CBO MEMORANDUM

CONTROLLING THE RATE OF GROWTH
OF PRIVATE HEALTH INSURANCE PREMIUMS

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This Congressional Budget Office (CBO) Memorandum was prepared in response to a request by the Subcommittee on Health of the Committee on Ways and Means of the U.S. House of Representatives. It analyzes two illustrative policy options that are intended to highlight some of the key issues surrounding the regulation of health insurance premiums. They are not based on any specific legislative proposal under consideration, nor on the Administration's health care proposal that is expected to be announced in the near future.

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SUMMARY

Policymakers are currently considering numerous proposals to limit the rate of growth of national spending for health care, including regulatory approaches to controlling the rate of increase in private health insurance (PHI) premiums. Such measures would place pressure on insurers--who pay for about one-third of total health spending--to reduce costs. In part because controls on premiums alone could have effects that would conflict with other policy goals, these proposals generally include other measures to ameliorate any adverse consequences.

This Congressional Budget Office (CBO) Memorandum analyzes two illustrative policy options that are intended to highlight some of the key issues surrounding the regulation of health insurance premiums. The first option is a "stand-alone" measure to limit the rate of increase in PHI premiums. It illustrates the types of unintended consequences--such as reductions in the availability or extent of insurance coverage--that could arise from such an approach. The second option incorporates a set of additional policy measures that could mitigate some of the potential adverse effects of such a stand-alone policy. The two options are not based on any specific legislative proposal under consideration, nor on the Administration's health care proposal that is expected to be announced in the near future.

A stand-alone policy to control the rate of growth of PHI premiums could put strong pressure on insurers to bring down the costs of care to be in line with lower revenues from premiums. In response to this pressure, insurers would probably take a variety of actions--increasing utilization review, avoiding potentially high-cost enrollees, reducing benefits, and cutting payments to providers are the most likely. Although such actions would probably result in lower spending on private health insurance, they would also have undesirable consequences. Private health insurance benefits would be lower, out-of-pocket spending for health care would rise, high-risk individuals would find it harder to obtain coverage, and technological progress in health care would probably occur more slowly.

Softening some of the adverse effects of premium controls would entail significant restructuring of the health insurance industry. Specific measures would include standardizing the benefit package across insurers, making renewal of policies mandatory at an "affordable" price or instituting universal coverage, changing enrollment practices and adjusting for differences in characteristics of enrollees among insurers, and limiting balance billing and cost shifting. Some of those additional measures would increase spending, at least in the short run. Whether or not the combined policies would reduce health expenditures in the long run would depend crucially on the specific ways chosen to put each individual component into place, the effectiveness of the enforcement mechanisms, and interactions with any other policy measures that might be undertaken at the same time. An analysis of these issues is, however, beyond the scope of this memorandum.

INTRODUCTION

Since 1965, national health expenditures (NHE) have risen at an average annual rate of 6 percent after adjustment for inflation, reaching $751.8 billion, or 13.2 percent of gross domestic product (GDP), in 1991.[1] Despite this increase, about 35 million Americans--roughly one in seven--lack health insurance. Without any change in law or current practices, the Congressional Budget Office (CBO) projects that NHE will reach $1.3 trillion in 1997, or about 17 percent of GDP and that the number of uninsured Americans will reach almost 38 million.

Many policymakers believe that the share of national income devoted to health spending is excessive. Moreover, they realize that universal coverage would increase this share unless it is accompanied by cost controls. These concerns have led to numerous proposals for restructuring the way in which health services are delivered and financed. Among them are proposals to cap the rate of growth of health spending. Policymakers have considered a variety of regulatory tools that might achieve that end, including limits on the rate of growth of private health insurance (PHI) premiums.

This analysis discusses limiting the rate of growth in PHI premiums in the context of direct controls on insurers, including conventional insurers and health maintenance organizations (HMOs) and other insurance/delivery entities, as well as self-insured firms (those that self-fund the health benefits paid on behalf of their employees). Specifically, the analysis examines an illustrative option that assumes the federal government would establish--and could enforce--a maximum percentage amount by which insurers could increase average per capita premiums in a given year.[2]

Although health care proposals to limit premium growth could incorporate many additional elements--and, indeed, might include such controls only as a secondary consideration--this memorandum focuses on controlling premiums as an independent policy measure. Using this approach, one can distinguish the potential effects of controls themselves from the effects of other measures that might be included in a proposal for restructuring the entire health care system. The memorandum also examines a second option that includes additional measures that might accompany controls to mitigate or avoid some of their unintended consequences. The two options are not based on any specific legislative proposal under consideration, nor on the Administration's health care proposal that is expected to be announced in the near future.

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1. Personal health expenditures, which comprise all spending for direct patient care, reached $660.2 billion in 1991 and are projected to reach $1.2 trillion in 1997.

2. As discussed later, this option is only one of several different ways in which the rate of growth in PHI premiums might be controlled. For example, an alternative would be for the government to specify a ceiling above which premiums could not rise in any given year. Different options would generally have somewhat different effects, but examining the range of possible options is beyond the scope of this analysis.

Why Regulate Premiums?

The arguments made in favor of controlling the growth of PHI premiums as a tool to restrain health spending are two-fold. First, controls on PHI premiums would have the potential to limit growth in the price and volume of medical services simultaneously, whereas fee schedules or other policies that limited the rate of increase in providers' prices would not by themselves limit the quantity of care provided and could even induce an increase in quantity.

A second argument made in favor of controlling the growth of PHI premiums is that it would be a "macro-" rather than a "micromanagement" approach. Controls on health insurance premiums, according to this argument, would be less intrusive than other types of cost controls because the government would need only specify an allowable rate of premium increase, leaving insurers, providers, and consumers to determine how best to achieve that rate. In addition, even assuming that self-insured firms were included, regulators would need to monitor fewer "insurers" than health care providers, if price controls were imposed on them.

Although specifying a permissible increase in insurance premiums could be less intrusive than determining allowable rates of increase of prices for a vast range of health care products and services, controls on PHI premium growth could still entail significant regulatory effort. For example, to determine the allowed average rate of growth in premiums, one would have to distinguish cost increases that were "desirable"--say, because they reflected an aging population--from those that were not. Yet for a number of reasons, including the difficulty of measuring changes in productivity, interested parties would almost certainly disagree on what rate of increase should be allowed.

Important Considerations

Three important considerations have a bearing on how effective PHI limits could be in controlling the rate of growth in health spending and on how desirable they would be in view of other policy objectives:

- Spending by private insurance--that is, conventional insurers, self-insured firms, and health maintenance organizations--accounts for less than a third of national health expenditures, so that efforts to constrain premiums would leave much of the market for health care unaffected directly.

- Effective limits on premium increases would affect both the quantity and quality of health insurance coverage available to consumers and their future access to new medical technologies. By taking the relationship between premiums, coverage, and

benefit levels into account, policymakers could avoid some unintended, undesirable outcomes.

