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EFFECT OF NEW FEDERAL POLICIES ON MEDICAL INSURANCE

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MR. CARL L. LOEFFEL: The first area of discussion pertains to cost shifting. How will Federal budget limitations on Federal financing of the Medicare and Medicaid programs affect medical care cost inflation for employers and insurers? Indeed, insurers have become increasingly aware of what has been labelled as cost shifting. In my discussion, cost shifting refers to the practice by medical care providers to offset the reduced levels of income from patients of one third party payor with increased income from patients of other third party payors. Since there are a number of third party payors and there are a number of billing formulas, the pattern of shifting costs may become rather complex. Even with a common definition of what an equitable payment might be, it is sometimes difficult to determine who is supporting whom. The largest third party payor is the government through the Medicare and Medicaid programs. The cost shift relative to these two programs is very substantial and is my major subject for this afternoon.

Up to now the emphasis on the government cost shift pertains to that occurring in hospitals. Figures in advertisements indicate this cost shift increased from $1.1 billion in 1975 to $3 billion in 1979 and was projected to have reached $4.8 billion in 1982. These figures were developed by an HIAA joint study group which represented a number of major companies. While these numbers are very significant in their own right, when they are added into a very inflating hospital cost the results are staggering. Employers, through their insurers, have been paying a substantial portion of these costs.

In order to review how changes proposed by the Federal government will affect the cost shift, one must review at least briefly the causes of the government cost shift on hospitals. When the government pays for hospital services under the Medicare and Medicaid programs, it pays on a so-called cost formula which does not recognize all amounts entering hospital charges. For instance, its share for malpractice insurance, research and bad debts and of return on invested capital is substantially below that built into hospital charges. Additionally, the government places limits on what it will pay under Section 223, based on the nature of the hospital and its location. As government tightens up by limiting unrecognized expenses categorically or administratively, it reduces what it will pay relative to the charge paying patient.

Of course, there are some who would argue that the government is only being a prudent payor and that it negotiates payment formulas with hospitals. However, one wonders to what extent government negotiates when it can unilaterally mandate a 2% reduction, as has been proposed.

Once hospitals are obliged to accept a reduced level of reimbursement, they must reduce costs, draw on surplus or increase income from other patients.

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The inner city hospitals who have large Medicare/Medicaid patient populations and relatively few charge paying patients are reportedly in a poor financial position.

If this situation continues, the cost shift will increase due to at least three forces. The most obvious is inflation in hospital costs. Those items which cause such inflation have been documented elsewhere. The major point I would mention here is that there is no evidence that inflation in these items will abate in the near future.

The second force is continued government contraction in what it will recognize as allowable costs for its patients. The future here is not bright either because what government will pay is dependent upon what it can pay, which is limited by its tax collections for Social Security, which are already under pressure.

The third force is perhaps the most ominous. As our population gradually ages, more people will achieve Medicare eligibility with an even greater increase in aged people in hospitals. This introduces a leveraging effect between the government cost paying patient and the charge paying patient.

There is at least one further factor that should be introduced and that is that all private paying patients are not charge paying patients. Many private paying patients are insured by insurers who pay on some cost based formula or have some form of discount. This is particularly true in areas where Blue Cross has a substantial discount. For instance, according to American Hospital Association figures, Blue Cross has a 32% discount on average in the greater New York City area. This tends to insolate such plans from sharing in paying for the government cost shift, limiting the burden to those who otherwise pay. As this discontinuity increases, other insurers are competitively forced from the market.

The recent proposals from the government tend to follow four different avenues. One is to further increase the cost shifts, encouraging other cost based payors to seek additional relief at further expense to charge based payors.

The second is to institute major structural changes in the method hospitals are compensated. For instance, hospitals might be compensated by a flat fee based on diagnosis, adjusted by type of hospital and location and perhaps other factors. These may be desirable as a way to force cost containment in hospitals if all patients were treated similarly, but to the extent that such only applies to a limited class of patients, hospitals can continue to shift cost to other patients.

A third avenue is to require greater co-payments by Medicare/Medicaid patients. For instance, Medicare patients might be required to pay 10% of their cost beyond the deductible amount up to an out-of-pocket limit of $1,000. This would be partially offset by improving the catastrophic nature of the plan. Savings attributed to such a plan pertain not only to the greater co-payment but also decreased utilization. In regard to Medicaid, one wonders whether greater payments will not mean greater bad debts which, in turn, will increase the cost shift. As politically unpopular as this avenue may be, it does seem that it would save some money, relieving pressure on the government and at the same time liken the Medicare program to those offered by private insurers.

