

PREFACE

In an April 6, 1982, request from the Chairman, Subcommittee on Oversight, House Committee on Ways and Means, we were asked to provide an analysis of the procompetition strategies for health care cost containment focusing on a description of their major features, their underlying assumptions, and the bases upon which their impact on health care costs have been estimated.

This study describes the two major procompetitive approaches--the cost-sharing approach and the alternative delivery system approach. The cost-sharing approach relies on increased consumer sharing of health care costs as a means of encouraging consumers to use fewer health care services and to shop among providers for the lowest prices. The alternative delivery system approach relies on increased development of and participation in prepaid health care plans commonly known as health maintenance organizations, which provide health care services and have strong incentives to develop efficient, less costly methods of providing care.

The evidence indicates that both approaches offer potential for reducing consumers' use of health care services and contributing to reduced inflation in health care costs. For example, several major studies have shown that increased consumer sharing of health care costs reduced the quantity of services used and, as a result, lowered total health care expenditures. Little is known, however, about the effects of greater cost sharing on the long-term health status of consumers or their long-term expenditure pattern. Also, it is not clear whether consumers will accept increased cost sharing in view of their apparent desire to minimize the risk of out-of-pocket health care expenditures.

One type of alternative delivery system, the prepaid group practice health maintenance organization, has proven effective in reducing enrollee costs. The reductions were achieved through lower hospital admissions. In the short term, however, enrollment capacity limitations and obstacles to establishing new plans will limit enrollment in prepaid group practices. Other types of alternative delivery systems are not faced with these obstacles, but neither have they yet demonstrated the kind of cost savings attributable to prepaid group practice health maintenance organizations.

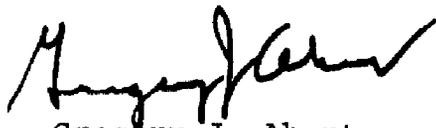
Several other issues surround the implementation and effects of either competition approach, most notably the (1) potential for inadequate or costly health insurance coverage for the aged and persons in low income brackets, (2) ability of consumers to obtain and understand the information necessary for making informed choices, (3) impact on administrative costs, and (4) impact on teaching and research hospitals.

The study consists of four parts:

- Chapter 1 discusses rising health care costs and imperfections in today's medical marketplace.
- Chapter 2 discusses the cost-sharing approach.
- Chapter 3 discusses the alternative delivery system approach.
- Chapter 4 discusses other issues and major decisions remaining in designing and implementing competition models.

The information contained in this study was obtained from many sources. We conducted an extensive literature search of the major studies, publications, and articles on health care competition and interviewed officials and representatives from organizations with diverse views on the procompetitive proposals including the Department of Health and Human Services; the Office of Personnel Management; the Congressional Budget Office; Blue Cross/Blue Shield; the Health Insurance Association of America; the American Federation of Labor and the Congress of Industrial Organizations, Committee for National Health Insurance; and the Washington Business Group on Health. We also reviewed the testimony on competition of the American Medical Association, the American Hospital Association, and the Federation of American Hospitals before the Subcommittee on Health, House Committee on Ways and Means.

While we did not verify statistical information cited in this study, we discussed the draft with officials of the Department of Health and Human Services and the Congressional Budget Office and knowledgeable people outside the Government. Their comments have been incorporated as appropriate.



Gregory J. Ahart
Director
Human Resources Division

C o n t e n t s

	<u>Page</u>
PREFACE	i
CHAPTER	
1 INTRODUCTION	1
Imperfections in today's medical marketplace	3
Competitive strategy for health care cost containment	4
Objectives, scope, and methodology	6
2 THE UNDERLYING CONDITIONS OF THE COST-SHARING APPROACH	8
Scenario of the cost-sharing approach	8
Impact of increased cost sharing on utilization of medical care and medical care prices	9
Key events and underlying conditions	12
Summary	21
3 THE UNDERLYING CONDITIONS OF THE ALTERNATIVE DELIVERY SYSTEM APPROACH	22
Scenario of the alternative delivery system approach	22
Impact of alternative delivery systems	23
Key events and underlying conditions	26
Summary	30
4 OTHER ISSUES AND MAJOR DECISIONS REMAINING IN DESIGNING AND IMPLEMENTING COMPETITION MODELS	32
Changing the tax treatment of health benefits	32
Multiple choice of health plans	35
Uniform employer contributions	38
Medicare vouchers	39
Time frame for impact of competitive approaches	43
Impact of competition on teaching and research hospitals	44
Summary	45
APPENDIX	
I Letter dated April 6, 1982, from the Chairman, Subcommittee on Oversight, House Committee on Ways and Means	47

ABBREVIATIONS

CPI	Consumer Price Index
FEHBP	Federal Employees Health Benefit Program
GAO	General Accounting Office
GNP	gross national product
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IPA	individual practice associations
PGP	prepaid group practice
PPO	preferred provider organization

GLOSSARY

Actuarial class	a grouping of individuals by such factors as age, sex, and location for estimating medical expenses and claims
Adverse selection	the tendency of persons with poorer than average health risks to purchase more insurance than persons with average or better health--the result is a concentration of persons with poor health risks in comprehensive plans and a reduction in the carrier's ability to spread medical costs among a mix of both high and low users of medical services
Alternative delivery system	a system for financing and delivering health care services from participating providers on a prepaid basis to a voluntarily enrolled population--such systems are commonly known as health maintenance organizations
Catastrophic coverage	a feature of insurance plans to limit the amount the insured would pay out-of-pocket if large medical bills were incurred
Coinsurance	the arrangement by which an insurance plan and the insured share in paying the cost of medical expenses
Cost-based reimbursement	payment for medical expenses (usually hospital expenses) on the basis of the costs incurred by the provider--usually dollar-for-dollar (see fee-for-service reimbursement)
Deductible	the amount of expenses which must be paid by the insured before becoming payable by the carrier
Fee-for-service reimbursement	payment for medical services on a unit basis--the predominant method of payment for physician services

Health maintenance organization	a system that delivers health care to a voluntarily enrolled population for a fixed prepayment
Individual practice association	a form of health maintenance organization in which participating physicians maintain their individual office practices and are paid on a fee-for-service basis
Preferred provider organization	a group of hospitals and physicians which contract on a fee-for-service basis with employers, insurance plans, or other third-party administrators to provide comprehensive medical service--users of preferred providers can receive economic incentives, such as the waiving of coinsurance or deductibles which would have to be paid if nonparticipating providers were used
Prepaid group practice	a form of health maintenance organization in which physicians (1) are members of multispecialty group practices, (2) are paid on either a salary or per enrollment basis, and (3) generally share centrally located medical facilities and ancillary personnel
Primary care	the care provided at an individual's first contact with the health care system
Primary care network	a type of individual practice association health maintenance organization in which primary care physicians maintain both clinical and financial control of the total health service for voluntarily enrolled members for a prepaid amount
Provider	an individual or institution, such as a physician or hospital, which delivers health services
Third-party payer	an entity, such as an insurance company, responsible for payment of health care costs incurred by a patient
Tertiary care	medical care by specialized providers, generally for rare disorders or serious long-term conditions of relatively low frequency and usually provided at a regional medical center

CHAPTER 1

INTRODUCTION

Dramatic increases in health care costs, particularly for Medicare and Medicaid, have focused congressional attention on alternative approaches for cost containment. National health expenditures increased from \$41.7 billion (6 percent of the gross national product (GNP)) in 1965 to \$286.6 billion (9.8 percent of the GNP) in 1981. During this 16-year period, health expenditures increased at an average annual rate of 12.8 percent, exceeding the 9.5 percent growth rate for the GNP. Per capita health expenditures also increased significantly from \$211 in 1965 to \$1,225 in 1981. 1/ Assuming that historical trends and relationships continue as they are today, the Health Care Financing Administration (HCFA) projects that national health expenditures will reach \$462 billion in 1985 and \$821 billion in 1990. HCFA also projects that the proportion of national health expenditures financed by the Federal Government will increase from 28.7 percent in 1979 to 32 percent in 1990. 2/

Health care expenditures vary markedly for different population groups. Because of chronic diseases and increasing physical impairment requiring frequent health care services, a disproportionate amount of health expenditures is used for the aged. For example, of the \$168 billion spent for personal health care in 1978, 12 percent was spent on persons in the under 19 age group (31 percent of the population), 59 percent was spent on persons in the 19 to 64 age group (58 percent of the population), and 29 percent was spent on persons 65 and over (11 percent of the population). Reflecting the greater use of health care services, the average medical care bill for the 65 and over age group reached \$2,026 in 1978, compared with \$764 for the 19 to 64 group and \$286 for the under 19 group. 3/

Rates of hospital use also vary among different population groups. For example, both men and women 65 years and older and women of childbearing age are more likely to require hospitalization than other groups. According to the 1978 Health Interview Survey, the annual number of hospital days used ranged from about

1/Robert M. Gibson and Daniel R. Waldo, "National Health Expenditures, 1981," Health Care Financing Review, September 1982.

2/Mark S. Freeland and Carol Ellen Schendler, "National Health Expenditures: Short-Term Outlook and Long-Term Projections," Health Care Financing Review (Winter 1981), pages 97 and 112.

3/Charles R. Fisher, "Differences by Age Groups in Health Care Spending," Health Care Financing Review (Spring 1980), pages 65 to 68.

6 days per user for the under 17 age group to about 16 days per user for the age 65 and over group. 1/ 2/

Other major users of health care resources include residents of nursing homes; patients with chronic diseases, such as end-stage renal disease; and patients who require intensive level hospital care.

Hospitals and physicians are the largest recipients of health care expenditures, receiving 41.2 and 19.1 percent, respectively, in 1981. Other major expense areas include nursing homes (8.4 percent), drugs/medical sundries (7.5 percent), and dentists (6 percent). Third-party payers, such as insurance companies and the Federal, State, and local governments, have paid larger proportions of personal health care expenditures. For example, in 1950 consumers directly paid for 65.5 percent of their personal health care expenditures with the balance paid by third parties. However, by 1981 consumers directly paid for only 32.1 percent of total personal health care expenditures. 3/

Rising health care costs are a major concern of Federal officials primarily because of the impact on the Medicare and Medicaid programs. In 1981, Federal spending for Medicare and Medicaid totaled almost \$60 billion. In May 1982, the Congressional Budget Office estimated that expenditures will reach \$133.6 billion in 1987, or about 12 percent of the total Federal spending for that year. 4/

Federal and State governments have used various regulatory measures to curb the supply and demand for health care. These measures included restrictions on hospital capital expenditures and physician utilization review. With continued health care cost increases, economists and Government officials are seriously questioning whether such regulatory measures have been effective in containing costs and are desirable. The situation is exacerbated by extensive coverage of health care costs by the third-party payers (e.g., insurance companies, Medicare, and Medicaid) and by the primary method of payment for health care services. Extensive third-party coverage tends to encourage patients to demand high quality care without significant consideration of the

1/See footnote 3 on page 1.

2/Vincent P. Barabba, "Population Trends and the Cost of Medical Care," National Commission on the Cost of Medical Care 1976-1977, Volume 2/Collected Papers, 1978, page 31.

3/Gibson, op. cit.

4/Congressional Budget Office, "Containing Medical Care Costs Through Market Forces," May 1982, page 2.

cost. The principal payment mechanisms (payment on a unit of service basis for physicians and on a cost reimbursement basis for hospitals) tends to encourage providers to deliver more rather than less care.

Several proposals, commonly referred to as procompetition proposals, have been suggested as alternatives to the present health care delivery and financing systems. These proposals seek to increase (1) marketplace competition among health care providers and (2) provider and consumer sensitivity to health care costs which in turn would encourage more cost-efficient use of health care services.

IMPERFECTIONS IN TODAY'S MEDICAL MARKETPLACE

Economists have defined certain key elements necessary for pure competition. ^{1/} These elements describe the behavior of both buyers (i.e., consumers) and sellers of goods and services as well as certain characteristics of the marketplace. In theory, if all the elements are present, the market will operate efficiently and effectively without regulations or controls from the outside. Given an efficient, effective marketplace, the demand (i.e., the desire for goods and services) and supply (i.e., the quantity available) determine the price of goods and services.

