Can Defined Contribution Health Insurance Reduce Cost Growth? (and *Save* Employer-Sponsored Health Insurance?)

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for

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Overview

■ Recent Trends in ESI that Worry Employers

■ How We Got Here: from FFS to DC, via Managed Care

■ How DC *COULD* contain cost growth

■ Limits on DC's ability to contain cost growth

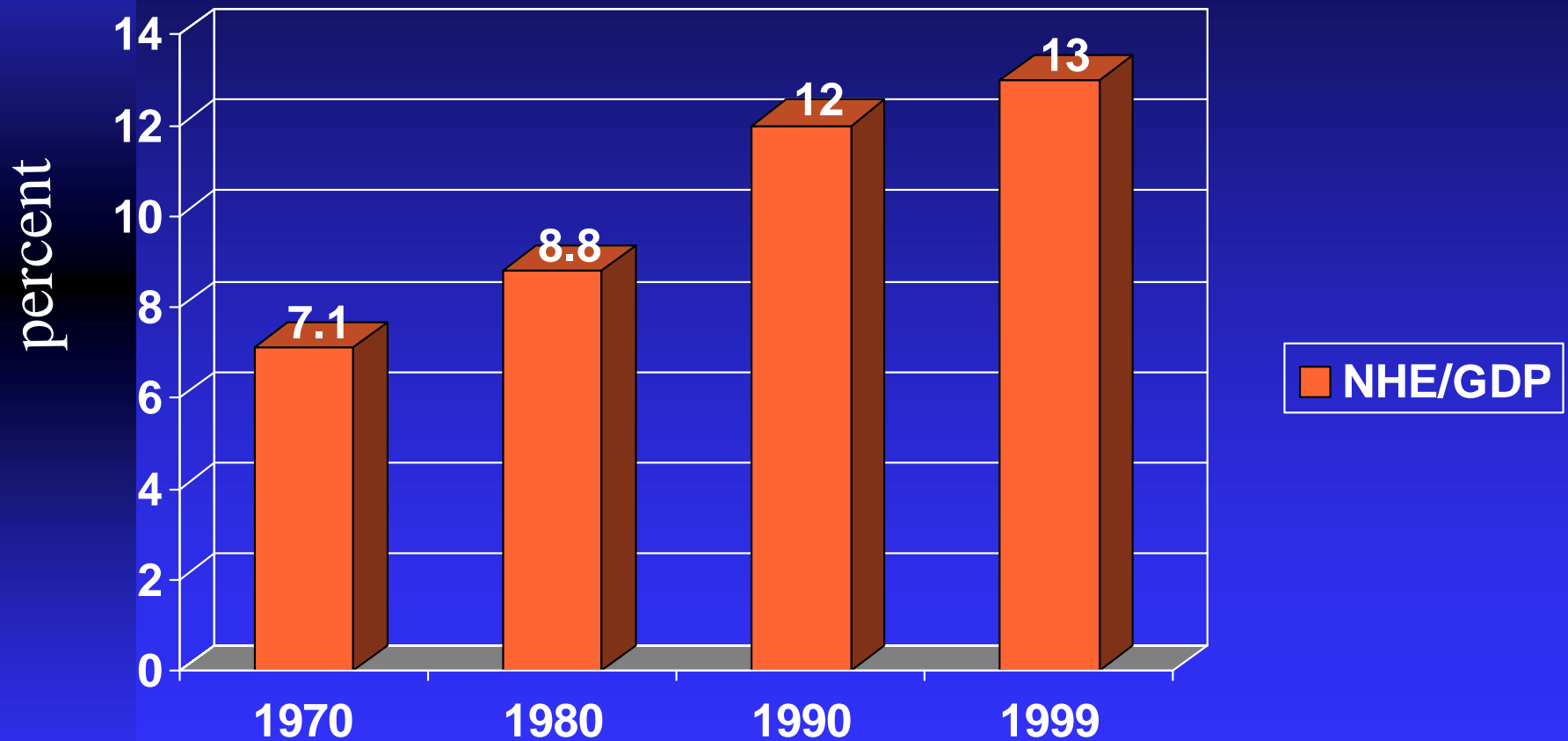■ Prospects for the future: beyond DC

Worrisome Recent Trends

- Health benefit costs per enrollee
- Rising complexity of health care purchasing
- Responses: Decreasing Employer Share?
- More Decliners => something's wrong with this wage-HI bargain
- Patient Protection backlash . . .
