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Introduction

When the seventh annual *Frontiers in Health Policy Research* meeting was held in Washington, D.C., in the summer of 2003, the climate for health care reform had decidedly changed from only a few years earlier. The projected federal budget surplus had been replaced by a budget deficit, with red ink projected to flow for the foreseeable future. Solutions to rising health expenditures seemed elusive as commercial health insurance premiums continued to rise at double-digit rates for the third consecutive year. The only major Medicare reform under serious consideration in Congress was a much-desired expansion of coverage for prescription drugs; plans to cope with rising Medicare expenditures were, for the time being, a lower priority. Along with rising health expenditures, the number of uninsured increased. The economic challenges were intense.

The papers in this volume represent some of the best thinking among leading economists about these contemporary health policy challenges. The authors, affiliated with the National Bureau of Economic Research, aim to foster a dialogue with the policy community. The papers were presented at a meeting attended by both academic researchers and health care experts within government and private organizations, and they are written for anyone concerned about the U.S. health care system and its future.

To many observers, pharmaceuticals epitomize both the successes and failures of the U.S. health care system. The rapid pace of innovation has made it possible to treat a range of conditions—such as high blood cholesterol, anemia, depression, and some cancers—more effectively than ever before. The benefits of innovation are genuine and substantial. But the medications that have been introduced for these conditions are often expensive. In recent years, pharmaceuticals have attracted a good deal of policy attention because they have comprised

the leading component of health expenditure growth. Reports that residents of Canada and the wealthy nations of Europe pay less for the same drugs have fueled the debate about the fairness and sustainability of pharmaceutical markets in the United States.

Outside the United States, particularly in western Europe, reference pricing has become a popular approach to the provision of pharmaceutical benefits. The logic of reference pricing is similar to the use of tiered copayments for drugs in private health plans in the United States. A group of closely substitutable drugs is defined, and the payer (a health authority or health plan) usually adopts the price of the least expensive drug in the group as the reference price. The patient is free to choose any of the drugs in the class but must pay the difference between the drug's price and the reference price. Unlike direct price controls, this approach enables markets to function, with support for higher prices dependent on the demand for perceived superiority.

In both a theoretical analysis and an empirical examination of the effects of reference pricing in three countries, Patricia M. Danzon and Jonathan D. Ketcham show that reference pricing approaches may not simply lower prices—they may have effects on the rate of introduction of new drugs, on their success in the market, and therefore on the returns to innovation. Danzon and Ketcham analyze reference pricing in Germany, the Netherlands, and New Zealand. They show that, in countries with the most aggressive reference pricing, the availability of new compounds is significantly delayed. Although their analysis does not address the full welfare consequences of reference pricing and alternative approaches to providing a pharmaceutical benefit, they draw important lessons for the design of a Medicare drug benefit.

Most of those in favor of a Medicare drug benefit share the assumption that any such benefit, at least initially, should be a stand-alone program; that is, it should be complementary to traditional Medicare, not an integrated benefit within Medicare. In this respect, it contrasts with nearly all other health insurance, which includes medication coverage as one of the many categories of covered products and services. The voluntary nature of the Medicare drug benefit and its pricing can make participation unattractive for Medicare beneficiaries who don't expect to spend much money for prescription drugs or otherwise would gain little by participating in the program, giving rise to adverse selection.

According to Mark V. Pauly and Yuhui Zeng, this kind of adverse selection could be a threat to any stand-alone Medicare drug benefit. Examining multiyear data on a large group of workers covered by

employment-based health insurance, they find that high-cost users of prescription drugs tend to have high expenditures from one year to the next, so that drug expenditures are more predictable than other health expenditures. This predictability of spending makes a drug benefit particularly vulnerable to adverse selection. Pauly and Zeng show that even large subsidies might fail to keep a voluntary Medicare drug benefit from being subject to a death spiral as the program becomes attractive to an ever-shrinking pool of beneficiaries with ever-increasing average drug expenditures. They also show, however, that bundling the drug benefit with other coverage can mitigate adverse selection.

At the foundation of nearly every Medicare reform proposal is a set of assumptions about the program's future liabilities. Some aspects of these projections, such as the number of Medicare beneficiaries in different age categories, are not controversial, while others, especially per-beneficiary expenditures, are more speculative. Expenditures per beneficiary depend on reimbursement rates, rates of utilization of covered services, and the types and costs of forms of care that are introduced in the coming years. Health status is decisive here; healthier Medicare beneficiaries are expected to use less, and less expensive, health services. High-cost users of Medicare-covered services, especially those who are approaching the end of their lives and those with disabilities, use more.

Recent evidence suggests that rates of disability are declining among the elderly: good news both because it is a harbinger of better quality of life for the elderly and because it suggests that Medicare expenditure growth may well be lower than many had expected. But will the trend continue for future cohorts of the elderly? Jayanta Bhattacharya and colleagues address this question by combining data on current Medicare beneficiaries with data on younger cohorts and projecting future Medicare expenditures based in part on their current health characteristics. They show that declining disability will suppress per-capita Medicare expenditure growth for the near term (less than twenty years), but in subsequent years the rising disability rates among current cohorts of the young will lead to an increase in per-capita Medicare expenditures.

Determining the impact of financial incentives on the quality of care has been a vexing issue for economists and policy makers alike. In their paper, William H. Crown and colleagues develop a novel way to investigate this issue. They examine the effect of out-of-pocket payments for asthma medications on the relative use of controller and reliever

medications. Greater use of controllers is a sign of better quality care, and this information allows the authors to learn about the impact of cost sharing on quality. Using data from many large firms, Crown and co-authors find that cost sharing has little impact on the use of controller medications relative to reliever medications. This finding suggests that increases in cost sharing may not be particularly harmful, although it leaves open the question of which policies might be more effective in improving the quality of care.

Beginning in the 1990s, health insurance markets began to change dramatically as several health plans converted from nonprofit to for-profit status, often as a prelude to mergers. This phenomenon was part of the growing consolidation among health plans nationwide. Although considerable public attention has been paid to this phenomenon, and concern about it has increased among employers, hospitals, other health care providers, and the general public, the welfare consequences of such conversions have not been studied thoroughly. Nancy Dean Beaulieu examines a specific for-profit conversion, that of the CareFirst corporation in Maryland, the District of Columbia, and Delaware. Beaulieu reviews the reasons for considering for-profit conversions, the multiple considerations in determining whether a for-profit conversion might be in the public interest, the effects of conversion on the quality of care, and the role of market concentration. She also examines evidence concerning one of the key arguments supporting conversion—that the greater size made possible by the improved access to capital in a conversion would help plans to achieve economies of scale that would otherwise be absent. In addressing these issues, her paper also supplies an agenda for future research on for-profit conversions.

Although the papers included in this volume do not offer policy recommendations, each of them highlights important research findings that bear on current policy initiatives. Each paper is likely to remain relevant to health policy controversies in the years to come.

The conference at which these papers were presented was the work of many people. We are particularly grateful to Donna Mattos and Lita Kimble for arranging the meeting. Funding for the Frontiers in Health Policy Research conference comes from the National Bureau of Economic Research (NBER); we are grateful for their support.

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