The fourth avenue is to limit the population eligible for Medicare. The most recent idea is to make private insurance primary to Medicare for those under age 70 covered under group insurance. At the present time, this is a rather small group but could increase, especially if the Social Security retirement age is advanced. This would relieve some of the stress on Social Security by placing the cost directly on employers. Further, since the number of people primarily insured by Medicare is reduced, the cost shift is reduced.

One of the greatest problems of the cost shift in hospitals is that it is, in effect, a hidden tax. Very few citizens are aware of the presence of this tax, much less of its magnitude or results. However, it is difficult to muster public concern on the issues.

On the other hand, there is a cost shift in Part B of Medicare which the public is far more aware of. Aged individuals who have submitted claims are keenly aware of the fact that Medicare does not recognize a substantial portion of doctors charges. While this form of cost shifting may be as unjust as the hospital one, there is an advantage in that it is more apparent to the public.

The magnitude and direction of the cost shift should be significant, not only to the actuary, but also to the marketing people who must determine where they should concentrate their efforts. Since the government cost shift places the greatest burden on charge paying patients, those areas in which the greatest discount is afforded the Blues will become more difficult for commercial insurers to compete in profitably.

Trend factors by area may become more necessary in order to react rapidly with changing conditions to reflect not only the cost shift but also changes in the local pattern of other third party payers. For instance, if an HMO or Blue Cross contract is changed, there is likely to be a different pattern of cost shifting.

The above assumes that employers will not react in a more effective way. There is the potential for employers offering more cost effective plans, or there is the potential for more effective coalitions. Further, additional pressure may be brought to the states to develop experiments similar to those tried in Maryland and New Jersey, which tend to reduce the level of cost shifting by standardizing reimbursement formulas for all.

The second part of this subject is the pro-competition issue. Pro-competition or consumer choice bills, what are their likely affects?

MR. GORDON TRAPNELL: The important things about the pro-competition, consumer choice bills are the basic concepts that are woven into them and the economic principles that motivate the proposals. The contents of the particular bills introduced in the Congress are really not very informative even as to what to expect to be considered seriously.

Most of these bills are collections of intellectually appealing ideas put together by academically oriented legislative assistants who know a lot about the economic literature but very little about health insurance. The main purpose of the proposals is to attract favorable publicity for the sponsors and to attract attention to the issues. No votes would be taken until there had been an extensive exploration of the probable impact of each provision.

This is usually supplied by those to be affected by proposals. After such examination, it is unlikely that any of the sponsors, much less their colleagues, would vote for the bills they have introduced.

For these reasons, I will present the principal ideas in the competition bills, explain the economic reasoning leading to their being proposed and the most likely actuarial consequences of implementing them.

1. Taxing Employer Contributions for Health Insurance

Most of the pro-competition proposals would limit the tax advantages of employer contributions for health insurance benefits.

This feature is usually a surprise to observers who are not familiar with the health economics literature. A review of the reasoning motivating these proposals is helpful not only in understanding how they came to be but also for an insight into the perception of the basic problems of health insurance and hence, the types of solutions likely to be considered.

a. Perverse economic incentives of present taxation

The basic economic reasoning behind the tax proposals is as follows. Insurance coverage of medical services leads to higher utilization of services. Further, payment of most or all of cost or customary and prevailing charges removes the natural restraints to price inflation. Thus, overinsurance is a primary cause of high costs and a higher rate of inflation.

An economist views a third party payment as removing the restraints of prices on the quantity demanded. Free from concern about quantity, there is no restraint on the prices charged. These conclusions follow from the most basic of all traditional economic models - the intersection of downward sloping demand curves and upward sloping supply curves resulting from the competition of many small firms and many consumers. Thus, reducing insurance should remove barriers to natural competitive forces.

Further, the present tax advantages of employer payments for health insurance subsidize spending for health care, compared to other things employees purchase. The tax subsidy may run as high as 60% in a state with a maximum income tax bracket of 10% and averages 41% for all employed persons (Social Security taxes must be included for this below the maximum wage base). Another way of putting this is if an employer pays $10 in health benefits rather than wages, the employee has the benefit of around $9 (depending on administrative costs), but if the same amount is paid in wages, the average employee gets only $6 and the high paid employee only $4.