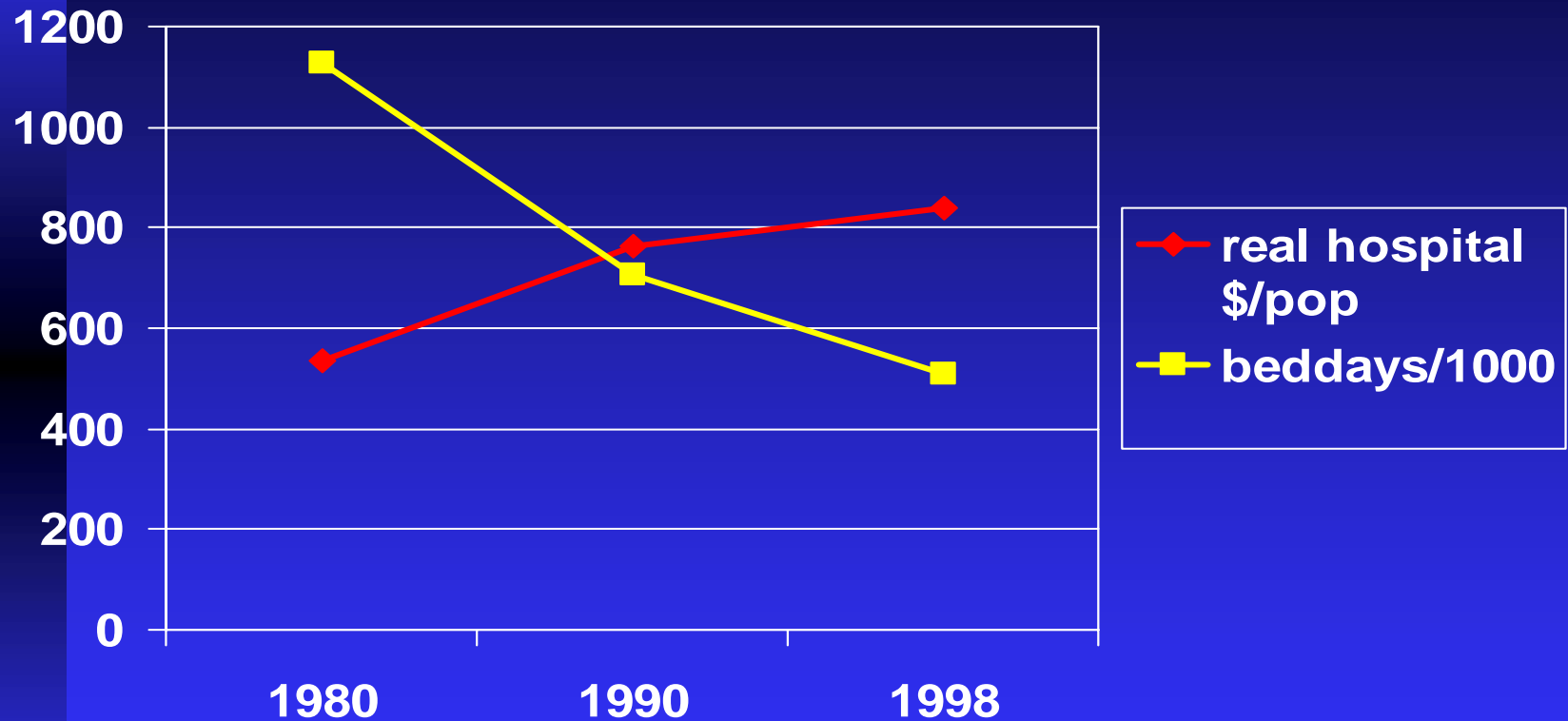
How we got from FFS to DC as a panacea

- cost growth => managed care
- But managed care fell from Grace
- Cost growth is returning (maybe never really went away?)
- Perhaps DC is the next "silver bullet" ?

National Health Spending's Claim on GDP over time

Source: HCFA Office of the Actuary.

Interesting fact about cost growth

Legend:
- real hospital $/pop
- beddays/1000

Y-axis: 0, 200, 400, 600, 800, 1000, 1200

X-axis: 1980, 1990, 1998

Sources: HCFA, NCHS. EROP.

What Drives Cost Growth Anyway?

- Aging?   2%
- Insurance?   10-13%
- Income growth?   5-23%
- Medical price inflation?   0-20%
- Defensive medicine?   0%
- Technology?   50-66+%

Sources: Newhouse; Cutler.

