
MEDICARE VOUCHERS AND THE PROCOMPETITION STRATEGY

by Paul B. Ginsburg

Prologue:

Since its creation in 1965, Medicare has joined Social Security as the bedrock components of a system of social insurance designed by the federal government to protect the nation's elderly citizens in their retirement years. But Medicare is perceived in many policy quarters today as a program in trouble. Buffeted by forces over which it has only limited control, Medicare faces the increasing likelihood that Congress will seek changes in the program, which cost taxpayers \$42 billion in fiscal 1981. One possible change which has attracted attention is a proposal to provide Medicare beneficiaries a voucher through which they could shop for the package of medical care benefits that best meets their individual needs. The administration, many of whose top policymakers believe that greater consumer cost sharing is one effective road to cost containment, is attracted to a voucher approach. David Stockman is a strong advocate of such an approach. But there would be problems to overcome in transforming Medicare into a program that arms individual consumers with dollars to shop, rather than one that reimburses for care once it is rendered. Paul Ginsburg is deputy assistant director for income security and health of the Congressional Budget Office (CBO). Ginsburg, an economist, has become increasingly influential in congressional health policy circles as members of Congress have sought guidance on issues and informed views, independent of those of the administration. Philosophically, Ginsburg, like most economists, believes in the virtues of the marketplace, but his view is tempered by what he considers are the unique characteristics of the institutions of health care. Ginsburg believes that a mix of incentives, some reflecting competition and others regulation, would be the most effective policy blend in shaping the future of the health care sphere.

Since the defeat of the Carter administration's regulatory hospital cost containment proposal in 1979, Congress has been looking at a market approach to the financing and provision of health care as an answer to moderating costs. Some of the proponents of this idea were leaders of the opposition to the Carter containment plan; for example, David Stockman, Rep. Richard A. Gephardt (D-Mo.), Rep. James Jones (D-Okla.), and Health and Human Services Secretary Richard S. Schweiker, when he was a Republican senator from Pennsylvania. Some supporters of the Carter plan have offered competition proposals as well, suggesting that few politicians are satisfied with the status quo in health care. Former Rep. Al Ullman (D-Ore.), who was chairman of the House Ways and Means Committee, sponsored a procompetition bill while also supporting Carter's containment plan. The Reagan administration has endorsed the competitive approach with enthusiasm, although it has been slow to develop a proposal.

Until recently, much of the emphasis of efforts to encourage greater use of market principles in medical care has been on employment-based, private health insurance. Legislative proposals have called for capping the amount of employer contributions that are not taxable to the employee, not taxing refunds paid to employees choosing plans with premiums lower than the employer's contributions, and requiring employers to offer a choice of plans with a fixed contribution.

However, with the increasingly important role that Medicare is playing in the financing of medical care, the administration, a few legislators, and some private health interests have considered it important to change provisions of the Social Security Act so that Medicare also would encourage greater use of the market. Medicare is the primary insurer for 29 million persons, but given the high rate of medical care used by this population, the program accounts for a much larger percentage of expenditures for those services it covers. For example, Medicare beneficiaries account for about one-third of expenditures in community hospitals, which totaled almost \$80 billion in 1980. The absence of such an important purchaser of medical care from reforms to promote competition would certainly dilute pressures on providers to contain costs. Interest in reforming Medicare also stems from rapidly increasing costs. In 1981, federal outlays totaled \$42 billion. Despite the cuts made in the Omnibus Reconciliation Act of 1981 (P.L. 97-35), outlays are projected to increase to \$64 billion in 1984.

This paper was written in a private capacity. The views expressed do not necessarily represent those of the Congressional Budget Office. The author has followed the CBO policy of not making recommendations, however.

As one approach to transforming Medicare into a program that is more responsive to market signals, some policymakers have suggested a system of vouchers. Under such an approach, Medicare beneficiaries using vouchers issued by the Department of Health and Human Services (DHHS), could apply them toward the purchase of any qualified private health plan operating in their area. Plans would qualify by providing a minimum benefit package and meeting other requirements (such as an annual open enrollment period) that would be stipulated by DHHS.