This strong tax preference for health insurance premiums over wages leads to insuring as many services as possible. The tax subsidies more than pay for the extra cost of administration (including actuaries' salaries) and higher utilization. (The higher fees must be paid by the uninsured as well as the insured.) In fact, many services for which insurance makes no economic sense become feasible with these subsidies. Good examples are annual physicals, routine dental exams, service prescription programs, a pair of new eyeglasses each year, etc. And the primary beneficiaries are not the employees, the insurers or their consultants - but the providers. (Why can't someone figure out how to have Actuarycare?)

These are the basic reasons why many health economists believe that tax neutrality (i.e., not subsidizing health insurance premiums compared to wages) would increase competition.

b. Proposals for tax neutrality

Three ways to change the present perverse incentives to overinsurance may be considered:

- o Tax employees on employer contributions as ordinary income;
- o Tax employers as profits, by disallowing the deduction;
- o Tax the insurance, i.e., a premium tax.

In each case, the tax may be levied on all or part of the employer contribution (e.g., that part over a dollar maximum) and may be applied to all or a percentage (e.g., tax 50% or 75% of the employer contribution, rather than 100%).

Taxing employees has the most straightforward effect. The present tax preference for health services in kind rather than cash is directly removed. Employees will be more ready to accept cash rather than higher benefits. Over the long run, certain types of insurance benefits will disappear for sound economic reasons. All of this would be gradual and take a very long time to happen, much to the disappointment of the economists who are used o changing parameters in computer models and seeing the results immediately.

What happens if the employers are taxed is more difficult to analyze. Corporations are conduits for taxes on others: employees, stockholders, suppliers and customers. Who pays the new tax depends on this incidence. In addition, the tax would be unevenly applied. Corporations that failed to make any money, that enjoy tax preferences, that are non-profit, etc., would be unaffected. To the extent that taxes are payable, however, there would probably be a much sharper employer reaction to the tax than the case if employees are taxed. Employers would regard such a tax as adding insult to injury of high health care premiums that they believe are beyond their control.

Taxing premiums would have long run effects similar to taxing employees, since the primary effect is to counter the present tax advantages of income in kind. But in the short run, most of the tax would fall on employers and be shifted to whoever pays corporate taxes. The impact would also vary for low and high paid employees, unless the premium tax rate was very high.

c. Conflicting public objectives: catastrophic protection and tax neutrality.

Achieving tax neutrality would conflict with another important policy objective: to provide genuine insurance protection against catastrophic financial losses due to illness. This problem is met in the pro-competition bills by:

- o Taxing employer contributions over some limit (presumably that needed to purchase minimum catastrophic protection;
- o Requiring that a policy meet minimum standards for catastrophic protection for any tax preference.

Taxing only the excess over a "cap" also has major practical advantages. The cap can be set high enough to avoid a revolution against the proposal. Opposition can be further muted by grandfathering any contribution already higher. At such a level, the cap would at least discourage further over-insurance.

But the aim would be to gradually make the caps binding by raising the caps at a rate less than the expected rate of increases in premiums. (Even indexing to the Medical CPI would result in a growing proportion of employer contributions being subject to taxaction.)

2. Equal Employer Contributions and Rebates

Most of the "pro-competition", and all of the "consumer choice" proposals, require that employees be permitted to choose between several insurance plans and benefit from any difference in cost. Two approaches are taken in these bills:

- o Requiring equal employer contributions to all options;
- o Requiring that a major portion or all of the excess of the employer contribution to a higher option over that to a lower option be paid as cash rebate to those electing the lower option.

Equal employer contributions are usually required in the context of multiple options. If the employer contribution exceeds the cost of an option, it must be paid as a rebate, making this approach a special case of the rebate approach.

In order that the rebates have a value to employees comparable to health benefits, most rebate proposals provide for all or most of the rebates to be tax free. Theoretically, neither income nor payroll taxes should be levied for tax neutrality.

Some of the proposals contain additional features. Multiple insurers may be required as well as multiple options. (In fact, it is difficult to explain to advocates the differences between multiple options and multiple insurers.) Some proposals require that an employer permit employees to choose any plan meeting Federal requirements, reducing the employer's role to collecting any employee contributions and forwarding the premiums to the proper plans. Finally, all of the proposals require annual open enrollments to assure that the plans maintain the quality of services and allow enrollees to learn from their experience with options and improve their choices.

The equal employer contribution (or 100% rebate) proposals also require that each option be self-supporting. Since the outlays of high option plans which pay only moderately more in benefits (10% to 15%) are sometimes double or even triple those of low option plans, participants in low options would benefit primarily from selection rather than savings attributable to their choice.

In order to understand why such arrangements can be seriously proposed, it is helpful to review the economic models that underlie these proposals.

