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The Economics of Health Care Reform

by Charles T. Carlstrom

Few things are as important to Americans as good medical care. In 1992, we spent about 14 percent of our national output on health-related services, and by the year 2000, that share is expected to reach nearly 19 percent.[1] To some, these numbers are frightening. To others, they merely reflect the preferences of a health-conscious and aging society. As Congress and President Clinton iron out the final details of a health care reform package, it has become clear that the scope and scale of the legislation are destined to affect the course of American lives for years to come.

Although the administration's original proposal, entitled the Health Security Act, did not have enough support to survive the legislative process intact, it is likely to be a guidepost for the direction health care reform will eventually take. In fact, its basic elements — universal coverage, mandatory participation in regional health alliances, community-based insurance premiums, employer-paid health insurance, and standby price controls — are included to some degree in all of the reform proposals currently being discussed in Congress.

This *Economic Commentary* looks specifically at the economics of health care reform. Because the competing plans are too numerous to discuss in detail, I focus on the major elements of the original Clinton plan to highlight how this and similar legislation would deal with the underlying economic issues affecting the U.S. health care industry.

Universal Coverage

President Clinton has vowed to veto any reform package that does not provide for universal coverage.[2] Today, approximately 14 percent of Americans lack health insurance (see figure 1). Of those who are covered, 76 percent carry private insurance, while the remainder are insured through government programs. The two principal forms of government insurance are Medicare and Medicaid, which provide coverage for the aged and the poor, respectively. The original intent of these programs was to ensure that every American would have access to medical care. While each has succeeded in greatly expanding the number of persons covered by insurance, universal coverage has never been achieved.

Although many would contend that the issues of universal coverage and health care reform can be logically divorced from one another, the President has argued that universal coverage is a necessary component of any cost-saving package. One reason is that most of the 35 million people who lack health insurance *do* receive medical treatment. In fact, in 1994, the uninsured are expected to consume more than $1,200 per capita in medical services — only 39 percent of which they will pay for themselves. The remainder of the tab will be picked up by taxpayers and private payers.[3] These private payers frequently end up being *everyone* who purchases medical care, since hospitals write off as "unreimbursed costs" a large share of the expenses incurred by uninsured individuals. This practice in turn helps to drive up medical prices.[4]

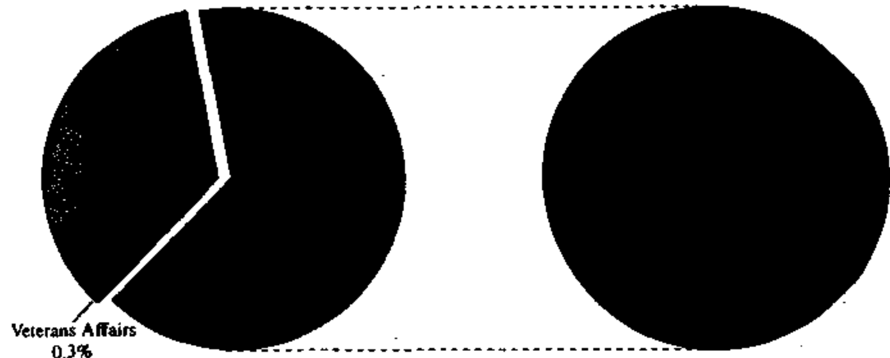
Although President Clinton's original health care reform proposal was roundly criticized in many quarters and could not muster enough support in Congress for passage, at least one of its three basic provisions — universal coverage, mandatory participation in regional health alliances, and community-rated insurance premiums — appears in all of the major reform initiatives now being considered. Thus, rather than trying to sort out the pros and cons of a myriad of alternative plans, this article uses the original Clinton proposal to analyze how Americans' pocketbooks — as well as their health — are likely to be affected by each of these three provisions.

There are other reasons why some insist that universal coverage is a necessary part of any reform package. Today, the health insurance industry is based on *experience ratings*. Premiums depend on the expected cost of providing insurance to an individual or subgroup and thus are directly related to a person's age, sex, and health status. Many argue that *community ratings*, wherein everyone residing in a given geographical area pays the same premium, would be more equitable as well as more efficient.

Experience ratings are considered inefficient because insurers spend a vast amount of resources trying to ascertain an individual's health status. Due to adverse selection, this "waste" is probably necessary. Adverse selection refers to the increased incentive for those with poor health or chronic illnesses to purchase health insurance under community-rated plans. This forces insurance companies to charge premiums that are not actuarially fair for normal, healthy individuals. As a result, healthy persons have a tendency to forgo coverage.