Those beneficiaries choosing a plan with a premium lower than the voucher would receive cash for the difference from Medicare, while those opting for a plan with a higher premium (and more comprehensive benefits) would pay the extra amount from their own funds. In H.R. 850, the bill sponsored by Gephardt, the voucher would be based on 1982 Medicare expenditures, less premiums paid by beneficiaries. That figure would be indexed by the GNP deflator. Thus, in 1984, the first year that the voucher would be effective, the average-aged beneficiary electing a qualified private plan would receive \$1,845 a year.

This article analyzes the Medicare voucher idea. It also considers some alternatives that could be considered to encourage greater use of the market. The article begins with a discussion of the mechanisms for containing health care costs through the market and how vouchers would make use of these mechanisms. Then it discusses the problems with the voucher approach. Alternatives discussed include reforms in the reimbursement of health maintenance organizations (HMOs) by Medicare, a surcharge on insurance policies that supplement Medicare, and changes in the Medicare benefit structure.

The Market and Cost Containment

There are two mechanisms through which private incentives can contain health care costs: cost sharing, and increased enrollment in HMOs. Depending on the preferred policy approach, both mechanisms could be employed through vouchers. The cost-sharing approach imposes through the insurance contract requirements that patients pay part of the bill. Cost sharing reduces medical costs by inducing the patient to limit the use of services and to be more sensitive to price differences among providers. Because consumers must pay a greater share of the cost, they tend to use health services more prudently. If the extent of cost sharing increased in Medicare, the result would be lower rates of use of services and lower medical prices.

The evidence that cost sharing does reduce spending on medical services is strong, but the mechanism is nevertheless controversial. Data from the RAND national health insurance experiment, for example,

indicate that randomly assigned families, with a 25 percent coinsurance requirement that remains in force until an annual ceiling of \$1,000 in out-of-pocket expenditures is reached, spent about 15 to 20 percent less on medical care than families with no cost-sharing requirement. Since the experiment did not saturate any markets, such results do not include potential price changes from a general increase in cost sharing. Generally speaking, econometric studies (see Feldstein, 1981)¹ indicate that markets with more cost sharing tend to have lower medical prices.

One controversial issue raised by the use of cost sharing is whether the patient is a good judge of what care should be sacrificed. The conventional wisdom on this point is that preventive care and early treatment would be the first services to go (see, for example, the recent testimony of Douglas Fraser, Chairman, Committee for National Health Insurance),² but data supporting this viewpoint is very slim. Some analysts feel that patients are good judges of the merits of some types of care, with reliance on physicians through an agency relationship for judgments on more technical decisions. In either case, cost sharing does reduce the extent of financial protection provided by insurance, a problem of particular concern to the elderly.

The second mechanism involves increased enrollment in HMOs or other alternative health care delivery systems. The research literature indicates that at least the prepaid group practice model (PPGP) of HMO has substantially lower costs than insured-fee-for-service practice. Lower rates of use of hospital care in general, and lower surgery rates in particular, are the principal factors behind this phenomenon. For example, the Kaiser-Permanente Medical Care Program uses about 1,900 days of hospitalization per 1,000 for its Medicare-eligible members, compared with a national rate of about 4,200 days per 1,000 elderly individuals.

An HMO strategy is less controversial than a greater reliance on cost sharing, but nevertheless there are skeptics. A recent study by Scitovsky³ suggests that the lower costs of PPGPs are more from group practice than from prepayment, thus casting some doubt on the potential of additional cost savings through expansion of HMOs other than through the slow and expensive process of developing new groups. Others note the small market share of HMOs at present (4 percent of the population); and limits to more rapid growth from shortages of capital and a lack of experienced managers.

Gephardt and some of the other legislators who advocate the competitive model, envision increased use of market forces spurring the development of health plans which borrow some characteristics from HMOs, but are less structured. These range from plans that place independent physicians who deliver primary care partially at risk for all services used by a patient; to plans that limit choice of providers to those who are low

cost; to plans that give the patient financial incentives to choose low-cost providers. Few plans currently operating in the United States reflect these characteristics. Whether their limited availability stems from an absence of incentive to contain costs, or serious drawbacks in operating such plans, is a difficult question to answer.

The cost-sharing strategy tends to win support from policymakers of a conservative persuasion and be opposed by individuals holding more liberal views. The HMO strategy, on the other hand, draws support from quarters that span the political spectrum.