- Effective mechanisms to enforce the controls would be required, and these could be difficult to design and costly to put in place.

PHI Premiums and Health Spending. Private insurers spent $244.4 billion in 1991--$209.3 billion for personal health care and $35.1 billion for administrative costs (including profits)--thus accounting for about one-third of NHE. (Out-of-pocket spending by consumers was $144.3 billion, or about 20 percent of NHE; governments at all levels spent $330 billion, or about 44 percent of NHE.[3]) Even if PHI premiums and spending by insurers were directly linked, only a modest share of total health spending would be subject to controls. As a result, it would be difficult to achieve large reductions in the overall rate of increase. If no other action were taken, lowering the annual rate of growth in NHE from 6 percent to 4 percent, for example, would require holding the growth in private insurance spending to zero and that costs not be shifted from insurers to consumers.

A related point is that, because health care providers can charge different prices to different consumers, efforts to control one source of spending may not hold down overall spending. For example, a recent CBO analysis of cost-shifting by hospitals found that "the share of unreimbursed costs [from uncompensated care and publicly insured patients] offset by private payers increased from 37 percent in 1980 to 55 percent in 1989." That increase reflected, at least in part, efforts to constrain government spending.[4] Thus, even if controls on PHI premiums reduced spending by private insurers, they would not necessarily cut total expenditures, particularly if providers were able to increase the revenues they received from patients, governments, or other sources such as charitable organizations.

Maintaining the Quantity and Quality of Insurance Coverage. According to economic theory, when the price of a good or service is constrained below the level that would have prevailed in a competitive market, producers will respond in various ways.

First, producers can bring less of the good or service to market. In this instance, such a response would mean offering insurance coverage to fewer individuals or avoiding high-cost enrollees.

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3. Suzanne W. Letsch, Helen C. Lazenby, Katharine R. Levit, and Cathy A. Cowan, "National Health Expenditures, 1991," *Health Care Financing Review*, volume 14, number 2 (Winter 1992), Table 15.

4. Congressional Budget Office, "Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals 'Cost Shift'?" CBO Paper (May 1993), page vi.

Second, producers can attempt to reduce their costs of production, while holding constant the quality of the product. Reducing these costs might entail paring administrative costs or spending for currently covered services, either by lowering prices paid to providers or eliminating less necessary care. (But if reducing costs were easy to do, insurers would probably have done so already.)

Finally, producers can adjust the quality of the product in an attempt to produce a close substitute at a lower cost. In the case of health insurance, such an adjustment could be made by placing limits on the services covered (including new technologies), reducing the range and depth of coverage for health care services, through higher deductible amounts and copayments, and so on. Some services might no longer be covered at all, while coverage of others might be limited. Although state mandates might prevent conventional insurers and health maintenance organizations from eliminating coverage of some specific services, self-insured firms are not subject to such mandates.

The main goal of controlling growth in PHI premiums is to give insurers greater incentive to increase efficiency--say, by reducing overhead expenses and eliminating unnecessary care. But insurers might also respond to controls by using the same strategies they have employed in the past. Those include aggressive risk selection to avoid insuring potentially high-cost individuals, limits on covered services, and increases in cost sharing on the part of insured individuals. Even though such steps might well reduce health spending, many people would view at least some of them as undesirable.

Enforcement Mechanisms. Another factor critical to the success of controls on PHI premiums is how effective enforcement mechanisms would be in ensuring compliance among insurers. Controls that depended on insurers voluntarily limiting increases in premiums would probably have minimal effect. Insurers would simply have no greater incentive to control costs than they do now. By contrast, stringent controls would require significant regulatory oversight and could add imbalance to the allocation of resources as insurers and others attempted to avoid the controls.

Another problem is that experience with price controls in other sectors demonstrates just how difficult it is to anticipate all of the possible market responses to controls and take them into account in developing enforcement mechanisms. Analyzing an option to control PHI premiums will help illustrate some general responses insurers might take; specific ones would depend on the details of the particular policy.

BACKGROUND

Health insurance premiums represent the price of two products: prepayment for some routine medical care, and protection against financial losses for large, unforeseen medical expenses. In principle, therefore, increases in the prices of

these products could be controlled just as the prices of many other products are (or have been) controlled. The market for health insurance differs in important ways from other markets, however, and these differences are critical for assessing the effects of limiting increases in premiums.

The Market for Health Insurance

In terms of primary insurance, about four-fifths of Americans under age 65 with health insurance had employment-based coverage in 1992--either as policyholders, or as their dependents. Hence, it is by far the most important source of coverage (see Table 1). Another 8 percent of the insured nonaged population obtained coverage through individually purchased policies (or through groups not related to their employment); the rest were covered under public programs.

Private health insurance coverage is provided in a number of ways. In addition to traditional fee-for-service (FFS) plans offered by conventional insurers, a variety of insurance plans based on contractual arrangements with networks of "preferred" providers have been developed. These new arrangements range from relatively loose networks based on agreements to discount customary fees through various types of health maintenance organizations (HMOs).

Under FFS plans, insurers pay a specified share of costs for covered services and allow participants considerable range in their choice of providers (subject to restrictions on the types of providers that are covered). FFS plans typically have a deductible amount, up to which the insured person pays 100 percent of charges, as well as a "stop-loss" amount--that is, a maximum out-of-pocket amount--beyond which the insurer pays 100 percent of allowed charges. For the difference between the deductible and stop-loss amounts, FFS plans pay a specified percentage of allowable provider charges, which may be below actual charges. The insured is typically responsible for the remaining percentage of allowable charges, charges in excess of the amount allowed by the insurer, and all charges for uncovered services.

Health maintenance organizations combine the financing and delivery of medical care. That is, participation in an HMO provides financial protection similar to what a conventional insurer offers--but with almost no cost sharing. It does so, however, with the proviso that a designated network of providers furnishes all (or most) medical care. These networks include staff model HMOs, in which the HMO owns its clinical facilities and employs physicians who serve only the organization's members; group model HMOs that contract with multispecialty medical groups to provide services to their members; and independent practice associations that contract with individual physicians to provide services to members.

TABLE 1. SOURCES OF HEALTH INSURANCE COVERAGE OF THE INSURED NONAGED NONINSTITUTIONAL POPULATION, MARCH 1992

Source of Coverage[a]	Number of People (Millions)	Percentage of Insured Population
Insured	185.7	100.0
Employment-Based[b]	148.2	79.8
Policyholder	71.6	38.6
Dependent	76.6	41.3
Other Private	14.3	7.7
Public	23.2	12.5

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March 1992.

NOTE: "Nonaged" refers to people under age 65.

a. "Source of Coverage" refers to the individual's primary insurance coverage when there are multiple sources of coverage.

b. As defined here, the number of people covered by employment-based health insurance includes federal, state, and local government employees and retirees, as well as those covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Another 1.6 million people aged 65 and older who are not shown in the table have employment-based health insurance as their primary coverage.