The first key element of the competitive market is a large number of buyers and sellers. This large number is necessary so that one or relatively few cannot affect the market price of the goods and services being bought and sold. Second, if consumers make bad choices, they must bear the consequences of their decision. This leads to the third element, knowledgeable consumers. Consumers must understand the products (i.e., goods and services bought) and weigh the value of the products against the price when making purchase decisions. Finally, the market must be structured so that sellers can enter or leave the market freely. This free movement enables a new seller to compete with established sellers and, if successful, possibly cause some established sellers to leave the market.

The medical marketplace departs from the economist's model of pure competition in several important aspects. First, the structure of the third-party payment system isolates many consumers from the financial effects of their use of the health care system. Thus, the price of care for many is no longer a significant factor in health care decisions. As a result, consumers desire and health care providers deliver extensive, high quality care even when only marginal value would result.

^{1/}Institute for Health Planning, Inc., "Economics of Cost Containment," Prepared for Bureau of Health Planning, Hyattsville, Maryland, 1979.

Second, because of the complexity of health care, consumers are generally unaware of the need for, the effectiveness of, and the most efficient method of delivery of health care services. Instead, consumers select providers, primarily physicians, and rely on them to make the key decisions regarding the provision of health care services. For example, in most cases physicians determine who will go to the hospital, which hospital they will enter, how long they will stay, and what diagnostic and treatment services they will receive. Because of physicians' dominant role, it has been estimated that 70 percent of all health care expenditures are directly influenced, if not controlled, by the decisions of physicians. ^{1/}

Third, the number of providers are small enough in some market areas to influence the prices of health care services. To illustrate, in many rural areas and small towns, there are so few providers that any one of them can significantly affect the price of services.

Finally, there are restrictions on entering the health care field. Compulsory licensing of physicians, nurses, and other health care providers is the most obvious restriction. Other restrictions include hospital limits on the number of physicians with admitting privileges and certificate-of-need restrictions on new facility construction. While these restrictions may serve to maintain high quality standards and limit capital expenditures, from an economic standpoint they serve to restrict competition.

COMPETITIVE STRATEGY FOR HEALTH CARE COST CONTAINMENT

Competition proposals seek to restore elements of competition to the health care market. More specifically, the proposals seek to increase consumer and provider sensitivity to health care costs thereby encouraging more rational decisions regarding the consumption of services. Procompetition advocates support a restructuring of health insurance so that benefits are selected from a range of health plans by consumers who have a financial stake in the cost of the plan selected. Advocates have proposed two major approaches for these changes

- the cost-sharing approach and
- the alternative delivery system approach.

^{1/}Mark S. Blumberg, "Provider Price Charges for Improved Health Care Use," Health Handbook, George K. Chacko, editor, Amsterdam, North Holland, 1979, pages 1,049 to 1,101.

The cost-sharing approach requires increased consumer sharing of health care costs at the time services are obtained. Under this approach, reduced coverage by third-party payers would require consumers to pay a larger part of the cost of services directly. The increased sensitivity to costs that would result would encourage consumers to use fewer health care services and obtain services from providers with the lowest prices. Both the decrease in service use and the increased awareness of price in choosing providers would serve to lower costs.

The alternative delivery system approach relies on increased development and participation in prepaid health care plans, such as health maintenance organizations (HMOs). Because HMOs provide services in return for a fixed prepaid premium regardless of the services used by individual consumers, they have strong incentives to control utilization and provide services efficiently. Increasing the number of these more efficient health delivery systems and placing them in competition with traditional providers would also encourage traditional providers to furnish services in a more efficient, less costly manner.

To increase consumer sensitivity to price and encourage more rational choices, several mechanisms are commonly included in various proposals. These mechanisms include

- limiting the amount of employer health insurance contributions excluded from employee taxable income;
- providing employees an opportunity to choose from a variety of available health plans;
- providing uniform employer contributions to employee health insurance, regardless of the plan selected by the employee; and
- giving beneficiaries of publicly financed health programs, such as Medicare, an opportunity to choose private health plans through a voucher system.

Enthoven ^{1/} and others recognize that not everyone must choose a cost-sharing or alternative delivery plan for these approaches to have the desired effects. They expect that enough people will participate in such plans to achieve the degree of competition needed to have an impact on costs. Traditional insurers (i.e., those providing comprehensive coverage, allowing free choice of providers, and paying on the basis of fee-for-service and cost reimbursement) would then feel the effects of increased competition

^{1/}Alain C. Enthoven, Health Plan; The Only Practical Solution to the Soaring Cost of Medical Care, Addison-Wesley Publishing Company, Inc., 1980, pages 71, 132, 144, and 145.

through the loss of enrollees. To remain competitive, traditional insurers will encourage physicians and hospitals to become more efficient in their service delivery and to hold down prices. Providers will also experience competitive pressures from the loss of patients and, as a result, will become more efficient. At this time, it is not known how many consumers would have to switch from traditional plans to the alternative approaches to have this effect.

Table 1 illustrates how the competitive strategy is to achieve lower costs and prices for the consumer.

OBJECTIVES, SCOPE, AND METHODOLOGY

The overall objective in this study was to identify and analyze how the two major procompetitive models would work. In this regard, we identified the

- key events and conditions which must occur within the models to achieve the goal of containing health care costs,
- evidence supporting the likely existence of each event and condition, and
- possible obstacles and major decisions to be made in designing and implementing procompetitive models.

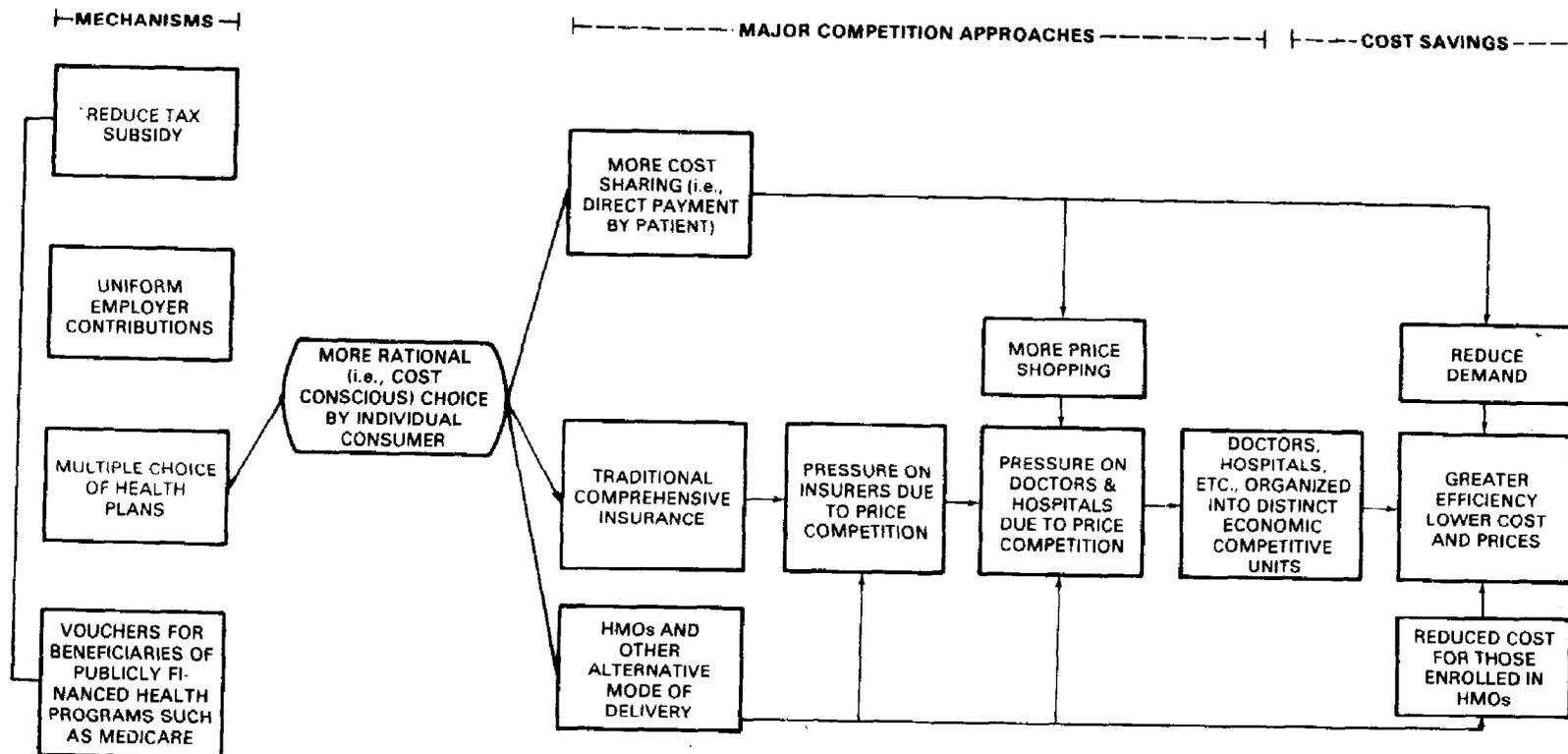
At the outset of the review, we conducted an extensive literature search for the major studies, publications, and articles on health care competition. In this process, we also used a draft annotated bibliography on competition prepared for the National Center for Health Services Research. ^{1/} We interviewed officials and representatives from organizations with diverse views on the procompetitive proposals including the Department of Health and Human Services (HHS); the Office of Personnel Management; the Congressional Budget Office; Blue Cross/Blue Shield; the Health Insurance Association of America; Interstudy, Inc.; the Group Health Association of America; the American Federation of Labor and Congress of Industrial Organizations, Committee for National Health Insurance; and the Washington Business Group on Health. We also reviewed the testimony on competition of the American Medical Association, the American Hospital Association, and the Federation of American Hospitals before the Subcommittee on Health, House Committee on Ways and Means.

While we did not verify statistical information cited in this study, we discussed the draft with officials of HHS and the Congressional Budget Office and knowledgeable people outside the Government. Their comments have been incorporated as appropriate.

^{1/}Applied Management Sciences, Inc., "An Annotated Bibliography of Research on Competition in the Financing and Delivery of Health Services," Second Draft, Prepared for the National Center for Health Services Research, March 4, 1982.

TABLE 1

THE DYNAMICS OF PROCOMPETITION



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SOURCE: Dr. William C. L. Hsiao, Associate Professor Economics, Harvard University, School of Public Health.

CHAPTER 2

THE UNDERLYING CONDITIONS OF

THE COST-SHARING APPROACH

It is generally accepted that most health care consumers have insured themselves and their families against large out-of-pocket medical expenses to the extent that the price of services is not a major factor when seeking care and selecting a provider. Moreover, the comprehensive nature of insurance coverage causes consumers to accept elaborate and expensive medical care, regardless of the need or benefits, and to not seek out the lowest cost providers. The goal of the increased consumer cost-sharing approach is to encourage consumers and providers to use more economical medical services and to increase price competition among providers by

- making consumers face greater out-of-pocket medical costs when seeking such care and
- encouraging providers to hold down prices in response to the threat of losing patients.

SCENARIO OF THE COST-SHARING APPROACH

The increased cost-sharing scenario postulates that employees, when faced with paying a greater portion of their health insurance premiums and provided an opportunity, will choose insurance plans with extensive cost-sharing provisions in order to reduce their insurance costs. Greater consumer cost sharing may also be accomplished through employers sponsoring health plans with greater cost sharing. This increased cost sharing would encourage consumers to limit the use of health services and to shop for the most efficient providers. Because of consumer concern about service prices, providers would compete for patients. Cost savings to the health care system would result from (1) the providers holding down prices as a result of competition among other providers and (2) consumers' reduced demand for medical services. 1/

Operation of the cost-sharing approach involves the following sequential events:

1/Paul B. Ginsburg, "Altering the Tax Treatment of Employment-Based Health Plans," Milbank Memorial Fund Quarterly/Health and Society, Vol. 59, Number 2 (Spring 1981), pages 225 and 227.