Why Technology Drives Costs

■ Increases diagnostic and treatment options

  ◆ may improve outcomes

  ◆ we want it! (May not equal to must)

■ Affect both volume and price

  ◆ less invasive => wider use

  ◆ price effect often increasing in short run

■ Complementary effects

  ◆ upstream and downstream use

  ◆ longer life / other disease costs

Health Care Cost Growth is World Wide
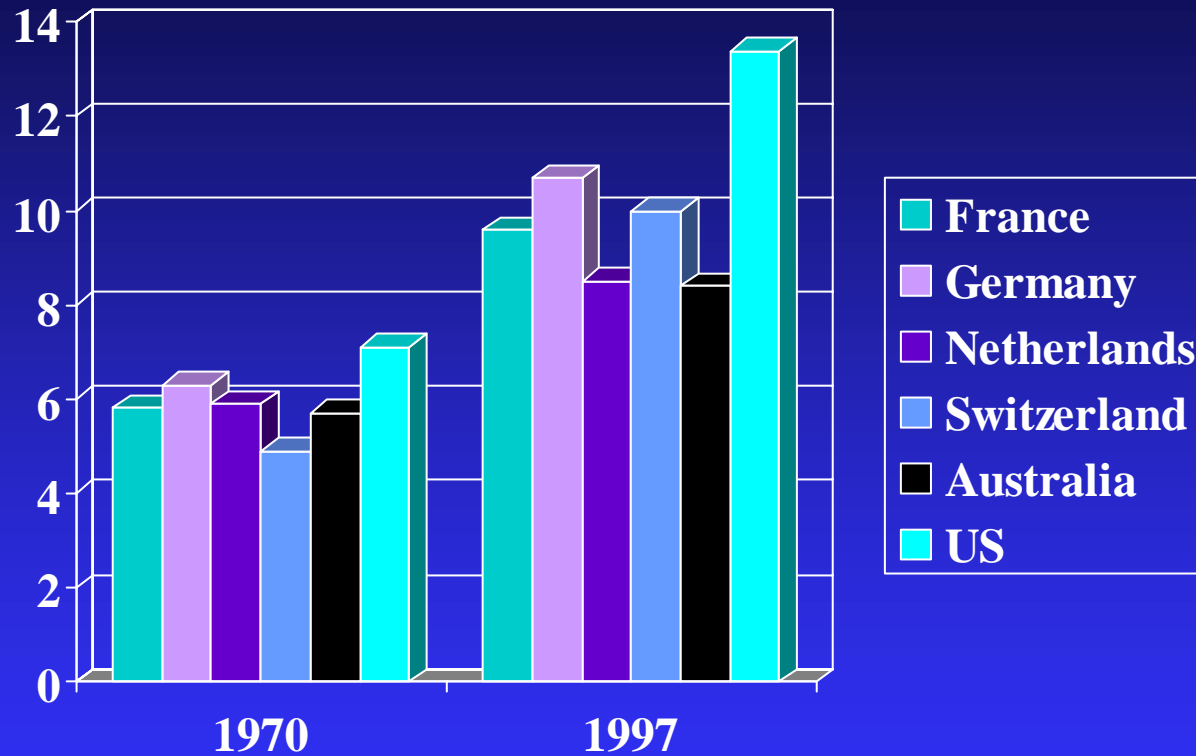
NHE percent of GDP

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Source: NCHS.

Longer term cost growth

■ NHE/person growth (nhe) has exceeded GDP/person growth (gdp) in real terms since 1929

- ◆ 1940s nhe - gdp   = 0.9% per year
- ◆ 1950s   = 2.1% per year
- ◆ 1960s   = 3.4% per year
- ◆ 1970s   = 1.5% per year
- ◆ 1980s   = 2.7% per year
- ◆ 1990s   = 0.4% per year

Source: Newhouse, HCFA, Economic Report of the President.

Why Managed Care Fell From Grace

- it did what we asked (no good deed . . .)
- utilization management
  - => patients and providers unhappy
- selective contracting
  - => providers and patients unhappy
- = double whammy/backlash => Patient Protection Acts
- Cost growth is returning (did it ever leave)?