The distinction between FFS plans and other arrangements has become blurred in recent years. Conventional insurers, for example, have taken steps to reduce the costs of their FFS plans by increasing oversight of the services used by their insured customers--a process known as "utilization review." Insurers have also begun to offer a variety of plans under which insured individuals can obtain lower deductible amounts and coinsurance payments if they use the services of members of preferred provider organizations (PPOs) who have contracted with the plan. Insurers select such providers on the basis of a variety of criteria. These typically include willingness to accept discounted fees and abide by the plan's guidelines for providing services.

Point-of-service (POS) plans, which accounted for about 7 percent of private coverage in 1991, are newer variations on the preferred provider model and are offered by both conventional insurers and HMOs. They are more tightly managed than earlier PPOs, but they offer enrollees the same opportunity to use a non-network provider by paying more out of pocket.

One difference between FFS plans and HMOs is that the latter generally subject enrollees to much less cost-sharing in the form of deductible amounts and coinsurance. For example, in the FFS plans, the average deductible in 1991 was about $200 per person; the typical HMO did not require a deductible amount. Similarly, HMOs required an average copayment of $5.00 per visit, while most other types of plans required enrollees to pay up to 20 percent of covered charges after they satisfied their deductible amount. Although lower cost-sharing increases the use of medical care and HMOs tend to cover a wider range of services, their lower use of inpatient hospital services and healthier populations allow HMOs to offset these costs. Premiums vary somewhat across the FFS/HMO spectrum, but by less than the variation in services covered and cost sharing might suggest.

Why the Market for Health Insurance Differs From Other Markets

The market for health insurance differs in important ways from markets for other products, including other types of insurance. First, most private health insurance is employment based, with employers nominally responsible for paying a significant share of the premiums.

Second, unlike most other goods and services, the costs of producing health insurance--that is, providing consumers with a specified level of financial protection--depend on the characteristics of the consumer of the product. These characteristics include not only the consumer's health status, but also the propensity to consume health services given that health status. At the same time, insurers have less knowledge of these characteristics than do the insured individuals themselves.

Finally, when they purchase health services, consumers generally turn over most decisionmaking to providers. Especially among insured patients, the financial costs of treatment play a relatively small role in their purchasing decisions.

Employment-based health insurance predominates for three reasons. First, premiums paid by employers are a deductible expense to the employer (like cash wages) and are not subject to federal income and payroll taxes at the employee level. This preferential tax treatment means that even if employers reduce the cash wages of their workers by the amount of their contributions for health insurance--as economists generally assume--they can still make employees better off by purchasing more health insurance than the employees would choose if they paid for it themselves from after-tax income.[5]

Second, groups of employees--especially workers in large firms--represent a convenient method of pooling sufficiently large numbers of individuals to generate predictable risk pools for insurers. Because these individuals have not come together for the express purpose of buying health insurance, the insurer can treat groups of employees as essentially random draws from a larger population with the same distribution by age and gender.

Finally, the costs per person to insurers for sales and marketing are lower the larger the group buying the product.

Because insurance is more costly to provide to some consumers than to others, categories have been developed in which premiums reflect differences in average expected costs. For individuals and small groups, rating categories are typically based on characteristics such as age and gender; in these markets, insurers obviously have a strong incentive to avoid people or firms that represent above-average risks and to seek out below-average risks. Excluding coverage of preexisting conditions and medical underwriting--that is, basing premiums on the specific risk factors for the group or individual to be insured--has become more common in recent years. However, many states have enacted legislation to regulate the health insurance market for small groups, which may be reversing the trend toward such exclusions.

For large groups (excluding self-insured firms), premiums tend to be experience-rated--that is, they depend on the group's prior history of claims. Excluding coverage for preexisting conditions and medical underwriting is much less common in the large group market.

Differences in risk also affect the behavior of consumers. Individuals can assess their own (or their dependents') health status much more accurately than

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5. Some employees may not value the marginal dollar spent on insurance as much as its after-tax cost, but the total value of insurance is presumably greater than its cost for most people.

can insurers for the simple reason that they have knowledge of family medical history that would not be easily available to an insurer and because only individuals know their own propensity to use health services. Within any given risk category, "bad risks" (individuals who expect to use relatively more health services) will have a greater demand for insurance than "good risks." Other things being equal, bad risks are more likely to purchase insurance (either on their own or by seeking employment in which health insurance is provided), to purchase more comprehensive policies, and to retain insurance (say, by not changing jobs). Bad risks are also more likely than good risks to respond to modifications in benefits by changing plans.

Furthermore, the nature of insurance coverage--whether provided through an FFS plan or an HMO--means that individuals do not pay the full marginal cost for most medical care. Faced with artificially low prices, both good risks and bad risks consume more care than they would purchase if they were paying for it out of pocket. As a result, insurance premiums must collectively pay for a larger quantity of medical care than if individuals were paying for their own care.

The complexity of modern medicine compounds this tendency to consume more health care because one has insurance. Especially for serious and potentially high-cost illnesses, most consumers must delegate authority for treatment to providers. As in other markets where insufficient information requires consumers to rely on the advice of producers, the quantity of medical care demanded depends in part on the decisions of the suppliers. Because health care providers can influence the volume of services, a reduction in the prices they receive per unit of service does not cut expenditures commensurately.

The features that distinguish the market for health insurance from other markets affect the design, implementation, and effects of any policy to control premiums. The close connection between health insurance and the labor market, for example, means that policies intended to affect the market for health care could also influence wages and, possibly, employment. Policies regulating the price of health insurance might have profound effects on coverage as insurers and consumers could respond in a variety of ways.

Premiums and Health Spending

One needs a knowledge of both the micro and macro relationships between premiums and health spending to understand how controls on PHI premiums might translate into lower health spending, as well as the consequences such controls might have for health insurance coverage. The micro relationship links the generosity of the benefit package and the premium; other things being equal, plans with more generous benefits generally have higher premiums. A number of other factors also affect premium levels--for example, differences in the

demographic characteristics of the insured population, the costs of medical care in different areas, and the administrative costs of insurance for groups of different sizes, especially sales and marketing costs.

The relationship between revenues from premiums--that is, the total of premium payments from all insured people--and total health spending is imprecise for two reasons. First, the fraction of NHE reimbursed by insurers may change as more or fewer services are covered, as more or less cost-sharing is introduced, or as government health spending increases or decreases. Second, the link between premiums and spending by insurers is not fixed.

The two will be roughly equal over the long run--administrative costs and normal profits aside--but need not be equal in any given year as insurers experience above- or below-average profits. In fact, economic theory predicts that if the gap between revenues from premiums and spending were to be consistently large, firms would enter the health insurance market to reap the gains and drive excess profits down. If revenues consistently trailed spending, some insurers would be forced to raise premiums or go out of business. For these reasons, the degree to which controls on premiums might affect health spending could vary from year to year.