Many policy analysts apparently regard the premium rate charged an enrollee in a group insurance plan as the price of the service, like that charged

for any other goods or service. In competitive markets (i.e., markets obeying certain basic assumptions concerning economic behavior), different prices would represent differences in the products, as reflected in the underlying demand and supply relationships.

In reality, group insurance premiums represent averages for the group insured and may not represent an appropriate price for any particular member. Thus, to many pro-competition advocates, self-supporting (or experience rated) premiums for different options reflect the value of the expected services to be obtained by joining the plan. They thus attribute most or all of the differences in outlays to plan differences (e.g., benefits covered, cost-sharing, etc.) and differences in reimbursement rates, utilization controls, etc.

Such proponents seek to find conditions under which the choice of insurance plans would fulfill the conditions of the classic economic model of firms in free competition. This model requires many purchasers and suppliers, each buying or selling a standard commodity. Each must accept a market dictated rate which represents the aggregate of all the consumer demand curves and supplier offer curves.

The facts of group health insurance are fitted into this simple model. The premium is regarded as the market determined price. Multiple insurers are needed for the supply conditions. Individual choices of plans by employers are needed for the demand equations. Free entry and exit of suppliers is needed to assure an unlimited number of potential competitors. Open enrollments are needed to supply an adequate number of purchasers and to avoid the awkwardness of the implications of long run contracts at changing prices. The demand curves reflect the utility frontiers of the consumers.

There are, of course, many problems with this simplified view of health insurance. The most important is biased selection. The idea that the particular consumers purchasing a product would change the cost of producing it is novel to economists. There is also a tendency to think of selection as a random process. The most difficult point to explain is that the financial rewards to an insurer for selecting good risks is of a much greater magnitude than the rewards for efficient operation, negotiating lower reimbursement rates, plan design that discourages unnecessary utilization, etc. An indication of the relative order of magnitude of these can be obtained from an examination of the Federal employees benefit plans, where there are several "low option" plans which provide 80% to 90% of the benefits of competing "high option" plans but with premium rates less than half (since each option is self-supporting). Ironically, advocates of equal employer contribution cite the Federal plan as evidence that competition will work and have the desired benefits!

Rebate proposals bear an interesting relationship to proposals to tax employer contributions. The logical extension of the tax preferences given to employer payments for premiums over cash waiges imply a potential subsidy for all health expenses. To the extent that employees do not make use of this potential, they should be allowed to shelter cash income. Some rebate proposals would, in fact, permit the sheltering of income equal to the cost of all health care services (e.g., Hatch Bill).

Most rebate proposals, however, only seek to reduce the present level of coverage. This requires that the rebates be determined relative to what

already exists rather than in absolute terms. This relativity of purpose leads to serious problems in designing a rebate plan that fulfills the policy objectives without creating significant new opportunities for tax preference income.

As a result of selection, a requirement for high and low option with rebates based on equal employer contributions would force an employer to pay rebates that greatly exceed the savings generated when the employees getting the rebates changed to the low option. Employers would have to choose between retaining the high option plans and paying substantially more for health insurance (including the rebate payments). Further, healthy employees would receive a monetary reward for being healthy. (The primary result would probably be massive evasion of the requirements for high and low options. Only if the required plans were specified in great detail would employers be stuck with them. The advocates have not given much thought to these problems, probably out of ignorance of the complexities of the plans and the opportunities to defeat the requirements.)

Rebate - equal employer contribution proposals should, however, be taken seriously. The problems leading to the proposals are real: incentives to overinsure, overutilize and overpay and the absence of competitive pressures on providers. The deficiencies of the proposals are primarily technical: measuring the expected cost to insure a particular employee or family. If the rebate could be calculated so as to reflect the savings in claims that are produced by the switch of a participant from one option to another and this amount offered as the rebate, these proposals would work as intended. Although such calculations go well beyond the present limits of actuarial science, this may not always be the case. Research could well produce far more accurate rating methods than are presently available.

These considerations lead to the suggestions of a voluntary rebate - equal employer contribution proposal. If employers are permitted the option of paying tax free rebates to employees, the government can confine its interest in the matter to assuring that the rebates are substitutes for higher insurance coverage. This, in itself, is no simple matter, but simple rules could be followed that would discourage most abuse. Employers would, out of self interest, install rebate plans only if the technical problems could be solved. A promising scheme would be to permit tax free rebates up to one of the following limits (choice to be made by the employer):

- o 25% of the difference in self-supporting (i.e., experience rated) premiums for the options.
- o 50% of the difference in "whole group" premiums (i.e., the difference in the high option and if they were all in the low option).
- o 75% of the difference in the actuarial value of the coverage for particular actuarial categories (including at least age, sex and area).
- o 100% of an actuarial estimate of the actual savings generated when an employee changes option.