How cost growth can "hide" for a while

- consider "any" vs. "exclusive" plans.
- suppose $P_{any} = 110\%$ of P_{exc}.
- suppose both grow at 10% per year
- initial market share is 50-50.
- in year two, 25% switch to lowest cost plan.
- Then measured per worker premium "inflation" = 7.4%, not 10%, which we know it to be!

DC health is not one thing

- theme: shifting choice and responsibility from employer to employee
- Models
  - simple, cafeteria, multiple employer, non-group
- Design Choices that can't be avoided
  - loads; selection potential; nature of ER contribution, plan selection/bargaining
- Net Impact: depends on both model and design choices

How DC health insurance *could* work

- DC => workers choose lowest cost plans
- lowest cost plans reduce diffusion, and ultimately development, of new medical devices and techniques, use/focus on cost-effective technologies only
- all plans adopt lower rate of technological change to compete on price with efficient plan

Limits on power of DC to work

- Private health insurance pays for 1/3 of NHE
  - Medicare plus Medicaid may be more important as standard setters for care/technology purchasers
- Not all workers offered choice of plans (57%)
- 27% of employers who offer use a fixed HI contribution of some type
- Note: no insurer is offering 1960s technology at 1960s prices; can we credibly slow technological growth?

Sources: MEPS; Fronstin, 2001

DC will impart price incentives to choose lowest cost plan

- **Elasticity of switching is higher (-2 to -4), but still not huge**

- **bottom line: cost growth in lowest cost plan**
  - Why might it differ?
    - can it PROVE that cost-effective care entails using older technologies?
  - No evidence on this point, maybe lowest cost today are just better at reducing bed days.
  - There is evidence that markets with high MC have slower adoption rates, => some hope ...

Changing Market Shares of Plan Types

|	1988	1993	1996	1999
Conventional	73%	46%	27%	9%
PPO	11%	26%	28%	38%
POS	—	7%	14%	25%
HMO	16%	21%	31%	28%

Source: Levit et al. 2000.

Example to Illustrate Possible Effects of DC

- Two plans, efficient and inefficient
- original market share, 80% inefficient
- growth rates: 4% efficient, 8% inefficient
- switching elasticity = -3 with DC
- switching elasticity = -.5 without DC
- Will show market shares of inefficient plan, average premium growth rates w/ and w/o DC