Premiums, Plan Generosity, and Characteristics of the Insured. In setting premiums, insurers must calculate their expected liabilities--how much they expect to pay out in claims--which will depend on the generosity of the plans they issue, the characteristics and claims history of their insured customers, and the prices of providers. For a particular group or category of ratings, premiums then represent the expected liabilities, plus overhead and desired profits, divided by the number of insured individuals. This relationship means that, given a set of prices charged by providers, if one changes "choice variables" such as the generosity of the benefit package or the characteristics of the people insured, it will modify the premium an insurer needs to achieve a specific level of profits. It also means that limits on the premium that the insurer can charge would probably induce changes in these choice variables, unless the insurer was prevented from doing so.

Although discussions of health care reform are often couched in terms of whether or not people are insured, health insurance is anything but a standardized product. Policies vary in their amount of cost sharing and the range of services covered, and their premiums vary according to the number and types of people who are covered. In 1991, for example, the total cost of an employment-based plan with the median level of generosity is estimated to have been about $1,300 for single coverage for the typical policyholder and about $3,200 for family coverage (see Table 2). Policies with greater amounts of cost sharing are less expensive, other things being equal, and costs are higher for policies with a broader range of coverage (for example, those covering prescription drugs, dental care, and so on).

TABLE 2. ACTUARIAL COSTS OF HEALTH INSURANCE BY GENEROSITY OF THE PLAN, 1991

	Percentage of Covered Employees With Less Generous Plans				
	10	30	50	70	90
Whole Group Premium (Dollars)					
Single	1,141	1,241	1,310	1,364	1,418
Family	2,750	2,996	3,174	3,308	3,427
Type of Plan					
Major medical only	x	x	x		
Basic plus major medical				x	x
Deductible (Dollars)					
Single	200	100	50	50	50
Family	700	350	150	100	100
Coinsurance Rate (Percent)					
Hospital	20	20	20	0	0
Physician	20	20	20	20	0
Other	20	20	20	20	0
Out-of-Pocket Limit Per Person After Deductible Amount (Dollars)	1,500	900	500	500	0

SOURCE: Congressional Budget Office, based on data from the Actuarial Research Corporation.

NOTES: Whole group premiums are premiums based on applying the coverage to the entire (current) employer-sponsored insurance population.

Premiums shown are calculated by ranking plans according to their actuarial value (expected rate of payment) and then adjusting this actuarial value to a whole group premium that is consistent with the 1991 National Health Accounts.

Plans are described as basic if they provide some first-dollar coverage--that is, no deductible--and carry a low (or zero) coinsurance rate for specified services. Major medical plans cover a wider range of services, including services for which basic coverage limits have been reached. Major medical plans typically require payment of a deductible amount and coinsurance.

Premiums also vary according to the characteristics of the insured. This variation reflects differences in the likelihood of illness and use of services, with older individuals generally costing more to insure than younger individuals. For example, expenditures on medical care for the typical man between the ages of 25 and 34 are more than 50 percent below the average for all people, and expenditures for people 75 and older are about triple the average (see Figure 1). And while there is little difference in health expenditures for men and women at age 55 and beyond, younger women have higher expenditures, on average, than younger men because of the costs of maternity care.

Trends in Premiums and Insured Spending. Proposals to regulate health insurance premiums rely on the presumption that health care expenditures made by insurers on behalf of insured individuals cannot exceed revenues from premiums in the long run. This presumption is correct on average. If it were not, insurers could not stay in business. Therefore, if one effectively controlled the growth of revenues from premiums, insurers ultimately would lower spending, although total health spending would not necessarily fall. At any point in time, however, the presumption of a link between premiums and spending is not necessarily true for a given insurer or the insurance industry as a whole. In some years, insurers earn abnormally large profits because their actual liabilities are less than their expected liabilities; in other years, insurers incur losses or abnormally low profits because their actual liabilities exceed their expected liabilities.

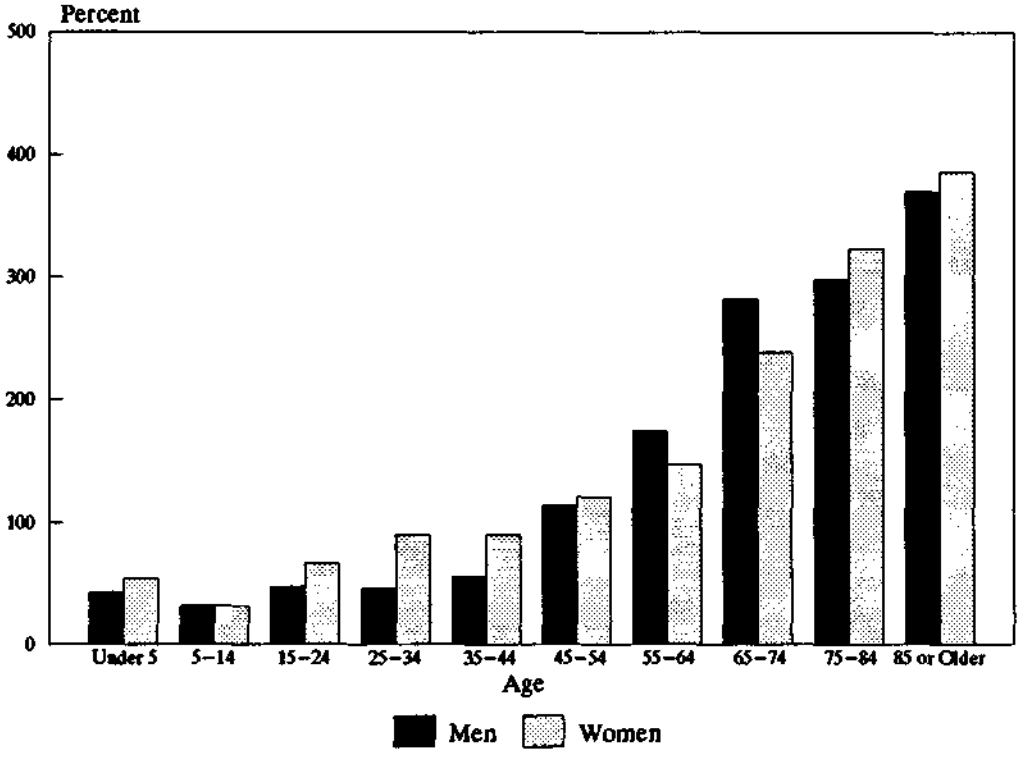
Analysts have pointed to a pattern of variation in premiums and liabilities known as the underwriting cycle.[6] This cycle suggests that profits of insurers tend to fluctuate systematically, with several profitable years followed by several unprofitable years. Although the reasons for the cycle and whether it will continue are not clear, its existence could have implications for imposing controls on the rate of growth of premiums. Specifically, controls imposed in a "bad" year could prevent insurers from recovering from previous losses, thereby hurting their long-run profitability and causing some insurers to go out of business. By contrast, if controls were imposed at the top of the cycle, insurers might have less incentive to constrain costs, at least in the short run.