- (1a) Employee selection of insurance plan with extensive cost sharing.
- (1b) Employer-sponsored health plans with more cost sharing.
- (2a) Consumers and providers avoid uneconomical and unnecessary medical care.
- (2b) Consumers consider service prices when choosing providers.
- (3) Price competition among providers for patients.
- (4) Cost savings: (a) providers are encouraged to hold down prices and provide only necessary medical services and (b) consumers avoid care of little marginal value and obtain care from more efficient providers.

Table 2 illustrates the events of the increased cost-sharing scenario.

IMPACT OF INCREASED COST SHARING
ON UTILIZATION OF MEDICAL CARE
AND MEDICAL CARE PRICES

Several major studies have shown that increased consumer cost sharing reduced the quantity of health care services used and, as a result, reduced health care expenditures. For example, using a study by Newhouse and Phelps, ^{1/} Ginsburg projected that by increasing consumer cost sharing from 0 to 25 percent, hospital care expenditures would be reduced by 17 percent. ^{2/} An empirical study by Scitovsky and McCall ^{3/} found that the introduction of a 25-percent coinsurance (cost-sharing) provision to a prepaid plan offered to Stanford University employees and their dependents led to a 24.1-percent reduction in physician visits and a 23.8-percent reduction in the cost of physician service.

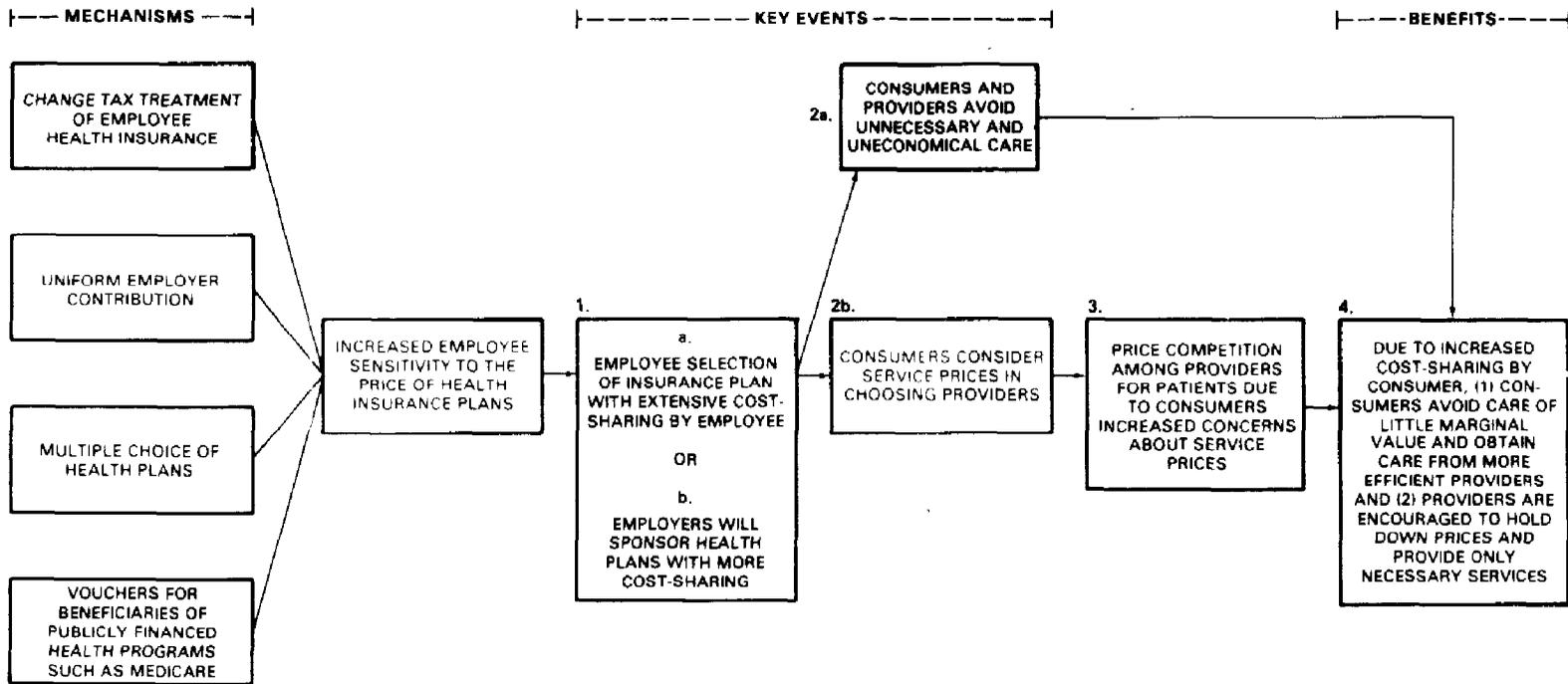
HHS is sponsoring a long-term study on the effects of cost sharing. The study of 2,756 families, being performed by the Rand Corporation, includes a controlled trial of alternative health insurance policies with various levels of consumer coinsurance--0 (no cost sharing), 25, 50, and 95 percent up to a maximum annual

^{1/}J. E. Newhouse and C. E. Phelps, "New Estimates of Price and Income Elasticities of Medical Care Services, The Role of Health Insurance in the Health Services Sector. New York: National Bureau of Economic Research, R. N. Rosett, editor, 1976.

^{2/}Ginsburg, op. cit., page 229.

^{3/}Anne A. Scitovsky and Nelda McCall, "Impact of Coinsurance on the Demand for Physician Services," Health Handbook, North Holland Publishing Company, 1979, page 1,027.

TABLE 2
SCENARIO OF THE COST-SHARING APPROACH



out-of-pocket expenditure for the family. 1/ Interim results 2/ 3/ from the study suggest that, as consumer cost sharing was reduced from 95 percent to 0, medical expenditures increased by 58 percent. Conversely, increasing consumer cost sharing from 0 to 25 percent resulted in:

- an estimated 19-percent reduction in medical expenditures;
- declines in the annual probability of physician visits and hospital admissions by 7 and 21 percent, respectively; and
- lower total expenditures for ambulatory care of 20 percent.

According to the study, increased coinsurance had little impact on the cost of care provided in hospitals--the largest, fastest growing segment of health care costs. The researchers concluded that, because the \$1,000 maximum out-of-pocket cost threshold had been exceeded for most hospitalized patients, neither the patients nor the physicians had an incentive to seek care in lower cost hospitals or to limit the services received. 4/

Research evidence indicates that increased consumer cost sharing reduced consumers' total medical bills. After an extensive analysis of the data, Ginsburg concluded that much of the reduction in patients' bills was caused by a reduction in the quantity of services provided. Ginsburg reported that patients with increased cost-sharing plans were provided fewer tests and other procedures per hospital day. As a result, the total cost of their bills was reduced. 5/ 6/

1/The maximum annual expenditure was a fraction of family income, either 5, 10, or 15 percent to a maximum of \$1,000.

2/The study excluded families whose heads of household were eligible for Medicare at the beginning of the study or became eligible during the study period. Therefore, the results may not be applicable to the elderly.

3/These results are based on 40 percent of the data that will be ultimately collected.

4/Joseph P. Newhouse, et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," Rand Corporation, January 1982, pages v, 12, 16, and 18.

5/Ginsburg, op. cit., page 230.

6/Interim results from the Rand study were not available when Ginsburg made his analysis.

A concern expressed by some is that increased cost sharing will result in consumers avoiding or postponing preventive care or early treatment for illnesses; consequently, more serious problems may develop. This postponing of needed care may also result in a lower overall health status which in the long term could require a higher level care at increased costs. Because of the limited available evidence, little is known about the impact of cost sharing on the health status of consumers or on long-term health care expenditures. Interim results of the Rand study, however, indicate that greater consumer cost sharing does not increase total medical expenditures in the short term. Predicted total expenditures per person over a 2- to 3-year test period were lower for plans with cost sharing than for plans with no cost sharing. Developing additional information on this issue is a major objective of the Rand study.

KEY EVENTS AND UNDERLYING CONDITIONS

Following, is a description and assessment of the evidence in support of the key events and conditions underlying the cost-sharing scenario.

Event 1a: Employee selection of insurance plans with extensive cost sharing

Most procompetition proposals provide employees a choice of accepting or rejecting health plans with extensive cost sharing.

Condition: Given an economic incentive and a choice of health plans, a sufficient number of employees will choose plans with more cost sharing

Two key questions relevant to this condition are (1) how many employees will choose health plans with more cost sharing and (2) what level of cost sharing will they accept?

It has not been determined with any degree of precision the proportion of health insurance policyholders that will have to select plans with greater cost sharing to increase competition. At this point, the evidence is limited and inconclusive as to exactly how consumers will respond to economic incentives to choose health plans with greater cost sharing.

The selection of health insurance is a highly complex decision requiring consumers to make value judgments often based on limited information. Insurance contracts are complicated and generally offer varying levels of coverage for different expenses through various deductibles, coinsurance, and exclusion provisions. Usually, consumers have little objective information on the likelihood that medical expenses will occur and the amount of such

expenses. In addition to the cost of the plan, several other factors are important in consumers' selection of health insurance. These factors include: 1/

1. The degree of risk aversion - the greater the desire to avoid risk, the more individuals are willing to pay for insurance.
2. The probability of a health expense - the higher the probability, the more likely the individual will desire insurance coverage.
3. The magnitude of the amount of the anticipated expenses - the larger the anticipated health care cost, the more likely the individual is to seek insurance coverage.
4. The income of the individual - at both low and high incomes, the individual may prefer to self-insure rather than purchase health insurance.

The extent to which the population is risk averse is a major concern regarding the willingness of consumers to accept greater cost sharing. The cost-sharing scenario assumes that many people will choose increased cost-sharing plans if adequate economic incentives are provided.

There is considerable evidence suggesting that consumers are risk averse regarding health care insurance. That is, many consumers prefer to pay a fixed amount for health insurance to avoid the risk of incurring an expense of unknown size. It is unclear, however, the extent to which this risk aversion will affect consumer willingness to accept plans with extensive cost-sharing provisions.

The experiences of Medicare beneficiaries and participants in the Federal Employee Health Benefit Program (FEHBP) have been used to support the contention that consumers are risk averse and will pay higher premiums for comprehensive coverage. For example, McClure 2/ and others point out that a large number of the elderly supplement Medicare coverage with additional insurance. To illustrate, in 1979 about two-thirds of all persons 65 and over carried private hospital insurance, 43 percent carried private surgical coverage, and 44 percent carried private in-hospital physician coverage even though virtually all of the aged were covered under

1/Paul J. Feldstein, Health Care Economics, John Wiley and Sons, Inc., 1979, pages 114 and 115.

2/Walter McClure, "Comprehensive Market and Regulatory Strategies for Medical Care." Prepared for the Bureau of Health Planning, Hyattsville, Maryland, 1979, page 95.

Medicare. 1/ In regard to the FEHBP, McClure points out that only 12 percent of Federal employees chose low option plans in 1976 suggesting that consumers want comprehensive coverage even when they must pay substantially more for it. 2/

Others have pointed out, however, that there are significant reasons why experiences with the Medicare and FEHBP beneficiaries cannot be used to support the contention that consumers are highly risk averse. For example, some HHS officials believe that Medicare beneficiaries purchase supplemental policies because they expect high medical expenses and these policies represent a form of prepayment, not risk aversion. Further, Gold 3/ pointed out that two factors preclude using the FEHBP to conclude that consumers are risk averse. First, all plans offered under the FEHBP have comprehensive benefits, even those designated as "low-option" plans. Consequently, Federal employees do not have an opportunity to select plans with extensive cost sharing. Second, the formula used for determining the Federal Government's contribution to employee health insurance often provides a smaller contribution to low-option plans, thus encouraging employees to select a high-option plan. 4/

1/Majorie Smith Carroll and Ross H. Arnett III, "Private Health Insurance Plans in 1978 and 1979. A review of Coverage, Enrollment, and Financial Experience, "Health Care Financing Review, September 1981, pages 56 and 69.