Experience ratings are one way of bringing these individuals back into the system, since those with little risk of becoming ill are charged lower premiums than the high-risk population. Unhealthy persons are effectively excluded from experience-rated plans, since insurance companies generally refuse to cover pre-existing conditions. For community ratings to work, it is important that those in excellent health continue to purchase medical insurance. Mandatory coverage, with subsidies for the poor and unemployed, is one way of ensuring that outcome.[5]

FIGURE 1 PRIMARY SOURCES OF HEALTH INSURANCE



SOURCE: Congressional Budget Office calculations based on the March 1992 *Current Population Survey*.

Employer-Provided Health Insurance

Currently, most private health insurance is provided through employers. In fact, more than 91 percent of those with private coverage have some or all of their premiums paid for either by their company or by the employer of their spouse or parent (see figure 1). This has led to a significant fraction of the population feeling locked into their current job because they fear losing their health benefits.[6] Critics of our present system argue that the reason employment and health insurance are linked so closely is the substantial tax break that exists for employer-provided medical benefits. Employees are not taxed on fringe benefits such as health insurance, while firms can deduct the cost of providing these benefits on their corporate income taxes.

Despite the alleged inefficiencies of employer-provided health insurance, the President's plan (as well as several others) would keep and build upon that facet of our current system. Job lock is expected to be minimized by three changes that are shared by many reform initiatives: universal coverage, standardizing the amount of insurance employers must provide, and instituting community ratings to eliminate rules against pre-existing conditions.

The cornerstone of the original Clinton plan is mandatory employer-provided health insurance.[7] All firms with fewer than 5,000 employees would be required to join a regional alliance that would either purchase coverage directly or contract with private insurance companies. In addition, the Medicaid program would be dismantled, with beneficiaries required to enroll in health plans through a regional alliance. Since membership in these alliances would be compulsory, any adverse selection problems would be eliminated. Supporters also believe that the sheer size of the alliances would give health insurance buyers the market clout to demand lower premiums.

Firms with more than 5,000 full-time employees (as well as the U.S. Postal Service) could opt out of joining the regional alliances and instead form their own corporate alliances. However, if at any time in the future a company decided to join a regional alliance, it would forever forfeit its right to opt out of the system.

While this element of health care reform is arguably the foundation of the Clinton proposal, it is also the provision least likely to survive a congressional vote. Senator Mitchell's plan, which mirrors the President's in many ways, would make enrollment in the health alliances voluntary — a compromise that might prove far less innocuous than it appears at first glance. Allowing individuals and firms to purchase insurance outside the cooperatives would, in the words of a recent *New York Times* editorial, "invite the healthy to peel away and leave the chronically ill."[8] This in turn would endanger the move toward community ratings. To minimize that risk, the Mitchell plan restricts the ability of insurance companies to discriminate based on pre-existing conditions.

Another element of most of the reform bills now being considered is a standardized benefits package of employer-provided insurance. Under the administration's proposal, regional alliances would be responsible for purchasing health insurance and for deciding which insurance plans to buy and what medical procedures to cover. Each alliance would be required, however, to offer at least one traditional fee-for-service plan. Under Senator Mitchell's alternative, all firms providing insurance for their workers would be required to purchase a standard package of benefits.[9] The danger here is that decisions regarding what types of research and development are undertaken would largely be made, at least indirectly, by government agencies via the choice of what drugs and procedures were covered.

Job Lock and Small-Firm Subsidies

A particularly contentious issue in the ongoing health care debate is whether to require firms to purchase coverage for their employees. Opponents argue that such a rule would be particularly punitive for small firms. Therefore, virtually all of the plans that contain employer mandates provide for some type of government subsidy for small companies. Under the original Clinton proposal, small firms with below-average annual wages would have their "contributions" held to between 3.5 and 7.9 percent of payrolls, depending on employment and payroll size.

Unsubsidized employers within a regional alliance would be required to contribute 80 percent of the average total premium for all single workers without children. For married couples and individuals with children, this calculation is more complicated. Workers in both small and large firms would be responsible for paying 20 percent of their own health insurance. Table 1 estimates total premiums for full-time workers and employer contributions for unsubsidized firms in 1994.

TABLE 1 ESTIMATED TOTAL PREMIUMS AND UNSUBSIDIZED EMPLOYER SHARES (per full-time worker in 1994)

	Total Premiums	Unsubsidized Employer Shares
Single person	$2,100	$1,680
Married couple	4,200	2,315
One-parent family	4,095	3,033
Two-parent family	5,565	3,033

SOURCE: "An Analysis of the Administration's Health Proposal," Congressional Budget Office study, February 1994.