CONTROLS ON PREMIUMS AS A STAND-ALONE MEASURE

Assessing any option to change the conditions under which medical care is delivered or financed requires taking into account possible behavioral changes by a wide range of people and institutions. Controlling the rate of growth in PHI premiums would affect not only insurers and health care providers, but also consumers, workers, and taxpayers), and governments.firms (both as employers

6. Jon Gabel, Roger Formisano, Barbara Lohr, and Steven DiCarlo, "Tracing the Cycle of Health Insurance," *Health Affairs* (Winter 1991), pp. 48-61.

Figure 1.
Personal Health Care Expenditures per Person, by Age and Gender, 1987
(As a percentage of average overall expenditures per person)



SOURCE: Congressional Budget Office calculations based on data from the 1987 National Medical Expenditure Survey.

NOTES: Excludes expenditures for the institutionalized population.

Personal health care expenditures include spending for hospital care, services of physicians and other health professionals, dental care, home health care, vision products and medical durables, drugs and other medical nondurables, and other personal health care services.

Data refer to average expenditures for personal health care services for all persons, including those with no expenditures.

and as insurers themselves), individuals (as health care consumers, workers, and taxpayers), and governments.

This section examines the potential responses of one set of actors--insurers (including self-insured firms)--to one option for controlling the growth in PHI premiums. In the option examined, controls on premiums would be put in place with no additional constraints on the behavior of insurers. The complexity of the market for health insurance makes it impossible to predict which responses would result and which would dominate. It is possible, however, to examine some of the possible outcomes.

An Illustrative Measure to Control Premiums

Conceptually, the simplest way to control the rate of increase in PHI premiums would be to specify a maximum amount by which each insurer's average premium could increase in a year, together with some type of penalty in the event that maximum was exceeded. But what exactly to control and how to control it would be choices for policymakers: how would premiums be defined for the purpose of determining permissible rates of increase? On whom should the responsibility for meeting those targets be placed--that is, who would pay the penalty? And how would targets be enforced? The following discussion examines these questions in the context of an illustrative option that would limit the rate of growth of average per capita PHI premiums.

Defining Average Per Capita Premiums. For a conventional insurer or HMO, average per capita premiums are defined as the insurer's total revenues from premiums divided by the total number of individuals (including dependents) it insures. For a self-insured firm, average per capita premiums are defined as the firm's total expenditures for health care on behalf of its employees divided by the number of employees (including retirees) and their dependents eligible for such care. Average premiums would have to be expressed in terms of the cost per covered individual rather than the cost per policy to avoid situations in which insurers reduced the average cost per policy by splitting coverage into multiple policies.

For the same reason, regulators would also have to prohibit insurers from offering supplementary policies.[7] In addition, insurers would be required to ascertain and monitor the number of people covered, which some carriers do not typically do today.

Under this option, responsibility for limiting the growth in premiums would be placed on insurers and self-insured firms. The measure would not impose restrictions on newly written insurance policies, provided their inclusion

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7. Medigap policies that supplement Medicare's benefits could be excluded from this prohibition.

did not cause the average premiums of insurers to increase more than the allowable amount. Nor would it specify the benefits that could be offered or the individuals who could be insured. Insurers would be free to offer any (basic, but not supplemental) policy desired, subject to other federal and state regulations already in place.

Controls could, however, be specified in other ways. Instead of regulating the rate of growth of average per capita premiums, one could place limits on the rate of increase for particular policies, so that increases were regulated at the level of each individual or group of individuals insured. Alternatively, premiums could be averaged for states (or other entities besides insurers). For example, the limits on expenditures that would be established for geographic regions under some health care proposals would cap the rate of growth in average per capita health expenditures, meaning that the rate of growth of "premiums" was implicitly capped.

Different definitions would have different implications for how to enforce limits on premiums and for responses on the part of insurers and others. Exploring these possibilities is beyond the scope of this memorandum.

Establishing Enforcement Mechanisms. A cap on the rate of increase in PHI premiums could be enforced in a number of ways, perhaps the most straightforward of which would involve eliminating any financial benefit associated with premiums in excess of the amount of increase allowed. For example, in the case of conventional insurers and HMOs (and other insurance/delivery entities), enforcement might be achieved by imposing a 100 percent tax on all premiums in excess of the target.[8] Taxing revenues from premiums rather than profits would help to ensure compliance on the part of non-profit insurers.[9]

As defined here, a limit on the growth in average per capita premiums for self-insured firms would represent a limit on per capita health care spending, not revenues. This limit would strengthen the incentives of firms to reduce health care costs. The federal government could penalize firms for exceeding the target rate of growth in health costs by not allowing excess spending to be deductible from their income for tax purposes or by imposing an excise tax of 100 percent on health spending above the target amount.

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8. If the allowed rate of increase were 5 percent, for example, and an insurer's average per capita premium rose by 8 percent from $1,000 to $1,080, then it would pay a tax of $30 for every individual it insured.

9. In some states, Blue Cross and Blue Shield plans are required to subsidize their individual lines of business with revenues from other lines. Depending on exactly how controls were imposed, some allowance for these plans (and others with special circumstances) might be considered.

Reactions of Insurers and Self-Insured Firms to Controls on Premiums

If backed by a sufficiently powerful enforcement mechanism, controlling premium increases would put strong pressure on insurers and self-insured firms to reduce their expected costs. Their responses to that incentive would fall into four broad categories: expand the use of managed care; reduce the riskiness of the individuals they cover; cut benefits; and lower payments to providers. Insurers and self-insured firms might institute such strategies in slightly different ways, but the likely outcomes of any one strategy would be quite similar. Which strategies were chosen--or which were successful--would, however, have important implications for health care coverage.

Expanding the Use of Managed Care. Over the past decade, insurers have increasingly begun to manage the care of the patients they insure and, by 1991, only about 8 percent of employees were in plans without some type of managed care component.[10] Managed care is designed to influence the decisions made by providers of care to ensure that only services deemed necessary and appropriate are furnished. Three important aspects of managed care are utilization review, which entails reviewing or intervening in the decision to provide covered medical services; limiting insured patients to the use of designated providers (as in HMOs), or giving them financial incentives to do so (as in PPO and POS plans); and negotiating lower fees with providers or developing financial incentives for them to provide care more cost-effectively (discussed separately below).

Whether increased utilization review and other steps would allow insurers to control the growth of spending without reducing benefits is open to question. Utilization review, for example, requires additional administrative expenses that would offset some or all of the reduction in direct costs. Further, the limited available evidence indicates that managed care achieves a one-time reduction in health care costs, but may not reduce the rate of growth in health spending over the long run. A one-time reduction might be considered a satisfactory outcome if controls were put in place as a stopgap measure, but it would not achieve the goals of a permanent policy to restrain growth in premiums. Moreover, because some HMOs have already achieved these one-time savings, they might find it difficult to meet targets set as a percentage increase over past premium levels (which is the type of control analyzed here).