Opponents of cost sharing tend to hold this view because of a belief that price is not an appropriate mechanism to ration medical care. They fear that additional cost sharing would tend to increase inequalities in access to medical care, particularly among the more vulnerable. Many economists, however, support additional use of cost sharing, maintaining that medical care is not all that different than other goods and services and that prices perform a useful role. In order to provide access to medical care for all persons, most economists tend to favor making cost-sharing income related, but they also favor programs targeted toward the poor, such as Medicaid. Cost sharing tends to be supported by physicians, commercial insurers, but not the Blue Cross and Blue Shield Associations, and proprietary hospitals.

HMOs have some strange bedfellows as supporters. Interests reflecting a liberal persuasion, such as the AFL-CIO and the United Auto Workers, support HMOs because they contain costs without use of prices at the time of services. More conservative interests, such as the Washington Business Group on Health, and the Chamber of Commerce of the United States, support HMOs because of their potential to use the market in health care. The American Medical Association has a long history of opposition to HMOs, though in recent years its attitude seems to have moderated.

The Voucher Option

Medicare vouchers could be an option offered to those enrolled in the program or they could be mandatory, replacing Medicare as it has been known since its creation almost seventeen years ago. Because most of the bills introduced to date would make vouchers a voluntary option, that approach is discussed first. Mandatory vouchers are then discussed as an alternative.

As noted earlier, Medicare vouchers have the potential to work through both strategies—cost sharing and HMOs. Cost sharing might be increased by granting beneficiaries the opportunity to obtain a cash refund in return for accepting additional cost sharing. Under the current

Social Security Act, those Medicare beneficiaries willing to pay additional premiums to reduce their cost sharing can do so by purchasing private health insurance that supplements Medicare. But those eligible individuals wanting to convert some of their Medicare benefits to cash cannot presently do so. The voucher proposals would provide such an outlet.⁴

Vouchers would further the HMO strategy by establishing incentives to join HMOs whose costs are lower than fee-for-service medicine. Under current law, Medicare beneficiaries get little financial benefit from joining HMOs. Most HMOs are reimbursed by Medicare on a fee-for-service basis, so that savings from lower rates of hospital use accrue directly to Medicare. Under a voucher system, by contrast, Medicare payments would not be based on the experience of a particular HMO, but rather on Medicare's experiences in the fee-for-service system in a locality. Consequently, those enrolling in HMOs with lower costs than the fee-for-service sector would be rewarded, either through the reduction or elimination of cost-sharing requirements or additional benefits.

The Health Care Financing Administration has sponsored several demonstration projects to test whether Medicare beneficiaries, if offered incentives, will join HMOs. While formal evaluations are not yet available, Robert J. Erickson of the Kaiser Foundation Health Plan recently stated: "The demonstrations prove that if Medicare beneficiaries are rewarded for their willingness to enroll in organized, efficient health care delivery systems by sharing the savings with the Medicare program, they will do so."⁵

Medicare vouchers would pose some serious policy problems. The major problems involve obstacles that private insurance plans would encounter in competing with Medicare (a problem when vouchers are voluntary), and adverse selection, the phenomenon of individuals choosing plans on the basis of their expected medical care use. These problems tend to be more severe when traditional insurance plans with greater cost sharing are involved, raising the possibility of limiting the use of vouchers to individuals who enroll in HMOs.

Problems faced by private insurers in competing with Medicare could keep vouchers from becoming a viable option. For one thing, private insurers have selling costs while Medicare does not, and selling insurance to individual aged and disabled persons could be very expensive. Today, administrative costs other than claims processing for individual health insurance policies average about one-third of their premiums. The active role prescribed for the Department of Health and Human Services in informing eligible individuals of the plans available to them in proposals such as H.R. 850 would certainly reduce these costs, but it would not eliminate them.

Private insurers' costs would also be higher because they often must

pay providers at higher rates than does Medicare. The problem is most serious for hospital care, where Medicare does not permit additional charges to the patients. Data from the Health Care Financing Administration indicates that in 1979, Medicare determinations of allowable costs averaged 17 percent less than charges. According to Burton E. Burton, testifying on behalf of the Health Insurance Association of America, "It is impossible for the savings achieved through private administration to offset the substantial reimbursement advantage of the government program. Hence, private carriers could not deliver the same benefits from the premium provided."⁶

The problem of private insurers competing with Medicare is particularly acute with respect to those beneficiaries interested in a richer benefit package than Medicare provides. Today, such persons may purchase private policies to supplement Medicare, an option that roughly half of the program's participants select. These purchases of supplemental policies are implicitly subsidized by Medicare.