2/Walter McClure, "Implementing a Competitive Medical Care System Through Public Policy," Journal of Health Politics, Policy, and Law, Volume 7, number 1, Spring 1982, pages 2 to 43.

3/Marsha Gold, "Competition Within the Federal Employees Health Benefits Program; Analysis of the Empirical Evidence," Unpublished paper, November 1981, pages 3 to 6.

4/The Government's contribution for nonpostal employees is 60 percent of the average premium cost of the six largest plans, limited to 75 percent of an individual plan's premium. Because 75 percent of the premium for most low-option plans is less than the Government's maximum contribution (60-percent limit), employees choosing low-option plans receive a smaller Government contribution. For example, the maximum Federal contribution in 1982 for family enrollment is \$1,038.18. For those employees selecting the Blue Cross/Blue Shield high-option family plan, the Federal contribution is \$1,038.18. Whereas, the Federal contribution for those employees selecting the low-option family Postmasters Benefit Plan was \$447.72, or \$590.46 less than the Blue Cross/Blue Shield plan.

Some evidence suggests that many employees, when offered a choice, will choose health plans with greater cost sharing. For example, a recent study by Farley and Wilensky 1/ based on 1977 data suggests that employees, when given a choice of plans, were about evenly divided in selecting the most or least expensive options. This occurred despite the additional employer compensation associated with selecting the most expensive option when the employer pays a fixed percentage of the premium regardless of plan selected. Farley and Wilensky concluded that employees do not highly value additional insurance benefits relative to other uses of their income.

Another concern is that employees will be reluctant to accept increased cost sharing for major expense items, such as inpatient hospital services. Ginsburg points out that employees would probably first reduce the least costly types of coverage, such as dental care, vision care, and outpatient mental health services. 2/ Since the most significant proportion of health care cost increases is attributable to hospital cost escalation, the question arises as to whether increased cost sharing will have an effect on the major component of cost growth.

Event 1b: Employer will sponsor health plans with more cost sharing

Greater consumer cost sharing could be accomplished without providing employees the option of selecting a health plan with extensive cost sharing by encouraging employers to include greater cost sharing in their employee health plans. One indirect way of doing this would be to reduce incentives for employers to increase their contributions to employee health insurance. This may, in the long run, result in less comprehensive coverage with greater employee cost sharing as employer contributions fail to keep pace with benefit costs. Limiting the amount of health insurance contributions employers could deduct as a business expense would reduce employer incentives to increase contributions to employee health insurance.

Event 2a: Consumers and providers avoid uneconomical and unnecessary medical care

The next major step in the cost-sharing approach is that consumers will reduce their demand for health care services as a result of greater cost sharing. The approach also anticipates that

1/Pamela J. Farley and Gail R. Wilensky, "Options, Incentives, and Employment-Related Health Insurance Coverage," Advances in Health Economics, JAI Press, Volume IV, forthcoming (pages 25 and 26 in paper).

2/Ginsburg, op. cit., page 229.

providers will hold down prices because of consumer cost sharing. Some believe that much of the health care provided currently is more elaborate than needed or of questionable value. Reliable estimates regarding the extent of such care, however, are unavailable.

Condition: Consumers will be able
to judge appropriately when
to seek health care services

The cost-sharing approach postulates that increased cost sharing will raise consumer sensitivity to the cost of services and thereby encourage consumers to avoid uneconomical and unnecessary care. The key question under this step thus becomes: Will consumers seek care when it is essential to do so and will they avoid care when it is not needed?

It is recognized that most consumers are not well prepared (i.e., educated) on when to seek needed care. It is also generally recognized that extensive use of third-party coverage has encouraged consumers to seek, and providers to deliver, services of little marginal benefit to the patient. As previously discussed, increased cost sharing can reduce the use of health services in the short term. However, the evidence does not indicate whether the services foregone were for early treatment or preventive care which may result in lowered health status and ultimately greater costs.

Event 2b: Consumers consider service
prices in choosing providers

The next major step in the cost-sharing scenario is that consumers will consider prices in choosing providers when medical services are needed. Because consumers will be subject to greater out-of-pocket expenses for care, it is expected that they will consider the prices of various providers before deciding which provider to use.

The type of cost-sharing feature and the level at which it is set should have different effects on when, and the extent to which, consumers will shop for providers. ^{1/} Greater cost sharing could be incorporated into health plans in a number of ways. Two ways are deductibles and coinsurance provisions. Since deductibles require consumers to pay a fixed amount initially, the impact of cost sharing would be immediate. Higher deductibles would increase consumer incentives to shop for providers with lower fees. If the deductibles have been exceeded or are likely to be exceeded, however, consumers would have little incentive to shop for providers since their out-of-pocket costs will be the same regardless of the providers' fees.

^{1/}Paul J. Feldstein, op. cit., pages 104 to 106.

Coinsurance, by requiring consumers to pay a percentage of their health care bills out-of-pocket, also provides an incentive to shop for less expensive providers. However, when catastrophic coverage begins, cost sharing by consumers ends, eliminating the incentive to shop for providers. If the catastrophic level is set too low, patients may not shop for the most cost-effective providers. Conversely, if the limit is set too high, cost sharing by patients may cause them to avoid needed medical care. This may occur particularly for low-income patients. Some, such as Feldstein, ^{1/} believe that varying the catastrophic threshold by income level would help prevent this situation.

Condition: Consumers will be willing to shop for providers

The first necessary condition for this step to occur is that consumers will be willing to seek out cost-efficient providers. ^{2/} It is unknown, however, how many consumers must be willing to shop for providers in order for price competition to develop. It is widely accepted that consumers do not currently shop for providers based on price. Although there is little evidence on the willingness of consumers to shop for providers, the likelihood of consumers shopping for providers would probably differ depending on how consumers perceive the seriousness of the illness or the urgency of treatment. The more serious their illness or urgent the treatment, the less likely consumers would be willing to shop for providers. Sick or injured patients are under a great deal of stress; therefore, psychological and family considerations may be more important than economic factors in choosing providers.

Data on Medicare indicate that a substantial number of beneficiaries do not shop for physicians who are willing to accept Medicare allowances as full payment for their services. For example, in 1979 physicians charged Medicare beneficiaries about \$1.1 billion in excess of Medicare allowances. ^{3/} This seems to indicate that beneficiaries elected to remain with their traditional physicians even though they would be responsible for physician charges in excess of Medicare allowances. It should be noted, however, that physicians accepting Medicare reimbursements as full payment vary across geographical areas, thus limiting the opportunity for beneficiaries to shop for those physicians.

^{1/}Martin Feldstein, "A New Approach to National Health Insurance," The Public Interest, Vol. 23, Spring 1971, page 99.

^{2/}Increased cost sharing by consumers is assumed to have an impact on their decisions to seek care.

^{3/}U.S. General Accounting Office, "More Action Needed to Reduce Beneficiary Underpayments" (HRD-81-126, Sept. 3, 1981).

Some employers and insurance companies offer economic incentives, such as no copayment or deductible, if beneficiaries obtain services from certain providers--referred to as preferred provider organizations (PPOs). PPOs are a new type of health care delivery system made up of groups of hospitals and physicians which contract on a fee-for-service basis with employers and insurance companies. Subscribers may use nonparticipating providers but usually they must share in the cost of services provided.

Some employers and unions believe that the PPO concept has a long range potential for directing employees to providers that are identified either as practicing cost-conscious medicine already or as organizing to do so. Because of the newness of PPOs, however, little data are available to measure their performance. 1/

Condition: Consumers will have adequate information regarding the prices of comparable services from available providers

Inherent in the cost-sharing scenario is the condition that the health care consumer will be sufficiently well informed to make economically rational decisions regarding the selection of providers for comparable services. Economists agree that consumers need adequate information for effective competition to exist among providers. However, it is unclear (1) how many consumers must be well informed and (2) the level of knowledge consumers must possess to be well informed.

It is generally accepted that consumers now have limited technical knowledge regarding most aspects of health care, including the prices of various providers, the types of available medical treatments, and the quality of care provided. Some economists (including Pauly 2/) believe that it is not essential for all consumers to have such extensive knowledge. They contend that consumers can become adequately informed about medical care services through physicians or experiences of friends, relatives, and associates.

Enthoven believes that the consumer's ability to shop effectively for medical services could be limited by the nature of medical care. The argument is made that the purchase of individual units of medical care is unlike the purchase of other services or

1/Linda Krane Ellwein and David D. Gregg, "Interstudy Researchers Trace Progress of PPOs, Provide Insight into Future Growth," Federation of American Hospitals Review, July/August 1982, pages 20 and 24.

2/Mark V. Pauly, "Is Medical Care Different?," Competition in the Health Care Sector: Past, Present, and Future, Proceedings of a Conference Sponsored by the Bureau of Economics, Federal Trade Commission, March 1978, pages 23 to 25.

products in that physicians, for most illnesses, cannot quote a fixed price for treatment in advance. In seeking a cure, consumers buy a sequence of medical services whose composition is uncertain at the outset; consequently, the provider cannot provide a price for the cure. 1/

Event 3: Price competition
among providers for patients

The next major step in the cost-sharing scenario is that significant price competition among providers for patients will occur. Such price competition would result from consumers' increased awareness of service prices and subsequent shopping for the best price. In response to price competition, providers would become more efficient in their delivery of services. The anticipated results of this greater efficiency and consumers' reduced demand for uneconomical services will be lower prices and lower overall health costs.

Condition: Providers will experience a
threat of revenue loss and will respond
by adopting more efficient practice styles

The cost-sharing approach postulates that potential revenue losses and consumer cost sharing will encourage providers to hold down their prices. This notion is based on economic theory and experience in other sectors of the economy. There is little evidence to indicate whether the health care sector will respond in this manner.

An overriding concern is that the cost-sharing scenario does not change the predominant method of provider reimbursement-- payments to physicians based on unit charges referred to as fee-for-service payments and cost-based reimbursement for hospitals. Some, including Enthoven 2/ and McClure, 3/ believe that these forms of reimbursement could allow providers to compensate for reductions in patients' use of medical services by (1) increasing unit prices of services delivered, (2) charging higher prices for patients with comprehensive insurance plans, and (3) increasing the quantity of services provided. Each of these actions would, in effect, allow providers to maintain their total revenues, especially if all providers react in the same manner. To the extent that providers successfully adjust their practices to compensate for these changes, they will not be faced with the threat of lost income. Thus, savings from improved provider efficiency would be minimized.

1/Enthoven, op. cit., pages 34 and 35.

2/Enthoven, op. cit., page 90.

3/McClure, op. cit., page 144.

There is some evidence to suggest that providers will try to maintain their total income level by shifting revenue sources, but the extent to which this will occur is unknown. For example, some hospitals increase prices to commercial insurance companies to compensate for costs not paid by programs, such as Medicare. Also, there are indications that some providers receiving reimbursement from the Medicare program compensate for lower fees by increasing service volume. In a study of the impact of the Economic Stabilization Program controls on physician Medicare fees, Holahan and Scanlon found that physicians blocked attempts to limit expenditures by (1) changing to a more complex mix of services and (2) increasing the number of services provided. As a result, the gross Medicare incomes of those physicians studied increased more during the price control period than in the year after. 1/ Furthermore, Rice and McCall found that physicians serving Medicare beneficiaries in Colorado responded to lower reimbursement rates by billing for more intensive services. 2/

McClure 3/ and Enthoven 4/ believe that in the short term providers will increase fees for patients with comprehensive insurance plans to compensate for reduced service demands. They contend that, if employers continue to pay the full cost of comprehensive insurance plans, providers could continue this practice in the long term. If employers do not pay for such plans, provider income will fall and providers will be forced to improve efficiency, cut prices, or move to areas with less competition.

Condition: Providers will not lower
the quality of services delivered

One concern regarding price competition is that providers may lower the quality of services delivered in order to provide services at a lower price. An accompanying concern is that consumers will not be able to recognize these differences in quality or may confuse differences in services with those in quality.

