most regulatory proposals are aimed at hospital services. Since most of the reductions in coverage

resulting from H.R. 5740 would be among consumers with the most extensive insurance, benefits for physician services, mental health services, and dental care would be affected more than benefits for hospital care. Further, increased cost sharing for hospital care would primarily affect the volume of hospital use--that is, fewer admissions and shorter stays--while regulatory proposals such as H.R. 2626 focus more on inpatient revenues per admission.

National Health Insurance

H.R. 5740 and most National Health Insurance (NHI) proposals have basically different purposes, but their effects could be complementary. NHI proposals aim to increase the number of people covered by health insurance and to improve benefits for at least some of those already covered. In contrast, H.R. 5740 attempts to induce those people who currently have extensive coverage to change to a prepaid plan or a conventional plan with more cost-sharing. Thus, H.R. 5740 would not complement proposals emphasizing universal comprehensive coverage. The one area of overlap is H.R. 5740's requirements that plans with premiums above a certain level at least provide catastrophic protection. This is consistent with the emphasis of many NHI proposals on catastrophic protection.

Combining H.R. 5740 and NHI might allow expanded coverage for needy individuals to be financed in part by limiting tax subsidies for the more affluent. Congressman Martin's Medical Expense Protection Act (H.R. 6405), which includes provisions very similar to those in H.R. 5740, takes this approach.

SUMMARY

In summary,

- H.R. 5740 would lower medical spending by $5 to $8 billion and increase tax revenues by $4 to $6 billion in fiscal year 1985. The proposal would have little effect on federal outlays.

- The ceiling on tax-free health insurance contributions is far more important for reducing medical expenditures than the requirement that employees be given a choice of plans. If, alternatively, the ceiling were removed, medical expenditures would be virtually the same as under current policies, but a substantial revenue loss would result. Making rebates tax free up to a limit would reduce health expenditures by the greatest amount, but would also eliminate the gains in revenue projected for the bill.

- H.R. 5740 is a cost containment proposal rather than a national health insurance proposal. Because H.R. 5740 has such different effects than other cost control proposals--particularly, the Hospital Cost Containment Act of 1979--its merits should be considered independently. In fact, it would be complementary to many other cost containment proposals.

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