These options vary in accuracy and complexity. Large employers may elect one of the complex methods. Smaller employers would not need to go to this expense. The rebates offered to particular employees would be only crude approximations of the savings generated by their choice of plans. But the

experience of the Federal employees plan, where employees are willing to pay extraordinary multiples of the differences in actuarial value for high option coverage, suggests that such crude approximations may be adequate for the purpose.

3. Multiple Insurers

The requirement of multiple insurers compounds the problems of rebate - equal employer contribution proposals, since effective means to cope with anti-selection (using presently available techniques) are removed. The gains from selection on one option cannot be offset against the losses on another. All rates must be self-supporting for those employees who select any option.

The insurers must compete to attract the youngest and healthiest employees. Benefits that help persons in poor health or with chronic conditions may be strictly limited (e.g., out-patient psychiatric care). Benefits that can be forecast and thus selected for may be restricted (e.g., preventive dental care).

Some of the problems of multiple insurers could be alleviated by varying the employer contributions by basic actuarial categories, such as age, sex and area. The experience of the Federal employees plan, however, shows that this would reduce the effects of selection only moderately.

Multiple insurers with equal employer contribution would be competitive, as is the case with the Federal employees plan. There would be increased pressure on insurers to reduce the cost of service, either by plan design or reimbursement rates. The primary focus of competition, however, would be on attracting low cost persons.

As is the case with multiple options, a technical advance in the science of actuarial classification could make multiple insurers feasible. The classification scheme would have to result in estimates of expected values of claims for any sub-group of employees relative to the entire group of within 5% to 10% of actual.

4. Vouchers

An extension of the rebate - equal employer contribution idea is to provide vouchers to beneficiaries of the government's medical insurance programs that can be used to purchase private coverage. Each beneficiary could make an annual choice among competing private alternatives. In most proposals the Federal program would remain as a residual option. (In at least one optimistic plan, there is specific provision for liquidating the Federal plan as it withers away, like the state in communist doctrine.) The amount of the voucher would be based on the "Average Adjusted Per Capita Cost" (AAPCC), a crude actuarial approximation of the cost for a Medicare beneficiary (adjusted for age, sex, geographical area, institutional status and welfare status).

The technical feasibility of vouchers, however, depends on the same factors as multiple insurers for an employment group. If there is a tendency of beneficiaries to remain in the family environment of a social insurance program, however, the effects of selection could be more striking.

Under present conditions, a voucher program would appear to have little impact. The substantial discounts obtained from providers by Medicare and Medicaid could not be matched by private insurers. Further, policies for those taking the vouchers would have to be administered on a franchise basis and pay premium taxes, and administrative expenses would be much higher than those of Medicare and Medicaid.

Insurers would have to obtain very select groups in order to offer the same coverage for less than the voucher. Further, to the extent that they obtain such groups, the vouchers will result in higher Federal spending. There may be situations in which insurance is feasible. Blue Cross has discounts as great as Medicare in some states. Employers may wish to include retired employees in a base plan despite a higher cost. But prospects for participation would appear too minimal.

5. Negotiated Provider Agreements

The best hope for real competition may not require major changes in national legislation. Under present laws, employers or their insurers may limit the providers that the plan will reimburse. The extreme of such limitations is paying only for HMO coverage. Many other options are feasible, including:

- o Limiting reimbursement for high cost providers and informing the insured concerning providers that accept the rate offered as payment in full.
- o Negotiating limited provider arrangements under which only the service of approved providers are reimbursed. (All providers willing to accept the terms would be approved.)
- o Exclusive franchises for a sufficient number of providers in each area.

Ironically, the present concentration of cost and responsibility on employers may result in a faster evolution of this type of competition. Insurers that can demonstrate negotiating capacity and existing arrangements may have competitive advantage over those that do not.

MR. THEODORE ALLISON: I would like to discuss with you what has been considered to be a major element of the Reagan Administration's health policy - one which could have an unsettling impact on the health insurance business, particularly group health insurance. I am referring to proposals to control health care cost inflation by stimulating more market competition among insurers and among providers of care.