1/John Holahan and William Scanlon, "Physician Pricing in California: Price Controls, Physician Fees, and Physician Incomes From Medicare and Medicaid," Health Care Financing Grants and Contracts Report, prepared pursuant to contract no. SSA 600-76-0054, pages 1, 5, and 6.

2/Thomas Rice and Nelda McCall, "Changes in Medicare Reimbursement in Colorado: Impact on Physicians' Economic Behavior" Health Care Financing Review, Vol. 3, Number 4, June 1982, pages 67 and 84.

3/McClure, op. cit., page 144.

4/Enthoven, op. cit., page 90.

Little evidence is available regarding whether providers are likely to lower the quality of services provided in a price competitive environment. Because of the importance of maintaining quality health care, however, McClure ^{1/} and Enthoven ^{2/} believe that such mechanisms as licensure for physicians and hospitals, to ensure continued high quality, should be maintained.

SUMMARY

The increased cost-sharing approach is designed to reduce consumer use of medical services and increase price competition among providers. The underlying premise is that by making consumers face greater out-of-pocket medical costs when seeking care, they will become more selective in using services and in choosing providers. This increased selectivity among consumers would stimulate greater competition among providers which, according to the scenario, would improve the efficiency of the health care system and result in cost savings.

Substantial evidence indicates that cost sharing reduces consumers' use of services; however, little is known about the impact on the health status of consumers or on long-term health care expenditures. Also, little evidence is available regarding whether consumers and providers will respond as expected in the scenario. For example, it is unclear how many consumers must choose cost-sharing plans for the scenario to work and whether consumers will respond to economic incentives by choosing such plans. A major concern is that consumers are risk averse and may not be willing to accept increased cost sharing. Further, consumers are not well prepared to judge when to seek medical care; consequently, another concern is that consumers with increased cost sharing may not seek necessary care. Technical information about most aspects of health care (such as provider prices, type of care available, and quality of care) is generally unavailable to consumers. Consequently, it is unclear whether consumers will be adequately informed when shopping for providers.

Little evidence is available regarding whether providers will hold down prices to consumers or will compensate in other ways for reductions in consumers' use of services. Another major concern is that providers will lower the quality of services in a price competitive environment. Little evidence is available to judge the extent to which this may occur.

^{1/}Walter McClure, "Implementing a Competitive Medical Care System Through Public Policy," op. cit., pages 2 to 43.

^{2/}Enthoven, op. cit., page 94.

CHAPTER 3

THE UNDERLYING CONDITIONS OF THE ALTERNATIVE DELIVERY SYSTEM APPROACH

Some including Enthoven 1/ believe that the most viable approach for health care cost containment is to change the perverse incentives inherent in the fee-for-service and cost-based reimbursement mechanisms which presently dominate the health care system. They believe that more efficient providers should be rewarded financially and that inefficient providers should be penalized. Alternative health care financing and delivery systems, commonly referred to as HMOs, change the traditional reimbursement arrangements by operating under fixed prepaid revenues which promotes efficiency. Such HMOs include prepaid group practices (PGPs) and individual practice associations (IPAs).

Since most employers pay the entire cost of their employees' health insurance and generally do not offer a choice of plans, Enthoven believes that consumers do not have an incentive or the opportunity to join alternative delivery systems. 2/ The goal of the alternative delivery system approach is to lower medical costs through delivery systems which emphasize and reward efficient service delivery practices. The alternative delivery systems are presumed to be more cost efficient than fee-for-service reimbursement systems.

SCENARIO OF THE ALTERNATIVE DELIVERY SYSTEM APPROACH

The alternative delivery system approach emphasizes the need for prepaid comprehensive health insurance coverage. The scenario envisions that consumers will become sensitive to the price of various health plans because of proposed limits on tax-free employer health insurance contributions and the opportunity to benefit from uniform employer contributions. As a result, more consumers will select alternative delivery systems which offer comprehensive coverage at the lowest cost. Insurance companies would follow suit by designing and developing their own alternative health delivery systems which include incentives for providers to practice cost-effective medicine. Cost savings would be achieved as consumers limit their choice of providers to those participating in such systems.

The alternative delivery system approach includes a series of sequential events:

1/Enthoven, op. cit., pages XXI to XXV, 118 and 119.

2/Enthoven, op. cit., page XXII.

1. Consumer selection of an alternative delivery system.
2. Price competition for enrollees among traditional insurance companies and alternative delivery systems.
3. Price competition for patients among traditional providers and alternative delivery systems.
4. Cost savings: reduced costs for enrollees in alternative delivery systems and in traditional insurance plans.

Table 3 shows the events of the alternative delivery system scenario.

IMPACT OF ALTERNATIVE
DELIVERY SYSTEMS

There is substantial evidence that PGPs have lower total enrollee health care costs (premium plus out-of-pocket expenses) when compared to enrollees in conventional insurance plans. 1/ Limited studies of IPAs show that similar cost savings have not been realized. 2/ Both types of alternative delivery systems lowered the use of hospital services. However, one possible reason for the failure of IPAs to achieve overall cost reductions was an increased use of ambulatory care.

Luft's 1980 comprehensive review of research studies on HMO performance found that PGPs clearly have been able to provide medical care for their enrollees at costs 10 to 40 percent lower than for enrollees in conventional plans. 3/ Similarly, a 1976 survey of the literature on HMO performance conducted by ICF, Inc. (a private consulting firm) for HHS found that total medical care expenditures were lower for enrollees in PGPs than for people with conventional coverage. The percentage of estimated cost savings under PGPs ranged from 6 to 46 percent. The survey found that the hospital utilization rates were consistently lower for the HMO enrollees, with rates varying from 20 to 70 percent less than conventional insurance plans. 4/

1/Harold S. Luft, "The Operations and Performance of Health Maintenance Organizations: A Synthesis of Findings from Health Services Research," Prepared for the National Center for Health Services Research, October 1981, page 19.

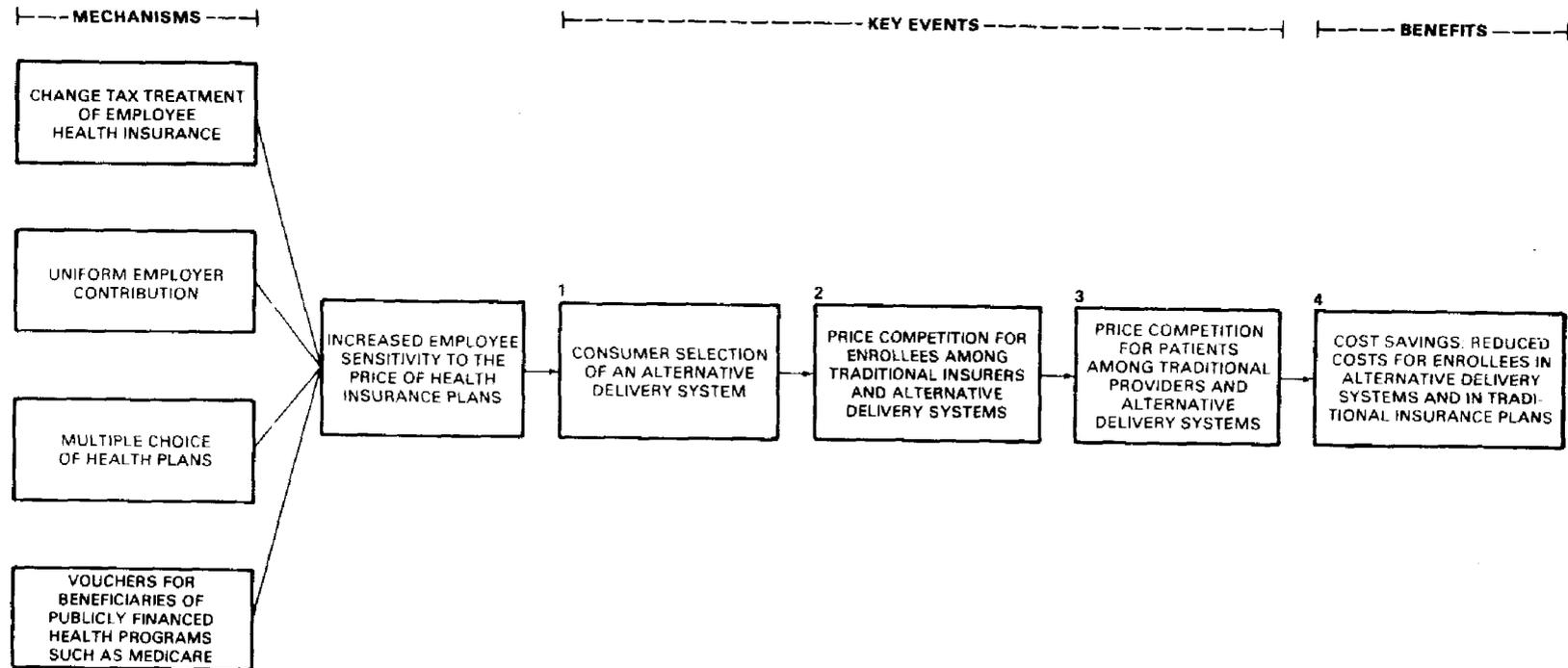
2/Harold S. Luft, "Assessing the Evidence on HMO Performance," Milbank Memorial Fund Quarterly/Health and Society, Volume 58, No. 4, 1980, page 508.

3/Ibid., page 511.

4/ICF, Inc., "Selected Use of Competition by Health Systems Agencies," Final report under Contract (HEW-HRA-230-75-0071) (Washington, D.C.: Dec. 1976).

TABLE 3

SCENARIO OF THE ALTERNATIVE DELIVERY SYSTEM APPROACH



Luft reported that PGP savings were due largely to lower hospital admission rates and that the plans had not realized lower costs per unit of service. 1/

A 1980 GAO study analyzed the results of the ICF study and concluded that the cost savings of the HMOs studied could not be projected to all HMOs because the studies primarily included only largely established plans and the data often were not adjusted for age and sex differences. 2/

The Luft study 3/ showed that total medical costs for enrollees in IPAs were no lower than for enrollees in conventional insurance plans. Although IPA enrollees averaged about 20 percent fewer hospital days than persons with traditional insurance, 1/ they typically had higher rates of ambulatory visits than the traditionally insured group. 4/ The lack of cost savings by IPAs may be due to these higher rates of ambulatory care. The Luft study, however, qualified its information on IPAs because it included results on only two studies of IPAs and they might not be representative. (GAO is currently reviewing a nationwide sample of HMOs including IPAs to identify the methods they are using to control health care costs and to compare their premiums with those that a health insurance company would charge for the same benefits.)

Some believe that primary care networks, a new type of IPA in which primary care physicians coordinate all patient care, will show cost savings. One of the largest of these networks was United Healthcare of Seattle, Washington. However, an HHS-sponsored study of this network found that, when data are adjusted for age and sex differences, enrollee costs were comparable to those in a traditional insurance plan and in a PGP.

Some studies of alternative delivery systems have raised the question as to whether the lower costs realized by HMOs are attributable partially to a different mix of patient population.

1/Harold S. Luft, "Assessing the Evidence on HMO Performance," Milbank Memorial Fund Quarterly/Health and Society, Vol. 58, No. 4, 1980, page 511.

2/U.S. General Accounting Office, "Health Maintenance Organizations Can Help Control Health Care Costs" (PAD-80-17, May 6, 1980), pages 15 and 16.

3/Harold S. Luft, "The Operations and Performances of Health Maintenance Organizations: A Synthesis of Findings from Health Services Research," op. cit., page 19.

4/Luft, op. cit., page 30.

Luft's studies led him to conclude that it is not likely that differences in case mix accounted for much of the cost differences between HMOs and traditional insurance plans. 1/

Because a small percentage of Medicare beneficiaries have joined HMOs historically, there is little research data available on the performance of HMOs for the over age 65 population. Although the research is limited, it suggests that Medicare beneficiaries who participate in HMOs have lower costs and hospital days compared to nonparticipants. A major unknown factor, however, is the extent to which the HMO participants are healthier than nonparticipants. HHS currently has several demonstration projects designed to obtain additional information on the performance of HMOs for the elderly. 2/

KEY EVENTS AND UNDERLYING CONDITIONS

Following is a description of the key events of the alternative delivery approach and the conditions which are required for the events to occur.