Although job lock as currently defined may not be a problem under many of the reform plans being considered, subsidies such as those spelled out in the Health Security Act could make it quite costly for low-wage workers at fully subsidized firms to move to an unsubsidized firm or to one subsidized at a lower rate. Consider, for example, a worker in either a one- or two-parent family who earns $15,000 per year. If this individual obtains work at a subsidized firm, management would have to pick up between $525 and $1,185 of his health insurance premium each year, depending on the subsidization rate. An unsubsidized firm, by contrast, would have to pay $3,033 per year. Thus, there would be a cost advantage of between $1,848 and $2,508 for this person to work at the subsidized firm.

Although this advantage applies only to companies hiring low-wage workers, the savings are likely to passed on to their employees. The Congressional Budget Office estimates that a person making less than $20,000 per year would, on average, receive a pay cut of more than 15 percent if he went to work at an unsubsidized firm instead of a subsidized one.[10] Since subsidized firms would tend to be smaller and less apt to offer career advancement potential, the proposed reform raises questions about both job and social mobility for low-wage workers.

This same reasoning implies that higher-wage workers will find it costly to switch from an unsubsidized to a subsidized firm. It also suggests that employers may sort workers according to salary. For instance, consider a large corporation that has both high-wage executives and a lower-wage cleaning staff. Management would have an incentive to hire out all janitorial services to small subsidized firms or to spin off a small subsidiary that would qualify for subsidies. Although some legal restrictions against this type of sorting are included in the Clinton legislation, it is not clear how successful they would be.

Cost Containment Provisions

Although cost containment was a major impetus behind the call for health care reform, most of the current proposals address the problem in only one way: direct government control of health care prices. The President's initial plan did include other less direct — and, supporters believe, very effective — provisions for containing costs. First, the large government cooperatives would have significant market power and presumably would be able to hold down price increases. Second, since the plan establishes community ratings, the current costs of administering an experience-rated system would be eliminated. Many also believe that the administrative expenses of insuring one large group instead of many small ones would be lower.

However, "standby" controls are in place to supplement these measures if necessary. Without further congressional approval, the President's plan mandates that by the year 2000, the per capita cost of the standard benefit package cannot increase by more than the yearly percentage rise in the Consumer Price Index (CPI) plus the percentage rise in real per capita GDP. That is, premiums cannot be hiked more than the average price rise for all goods and services, except for a slight adjustment for real output growth.

The danger with these controls — and with price controls in general — is that when price increases are artificially limited, the private market must find another way to allocate scarce resources. For example, price controls on gasoline in the 1970s produced shortages that resulted in long lines of motorists waiting to fill their tanks. Rent controls in New York City have led to a shortage of apartments and to landlords letting the quality of their properties deteriorate.

While economists are nearly unanimous in their disdain for price controls, President Clinton is not alone among those hoping to use them to slow the pace of medical inflation. Senator Mitchell's plan, for instance, calls for additional taxes on insurance companies that boost their prices beyond acceptable levels. Such price controls are especially dangerous in the medical field because, according to some, a primary reason why medical inflation has consistently exceeded CPI inflation is that the former is poorly measured.

One explanation for medical care prices rising at a faster rate than the cost of other goods and services is better and more expensive technologies. For example, 35 years ago it was impossible to keep a person with kidney failure alive. Today, with dialysis and immunosuppressant drugs (which have led to vastly improved transplant rates), the cost is approximately $30,000 a year.

Adjusting price indexes to account for better technologies not only is difficult but is in some sense impossible, as illustrated by the above example. How do you value technologies that previously did not exist? Although the Bureau of Labor Statistics incorporates a quality adjustment in its CPI number, the inflation rate for medical care is almost certainly biased upward for the reasons stated above. It is further skewed because changes in the number and type of nurses who minister to patients and in the availability of new equipment are both generally ignored when the price series for hospital rooms is computed.[11]

All of this suggests that even with effective health care reform, the standby price controls may have to be implemented to meet the President's objectives. If history is any guide, these controls may well have a deleterious impact on medical care. Possible consequences include reduced access to medical services, longer waiting times for both doctor visits and tests, restricted access to high-cost medical technologies, and a slowdown in the development of new technologies.[12]

■ Conclusion

The administration's health reform initiative—as well as most of the alternatives now being debated in Congress—has been designed to minimize the differences between the old regime and the new, at least during the initial phase-in. The President's original proposal called for a mandatory system that in many respects parallels what is now voluntarily chosen by many large companies. Workers would choose their health insurance coverage from a menu of two or three different plans, and the bulk of the cost would be paid for by employers, with employees picking up the remainder via payroll deduction. The major difference from today's system is that the "federal law rather than the employer would determine the benefits and the premiums."[13] Decisions that used to be made by the private market would instead be made by the government.