These proposals are a radical departure from the kinds of legislation which have been considered in recent years. During the 50's and 60's and on into the early 70's, the key word in health policy was availability. Hill-Burton support for hospitals and health manpower training funds were intended to improve the availability of care. The Kerr-Mills Act and then Medicare and Medicaid made care more accessible for the elderly, poor and disabled. Even while private insurance plans were becoming more comprehensive and being extended to an ever large segment of the population, there was intense debate about what form of national health insurance would best assure that everyone would have access to care.

In the early 70's, concern about rising costs began to surface. The Nixon Administration's support for the development of health maintenance organi-

zations was based on the belief that HMOs could provide quality care more efficiently and economically. The National Health Planning and Development Act of 1974 was designed to secure more rational allocation of capital investment in the health care system. Ostensibly, the purpose of the Professional Standards Review Organizations was to assure that government beneficiaries receive quality care, but a purpose at least equally important was to control Medicare and Medicaid cost by curbing overutilization.

As the concern about rising costs intensified, the regulatory schemes to control costs multiplied. Twice the Carter Administration proposed, unsuccessfully, to impose a cap on hospital revenues. And still the rapid rise in spending for medical care continues.

It is generally recognized that the Voluntary Effort, which was supposed to be an alternative to regulation, has failed. Inflation in medical care costs has continued to outrun inflation in the general economy. From 1965 to 1979, health expenditures grew at an average annual rate of 12.3%, while the annual growth in GNP was 9.2%. Now, as inflation in the general economy has slowed, medical care prices continue rapidly upward. The continuing increase in medical costs has a substantial impact on the Federal spending. The Congressional Budget Office projects that such spending will reach almost 11% of the Federal budget in 1984.

Faced with this problem, those who are philosophically opposed to the use of regulatory approaches to cost control have advanced the idea that competitive market forces will work where regulation has failed. Here's how the pro-competition advocates diagnose the problem:

1. Excessive costs arise because people use too much health services.

2. People fail to be prudent in using services because they have too much insurance and, therefore, are not conscious of costs.

3. The overly rich insurance plans have been created because employer contributions for health benefits are tax deductible expense for employers and represent tax-exempt income for employees.

4. This tax treatment distorts consumers' normal economic behavior. Given a choice, many would opt for reduced health benefits and more money.

5. On the supply side, an absence of competition among those who provide care leads to inflationary pricing behavior. Moreover, retrospective cost reimbursement, which is commonly employed by Blue Cross, Medicare and Medicaid, provides little incentive for cutting costs.

The first legislative proposal based on these premises actually appeard during the Carter Administration. It was the Consumer Choice Health Plan devised by Alain Enthoven, a guru of the pro-competition school. That scheme is no longer being considered seriously, but many of its concepts are incorporated in bills presently before Congress. Examples are S.433 introduced by Senator Durenberger, Chairman of the Senate Finance Subcommittee on Health, H.R.850 introduced by Representative Gephardt and David Stockman before he became the Director of OMB, and S.139, which is identical to a bill introduced in 1980 by Richard Schweiker, now Secretary of HHS.

While the bills vary in detail, they have common fundamental features:

1. A tax cap, limiting the amount of employer contribution which may be excluded from employee taxable income.

2. A requirement that if employers above a certain minimum size have a health benefit plan, they must offer employees multiple options. The Durenberger and Schweiker bills would require three options provided by three different carriers. The employer must make an equal contribution for all employees, regardless of the plan chosen.

3. The employers must make a cash rebate to any employees choosing a plan which costs less than the employer contribution.

4. The Gephardt/Stockman bill would extend consumer choice to Medicare beneficiaries by providing vouchers for the purchase of private insurance by those who wish to opt out of the Medicare program. This is also the intent of a bill introduced by Representatives Gephardt and Gradison.

The Reagan Administration promised a competition bill back in January but found it was difficult to develop a politically acceptable proposal. The President now has a package on his desk which contains three components:

1. A voluntary Medicare voucher.

2. A proposal which would have an impact on group health insurance.

   This would:

   a. permit tax free rebates to employees who select health insurance coverage options which are less expensive than the total amount of the employer's contribution.

      This is seen as an incentive for employers to offer multiple-choice plans.

   b. However, an employer could provide rebates tax free only if his contributions were subject to a tax cap. That is, contributions in excess of a limit such as $150/month for family and $60 for individuals would be treated as taxable income to the employee.

3. The third component of the draft proposal is said to call for restructuring Medicare Part A benefits:

   Daily Copayment

   Remove limits on day covered

   Out-of-pocket limit

   (This is not really a pro-competition proposal.)

   The third component is probably politcally dangerous, and this may account for the Administration's failure to act.

Although the Administration has proposed only a voluntary tax cap, a mandatory tax cap is on everybody's list as a revenue raising measure.