Event 1: Consumer selection of alternative delivery system

The initial step in the alternative delivery system scenario is the consumer's selection of an alternative delivery system. Inherent in this step is that (1) consumers are willing to select alternative delivery systems and (2) alternative delivery systems are available.

Condition: Consumers are willing to select alternative delivery systems

The decision to enroll in an alternative delivery system involves a simultaneous choice of both insurance coverage for medical services and style of service delivery. This differs from selection of traditional health insurance plans where the decision pertains only to insurance characteristics, i.e., benefits covered, premium cost, and cost-sharing provisions. The selection of providers is a separate decision, subsequent in time to choice of a health plan. In an alternative delivery system, the patient's

1/Luft, "The Operations and Performance of Health Maintenance Organizations: A Synthesis of Findings from Health Services Research," op. cit., page 51.

2/Sidney Trieger, Trudi W. Galblum, and Gerald Riley, "HMOs: Issues and Alternatives for Medicare and Medicaid," Health Care Financing Issues, pages 1, 2, 5, and 12.

choice of physicians is limited to those participating in a specific health plan. Consequently, inherent in the selection of an alternative delivery system is the assumption that consumers are willing to limit their choice of physicians to those in the plan. Access to and continuity of care appear to be factors affecting the decision to join an alternative delivery system. Berki and Ashcraft concluded that:

--Consumers are more likely to select an alternative delivery plan if it is located near their residence and if appointment waiting time is short. 1/

--Consumers that do not have an established relationship with a physician are more likely to join an alternative delivery system than consumers with a physician. 2/

According to Berki and Ashcraft, the social quality of an alternative delivery system--i.e., the attractiveness and location of delivery sites, prestige of the plan, and social status of clientele--is an important factor in the decisionmaking process. 3/ They also concluded that the evidence was unclear as to the importance of (1) the quality of care provided by alternative delivery systems 4/ and (2) the comprehensiveness of the services provided. 5/ In addition, Luft has found that negative employer attitudes tend to impede employee enrollment in HMOs. 6/

Several studies have found that when employees have been offered a choice of health plans, a sizable percentage, 20 to 60 percent, chose a prepaid health plan. 7/ For example, Farley and Wilensky found that, of the employees offered an HMO option

1/S. E. Berki and Marie L. F. Ashcraft, "HMO Enrollment: Who Joins What and Why: A Review of the Literature," Milbank Memorial Fund, Quarterly/Health and Society; Volume 58, No. 4, 1980, pages 581 to 603.

2/Ibid., page 599.

3/Ibid., page 603.

4/Ibid., page 601.

5/Ibid., page 600.

6/Luft, "The Operations and Performance of Health Maintenance Organizations: A Synthesis of Findings from Health Services Research," op. cit., page 130.

7/Paul J. Feldstein, Health Care Economics, John Wiley & Sons, Inc., 1979, page 294.

in 1977, 2.4 million or 34 percent enrolled. 1/ Greater access to HMOs and greater consumer sensitivity to the cost of health insurance may increase the number of HMO enrollments.

Condition: Alternative delivery systems are available

Because the alternative delivery system scenario allows a wide range of organizational structures which could qualify as alternative delivery systems, it is difficult to address the likelihood that such systems will be available in most areas and to most employees. However, the evidence available on current HMOs indicates that (1) most consumers currently do not have the option of selecting an HMO, (2) HMOs do not exist in many geographical areas, (3) increased enrollment in excess of 10 percent per year in PGPs may exceed their existing capacity, and (4) the resources required to establish prepaid plans are greater for PGPs than for IPAs. Because of these factors, the evidence suggests that the more cost-efficient PGPs will likely not be available to all consumers in a short time frame.

The Health Maintenance Organization Act of 1973 requires employers who offer any group health insurance and who have 25 or more employees to offer a qualified PGP and IPA, if available. However, even with this legislation, only 7 million, or 11 percent, of the 62 million employees with employment-based health insurance in 1977 were offered an HMO option. Of employees offered employment-related health insurance in 1977, the number offered an HMO was greatest (30 percent) in the western United States and lowest (3 percent) in the southern States. Almost all of the employees offered a choice of health plans in the western States had an HMO option. Farley and Wilensky concluded that encouraging employers to offer a choice of health insurance plans would probably encourage wider employee consideration of HMOs, but the geographic availability of HMOs could be a constraining factor in the short run. 2/

The availability of HMOs and the size of HMO enrollment varies significantly among the different geographical regions of the United States. Of the 243 HMOs available in 1981,

- 39 States, the District of Columbia, and Guam had 1 or more;
- 31 States and the District of Columbia had 2 or more; and
- 9 States had 10 or more.

1/Farley and Wilensky, op. cit. (pages 7 and 11 in paper).

2/Ibid., pages 7 and 8, 24 to 27.

Fifty-six percent of the enrollment in HMOs was concentrated in western United States, with 42.2 percent in California. HMO enrollment in the southern States was significantly less--4.7 percent of the total HMO enrollment. 1/

Enrollment in PGPs may be limited in the short run by capacity constraints. Some experts believe that existing PGPs cannot accommodate growth in enrollment by more than 10 percent per year. 2/ The Congressional Budget Office states that the development of new HMOs is dependent upon the availability of entrepreneurial talent and capital. 3/ Because PGPs hire their own physicians and have greater facility requirements than IPAs, larger amounts of capital and more time are needed to establish them. On the other hand, IPAs and PPOs require less capital and time to develop because they make greater use of existing provider arrangements.

Event 2: Price competition for enrollees among traditional insurance companies and alternative delivery systems

In the alternative delivery system scenario, such systems with their internal incentives for greater efficiency compared to the traditional reimbursement system will have lower costs and, consequently, will be increasingly selected. This will stimulate increased competition between traditional insurance plans and alternative delivery systems.

Condition: A sufficient number of consumers will select alternative delivery systems to bring competitive pressures on traditional plans

The opportunity for and willingness of consumers to select alternative delivery plans (assuming they are the best buy) is essential to the success of this scenario. As a result of the threat of the loss of enrollees, the traditional insurance companies will be encouraged to develop or sponsor alternative delivery systems or plans structured for greater cost efficiency. In our review of the literature, we were unable to identify data regarding the number of consumers who must choose alternative delivery systems to stimulate price competition sufficiently to prompt traditional insurance companies to become more cost efficient.

1/U.S. Department of Health and Human Services, "National HMO Census--June 30, 1981," DHHS Publication no. 82-50177, page 2.

2/Ginsburg, op. cit., page 233.

3/Congressional Budget Office, Containing Medical Care Costs Through Market Forces, May 1982, page 20.

Event 3: Price competition for patients among traditional providers and alternative delivery systems

According to the scenario, traditional providers will experience competitive pressures from the loss of revenue to alternative delivery systems. As a result, traditional providers will be encouraged to establish more efficient practice styles, such as organizing themselves into groups for greater price competitiveness.

Condition: In response to competition from alternative delivery systems, traditional providers will become more cost efficient and hold down their prices

To stimulate price competition, traditional providers must be threatened with a sufficient loss of revenue to encourage them to become more cost efficient. The effect of alternative delivery systems on traditional providers and on total costs is inconclusive. For example, Luft concluded that, while some researchers found that HMOs led traditional providers to reduce hospital use, other researchers attributed the reduction to other factors, such as population characteristics and pressure from large employers. 1/

Condition: Providers will not lower the quality of services delivered

A concern with the alternative delivery system approach is that providers will lower the quality of care delivered to reduce costs and obtain a competitive advantage. The evidence indicates that this has not happened with existing HMOs. Luft, in an extensive review of studies using different quality of care measures, concluded that there is little evidence to support that HMOs achieve lower costs by underserving and skimping on quality. He found that the studies suggest that quality of care in HMOs is comparable to, or somewhat better than, that in the community. 2/ As previously discussed (see p. 20), there is little evidence to indicate whether traditional providers would lower the quality of care.

SUMMARY

The alternative delivery system approach consists of a series of interrelated events which seek to reduce unnecessary care and lower medical costs through increased consumer selection of

1/Luft, "The Operations and Performance of Health Maintenance Organizations: A Synthesis of Findings from Health Services Research," op. cit., pages 79, 82, and 83.

2/Ibid., pages 52 and 57.

alternative delivery systems. The success of this approach is dependent on the greater efficiencies of alternative delivery systems and whether consumers and providers will respond as postulated in the scenario. Substantial evidence indicates that one type of alternative delivery system, PGPs, have lower total enrollee health care costs when compared with the health care costs of conventional insurance plan enrollees. However, limited studies of IPAs, another type of alternative delivery system, do not show similar savings.

The occurrence of each event in the alternative delivery system scenario is dependent upon the existence of a number of underlying conditions. Evidence varies concerning the likelihood that these conditions will occur. Some evidence is available demonstrating that when consumers are given the option to join alternative delivery systems a significant percentage do so. However, HMOs are not currently available to all consumers. In the short term, the opportunity for enrollment in PGPs is predicted to be limited due to enrollment capacity constraints and resources required to establish new plans. Evidence is unavailable as to the number of persons who must select alternative delivery systems to bring pressure on the traditional system to become more cost efficient. Also, evidence is inconclusive as to whether providers will lower the quality of care delivered rather than becoming more cost efficient, in response to competitive pressures.

CHAPTER 4

OTHER ISSUES AND MAJOR DECISIONS

REMAINING IN DESIGNING AND IMPLEMENTING

COMPETITION MODELS

Several mechanisms or features frequently included in various competition proposals are intended to increase consumer sensitivity to the price of health plans and encourage more rational choices. This chapter discusses other issues and major decisions to be made regarding these features:

- Changing the tax treatment of health benefits.
- Providing employees a multiple choice of health plans.
- Requiring uniform employer contributions to employee health insurance.
- Providing a voucher to Medicare beneficiaries for the purchase of private health care coverage.

Also, the chapter discusses the time frames and the potential impact of the competition approach on teaching and research hospitals.

CHANGING THE TAX TREATMENT OF HEALTH BENEFITS

Current tax policies subsidize the purchase of health insurance which has resulted in comprehensive, first-dollar coverage for most health care services, often including coverage for such traditionally self-budgeted items as dental and optometry services. Such comprehensive levels of coverage have largely removed price as a barrier to the use of health services and, consequently, have contributed to the rapid escalation of health costs.

Income exclusion

Employer contributions for health insurance are currently excluded from employee taxable income. Because such contributions are excluded, employees have strong incentives to seek extensive employment-based health insurance coverage. ^{1/} The value of the exclusion becomes greater as the employee's marginal income tax

^{1/}Congressional Budget Office, "Tax Subsidies for Medical Care: Current Policies and Possible Alternatives," January 1980, pages XI and 5.

rate increases. 1/ The marginal tax rate increases as income level increases; hence, the exclusion is more valuable to higher income taxpayers.

Proposed changes regarding the income tax exclusion include:

--Limiting the tax-exempt status of employer contributions for employee health insurance.

--Eliminating the tax-exempt status of employer contributions for employee health insurance and providing a uniform tax credit for health insurance premiums. 2/

Several concerns have been expressed regarding these suggested changes.

--At what level should the limit be set? If the limit is set too high, there will be little incentive for consumers to discontinue their current comprehensive plans. If the limit is set too low, there are two potential problems:

1. Cost sharing may be difficult for low-income families. Preventive services may be eliminated and necessary medical services delayed.

1/The financial value of the income exclusion is equal to the employer's contribution multiplied by each employee's marginal tax rate. The marginal tax rate is the rate of taxation for an incremental dollar of income and increases as income rises. For example, if a household's annual income is between \$10,001 and \$15,000, the corresponding marginal tax rate is 28 percent, whereas a household with an annual income between \$50,000 and \$100,000 has a marginal tax rate of 42 percent. Hence, if the employer contribution for employee health insurance for both households was \$1,000, the value of the tax exclusion for the household earning between \$10,001 and \$15,000 would be \$280 ($\$1,000 \times .28 = \280) while the value to the household earning between \$50,001 and \$100,000 would be \$420 ($\$1,000 \times .42 = \420). However, if the employer's \$1,000 contribution was included as gross income, the household with the larger income would receive only \$580 after taxes with which to purchase health insurance, if desired.

