Volume Title: Frontiers in Health Policy Research,
Volume 5

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Volume Publisher: MIT Press

Volume ISBN: 0-262-07234-3

Volume URL: http://www.nber.org/books/garb02-1

Conference Date: June 7, 2001

Publication Date: January 2002

Title: Introduction to "Frontiers in Health Policy
Research, Volume 5"

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URL: http://www.nber.org/chapters/c9855

Introduction

The fifth annual Frontiers in Health Policy Research Conference, held in Bethesda, Maryland, on June 7, 2001, brought together academic economists and health policy experts from Washington, including researchers, legislative staff, and government officials. The papers presented at that conference are gathered in this volume, which presents impartial, cutting edge research that is directly relevant to contemporary health policy debates.

Three papers focused on critical issues facing the Medicare program. For many years, the adoption of capitated risk plans has been proposed as a solution to many of Medicare's current and future problems. Prominent Medicare reform proposals, such as the premium support plan proposed by the Medicare Reform Commission, build on a foundation of beneficiary choice among competing health plans. Capitated plans are particularly attractive because they are expected to reduce costs, coordinate care, and provide enhanced services to Medicare beneficiaries. Such plans have been available for several years, sometimes under the name of Medicare risk plans or Medicare+Choice plans. Despite the great hopes for such plans, the number of Medicare beneficiaries who have enrolled in the plans has fallen far short of expectations. In fact, in the wake of the Balanced Budget Act of 1997, enrollment has decreased instead of increased. Although the disappointing enrollment reflects in part a lack of demand by beneficiaries, the well-publicized withdrawals of Medicare risk plans have also impeded the growth of capitation.

This impediment, according to Cawley, Chernew, and McLaughlin, results directly from inadequate reimbursement. They estimate the level of capitation payments necessary to make it profitable for Medicare risk plans to be offered in a county. Capitation payments may

need to be particularly high in sparsely populated counties, but they may also need to exceed current payment levels in other areas. According to the authors, premium payments in nearly 80 percent of the counties in their sample are now too low to support the availability of a single Medicare managed-care plan.

Because it provides nearly universal health insurance for a large and vulnerable segment of the U.S. population, Medicare would be expected to have large effects on the health and welfare of elderly and disabled beneficiaries. Furthermore, because the largest group of beneficiaries becomes eligible for Medicare simply by reaching their sixty-fifth birthday, one would expect to see immediate changes in the utilization of health services at age 65. Lichtenberg asks whether the age profiles of utilization, morbidity, and mortality reveal that Medicare is having a great impact on health. His work reveals that the effects of Medicare eligibility are not only detectable but surprisingly large. The evidence he examines suggests that Medicare does increase the utilization of medical services, as expected, and that this increased use is associated with improved health outcomes.

Because evidence of market failure is ubiquitous, health care markets are often cited as exceptions to general economic rules. One such exception may be competition among providers of health care. When there are more hospitals in an area, can we expect lower prices for their services? Since the hospitals may compete on quality as well as price, do we observe measurably higher hospital quality in markets characterized by a high level of competition? How would the answers to these questions change when hospitals are compensated for a fixed fee per admission (prospective payment), rather than receiving compensation for each service they provide? Meltzer and Chung note that earlier studies reported competition may increase hospital costs when hospitals are reimbursed on a fee-for-service basis, and it may have the opposite effect under prospective payment. These questions are critically important for policies regarding hospital competition, which might either raise or lower costs to Medicare and to consumers. The two authors raise the possibility that under prospective payment, competition might lower costs for patients who are unprofitable and raise costs for patients who are profitable. They address this question by examining data on hospital charges and cost-to-charge ratios from California in two different years, one just before implementation of Medicare's Prospective Payment System (1983), the other ten years later (1993). Classifying the degree of hospital competition within each county into four

categories, and focusing on the twelve highest-volume diagnostic categories, they report that increased competition led to an increase in cost growth in 1983 among the high-cost patients within these diagnoses, but had the opposite effect among these high-cost Medicare beneficiaries in 1993. They also find that cost reductions are largest for the most expensive patients.

Under many plans to extend health insurance coverage to the uninsured, including the Bush administration's proposal, subsidies would be used to enable the poor and the near-poor to purchase private health insurance. The subsidies would be administered in the form of refundable tax credits. One of the most controversial aspects of the tax credit approach is the size of the tax credit that would be needed to achieve a substantial increase in the number of Americans with health insurance. According to some experts, only prohibitively large subsidies would have the desired effect, but other work has shown that tax credits large enough to cut health insurance premiums in half would also cut in half the number of uninsured. Pauly, Herring, and Song address the effects of tax credits by asking how a flat tax credit of $1,000 would affect net premiums (individual market health insurance premiums minus the subsidy) and the uptake of health insurance. Their work uses several measures of net premiums to approximate more closely the premiums that the target population of insurance nonpurchasers face, and they estimate the distribution of insurance purchases based on the resulting net premiums. In part because their measures of premium costs are lower than those used in prior analyses, they find that the $1,000 tax credit would result in a surprisingly large increase in insurance purchases. A flat tax credit would do less for high-risk individuals than a risk-adjusted tax credit, and there are many questions about the risk profile of the individuals who would begin to purchase insurance under such a program. Depending on the risk profiles, as perceived by health plans, the net premiums might be either lower or higher than Pauly and his colleagues estimate.

The roles of for-profit and nonprofit institutions in health care continue to be hotly debated. Critics of for-profit hospitals and insurers argue that for-profit corporations provide lower quality care, shun the most vulnerable patients, and raise costs of health care. Critics of nonprofits argue that they are less efficient and provide lower quality of care; another point of view holds that market competition forces nonprofits and for-profits to behave in similar ways. To the extent that for-profits and nonprofits behave differently, conversions between the

two categories can have important welfare implications. Sloan argues that recent increases in the for-profit share of hospitals, resulting from hospital closings, mergers, and ownership changes, have the potential to alter hospital performance. After reviewing the literature on the relationship between hospital ownership and behavior, he analyzes data on hospital conversions from 1988–1996 to determine whether for-profit conversion affects the quality of care or costs. By examining utilization and inpatient mortality for selected diseases, Sloan finds that for-profit conversions are associated with reduced lengths of stay, but mortality remains unchanged. He also finds that pneumonia complication rates became more common after for-profit conversion. Whether this finding is a signal of general problems with such conversions or whether this is an isolated result remains uncertain. However, the study finds little other evidence of major effects of for-profit conversions on outcomes.