The reduction in cost sharing that results from purchasing such plans induces higher rates of use of medical services, but Medicare pays a large proportion of the costs of the additional use.⁷ If a private insurer were to offer a richer benefit package as a substitute for Medicare and a supplemental plan, it would have to include in its premium the entire cost of the additional utilization induced by the richer benefits.

These competitive problems may explain the lack of enthusiasm of private insurers for Medicare vouchers. Given the magnitude of the disadvantages, opportunities for profitable new business would be very limited. Indeed, obtaining a favorable selection of risks (discussed further below) or giving fewer benefits than the policy appears to (such as through "fine print" exclusions) might be the only way to profit in such a market. Those insurers of substantial reputation would not find the prospect of such a market appealing, especially since less reputable competition might seize such opportunities.

These competitive problems would affect HMOs somewhat less than traditional health insurers. First, HMOs either operate their own hospitals, as is the case with the Kaiser Foundation Health Plan and several other plans, or obtain discounts through bulk purchasing of hospital care, so Medicare's discount would not be as great a problem. Second, HMOs offer more than just a different benefit structure to Medicare beneficiaries; HMOs also offer a continuum of care, virtual elimination of paperwork, and elimination of the assignment problem where doctors charge more than Medicare will reimburse for services. Thus, such alternatives to the traditional system might be attractive to some Medicare enrollees, even if the economic value of an HMO is reduced by some of Medicare's competitive advantages.

Adverse selection, the phenomenon of persons choosing health plans on the basis of expected use of services, could be substantial and lead to increased, rather than reduced, federal outlays. As in the case of competition problems, adverse selection would be less serious in the case of HMOs than for traditional private plans. It is well established that in a choice between two traditional plans where the premium difference reflects experience, the plans with more extensive coverage will attract persons with higher than average use of services. But analysts disagree over the extent of the phenomenon. Their assessment is difficult because of the very limited experience with such choices and with methods of minimizing the phenomenon.

The experience with private insurance plans which supplement Medicare is instructive. A recent study by Link and others showed that after adjusting for other determinants of utilization, Medicare beneficiaries with private supplemental coverage who had no chronic conditions had 42 percent more physician visits and 33 percent more hospital days than similar persons without such additional coverage.⁸ These differences exceed by a substantial margin what would be expected on the basis of reduced cost sharing.

Much of the discussion of adverse selection has focused on situations where an employer offers a choice and the same insurer underwrites both options. In such a case, the employer has an incentive to minimize adverse selection (since a resulting increase in the premium of the high option plan would put pressure on the employer to increase its health benefits contribution) and the insurer has little interest in which option employees choose. By contrast, with a Medicare voucher, insurers would have substantial incentives to be selected by the best risks. Success in being selected by relatively low users could mean substantial underwriting profits. With insurers designing benefit packages and media campaigns to attract the low users, adverse selection could be substantial.

Those persons using their vouchers to purchase traditional private health insurance policies would likely be lower users than those remaining in Medicare for three reasons. First, private plans would be more attractive to those interested in less extensive benefits than Medicare than to those seeking more extensive benefits. Second, to the extent that it is not reflected in the voucher formula, those persons whose spending is lower than average by virtue of their age or area of residence, would be more likely to elect private plans. Third, insurers would have strong incentives to market selectively in order to obtain the best risks. The first reason requires some explanation.

Vouchers would be quite unattractive to persons seeking more comprehensive benefits than Medicare because of the ready availability under current law of private plans to supplement Medicare, and the

implicit subsidy to those plans by Medicare. Since those wanting more coverage than Medicare can obtain it by purchasing a supplemental plan, whether they use a voucher to purchase a private plan would depend on which has a lower price—the private plan versus Medicare and the supplemental plan.

In virtually all cases, Medicare plus the supplemental plan would have a lower price. As discussed earlier, the private plan would have selling costs and higher hospital reimbursements included in its premium. While supplemental plans have selling costs, they would apply only to the supplement, not to basic Medicare. All of the costs of such additional use would be reflected in the premium of private plans purchased by vouchers, putting them at further disadvantage.

