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Health Care Cost Dynamics Change With Defined Contribution Plans

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Historical Perspective

Initially both retirement and health care plans were defined benefit. The employer took all of the risk, paid most if not all the cost and designed the plan to fit their needs. This produced an era of employer paternalism utilizing a business model far removed from current business dynamics.

As employers felt the need to improve productivity, they introduced new business models. Compensation plans shifted from forms of "entitlement" to "pay for performance." It was a natural shift for defined benefit retirement plans (funded on an entitlement basis) to be replaced with defined contribution plans (401(k) plans). The opportunity for employees to add their own contributions (reducing taxable income) and the ability for employees to take it with them when changing jobs, expedited their acceptance.

With this success in mind, employers looked for other opportunities to apply the same concepts. Health care plans were targeted for generating additional savings. Section 125 plans were introduced, which allowed employers to reduce their contribution for health care (and other benefits) while shifting additional cost to employees. The employee's total cost was still less in the aggregate due to tax savings aspects of these plans (both income tax and FICA). As employer contributions became fixed, the defined contribution model became a reality.

The concept of defined contribution health care plans has a number of benefits. Two of the most important are (1) the ability to cap employer costs and (2) the potential for making employees more cost-effective health care consumers. It is this second benefit we need to focus on.

Health Care Cost Dynamics

A *Wall Street Journal* article compared health care cost expenditures as a percentage of gross domestic product (GDP) between various countries.[1] The figures

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showed that the United States spends 30% more on health care than any other country in the world. To put this excessive spending in perspective, the United States spent 13.6% of GDP on health care in 2000, while it spent 3% of GDP on national defense that same year.

The cost of health care in the United States is so high because the cost is subsidized to the point that consumers are insulated from the actual cost. Subsidies take the form of:

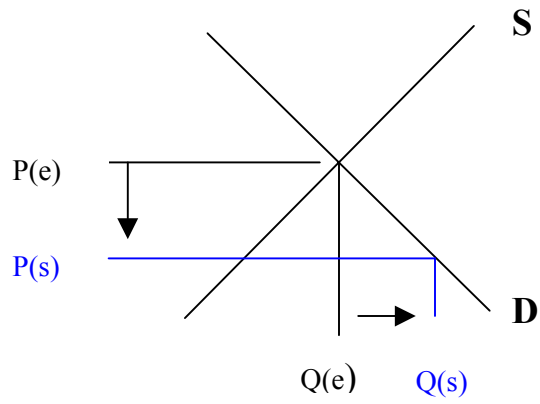
1. Employer subsidies through employee benefit plans and
2. Tax subsidies provided by the federal government.

Employer subsidies of health care coverage as a percentage of compensation increased from 1.47% in 1965 to over 6.56% in 1995.[2] This subsidy has created a tremendous drain on employer profitability.

In addition, federal government tax subsidies further insulate consumers from the actual cost. Section 125 plans allow employees to pay health care costs (premiums, deductibles, coinsurance, co-pays and items not covered under the plan) on a pretax basis. The level of this subsidy increases as the marginal tax rate paid by the employee increases, compounding the problem.

Figure 1 demonstrates the effect these subsidies have on the quantity of services demanded in the presence of a subsidy. At the intersection of the supply (S) and demand (D) curves, the market determines the price of the product as P(e) (price at equilibrium). At this price, Q(e) (quantity at equilibrium) of the product or service is demanded, and the market is in equilibrium. However, by artificially reducing the price that consumers pay to P(s) (price with subsidy), demand increases for the product or service to Q(s) (quantity demanded with subsidy).

Figure 1
Effect of Subsidy on Demand



This situation contributes to the United States' excessive health care spending compared to other countries, since price is not reduced, just subsidized. The level of services demanded is consistent with a lower price, while the actual price is higher. (Total expenditures = P(e) times Q(s) where the employee pays the subsidized price P(s) and subsidies make up the difference between the subsidized price and the actual price.)

Taking a less abstract view, consider how much of a product each of us would utilize if we paid only 10-15% of the actual cost. How cost conscious would we be regarding our electric bill if our next-door neighbor paid it for us? In either case, typical price restraints would not apply.

The majority of Americans have most of their health care costs subsidized in one form or another. They have no motivation to shop less expensive alternatives (such as investigating alternative health care) and often leave much of the decision making to their physician or health care provider. This situation creates the potential for supplier-induced demand[3] where more services than necessary are provided to achieve a provider goal (generating income, filling hospital beds, etc.).

During the 1990s managed care was able to generate significant savings through utilization controls and negotiating discounts. However, legislation and major changes in how the medical community negotiates is undoing much of this success. In addition, providers are refusing to grant further discounts and in some cases rescinding previously negotiated discounts. The result we are confronted with is health care costs are increasing at two or three times the rate of other goods and services.

Is Our Health Care System Better?