The presumption is that many employees would seek to avoid paying taxes on imputed income by choosing a plan costing less than the cap. But such employee action appears doubtful. Because no individual is in a 100% tax bracket, it would seem more reasonable that employees would rather receive the benefit - purchased at group rates - and pay tax on it, rather than forego the benefit. If the tax cap were to restrain insurance expenditures, it probably would not affect basic benefits, such as hospitalization - where the big bucks are - but it might inhibit the growth of coverages for care such as vision and dental treatment.

A single national tax cap fails to recognize that medical costs and therefore, plan costs, vary widely both in geographic areas and by age compositon of employee groups, among other factors. A single national tax cap would discriminate against employees in high medical cost areas and those in groups with higher than average age. It might discourage the employment of older workers. Conversely, it would allow tax-free purchase of much more generous benefit plans by young groups and those in low medical cost areas. These consequences could be avoided by varying the tax cap according to area and age. But this would greatly complicate administration and introduce undesirable - indeed, unacceptable - variables into the Federal tax code.

Presumably, the requirement for three different carriers is intended to increase competition among insurers. I do not need to tell this audience that this would be redundant. Moreover, such a requirement would be counterproductive. Multiple carrier plans will increase an employer's administrative costs.

Carrier uncertainty about the size and composition of the employee group to be insured could lead to higher rates and more restrictive underwriting.

In a situation where employees may choose among three plans with differing benefit levels, adverse selection is likely to operate; and a cash rebate would reinforce this likelihood. The lower cost plan would be selected most often by young lower-paid employees, except those who are unhealthy; and the higher cost plan would be selected by unhealthy employees of all ages and by older employees regardless of their health. To compensate for the tendency of younger employees to choose low-cost plans, an age factor could be computed into the refund calculation. Medical benefit plan costs vary by geographical area. To maintain equity, these cost variations could also be reflected in the determination of the refund. However, these complexities would introduce further administrative difficulties.

In addition to recognizing age and geographical area in calculating the rebate, it would be necessary to introduce controls against the adverse selection that would occur if employees are free to switch their enrollment between options whenever their health status changes. If adjustments and controls were not introduced to control adverse selection, the cost of the high-cost plan would, over time, increase disproportionately and be more likely to exceed the tax cap, resulting in taxable income to the older, less healthy employees, while younger, healthier employees would receive a windfall rebate.

Thus, introduction of multiple insurance plan choice, in conjunction with rebates, will not reduce aggregate health plan costs but may actually

increase them. The cost of the more comprehensive plan would rise, but there is nothing in the proposals to reduce the amount paid by the employer as a rebate. This strongly suggests that the rebate should not be the full difference in cost between the plans but should be reduced so as to approximate the actuarial value of the benefits foregone. In theory, this is an acceptable solution, but because it requires a determination of what the actuarial value of each benefits plan would have been had all employees enrolled in that plan, it represents formidable administrative complications. Furthermore, a reduction in the rebate also reduces the incentive to choose the lower-cost plan.

The concept of the Federal government providing Medicare beneficiaries with vouchers to purchase private health insurance policies as a way to stimulate greater competition in the health care system has a number of flaws:

1. Under the present Medicare program, providers are reimbursed at less than full charges, in accordance with regulations unilaterally established by the government. Insurance companies do not have the advantage of such reimbursement arrangements with providers. Last September, Alice Rivlin, Director of the Congressional Budget Office, told the House Ways and Means Health Subcommittee that Medicare reimbursement averaged 16% below hospital billed charges, and the most recent cuts in the budget reconciliation bill are likely to increase the differential. It is impossible for the savings achieved through private administration to offset the substantial reimbursement advantage of the government program. Hence, private carriers could not deliver the same benefits for the premium provided. Thus, unless some change is made in the reimbursement arrangements, insurance companies could not offer medical expense policies which would be competitive with the Medicare program.

2. Under proposals advanced to date, Medicare beneficiaries would be offered the opportunity of utilizing a voucher roughly equivalent to the average per capita cost of Medicare to obtain a private insurance policy, but they would not be required to do so. Those Medicare beneficiaries who do not utilize the voucher would remain under the government program. Assuming the problems of differential reimbursement cited above were resolved, it is likely that the younger beneficiaries in relatively better health would be more likely to choose to be covered under the government program because their vouchers could not purchase equivalent private coverage. This anti-selection would result in greater per capita cost to the government program. There is likely to be additional anti-selection inasmuch as beneficiaries using vouchers may come, largely, from geographical areas where the average per capita cost of Medicare is below the national average.