Because some persons seeking less extensive coverage might find vouchers attractive while very few seeking more extensive coverage would, the adverse selection would tend to be to the disadvantage of Medicare. Persons opting out of Medicare would use vouchers for an amount that would exceed what their Medicare benefits would have cost had they remained. Since the law entitles Medicare beneficiaries to a schedule of services, rather than to a dollar amount of assistance in purchasing health care, the adverse selection would increase federal spending on the program.

Adverse selection in choices between HMOs and Medicare would be a very different phenomenon. Since the benefits would tend to be similar, the phenomenon of low users tending to gravitate toward the less comprehensive plans does not hold. Analysts hypothesize that a key influence on HMO selection patterns is persons with chronic illness tend not to switch to group practice HMOs because it requires an individual to change his or her physician. As a consequence, persons switching to HMOs tend, at least initially, to be lower utilizers of care.

This tendency has been observed in some demonstration projects testing a choice between Medicare and HMOs. According to a study by Eggers, for the plans which required a change in physician, previous spending of those enrolling in HMOs was about 20 percent lower than that of those persons remaining in Medicare.⁹ Such a tendency is likely to erode over time to some extent. HMO populations tend to be stable; consequently as they age they become more susceptible to illness, while some of the chronically ill who remain in Medicare will either recover or die. Determining whether or not this will occur will require many years of additional monitoring of these experiments. Even if such erosion is in fact the case, it would provide little comfort to those concerned with the Medicare budget if large numbers of enrollees switched to HMOs each year.

Mandatory Vouchers

Some have suggested that vouchers be mandatory, at least for those who become newly eligible to Medicare. Making vouchers mandatory, at least for those individuals who become newly eligible to Medicare, would eliminate many of the problems that private health plans would encounter in competing with Medicare. Making vouchers mandatory also would avoid the increase in federal outlays caused by adverse selection, since voucher amounts would not be affected by adverse selection. On the negative side, a mandatory approach would channel a significant amount of resources into the process of choice among plans. The selling costs would be included in premiums paid by all of those eligible for Medicare. Also, the adverse selection would injure those Medicare eligibles seeking a relatively comprehensive plan.

These considerations are probably of less importance than the change in the nature of the Medicare entitlement that would necessarily be associated with mandatory vouchers. Under current law, persons eligible for Medicare are entitled to a defined set of medical services when needed. Since the cost of purchasing these services has soared, so have federal outlays. Under a mandatory voucher, the entitlement would instead be to a certain amount of money to be applied toward premiums of qualified private health plans. Such an amount could be equivalent to the cost of the current service entitlement, or it could be much less. For example, some have proposed basing the voucher on current spending in Medicare, and indexing it by the GNP deflator. Since the GNP deflator is projected to increase by 6 percentage points per year less than per capita spending in Medicare, such an amount would soon be much less than the cost of the services included in Medicare today. On the other hand, indexing by the GNP deflator plus 6 percentage points would not affect the level of federal support for health services for Medicare beneficiaries.

Despite the ability to set the voucher amount high enough so as not to reduce resources, many see a potentially intimate connection between mandatory vouchers and a reduction in resources. Pressure to cut federal spending is likely to remain high for many years. Recent testimony by the Director of the Congressional Budget Office, Alice Rivlin, indicated that despite the very extensive spending cuts enacted in the Omnibus Reconciliation Act of 1981, spending for national defense, interest of the national debt, and entitlement programs will almost equal revenues in 1984.¹⁰ Funding other programs would require further spending cuts, tax increases, or continuing large deficits. With such fiscal pressure, it might be much easier to cut the voucher amount (or allow it to grow more slowly than per capital medical care spending) than to reduce an entitlement to services.

Substantial disagreement exists as to whether mandatory vouchers' ability to facilitate spending cuts is a major asset or a major liability. Some feel that Medicare is an appropriate place to cut spending, because cuts in other programs such as Medicaid, food stamps, or school lunches would affect the needy to a greater extent. To them, the fact that vouchers make these cuts easier is a major asset. Others would rather solve the budgetary problem by increasing revenues or cutting defense spending. In their view, keeping Medicare spending difficult to cut would ultimately shift the mix of actions to balance the budget in this direction.