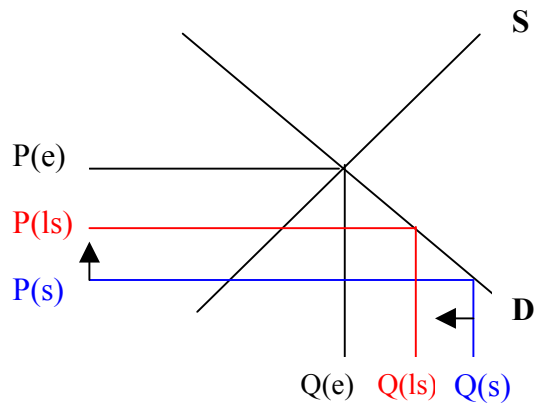
There is no doubt that we have a fine health care system. The question is whether we can afford it and whether it provides consumers with significantly better health. If we look at consumer satisfaction with health care systems of different countries, we find 60% of consumers in the United States believe fundamental changes need to be made in our system.[4]

Consumers in the United States have good reason for wanting change. When infant mortality rates (deaths per 1,000 of live births) and life expectancy for both men and women are compared by country, it appears that the extra money being spent on health care in the United States is not generating results in these two areas. The United States trails other countries in each category.

What Can Be Done

We have to change the economic model as shown in Figure 2 and eliminate as much price subsidy as possible. The price paid by consumers needs to increase from P(s) (price with subsidy) to P(ls) (price with less subsidy). This shift in price will lower the demand for health care from Q(s) (quantity demanded with subsidy) to Q(ls) (quantity demanded with less subsidy). This occurs because as consumers pay more of the actual cost they become better (more cost conscious) shoppers

Figure 2
Decrease in Demand from Less Subsidy



for health care. The goal is to have employees participate in a larger portion of the actual cost so they will consume less health care.[5]

The problem of over-utilizing medical services is referred to as "moral hazard" by economists and results from the following five types of actions.[6]

1. Demand increases because the consumer is not paying the full cost.
2. Consumers have less incentive to monitor the behavior of the providers.
3. High-cost/low-quality technology is adopted.
4. Preventive activities are reduced (exercise, dieting, etc.) since the consumer has little incentive to guard against the insured event.
5. Consumers have little incentive to shop the lowest price for medical services.

Requiring employees to pay a larger portion of their medical bills can minimize each of these actions.[7] There is little we can do about tax subsidies provided by the federal government. However, employers can make changes in their benefit plans that simultaneously limit employer cost while also

providing an incentive for employees to become more cost-effective health care consumers. With the shift to a defined contribution approach, employers have the opportunity to empower employees to become more cost-effective health care consumers. Strategies should focus on increasing the employee's participation in more of the actual cost of health care, as opposed to simply deducting more for health insurance via payroll deduction. Examples of strategies include increasing deductibles, coinsurance and co-pays so they represent more of the actual cost.

Another strategy could include offering access to alternative health care networks that both credential providers and provide discounts. This strategy gives employees a way to safely experiment with alternative care on a less costly basis.

These strategies will also impact the provider community. As demand for any product decreases, market pressure encourages producers to respond in creative ways. The economy for the first time would allocate resources to the provider community predicated on competitive market conditions as opposed to employers increasing their subsidies.

In Conclusion

We have an opportunity to introduce market competition in the health care industry and limit the tremendous transfer of wealth from the employer community. However, it will require work on the part of benefit professionals who will have to design, implement and communicate the changes described. Employers that implement these strategies will attract employees who are interested in participating in savings, as opposed to simply paying higher premiums. Thus, these strategies will contribute to a natural process for attracting the healthiest employees while minimizing employer cost.

Endnotes

[1] Alex Frangos, " Health & Medicine, Model vs. Model, A Comparison of Countries' Health Care Systems," *Wall Street Journal*, February 21, 2001, page R4.
[2] Rexford E. Santerre and Stephen P. Neun, *Health Economics Theories, Insights, and Industry Studies*, "The Demand for Employer Contributions to Health Insurance Premiums," p. 129.
[3] Santerre and Neun, *Health Economics Theories*, "The Supplier Induced Demand Hypothesis," p. 431. International studies indicate that Japanese physicians prescribe more drugs (40% more than their American counterparts) because doing so is financially rewarding. In Japan, physicians purchase drugs directly from manufacturers and sell them at a profit.
[4] Robert J. Blendon, Robert Leitman, Ian Morrison and Karen Donelan, "Satisfaction With Health Systems in 10 Nations," *Health Affairs* 9 (Summer 1990), Exhibit 2.
[5] Edwin Mansfield, *Principles of Macroeconomics*, "Medical Care: Can Benefit Cost Analysis Be Used?" p. 429. "Health insurance induces excessive health expenditures because people pay for only part of the cost of care." Henry Aaron of the Brookings Institute.
[6] Santerre and Neun, *Health Economics Theories*, pp. 400-401.
[7] Santerre and Neun, *Health Economics Theories,* p. 401.