Reducing Risks. A second strategy, one that has been widely used in the past, is risk selection. This strategy entails taking steps to avoid insuring individuals and groups likely to be above-average risks--that is, people whose expected health care costs are above average. In the current market, where insurers can

10. About 38 percent had fee-for-service plans that included utilization review as an integral part of the benefit package; 25 percent were in HMOs; and 29 percent used PPOs or POS plans. Cynthia B. Sullivan, Marianne Miller, Roger Feldman, and Bryan Dowd, "Employer-Sponsored Health Insurance in 1991," *Health Affairs* (Winter 1992), pp. 172-185.

price their products to reflect differences in risk among categories, risk selection involves attempting to avoid the higher-risk individuals in each category.

Under the simple measure outlined here, a greater degree of risk selection would be profitable even if the rate of return were the same on high- and low-risk enrollees. That is, even if insurers' base premiums--before the controls were put in place--allowed them to earn a satisfactory rate of return from high-risk enrollees, they would still have an incentive to replace those people with lower-risk enrollees, thus driving down their average per capita premium.

The strategy of reducing average per capita premiums through risk selection, however, faces diminishing returns. Once an insurer had eliminated its high-risk enrollees, it would then confront controlling the rate of growth in premiums for a group of low-risk individuals. Although some people develop high-cost illnesses over time, it would become progressively more difficult to achieve savings as the average risk declined. In the extreme, one cannot cut costs for people who do not use any medical care.

For conventional insurers, pursuing more aggressive risk selection could involve refusing to sell (or renew) policies to high-risk individuals or to small groups containing high-risk individuals, though in some states laws that have modified the health insurance market for small groups might mitigate these effects. Similarly, self-insured firms--particularly smaller firms where the costs of catastrophic illnesses could not be absorbed--would have stronger incentives than they do now not to hire such people. Because they are in closer contact with prospective employees, firms would probably be more successful than other insurers in deterring potentially high-cost applicants. Both insurers and firms would probably become more aggressive in refusing to insure against costs related to preexisting conditions. Even though age discrimination statutes and the Americans with Disabilities Act would diminish this effect, they would probably not entirely prevent firms from engaging in such practices.

The premium control measure outlined here would limit the rate of growth of average, but not of total, revenue from premiums. Consequently, insurers would have greater incentive than they do currently to engage in preferential risk selection by expanding their coverage of relatively low-risk individuals (young people, for example). In fact, insurers could offer policies to them at premiums that were below expected cost, thereby helping to avoid the penalty they might otherwise incur. Self-insured firms would have a similar incentive to hire lower-risk individuals, although the number of newly hired employees needed to change the growth in expected health costs might exceed the number needed to produce the firm's product.

Cutting Benefits. Another strategy for insurers and firms would be to adjust the generosity of benefits they provide so that the expected costs of each policy would fall (or not rise as rapidly). Three areas in which insurers could initiate change would be the amount of cost-sharing, allowable payments to providers

(which would affect "balance billing" amounts paid by patients), and coverage, including paying for new technologies.

One way to reduce costs would be to increase the amount of cost-sharing--that is, the amount that enrollees must pay out of pocket when they use medical services. For example, consider a reduction in the increase in premiums for a typical employment-based private health insurance policy of 5 percentage points below the expected trend between 1994 and 1995--in other words, by roughly half the expected growth rate. One way of reducing the increase in premiums by that amount would be to increase the deductible from $125 to $300 for single policies (and from $250 to $600 for family policies), and to increase the maximum out-of-pocket cost per person from $500 to $750. Additional increases would be required in subsequent years to continue holding down the growth in costs. HMOs would be less likely to increase cost sharing significantly, in part because such a step would raise their administrative costs if they had to monitor charges and payments by patients for every service. Furthermore, low cost sharing is one of the features of HMOs that appeal to consumers.

Another method of increasing cost sharing open to conventional insurers would be to adjust the formulas used to compute reimbursement rates (allowed amounts) for certain types of providers and covered services. For some providers, insurers now reimburse consumers only for charges deemed usual, customary, and reasonable (UCR)--that is, consistent with what other providers charge for the same procedure. Consumers pay the balance. But UCR amounts vary by insurer and procedure. For example, an insurer whose UCR standard was the 85th percentile--meaning that the insurer reimbursed enrollees (or their providers) for charges that did not exceed those of 85 percent of providers--might reduce the standard to the 75th percentile. In this way, it could shift the excess costs to consumers, who would then have to pay 100 percent of the nonallowed amount in addition to any required cost sharing. Insurers might also extend this practice to payment for hospital charges; a majority of conventional insurers now simply pay billed charges.

Finally, both conventional insurers and HMOs could reduce costs by dropping coverage of specific services. Except where specifically required by state or federal laws, these carriers might drop coverage for broad categories of services, such as outpatient mental health services, prescription drugs, dental care, or vision care. They could also drop it on a procedure-specific basis, for example, by eliminating payment for heart or lung transplants. Dropping certain kinds of coverage--especially for services that have a significant voluntary component--could also reinforce the efforts of insurers to weed out heavy users of medical care. In addition, they might not extend coverage to new technologies as rapidly as might otherwise have occurred.

Lowering Payments to Providers. Finally, insurers could attempt to reduce costs by reducing payments to providers, either by negotiating lower prices or shifting

financial risks to them. For conventional insurers, negotiating lower prices might take place through PPOs or similar arrangements in which providers agree to discount their charges in return for an increase in the number of patients they see. For HMOs, negotiation could occur directly with affiliated providers or their own staff. Shifting financial risks to providers might occur through agreements that provided for "capitation," a method of payment in which providers accept a fixed payment per patient, without regard to the eventual costs of treatment.

Whether negotiating lower prices would be successful in reducing expenditures is unclear. Conventional insurers and self-insured firms have limited direct leverage with providers. Moreover, even those able to negotiate lower prices may not be able to control the volume of services. Only staff model HMOs and some other vertically integrated organizations of providers have a significant degree of control over both providers' prices and volume. Furthermore, market pressures limit even this control, since HMOs must compensate providers at a level comparable to other organizations and to providers in private practice. Overly aggressive efforts to reduce compensation within a staff model HMO might make it more difficult to hire and retain physicians and other health care providers.

Capitation arrangements, in which insurers pay providers a fixed dollar amount per insured person irrespective of the number or nature of services the provider delivers, give providers much stronger incentives to control their costs than fee-for-service arrangements. In shifting financial risks to providers, capitation arrangements thus align the incentives of providers more closely with incentives of insurers and therefore help to reduce overall costs. But insurers would be successful in negotiating such arrangements only if providers were in a position to bear financial risks and able to control their costs to the extent insurers desire.

Implications for Health Spending

Faced with the need to control the rate of growth of premiums, insurers (including self-insured firms) could be expected to pursue all of the above strategies, albeit with varying degrees of success. Although insurers have in the past generally responded to reduced profits by working more aggressively to reduce risks and by cutting back benefits, it does not necessarily follow that these would be the preferred strategies for the future. On the one hand, these are strategies with which insurers are most familiar. On the other hand, they may have already exhausted much of the savings.