Alternative Medicare Reforms

A number of options other than vouchers have the potential of increasing reliance on market forces. Reforms in the method of Medicare reimbursement of HMOs could increase HMO enrollment through financial incentives to HMOs and enrollees. Cost sharing could be increased by applying a surcharge to the premiums of supplemental insurance policies, offering a choice of plans within Medicare, or altering the benefit structure to which beneficiaries are entitled.

Medicare could reimburse HMOs on a capitation basis instead of the present fee-for-service basis. Under H.R. 3399, a bill recently reported by the House Energy and Commerce Committee, Medicare would pay HMOs a per enrollee amount equal to 95 percent of what Medicare spends on similar persons in an area who obtain care through the fee-for-service sector.

Capitation reimbursement of HMOs is quite similar to vouchers. Under both options, Medicare would pay a fixed amount and establish a potential financial reward to those enrolling in efficient HMOs. Both would increase Medicare outlays initially as a result of adverse selection, and reward those already enrolled in efficient HMOs. (For example, if an HMO has costs 20 percent below fee-for-service costs, Medicare now gains most of the savings for current enrollees. Under capitation reimbursement, Medicare's gain would be limited to 5 percent of fee-for-service costs.)

A major advantage of capitation reimbursements over vouchers is limiting opportunities to opt out of Medicare to those enrolling in HMOs. This is desirable because HMO enrollment by Medicare beneficiaries has more potential than the purchase of private health insurance plans to contain costs and fewer problems such as adverse selection. With a smaller number of Medicare eligibles involved and a less severe degree of adverse selection experienced, the increase in federal outlays would be substantially smaller than under the voucher proposal, although it would nevertheless be there. Indeed some see this option as a useful "dry

run” prior to vouchers. Of course, by restricting private plan opportunities to enrollment in HMOs, they must be defined for the purpose of such a program. Should the definition be a tight one, some attractive plans would be left out and innovation stifled.

Differences between proposals for vouchers and for HMO reimbursement reform also reflect differences in attitudes towards markets and competition. Voucher proponents tend to have much more confidence in the potential of markets than those who advocate reforms in HMO reimbursement. Such differences manifest themselves in the treatment of the differences between HMO costs and the Medicare payment. Under H.R. 3399, for example, HMOs must direct the entire savings to the enrollee. Voucher proposals, such as H.R. 850, do not have such rules. They would rely instead on market forces to get savings to the enrollee. When regulation of the disposition of savings is desired, reimbursement policy is probably a more appropriate vehicle than vouchers.

There are several approaches through which the increased use of cost sharing by Medicare enrollees could be encouraged, including the imposition of a surcharge on premiums for supplemental policies, offering a choice of plans within Medicare or restructuring Medicare benefits. Earlier in the paper, a mechanism was described by which the purchase of supplemental policies by beneficiaries increases Medicare outlays. A surcharge roughly equal to the amount of additional costs to Medicare could alleviate this problem. Such a surcharge would have two major effects. First, it would decrease Medicare outlays. Some of the savings would come from receipt of the surcharge while the remainder would come from lower rates of Medicare claims by those deciding to discontinue their supplemental policies. Second, cost sharing would decrease. With the implicit subsidy from Medicare to purchasers of supplemental plans offset by the surcharge, some beneficiaries would decide that supplemental coverage was not worth the price and instead pay deductibles and coinsurance out-of-pocket at the time that services are used.

Medicare could develop a series of options with different benefit structures. Those choosing an option that is less comprehensive than the current Medicare benefit structure would get a cash payment reflecting Medicare’s claims experience with the option. Those selecting a more comprehensive option would pay an additional premium. These cash payments and additional premiums would vary by age, sex, location, and other relevant actuarial factors.

Such a choice would probably increase the average cost sharing. Those seeking less cost sharing can already purchase supplemental policies at very favorable premiums, so the number of persons choosing less cost sharing (either through a new Medicare option or continuing their sup-

plemental policy) would probably not increase substantially from current levels. In contrast, those seeking more cost sharing, who have no such option today, would be more likely to change plans.