Market Share of Inefficient Plan, with and without DC and higher switching elasticity
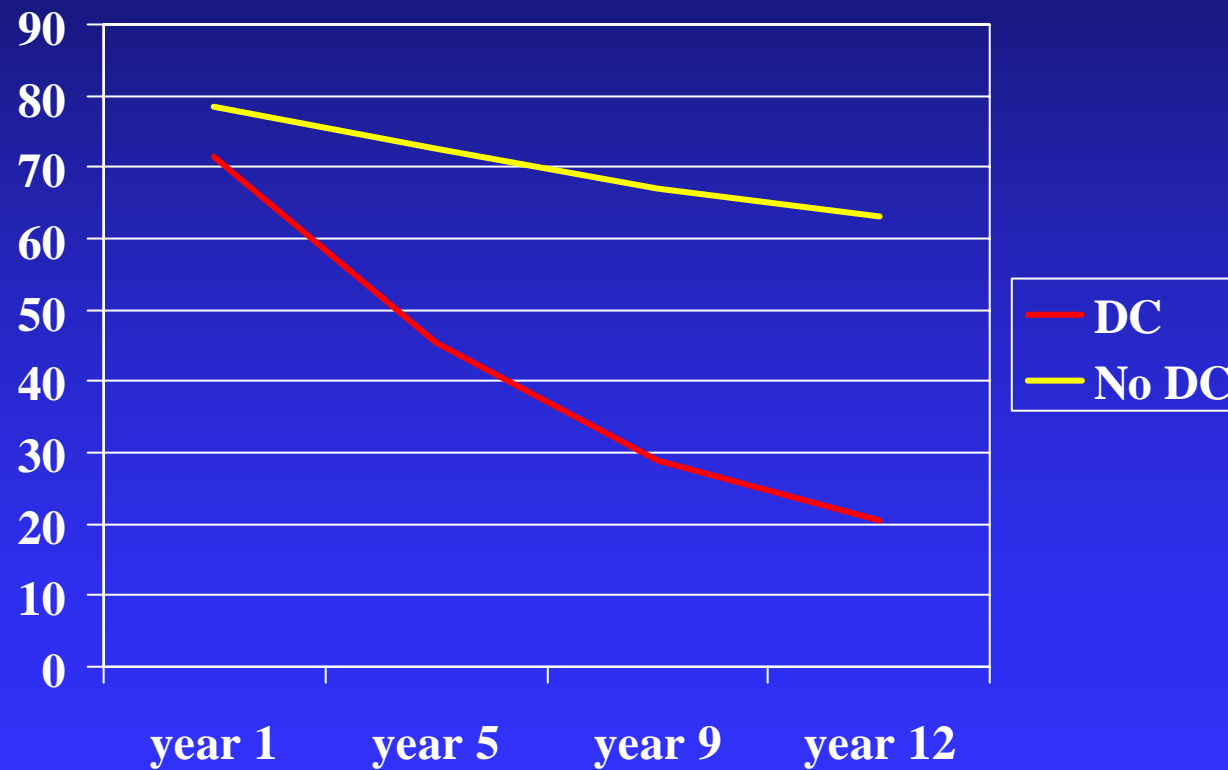
Employer Average Premium Growth Rate, with and without DC and higher switching elasticity
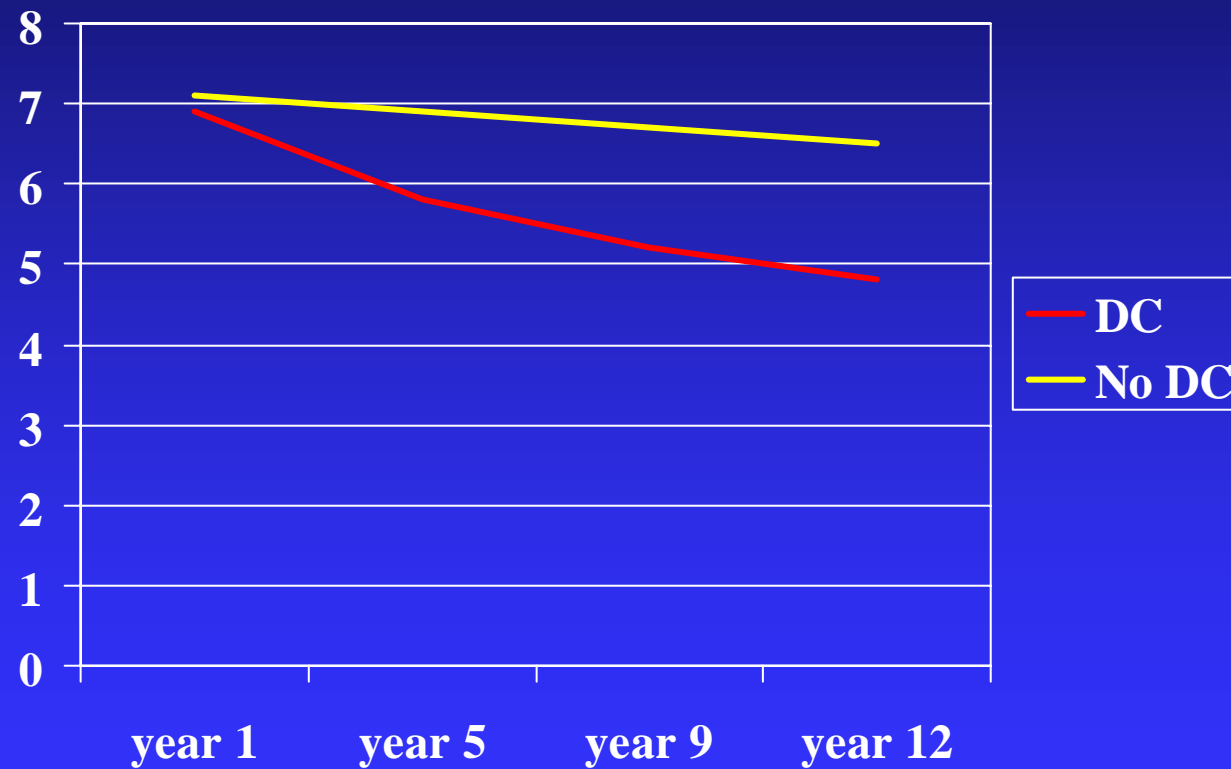
Beyond DC: Prospects for the Future

- Evidence-based health care is our only hope
  - must prove denial is not life-threatening
- DC can play an important role in imparting incentives to employees
- Incentives for plans and providers are still key
- Accountability/evaluation/monitoring infrastructure is also essential, must be financed, cheaper out of economies of scale