Thus, the effects of the illustrative stand-alone measure to control premiums on health spending and coverage are uncertain. Some insurers would probably be unsuccessful in reducing costs sufficiently to remain profitable after paying the required penalties, and would leave the market or merge with other

insurers as their profits fell below returns available elsewhere. Others might stop writing insurance for certain lines of business because controls on premiums would limit attempts to recoup any losses they might incur. Which strategy or strategies would be chosen by insurers who remained in business could not be determined in advance, nor is it possible to know which would be most successful. Several likely outcomes are discussed below.

Assuming they were effective, limits on the rate of increase in premiums for PHI would reduce insured health expenditures below what they would have been otherwise, but the direct effect on total spending for health care would be relatively modest. Controlling PHI premiums could also have indirect effects on health spending, with differing results. For example, to the extent that insurers shifted more of the costs of health care to consumers or dropped coverage for some insured individuals, health spending would decline because higher out-of-pocket costs would reduce the use of medical services. This effect might be offset slightly if insurers expanded coverage by seeking out below-average risks who are not now covered to drive down their average per capita premiums, and did not reduce their coverage of above-average risks. Both changes would be small because these responses would affect only a small portion of insured spending.

Increased use of managed care or improved administrative efficiency could reduce health care spending without making consumers much worse off. Premiums would fall (or rise by less) to reflect a real reduction in the cost of medical care. But if gains in efficiency associated with eliminating unnecessary care were easy to achieve, they would already have been found. Medical science is imprecise, and efforts to eliminate unnecessary care might also reduce appropriate care. The development of practice guidelines might make reductions in appropriate care less likely, but could also increase the use of services overall.

To the extent that insurers engaged in more aggressive risk selection, a drop in coverage for high-risk individuals--including people who were older or disabled--and, possibly, a small increase in coverage among low-risk individuals would be expected. Thus, the total number of people without health insurance might change only slightly, but the composition of the uninsured population in terms of risk might change. Moreover, individuals considered to be above average risks would probably have more difficulty finding employment.

The distributional consequences of cuts in benefits would depend on how insurers and firms reduced them. Increasing stop-loss levels, or dropping coverage of specific services, would tend to concentrate the effects on individuals with relatively high expenditures for health care or, perhaps, those with chronic illnesses. Increasing deductible amounts in fee-for-service plans would spread the effects of reduced benefits more evenly among all health care consumers, but might reduce access to primary care and preventive services in these plans, especially for low-income insured families.

Successful negotiations with providers to lower prices could also bring down health care spending, as long as providers did not attempt to bill consumers for the balance. To the extent that some component of the current incomes of providers includes what economists term "rent"--that is, an amount above what is needed to induce the provider to supply care--then price reductions would amount to a redistribution of income (away from providers and to insured individuals) with no implications for efficiency. But if the reductions exceed the rents, then access to care for patients of the most aggressive insurers could be restricted.

LIMITING THE EFFECTS ON COVERAGE FROM A STAND-ALONE MEASURE

If effective, the simple measure of controlling private health insurance premiums discussed in the preceding section would almost certainly reduce coverage for those people whom insurers consider to be above-average risks and would probably result in less generous benefits for many others. Many people would view such outcomes as an unacceptable price to pay for reducing the rate of growth in personal health expenditures. A question of interest, then, is if certain policies could be used along with controls on premiums that would preserve coverage while containing costs.

Certain policies, when combined, could mitigate some of the adverse consequences of a stand-alone measure. They are:

- Instituting a standardized benefit package;
- Mandating guaranteed policy renewal or universal coverage;
- Reducing risk selection by modifying insurers' enrollment practices and making actuarial adjustments when determining allowable increases in PHI premiums; and
- Placing limits on balance billing.

The success of these measures in ameliorating the effects of premium controls would depend on how each component was put in place and on interactions with any other policy measures that might be undertaken.

Components of a Policy to Control Premiums That Would Limit Effects on Health Insurance Coverage

The notion underlying proposals to control PHI premiums is that the controls would give insurers stronger incentives to reduce costs than they now have. Some cost reduction might take place through increased efficiency or lower

prices paid to providers. But insurers would also be likely to reduce costs by the methods they have used successfully in the past: aggressive risk selection and reductions in benefits. The policy components that could be combined with controls on premiums to lessen their effects on health insurance coverage and benefit levels are discussed below. Because each would be necessary, the order of discussion is only for convenience.

Specify a Standardized Benefit Package. A natural response on the part of suppliers to price regulation would be to change the nature of the product, either to lower the cost of inputs or escape regulatory definitions. The complexity of the typical private health insurance contract means that its generosity could be reduced in a number of ways, many of which would be difficult for either consumers or employers to evaluate.

To avoid benefit reductions of this type, regulators could take one of two steps: they could specify a benefit package--or a small number of such packages--that insurers could offer or they could require that insurers offer policies that are actuarially equivalent to one standard plan. Actuarial equivalence would mean that policies could differ in their details, but would cost the same, on average, for a given group or risk category. The impact on individual policyholders and their insured dependents of these two approaches could be quite different, however.

Specifying one standardized benefit package would be simpler than attempting to regulate actuarially equivalent policies, but would still require a significant amount of detail. Regulators would need to determine not only deductible amounts, coinsurance rates, and stop-loss levels, but also which services would be covered, how payment rates for those services would be set, and how these factors would vary over time. Furthermore, some provision for uniform claim processing standards would be necessary to be certain that insurers were not reducing expenses (and engaging in risk selection) by denying or delaying payment of legitimate claims. Moreover, because current plans could be more or less generous than the new standard, the allowed change in each insurer's average premium would be particularly difficult to calculate for the first year.

Specifying a small number of standard plans would give regulators greater flexibility in taking into account the full array of insurance/delivery systems that now exists. For example, standard plans might be devised separately for HMOs, FFS arrangements--with, possibly, varying degrees of generosity among plans--and other types of delivery systems. But this additional flexibility would, in turn, introduce greater regulatory complexity. In addition, regulators would need to make some decision about what changes in premiums would be allowed if purchasers changed from one standard plan to another. And again, determining the first year's allowable increase for each insurer would be extremely difficult.

In principle, allowing insurers to offer actuarially equivalent policies would preserve greater flexibility by giving consumers a larger number of choices. Solely on the basis of their attitudes toward risk, some people might prefer plans with high levels of catastrophic coverage and minimal protection for routine medical care, whereas others might prefer the opposite. Other things being equal, allowing consumers to purchase health insurance products that reflected such differences in preferences would increase economic welfare.