2/Congressional Budget Office, "Tax Subsidies for Medical Care: Current Policies and Possible Alternatives," op. cit., page XII.

2. Employees will be discouraged from choosing HMOs when they have premiums higher than traditional plans. ^{1/} As a result, the fee-for-service system will remain intact.

--Will the limit result in employees purchasing less comprehensive coverage? A major concern is whether limiting the income exclusion will encourage employees to purchase less comprehensive coverage. As discussed in chapter 2, the greater the consumer risk aversion, the more employees would be willing to use after-tax income to maintain comprehensive levels of coverage. Some including Ginsburg, ^{2/} believe that the limit will reduce the amount of health insurance purchased.

--Are there inequities regarding a uniform national contribution limit? Some contend that a single uniform limit would unjustly penalize persons residing in high medical cost areas. It has been suggested that the limit vary by geographic area. Several major objections have been raised to such regional limits:

1. Regional limits will tend to perpetuate cost differences between high- and low-cost areas. (A possible solution to this problem would be to phase out regional ceilings over time.)
2. Regional limits will complicate the administration of the program, especially as consumers move from one area to another.
3. Regional limits will establish a precedent by introducing regional variables into the tax code.

A single national contribution limit would also discriminate against the groups with high premiums due to such actuarial factors as age. Consequently, some contend that the limit should be varied according to the risk factors of the employee group. Critics of a nonuniform limit again cite the problem of increased administrative complexity.

--Will firms that self-insure find the limit difficult to administer? Self-insurance by firms, a growing trend

^{1/}Paul B. Ginsburg, "Altering the Tax Treatment of Employment-Based Health Plans," Milbank Memorial Fund Quarterly/Health and Society, Volume 59, number 2 (Spring 1981), pages 233 and 234.

^{2/}Ibid., page 231.

among employers, 1/ involves having the firm set up its own benefit plan and pay claims filed by employees. Under such an arrangement there is no simple formula to determine the cost of benefits per employee. Consequently, it will be difficult to determine when the employer's contribution has exceeded the exclusion limit and the employee is liable for extra taxes. 2/

As previously discussed, the value of the tax exclusion limit increases as the employee's marginal income tax rate increases. Enthoven favors a refundable tax credit over a tax exclusion limit because the credit remains the same regardless of the employee's income level. 3/ A tax credit is an amount subtracted from an individual's tax liability. A refundable tax credit provides a cash refund if the credit is greater than the tax liability.

MULTIPLE CHOICE OF HEALTH PLANS

Most employees who obtain health insurance as an employment benefit do not have a choice in the coverage they receive. In 1977, 18 percent, or 11 million of the 62 million people with employment-related health insurance, were offered more than one plan. 4/ This lack of choice may provide some employees with more comprehensive levels of coverage than they would have chosen if given a choice. Enthoven believes that this lack of choice has hindered the development of alternative delivery systems. 5/ Consequently, the procompetitive proposals include provisions permitting employees to choose their health coverage from a number of plans. To encourage employees to choose a health plan based on its merits rather than on the employer's contributions, the proposals usually require employers to contribute equally to the various plans, regardless of the plan selected.

Ginsburg believes that multiple choice would contribute to a slight decrease in health care costs from increased enrollment in HMOs. However, he notes that the impact on enrollment in HMOs would be limited because HMOs are already growing at a rapid rate.

1/Self-insurance currently involves 30 percent of the workforce according to Samuel X. Kaplan, "'Competition' Legislation: Care for Health Care Woes?", Risk Management, July 1980, page 42.

2/Blue Cross and Blue Shield Associations, "Competition and Consumer Choice," page 11.

3/Enthoven, op. cit., pages 121 to 123.

4/Farley and Wilensky, op. cit., page 7.

5/Enthoven, op. cit., page 73.

He also believes the fear that adverse selection will increase the cost of basic comprehensive plans and will discourage employers from offering plans with large amounts of cost sharing; thus minimizing the impact of multiple choice on the cost-sharing approach. 1/

Several concerns have been raised regarding multiple choice, including:

--Adverse selection: Adverse selection results from the selection of highly comprehensive plans by consumers who anticipate large medical care expenses and the selection of less comprehensive plans by those who anticipate little use of health services. As the percentage of high users of health care increases, the premium costs of the highly comprehensive plans also increase. Consequently, the cost of insurance increases for those who may need it most.

FEHBP is frequently cited as an example of a multiple choice program in which adverse selection has occurred, but has not been a major problem. Both the Congressional Budget Office and Blue Cross/Blue Shield have concluded that adverse selection has occurred against the Blue Cross/Blue Shield high-option plan. The Congressional Budget Office found that enrollees leaving the Blue Cross/Blue Shield high-option plan at the end of 1977 had claims 36 percent lower than the plan average, 2/ suggesting that the high utilizers remained in the plan. Similarly, Blue Cross/Blue Shield has reported that those transferring into the high-option plan during 1976 had claim costs during their first year which were 45 percent higher than the average enrollees. 3/ Despite this adverse selection, the Blue Cross/Blue Shield high-option plan remains the dominant plan in FEHBP. 4/

Various methods of reducing adverse selection have been suggested, including:

1. Variable rebates based on enrollee risk factors.
2. Limits on opportunities to switch plans.

1/Ginsburg, op. cit., pages 243 to 245.

2/Congressional Budget Office, "Containing Medical Care Costs Through Market Forces," op. cit., page 64.

3/Blue Cross and Blue Shield Associations, op. cit., page 9.

4/Federal employees were provided an opportunity to switch plans in May 1982; however, the results are not yet available.

3. Employee fees for switching plans. 1/

- Reduction in the employer's bargaining power with plans. Being unable to guarantee a fixed number of subscribers reduces employer leverage when bargaining for improved benefits and lower premiums. This may result in higher premiums.
- Increased administrative burdens. Negotiating and monitoring a number of health plan contracts as well as providing employees with information on all plans will increase employer administrative costs.
- Impact on self-insurance programs. Currently, many employers directly pay employee health expenses rather than obtain health insurance from private carriers. If such employers are required to offer a choice of health plans, the additional administrative burdens and employee participation in such plans may eliminate the advantages of self-insurance programs. 2/
- Marketing costs for plans will increase. Under multiple choice, health plans would be marketed to individual employees rather than to employers. As a result, marketing expenses are expected to increase which may be reflected in higher premiums.
- Employers and unions are more sophisticated purchasers of health plans than employees. Employers and unions may have greater available resources and expertise for purchasing health insurance. A major concern is that most employees will be unable to understand health insurance plans and make the necessary comparisons among various health plans. Reasons cited are the complex nature of health insurance policies, and the unavailability of anticipated medical expenses for different groups. Some have suggested that comparative information on health plans should be provided to employees to assist them in understanding and comparing health plans.

However, questions persist regarding who should appropriately provide such information, and how expensive it would be. Another option is for employers to establish minimum requirements for plans offered to their employees and screen out plans that do not meet the requirements.

1/Ginsburg, op. cit., pages 240 to 242.

2/Samuel X. Kaplan, "'Competition' Legislation: Care for Health Care Woes?", Risk Management, July 1980, page 42.

--Willingness of employees to switch health plans for a better buy. Experience among enrollees in FEHBP provides data on the willingness of Federal employees to change plans. FEHBP historically has offered Federal employees an opportunity, once a year, to select a health plan from among various plans. (The opportunity for Federal employees to change plans was not provided in 1981). However, only a small percentage of Federal enrollees switch health plans during open seasons. For example, the percentage of Federal enrollees switching health plans during 1980, 1979, and 1978 were 4.4, 4.3, and 3.2, respectively. 1/ 2/

A study by Gold on FEHBP concluded that enrollees' choices appear to be affected by changes in premiums. For example, the Blue Cross/Blue Shield market share dropped from 60 to 51 percent during 1970 to 1980 with most of the decline occurring in the last 5 years. The study attributed the substantial decline in Blue Cross/Blue Shield enrollment to a major rate increase of about 40 percent in 1976. 3/

UNIFORM EMPLOYER CONTRIBUTIONS

Many employers who offer employees a choice of health plans pay all or a fixed percentage of the cost regardless of the plan selected. This practice encourages employees to choose more expensive and comprehensive plans. Consequently, the procompetitive proposals frequently include provisions for equal employer contributions regardless of the plan chosen. If the contributions are more than the premiums, employees receive a rebate.

The concerns regarding uniform employer contributions pertain to rebates and include:

--Will cash rebates encourage inadequate coverage? Cash rebates will encourage employees, particularly those with lower incomes, to select health plans with inadequate coverage in order to obtain immediate cash. Because of this potential problem, it has been suggested that the rebate should not be in cash, but rather in such other benefits as retirement or life insurance. Establishing mandatory minimum coverage provisions for health plans would help alleviate this problem.

1/These figures were obtained from the Insurance Analysis Division, U.S. Office of Personnel Management, Washington, D.C.

2/Federal employees were provided an opportunity to switch plans in May 1982; however, the results are not yet available.

3/Marsha Gold, "Competition Within the Federal Employees Health Benefits Program: Analysis of the Empirical Evidence," unpublished paper, November 1981, pages 8, 12, and 13.

--Should the rebate be taxable? A tax-free rebate strengthens the financial incentives for employees to choose less comprehensive plans since they would receive the full benefit of each dollar reduction in premiums. A possible negative consequence of tax-free rebates is the potential for their use as tax shelters. This would be accomplished by an employer setting up a very expensive, highly comprehensive option that few employees would be interested in selecting. All employees opting for less substantial coverage would receive a sizable tax-free rebate. Two suggestions have been made as to how to limit this potential problem:

--Limit the employer's contribution which is tax free. This could be accomplished through either a dollar limit or a limit based on the most expensive premium for the health plan which enrolls a certain portion of employees.

--Limit the amount of the rebate which is tax free. 1/

--Will employer health insurance contributions increase? If adverse selection occurs, the more comprehensive plans will have higher premiums because of enrollees' higher utilization of medical services. If employer contributions are linked to the cost of these comprehensive plans, adverse selection would tend to increase such contributions. In addition, if rebates are available for the employees choosing the less costly plans, as adverse selection increases the employees' contribution, rebates would increase.

MEDICARE VOUCHERS

Some competition proposals would allow Medicare beneficiaries the opportunity to receive a Government-funded voucher for the purchase of health insurance in the private sector. The major objective of the voucher plan is to control the further escalation of Medicare costs while providing beneficiaries with the opportunity to purchase a health care plan in the private sector.

Medicare consists of two separate but complementary types of health insurance for the aged, certain disabled persons, and persons who suffer from end-stage renal disease and require dialysis or organ transplantation. Part A of the program provides protection against hospital and related institutional costs. Part B covers physicians' services and several other medical services.

1/Ginsburg, op. cit., pages 247 and 248.

Program costs for fiscal year 1982 are estimated at \$46 billion 1/ and have been increasing at an annual rate of 17 percent. 2/

Most voucher proposals offer Medicare recipients the choice of continuing with traditional Medicare coverage or receiving a Government-funded voucher to purchase a qualified health insurance plan in the private sector. 3/ To qualify, an insurance plan must include: A minimum benefit package covering the same services as Medicare, catastrophic expense protection, open enrollment, and demonstrated financial solvency. The proposals differ in regard to cost sharing.

The value of the voucher would be for a fixed amount. If a beneficiary chose a plan with a premium greater than the value of the voucher, the beneficiary would be responsible for paying the difference. Conversely, if the premium price was less than the value of the voucher, the beneficiary would receive a rebate.

The proposals base the initial value of the voucher on the average cost of care for a Medicare beneficiary in a given actuarial class. Actuarial classes would be determined by the following variables: age, sex, disability status, and residence. It has been suggested that in the future, the value of the voucher could be indexed to either the Consumer Price Index (CPI), the medical component of the CPI, or the actuarial experience of the largest private plans in an area.