3. Several proposals have advanced the concept of separate rating by age, sex, institutional status, disability, health status and geographical area in order to deal with this problem. The proposals would require considerable additional regulatory authority to assure uniform and equitable application of such measures and thus would add to the burden of Federal and state regulation of the insurance business. The cost of monitoring the carriers, HMOs and other entities involved could be substantial.

MR. RICHARD MURDOCK: My reaction is fright. I have been sitting here and listening to the complexities that we may be adding to the pricing and

design of group policies and tax systems. I wonder if these practices get at the root of the problems - the containment of medical care costs. Costs will be controlled when the people incurring the cost take a vested interest in them. There is a definite need for education among all of us that insurers are not money machines, that those dollars are going from one pocket and into another. It frightens me to think of all the problems we will go through with these tax rebates and other items just to get at this problem. I do not have much optimism.

MR. LOEFFEL: If this effort toward pro-competition is to reduce insurance and make people more cognizant of the cost, wouldn't this increase the bad debts, which in turn increases the cost?

MR. TRAPNELL: It depends upon who has the bad debts. With hospitals its obvious they would shift them, because the non-profit hospitals make up 85-90% of the total hospital dollars and have no other income resource. But with physicians, and professional providers, it is not clear that bad debts are just less income to the physicians. Research that I was able to do indicated that if bad debts to physicians were paid, they would pocket it. Although there may be some physicians that would lower their charges or reduce their increase, that seems to be the exception rather than the rule.

MR. ALLISON: I would like to address the remarks made by Mr. Murdock in which he indicated the need for an educational program. I could not agree more, except I would not rely on the effort of educational programs unless it were bolstered by economic incentives, such as greater cost sharing and more imaginative plan design. For instance, in dental plans we have waived the deductible if the person goes at least once a year to the dentist for preventive care. Other examples might be coverage for out-patient surgery and less cost sharing on out-patient services than in-patient services. These are all ways of reinvolving the patient in his health care cost.

MR. LANCE MALKIND: I would like to address Dick's comments about more education by the users of medical care. I think there is also the need for more education for the providers of medical care. Perhaps we in the industry could provide pressure for them to run their operations more effectively. For example, hospitals can be encouraged to reduce the amounts of the ancillaries they are performing, physicians could do a better job policing their members, thereby reducing the cost of malpractice insurance.

MR. TRAPNELL: If there is a solution along pro-competition lines, those are the right directions. The relevent competition is among providers, and unless we can focus the competition there, in spite of third party payment, there will not be genuine competitive pressure.

I used to joke with several economists, saying that if an economist from Mars were to arrive and to study our health insurance system, he would say, "It is the employers who are to control health care costs because they are the ones who pay the bills." Of course, that is where ultimately the cost pressure is focused. One of the unfortunate side effects of some "pro-competitive" bills is to remove employers from any role in regulating or structuring health insurance plans because they become merely a conduit keeping track of the funds to see they are paid to the right insurance company. Thus, the bill removes an agent, such as the employer, with interest and concentrated bargaining power to control the costs.

The employer has a focused interest and the resources to understand and act. It is one of the aspects of health insurance in the United States that I understand least as to why employers have played such a minor role. Of course, that can change. There is now a great deal of employer actions that one did not see five years ago. Perhaps five years hence there will be entirely different relationships between employers, insurers, hospitals and provider groups.

MR. ALLISON: I would like to call attention to the growing development of employer health care coalitions and, in particular, one recent development. In Maryland there is a coalition of employers, unions, insurers, Blue Cross and some government agencies. They sought a judgment by the Justice Department as to whether or not it would be an anti-trust violation if they should secure data showing hospital-by-hospital comparisons in terms of length of stay by diagnosis, etc. They very recently received a letter saying it would not be an anti-trust violation so long as they did not use the information in a way that would constitute coercion, boycott or intimidation. This means that employers in Maryland can look at data such as length of stay by diagnosis and ask questions.

MR. LOEFFEL: In the pro-competition environment do you see any problems developing with insurance departments? For instance, what happens if an employer says my low option plan will not have maternity coverage? In other words, are these areas where insurance companies and the Blues cannot compete?

MR. ALLISON: If the proposals become legislation, it would be Federal legislation which would have a real impact on state legislation. There may be a problem as to whether, like ERISA, it would preempt state legislation. In fact, some consideration has already been given as to changes in state legislation to make Federal pro-competition work. Even the pro-competition people often maintain the need for a minimum standard for the low option plan.