This option has three advantages over Medicare vouchers. First, it would economize on resources devoted to selling, since an annual offering by Medicare might be far less costly than marketing campaigns by competing private insurers. Second, adverse selection would be smaller. With Medicare offering the options, selective marketing would be avoided. Medicare outlays could still increase, however. If the entitlement to the current array of services were maintained, Medicare outlays would increase if those leaving the basic plan were lower than average users. Applying a surcharge to premiums for supplemental policies (discussed below) would make an increase in outlays from choice less likely, since more of those switching from basic Medicare would be higher than average users. Third, it would retain the hospital discount that Medicare achieved through its purchasing power. Such an option would not increase HMO enrollment. For this to happen, the option would have to be combined with either a voucher restricted to HMOs or a reform in the reimbursement of HMOs.

A more direct approach to increasing cost sharing would be a change in the Medicare benefit structure. Cost sharing for the second through thirtieth day of a hospital stay could be introduced, for example, possibly in a form that would vary with individual hospital charges so that those choosing less expensive hospitals would pay less. Some of the savings to Medicare could be applied toward increasing catastrophic protection, perhaps by adding an annual dollar limit to cost sharing. Such an option would reduce the use of hospital care and increase the degree of price competition among hospitals. Those desiring more extensive coverage could still purchase supplemental plans.

Medicare vouchers would be more successful in encouraging eligibles to enroll in HMOs or other alternative health care delivery systems than in encouraging increased use of cost sharing. Choice mechanisms appear to have more problems as devices to encourage increased cost sharing than as devices to increase HMO enrollment. Since choice is not necessary to increase cost sharing as it is to increase HMO enrollment, consideration might be given to alternative mechanisms to encourage cost sharing. In employment-based health plans, for example, cost sharing could be increased more easily by changing the benefit structure of the single company or union plan, possibly in response to a change in the tax treatment of employer contributions, than by setting up a choice mechanism. The analogue in Medicare would be to use benefit restructuring to achieve more cost sharing if this is what is desired, and restrict voucher use to HMO enrollment.

Notes

1. Martin Feldstein, *Hospital Costs and Health Insurance* (Cambridge: Harvard University Press, 1981).
2. Douglas Fraser, Chairman, Committee for National Health Insurance, Testimony before the U.S. House of Representatives, Ways and Means Subcommittee on Health, *Proposals to Stimulate Competition in the Financing and Delivery of Health Care*, 97th Cong., 1st sess., 30 September-1 October 1981.
3. Anne A. Scitovsky, "Use of Medical Services Under Prepaid and Fee-for-Service Group Practice," *Social Science and Medicine*, (1981) 15c: 107-116.
4. H.R. 4666 sponsored by Gephardt and Rep. Willis D. Gradison (R-Ohio) would not permit vouchers to be used to purchase health plans with more cost sharing than Medicare. Proposals such as this would work only through an HMO strategy.
5. Robert J. Erickson, Senior Vice-President, Kaiser Foundation Health Plan, Inc., Testimony before the U.S. House of Representatives, Ways and Means Subcommittee on Health, *Proposals to Stimulate Competition in the Financing and Delivery of Health Care*, 97th Cong., 1st sess., 30 September-1 October 1981.
6. Burton E. Burton, Senior Vice-President, Aetna Life and Casualty, Testimony before the U.S. House of Representatives, Ways and Means Subcommittee on Health, *Proposals to Stimulate Competition in the Financing and Delivery of Health Care*, 97th Cong., 1st sess., 30 September-1 October 1981.
7. For example, the supplemental plan might pay 20 percent coinsurance for physician services. But if physician visits increase by 20 percent because of the extra insurance, Medicare would pay 80 percent of the fees for the additional visits. In this example, Medicare would pay 40 percent of the full costs of additional coverage.
8. Charles R. Link, Stephen H. Long, and Russell F. Settle, "Cost Sharing, Supplemental Insurance, and Health Services Utilization Among the Medicare Elderly," *Health Care Financing Review*, Fall 1980, pp. 25-32.
9. Paul W. Eggers, "Pre-enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in 'At-Risk' HMO," Preliminary Findings, June 26, 1981.
10. Alice Rivlin, Director, Congressional Budget Office, Testimony before the U.S. House of Representatives, Ways and Means Subcommittee on Health, *Proposals to Stimulate Competition in the Financing and Delivery of Health Care*, 97th Cong., 1st sess., 30 September-1 October, 1981.

Reproduced with permission of copyright owner. Further reproduction prohibited without permission.