The following three major achievements are expected from the voucher system:

--Limiting Medicare costs. As previously stated, an important goal of the voucher system is to curb the escalation of the cost of the Medicare program. A voucher effectively limits the Government's contribution for the health care of those recipients who accept the voucher. Savings are incurred when the value of the voucher is less than the amount Medicare would have been obligated to pay had the individual remained in the traditional Medicare program. Initially, the value of the voucher, based on average per capita Medicare

1/Walter J. Unger, "Medicare Vouchers - The Concept and the Issues," Hospital Financial Management, January 1982, pages 12 and 13.

2/Health Care Financing Administration, "The Medicare and Medicaid Data Book, 1981," Health Care Financing Program Statistics, page 20.

3/No proposals have been made which would require mandatory acceptance of vouchers. One proposal makes the voucher program mandatory after one-half of all recipients have opted into it.

costs would cover the cost of services received for the average beneficiary. But over time, if the voucher is indexed to an indicator which rises at a slower rate than the price of medical services, the Government will realize savings.

- Providing an opportunity for a better buy. Many voucher advocates believe that Medicare beneficiaries should be provided with an opportunity to seek out plans in the private sector that are better tailored to their individual needs. For example, membership in an alternative delivery system which provides comprehensive coverage with little cost sharing may be most appropriate for some recipients. Other recipients may wish to participate in plans with lower premiums which require more extensive cost sharing than Medicare.
- Stimulating competition in the marketplace. A voucher system is intended to encourage greater competition as various delivery systems and carriers compete for a share of this new market. It is hoped that such competition will result in innovations in health care coverage and delivery.

Critics of the voucher concept have voiced a number of concerns including:

- Inadequate voucher values. Carriers and beneficiary groups are concerned that the dollar value of the voucher will not provide benefits comparable to Medicare. As stated previously, the value would be determined by the average per capita Medicare cost for beneficiaries in that class. This average does not consider several costs that private insurers must bear which the Medicare program is not subject to, such as advertising and marketing expenses, enrollment costs, reserve funding, premium taxes, and profit margins. An additional factor not considered in determining the voucher value is Medicare's lower reimbursement to providers. For example, the Social Security Administration has estimated that in 1979, Medicare reimbursements averaged 17 percent below billed hospital charges. 1/

If the relative value of the voucher were to decline over time, it will become even more difficult for insurers to provide a benefit package comparable to Medicare. Insurers

1/Statement of Burton E. Burton, Hearings before the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, 97th Congress, 1st session, September 30 and October 1 and 2, and 1981, page 332.

might negotiate better reimbursement agreements with providers or control utilization more effectively to meet this decline. Blue Cross/Blue Shield notes, however, that several other market responses are also possible, including

--raising out-of-pocket premiums for voucher enrollees,

--increasing cost sharing to voucher enrollees,

--reducing benefits, 1/ and

--enrolling preferred risk consumers through selective marketing. 2/

--Adverse selection. Many anticipate that the low health care users will opt for vouchers since they will be more willing to accept low cost plans with substantial cost-sharing provisions or join HMOs. Because the value of the voucher for the users opting out of the traditional Medicare program may exceed expenses had they remained in the program, the total cost of the Medicare program may increase. 3/

Various features are designed to minimize adverse selection. For example, establishing voucher values by actuarial class will make the value of the voucher somewhat proportional to likely utilization. The proposals which mandate cost sharing and minimum benefits which are comparable to Medicare benefits ensure that all plans have about the same coverage. This equivalent coverage feature is designed to make all plans equally attractive to high or low users.

--Adequate information for informed choice. A major concern is that Medicare beneficiaries will have inadequate information to choose an appropriate health plan. In a study of FEHBP, GAO found that Federal employees who

1/Minimum benefit requirements would prevent reduction of benefits below a certain level.

2/Blue Cross and Blue Shield Associations, "A Third Party Payer's Perspective - Medicare Vouchers, "September 28, 1981, pages 7 and 8.

3/Congressional Budget Office, "Containing Medical Care Costs Through Market Forces," op. cit., page 51.

want to make an informed choice would have difficulty in understanding and comparing health plans. 1/ Another concern is that carriers may use misleading marketing practices in order to encourage enrollment. For example, several problems emerged in California's Medicaid system. This program offered recipients the option of enrolling in a choice of prepaid plans. Complaints lodged against the program fell into two broad categories: misleading marketing practices and barriers to services. Salespeople from a number of the plans deceptively established credibility in their door-to-door marketing by dressing in white coats or by claiming to be welfare workers. In their attempt to keep costs down, some plans erected such barriers to services as contracting with hospitals 30 to 50 miles away, requiring long waits to see physicians and short operating hours, denying emergency services, and making few referrals. 2/

TIME FRAME FOR IMPACT OF COMPETITIVE APPROACHES

Both Enthoven 3/ and McClure 4/ do not view the competitive strategy as a "quick fix" solution to rapidly increasing health care costs because such costs necessitate major structural changes in the health care system which are not quickly achieved. McClure believes that it would take from 5 to 10 years to realize major benefits from the approaches. 4/ Enthoven has written that the enactment of his Consumer Choice Health Plan would not cause an immediate and drastic change in health care delivery and financing systems. Rather, the system would continue to operate substantially as before for the first few years. Later, the benefits of competition would emerge. Enthoven describes the evolutionary development of competition as follows:

1/U.S. General Accounting Office, "Federal Employees Need Better Information for Selecting a Health Plan" (MWD-76-83, Jan. 26, 1976), pages 4 and 5.

2/Jon R. Gabel and Michael A. Redisch, "Alternative Physician Payment Methods: Incentives, Efficiency, and National Insurance," Milbank Memorial Fund Quarterly/Health and Society, Volume 57, Number 1, 1979, page 11.

3/Walter Unger, "An Interview with Alain C. Enthoven: Is Consumer Choice and Competition in Health Care the Wave of the Future?", Hospital Financial Management, November 1980, page 26.

4/Walter McClure, "Implementing a Competitive Medical Care System Through Public Policy," Journal of Health Politics, Policy and Law, Vol. 7, No. 1, Spring, 1982, pages 2 to 43.

"Gradually, however, competitive economic pressures would have their effect. People would gradually change to more economical health plans. Less economical health plans would have to find more effective cost controls. Newly trained physicians in specialties in excess supply in a given area would find no health plans interested in contracting with them, and they would have to look for work in areas where their services were needed. Primary-care physicians would assume more of the responsibility for the total costs of care for their patients, and specialists whose costs were judged by such primary-care physicians to be excessive would find themselves obliged to negotiate lower fees in order to retain their referrals. Individual practice associations would tighten utilization controls and more carefully balance the specialty mix of their participating physicians to the needs of their enrolled populations. Prepaid group practices would continue to grow.

"In short, the competitive market would generate cost controls, but they would be private market controls based on individual and group judgments about cost versus value received, not public controls based on arbitrary uniform standards insensitive to the quality or value of the services and to individual preferences." 1/

Because of the long-term nature of the competitive approach, some believe that more immediate cost constraint measures may be needed. Such measures may include regulatory controls on hospital capital expansion and employer negotiation with providers. 2/

IMPACT OF COMPETITION ON TEACHING AND RESEARCH HOSPITALS

A number of issues have emerged regarding the impact of increased price competition on the hospitals which participate in medical education and perform biomedical research. Such teaching hospitals usually have per diem costs 1-1/2 to 2 times greater 3/ than community hospitals due to such factors as the medical education programs; the patient case mix; and the development of innovative methods for prevention, diagnosis, and treatment of medical

1/ Enthoven, op. cit., page 133.

2/ McClure, "Implementing A Competitive Medical Care System Through Public Policy," op. cit., pages 2 to 43.

3/ Eli Ginzberg, "The Competitive Solutions: Two Views," The New England Journal of Medicine, November 6, 1980, page 1,115.

problems. Currently, such costs are largely funded by patient care revenues. The concerns regarding the competition approach focus on whether higher per diem costs will place teaching hospitals at a distinct disadvantage with other hospitals in a highly price competitive environment. Whereas most hospitals provide primarily a single product (i.e., patient care), teaching hospitals provide multiple products which benefit society as well as individual patients. These services include:

- Undergraduate and graduate medical education.
- Applications of research.
- Tertiary care.
- Charity care.

The Association of American Medical Colleges believes that competitive pricing may affect the ability of teaching hospitals to meet these multiple responsibilities. 1/

One way to address this issue is to identify and separately fund medical educational and research activities. The Association has pointed out that it would be difficult, if not impossible, to separate such costs. The Association also recognizes that separate funding for educational activities may limit the flexibility of local decisions regarding residency programs and would subject medical education financing to an annual appropriations process. 2/

SUMMARY

Competition proposals include several features which are designed to increase consumer sensitivity to health plan and health care prices. These features include:

- Limiting the amount of an employer's contribution to an employee's health plan which may be excluded from the employee's taxable income.
- Providing an opportunity for employees to select a health plan from a variety of available plans.

1/Association of American Medical Colleges, "Price Competition in the Health Care Marketplace: Issues for Teaching Hospitals" Discussion Paper approved by Executive Council of Association of American Medical Colleges, March 1981, page 6.

2/Ibid., page 15.

--Providing uniform employer contributions to employee health insurance plans.

--Offering a voucher to Medicare beneficiaries.

Several concerns have been raised regarding these features. The most serious concerns relate to the (1) extent of adverse selection, (2) potential for inadequate health insurance coverage, and (3) increased administrative costs.

Adverse selection will occur in a multiple choice situation if high users select comprehensive plans and low users select the less comprehensive plans. The cost of such comprehensive plans will increase due to an inability to spread the medical costs of the sick across groups which include both low and high users. A parallel situation may occur in the Medicare program if Medicare beneficiaries who are low users opt for a voucher to purchase a private insurance plan, leaving only high users in the traditional program. Several approaches to reducing the likelihood of adverse selection have been proposed, including variable rebates and limits on opportunities to change plans.

A second major concern is that the desire of consumers for a rebate (i.e., available cash) may be an incentive for consumers to underinsure. To minimize this problem, it has been suggested that rebates be provided in a noncash form, such as additional life insurance benefits.

A third concern is that the competitive proposals will result in increased administrative costs. Additional costs could be incurred by employers in offering multiple plans and by insurers in marketing plans to employees.

Additional concerns pertain to the impact of the competitive approach on teaching hospitals and the length of time needed for competitive plans to have an impact on health care costs. The concern regarding teaching hospitals is whether the education and research roles they fulfill will allow them to be price competitive with other types of hospitals.

Increased competition cannot be viewed as a "quick fix" solution to rising health care costs. One estimate is that 5 to 10 years may be necessary to realize major benefits from the approach.

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SUBCOMMITTEE ON OVERSIGHT

April 6, 1982

NINETY-SEVENTH CONGRESS

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The Honorable Charles A. Bowsher
Comptroller General of the United States
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Bowsher:

As I am sure you are aware, health care costs have increased significantly in recent years in both the public and private sector. Among the hardest hit Government administered programs are Medicare and Medicaid, two programs which this Subcommittee exercises oversight responsibilities and is greatly concerned about. These circumstances have also increased the overall Congressional attention on identifying alternative approaches for containing health care costs and several legislative proposals, commonly referred to as "pro-competition strategies", have been suggested. Generally, these strategies call for introducing market forces into the health care financing and delivery systems through greater consumer cost sharing and expansion of alternative delivery systems. There are however, many concerns and questions over exactly how such strategies would operate and the bases upon which their impact on health care costs have been estimated.

I understand that your staff have completed some work in these areas which I believe would be very useful to me as well as other Members of the Congress. Representatives of your staff have informed me of a draft report on competition being developed by the Congressional Budget Office but after reviewing the draft report I believe it would be helpful for GAO to provide its analysis of the pro-competition strategies focusing on a description of their major features and underlying assumptions. In my estimation, information of a primer nature, available for public dissemination in June 1982 would best meet my and other Members needs. I would appreciate your consideration of this request.

With best regards,

Sincerely,



Charles B. Rangel
Chairman

(10 1057)



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