The Clinton plan thus envisions the government taking a more active role in many facets of the health care delivery system. Federal agencies would oversee the regional alliances, which nearly every firm would have to join. If these measures still failed to control costs, mandatory price controls on premium increases would kick in.

But the administration's plan certainly does not stand alone in this regard. Virtually all of the reform proposals now being discussed assign a more active role to the government. The unintended consequences of such a course — if experience with government intervention in other industries is any guide — may be a bitter pill for Americans to swallow. Given the magnitude of the possible side effects, perhaps this new approach to health care, like any new drug, should have to be proven safe and effective before being allowed into the marketplace.

Footnotes

1. See "Projections of National Health Expenditures," Congressional Budget Office (CBO) study, October 1992, p. ix; and "Managed Competition and Its Potential to Reduce Health Spending," CBO study, May 1993, p. ix.

2. There have been reports that the President may soften his stance on universal coverage in order to ensure that health care reform passes this year.

3. See *Economic Report of the President 1994*, U.S. Government Printing Office, p. 135.

4. I discuss the issue of unreimbursed costs in more detail in "The Government's Role in the Health Care Industry: Past, Present, and Future," Federal Reserve Bank of Cleveland, *Economic Commentary*, June 1, 1994.

5. See footnote 3, *Economic Report of the President 1994*, p. 139.

6. Studies indicate that between 10 and 30 percent of American workers feel tied to their current job for this reason.

7. The compromise plan submitted by Senator George Mitchell would not force employers to provide health insurance until the year 2000, and then only if more than 5 percent of the population still lacked coverage.

8. See "Mr. Moynihan's Gambit," *New York Times*, June 13, 1994. (Voluntary enrollment in the regional health alliances was also included in an earlier reform proposal submitted by Senator Daniel Patrick Moynihan.)

9. This provision of the Mitchell plan may have an unintended side effect: Firms that currently provide health insurance for their workers may cease doing so if the cost of the standard package is significantly higher than what they had been paying.

10. See footnote 3, *Economic Report of the President 1994*, p. 64.

11. See I.K. Ford and P. Strum, "CPI Revision Improves Pricing of Medical Care Services," *Monthly Labor Review*, vol. 111, no. 4 (April 1988), pp. 17–26.

12. Some believe that investment in new medical technologies is excessive and that such a slowdown would in fact be beneficial. Since employer-provided health care plans are not taxed, the government pays for approximately 40 percent of each health dollar spent. Along with such subsidies comes a tremendous incentive to favor newer and more expensive technologies that are only marginally better than the old ones.

13. See footnote 3, *Economic Report of the President 1994*, p. 48.

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The views stated herein are those of the author and not necessarily those of the Federal Reserve Bank of Cleveland or of the Board of Governors of the Federal Reserve System.

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A Conference on Federal Credit Allocation

by Joseph G. Haubrich and James B. Thomson

In October 1993, the Federal Reserve Bank of Cleveland and the *Journal of Money, Credit, and Banking* sponsored a conference that examined the costs, causes, and consequences of credit allocation by the federal government. The eight presenters looked at the broad rationales for government intervention in U.S. credit markets, analyzed some issues related to pensions and federal pension guarantees, and discussed a number of specific programs and regulations, including credit imperfections in housing markets, risk-based capital requirements for banks, and community investment rules. This article is an overview of those proceedings.

Employment Creation and Destruction: An Analytical Review

by Randall W. Eberts and Edward B. Montgomery

The capacity of markets to create jobs is typically measured by net employment changes. However, net job flows veil the dynamics underlying these aggregate figures. Recent studies have examined the cyclical behavior of the four components of net employment: jobs gained from business openings and expansions and jobs lost from business closings and contractions. This paper extends the inquiry to examine whether similar patterns occur across regions. The evidence indicates that regional employment changes are primarily associated with job creation, whereas cyclical employment fluctuations are associated with job destruction. Thus, policymakers need to differentiate between programs that stimulate regional job growth and those that help firms survive economic downturns.

A Monte Carlo Examination of Bias Tests in Mortgage Lending

by Paul W. Bauer and Brian A. Cromwell

Despite three years of data from the Home Mortgage Disclosure Act (HMDA) indicating that the rejection rate for black mortgage applicants is much higher than for whites, most banks have received regulatory compliance ratings of satisfactory or better. This result may stem from the absence of several key individual characteristics in the HMDA data, which can cause tests to find bias even when it does not exist. Here, the authors examine the steps involved in determining whether a bank discriminates against minorities and construct a simulation model to gauge how well some of these tests perform when the degree of bias is known. They find that for plausible levels of bias, the sample size is critical, but that low levels of bias can be difficult to detect even with large sample sizes.

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