In practice, however, the massive amount of information that would be needed to monitor actuarial equivalence means such a step would itself be an expensive choice. Regulators would need to compare the effect on expected costs of every detail of every policy--and every change in every detail--to determine whether the benefits provided were equivalent to the designated standard. In addition, they would need to make adjustments for differences in risk among policies arising from the characteristics of the insured population. Failure to do so would give insurers the opportunity to reduce costs by screening out higher-risk individuals and would punish firms that continued to insure such individuals. Unfortunately, simple and reliable risk adjustors do not currently exist, especially for small groups. Further, it is not clear that meaningful comparisons could be made across different types of plans (say, FFS versus POS).

Institute Mandatory Renewal of Policies or Require Universal Coverage. With premiums restricted, both insurers and employers would have incentives to cancel policies or lay off individuals they perceived to be above-average health risks. To avoid reductions in coverage arising from such risk selection, and to help reduce problems with adverse selection on the part of consumers, mandatory policy renewal or universal coverage would be needed. Initiatives to restructure the market for small group insurance already provide these protections in some states.

Guaranteed renewal--at a price that did not make the guarantee meaningless--for currently insured groups or individuals would mean that there would be no direct reduction in coverage. Coverage could fall over time, however, if insurers refused to issue new policies or to extend coverage to individuals who changed groups (say, because of changing jobs).

For universal coverage to be a possible solution, insurers would have to be able to offer the benefit package at the capped premium--that is, the cost of providing the mandated benefits in the most efficient manner would have to be at or below the cap. But universal coverage would also raise expenditures considerably, because use of services by the currently uninsured would rise. Moreover, much of the additional cost would probably have to come from taxpayers because three-fifths of the uninsured have family incomes less than twice the poverty threshold.

Require Changes in Enrollment Practices and Make Actuarial Adjustments. Even with--and perhaps especially with--guaranteed renewal and a uniform benefit package, insurers would seek to restrain growth in costs by avoiding risks. Additional steps would therefore be required to reduce the ability of, and incentives for, insurers to select risks. Three such steps would be crucial; the first two would raise insurers' costs.

First, and perhaps most important, prohibiting exclusions for preexisting conditions would eliminate a potent tool insurers now have. (In most cases, exclusions for preexisting conditions are limited to a stated period of time after enrollment, but permanent exclusions do occur.) Such exclusions essentially allow insurers to write unique insurance policies that eliminate coverage for each insured individual's most likely health risks.

The second step would require open enrollment--so that insurers would have to accept all applicants--on a periodic basis (say, once a year). Because insurers would be required to accept any group or individual who sought insurance, this step could help to overcome any preferential risk selection they might use. Open enrollment would probably also require community rating--a practice of charging similar rates to all people and groups in a defined area--or other restrictions on what insurers could charge. The purpose of open enrollment would be to give individuals freedom to switch plans without facing barriers from insurers. Community rating would eliminate one such barrier--namely, prices that would be exorbitant for high-risk individuals. It would probably not be necessary to have true community rating, in which premiums would be the same for all insured individuals; modified community rating by a limited number of categories might be sufficient.

Finally, if the growth in average per capita premiums were defined by an insurer's line of business, rather than for specific groups, some type of actuarial adjustment would be necessary to prevent insurers from reducing average premiums simply by expanding their portfolios of below-average risks. That is, by calculating a risk-adjusted, average per capita premium that took into account the health status and record of each insurer's clientele, regulators could determine whether the insurer was complying with controls through legitimate cost containment or selection. But, again, the quality of existing risk adjustors leaves much to be desired.

Even if average per capita premiums were defined for particular groups of individuals, which would make manipulation of the rules more difficult, actuarial or other post hoc adjustments might still be necessary. Especially for small self-insured firms, unexpected expenses could cause average per capita expenditures to exceed the target even if the firm had taken steps to ensure that it was in compliance before the fact. Making allowances for such unexpected events (through reinsurance, for example) would reduce the incentives of firms to lay off potentially high-risk employees; it could also prevent substantial losses to small insurers that had adopted effective methods to control costs.

Limit Balance Billing and Cost Shifting. If controls on premiums led to reduced reimbursements by private insurers, some medical care providers would presumably attempt to maintain their incomes by increasing their revenue from other payers. They could do so by "balance billing" consumers--that is, seeking payments over and above the charges allowed by insurers--or by increasing their revenues from government and other payers. To the extent that providers were successful in either of these steps, controls on premiums would be less successful in constraining health spending; instead, controls would largely result in a reallocation of that spending from insurers to consumers and taxpayers. Consumers faced with higher out-of-pocket costs would, however, reduce their demand for medical care.

Prohibiting balance billing by requiring providers to accept payments set in the standardized benefit package (or packages) would be one way to reinforce the incentives for cost containment that controls on premiums would create. But doing so would, in effect, constitute a direct form of price control on providers, something controls on premiums were intended to avoid. Preventing cost shifting to other payers could be more difficult. As providers attempted to maintain their incomes, the Medicare and Medicaid programs in particular would face intensified pressure to increase reimbursement rates--they are now well below private reimbursement rates--and could face increases in volume as well.

Effects of the Combined Policies

The combined policies described above would meet several policy goals. In conjunction with limits on balance billing, effective controls on PHI premiums would reduce the rate of growth of private health care spending as insurers brought costs in line with revenues from premiums. Guaranteed policy renewal would maintain coverage for some people who might otherwise lose it; alternatively, universal coverage would extend insurance to those who would otherwise be uninsured. Moreover, a standardized benefit package would not only make enforcement of premium controls less difficult, but would also help consumers to assess competing health plans.

Nevertheless, controlling premiums combined with the measures to ease selection problems and erosion of coverage would represent fundamental changes in the financing and delivery of health care. In other words, the effects of such regulation would extend well beyond reducing the rate of growth in private health insurance premiums.

In particular, some consumers would gain from these measures, but others would be made worse off. To the extent that cost containment on the part of insurers led to reducing unnecessary or inappropriate care, consumers generally would be better off as resources formerly devoted to health care were freed for other purposes. But efforts to reduce unnecessary care would almost certainly have the effect of eliminating some useful services; thus, some

individuals might be worse off even if consumers on the whole were made better off. The policy measures intended to ease selection problems and erosion of coverage could also have mixed effects. Community rating, for example, would raise health insurance premiums for some people while lowering them for others.

Controls on premiums--along with the other measures discussed above--would have a profound effect on the health insurance industry. Insurers who were unsuccessful in reducing costs--and unable (or unwilling) to use profits from other lines of business to subsidize their health insurance operations--would leave the industry at a cost to their shareholders, employees, and insured customers. But other insurers who did reduce costs might gain significant shares of the market.

Whether health care providers as a group became better off would depend on how the combined policies affected health spending, and particularly on whether universal coverage was achieved. Assuming a reasonably comprehensive standardized benefits package, expanding coverage to the uninsured would initially raise the incomes of providers by increasing the level of health care spending. Effective premium controls, however, would reduce the rate of growth of spending, thereby constraining providers' incomes in the future. If "guaranteed renewal" were incorporated instead of universal coverage, most providers' incomes would probably be constrained in the short run as well. In either case, some providers would gain and some would lose.