National Center for Policy Analysis

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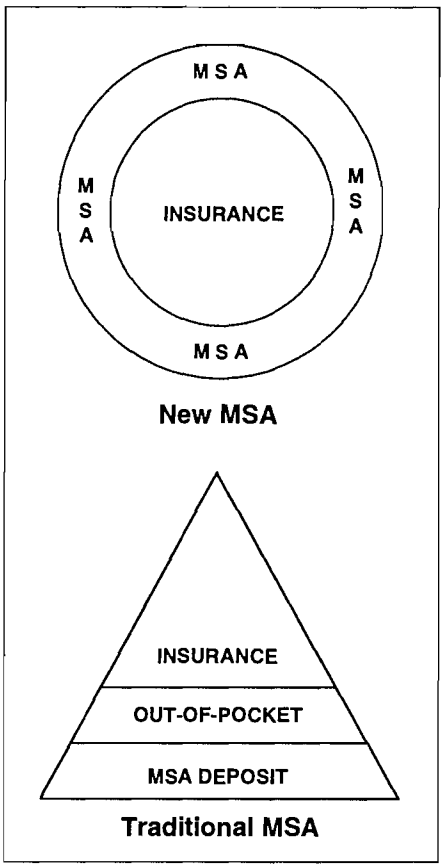
Solving the Problems of Managed Care

Not long ago, American health care was easily the best in the world. Today, we face a quality crisis. Almost 60 million Americans are now members of health maintenance organizations (HMOs), and an estimated 160 million are enrolled in some kind of managed care. Yet polls show that many of these people have no confidence that their health plan will make decisions in their best interest as patients.

What is causing the problem? What can be done about it? The National Center for Policy Analysis proposes some answers.

Source of the Problem: Employer Provision of Insurance. It is self-evident that the interests of the employer are different from those of the employees. Employers, of course, compete for workers in the labor market by offering fringe benefits in addition to wages. And the more generous the employer's health insurance, the more attractive the job. But the employer's primary interest is in healthy employees. Other things being equal, no employer has an incentive to advertise that the company health plan has excellent coverage for alcoholism and drug abuse, chronic conditions or other expensive-to-treat diseases.

Source of the Problem: Perverse Incentives for Insurers. In today's environment, individuals are often able to exercise choice among options created by an employer or plans competing in a regulated market. However, many health plans are required to charge the same premium to every applicant, regardless of expected health care costs. Under this one-price-for-all rule, the premiums sick people pay are well below the expected cost of their treatment, while the premiums of healthy people are substantially higher.



As a result, health plans face extremely perverse incentives to avoid the sick and attract the healthy. Indeed, plans that attract a disproportionate number of sick people eventually fail and leave the market. But since health plans cannot discriminate among enrollees on the basis of price, they tend to make quality adjustments instead. Specifically, each plan has an incentive to underprovide services to the sick and overprovide services to the healthy.

Solution: Individually Owned Insurance. Most people with private health insurance obtain it through an employer. The reason is the federal tax law, which excludes employer premiums from the employee's taxable income. This tax subsidy can reduce the cost of health insurance by 30 percent or more for an average-income family. By contrast, individuals who purchase their own insurance receive little or no tax relief. In addition to encouraging employer-based health insurance, the current system encourages waste. Since an extra dollar of earnings can be used to buy a dollar's worth of health insurance as an alternative to 70 cents of take-home pay, employees have an incentive to obtain too much health insurance, covering items that could have been purchased more efficiently out of pocket or might not have been purchased at all. We propose a neutral tax policy that eliminates these distortions.

As an alternative to employer-provided health insurance, employees should be able to purchase their own insurance and get similar relief under the tax law. They should get a tax credit that encourages them to purchase "bare bones" catastrophic insurance — leaving them free to purchase additional coverage with their own money. Employers should be able to help employees obtain individually owned insurance by supplying information, negotiating group discounts, etc.

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The advantages of these proposals are clear:

- Employees would be able to purchase insurance tailored to their needs, rather than insurance selected by their employer.
- People would have portable insurance that travels with them on their journey through the job market.
- Tax relief would extend to the self-employed and others who do not have employer-provided coverage.
- The limited tax subsidy would assure that the purchaser, rather than taxpayers, would bear the full cost of extra, nonessential coverage.
- Those who want to continue under the current system would be free to do so.

Solution: A New Medical Savings Account. Although current tax law subsidizes the payment of employer-based third-party insurance premiums, it provides virtually no tax relief to those who self-insure by putting funds aside to pay medical bills directly. Thus the tax law encourages us to turn over all of our health care dollars to a third-party manager. The exceptions are two MSA pilot programs — one for the elderly on Medicare and the other for small businesses and the self-employed. Yet these tax-advantaged MSAs are inadequate to deal with the challenge of managed care for three reasons:

- Contributions to tax-free (pilot project) MSAs can be made only by those with high-deductible plans — thus excluding enrollees in HMOs and most other managed care plans.
- The MSA deposit is mainly designed to pay deductible expenses and is exhausted at the point where third-party (often managed care) payment takes over.
- After the insurance period (usually one year), withdrawals from the MSA face taxes and penalties unless they are used to purchase medical care — a feature that forces the MSA to operate less like real self-insurance and more like prepayment for the consumption of medical care.

To remedy these defects and give MSAs more flexibility, we propose to make the tax law more neutral with respect to the use and withdrawal of MSA funds. Specifically:

- People who take advantage of the new tax credit should be able to make deposits to a new type of Medical Savings Account.
- The new MSA is designed to wrap around third-party insurance — providing funds with which to pay any uninsured medical expense. [See the diagram.]
- Deposits to the MSA would be made with aftertax funds, and withdrawals for any reason would be tax-free.
- Like the previous set of proposals, these would create a new option without taking away any current option.

Again, the advantages of these proposals are clear:

- Enrollees in HMOs and other managed care plans would be able to make MSA deposits and use the funds to pay nonnetwork doctors and purchase diagnostic tests and other services not covered by their health plan.
- Employers and insurers would have much more flexibility in designing plans; for example, they could provide first-dollar coverage for some services (e.g., preventive tests with proven payback) and high deductibles for others (e.g., general checkups) without jeopardizing the ability of the insured to have an MSA.
- A special type of fee-for-service plan — one that pays fixed fees for services and procedures — would become more viable because if the scheduled fee proved insufficient, people could use their MSA funds to pay the difference.
- Because MSA withdrawals would be tax-free, people could make risk-free MSA deposits — secure in the knowledge that they could have their money back without penalties if they had no medical expenses.
- Because MSA withdrawals would be tax free, people in future periods could make unbiased choices among medical care, other goods and services and personal savings.

These proposals — if implemented — would change the ways the private marketplace responds to the perceived deterioration of health care quality that has emerged with managed care.

This Brief Analysis was prepared by NCPA President John C. Goodman.