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THE CONSUMER CHOICE HEALTH SECURITY ACT (S. 1743, H.R. 3698)

INTRODUCTION

In the final days of the 1993 congressional session, a major bill was introduced which promises to change the national debate over health care reform. The Consumer Choice Health Security Act of 1993 (S. 1743, H.R. 3698), introduced in the Senate by Don Nickles of Oklahoma and in the House by Cliff Stearns of Florida, both Republicans, would effectively open up to every American family the same consumer-choice health care program now enjoyed only by Members of Congress, Administration officials, and nine million other federal workers and their dependents, as well as federal retirees.

Significantly, the Nickles-Stearns bill won the immediate backing of 24 original Senate co-sponsors, five more than the bill introduced by Senator John Chafee, the Rhode Island Republican, and only six short of the tally for the President's legislation. This means the bill has more support in the Senate than any other alternative to the Clinton plan. In addition to Connie Mack of Florida and Orrin Hatch of Utah, who with Nickles are the sponsors of the Senate measure, original co-sponsors include most of the Republican Senate leadership—among them Robert Dole, Thad Cochran, Trent Lott, and Alan Simpson. The House version boasts similar Republican leadership support, including Newt Gingrich of Georgia and Richard Armey of Texas.

One reason the Nickles-Stearns bill has gained strong support in Congress is in part because it is guided by most of the same principles as the President's plan—principles which strike a chord with Americans.[1] But it does so without the vast new regulatory bureaucracy and huge tax increases in the Clinton plan, and in a bill only one-seventh as long as the White House legislation.

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1 The President's principles are that reform must achieve: 1) guaranteed comprehensive benefits for all Americans, 2) effective cost control, 3) quality improvements, 4) increased choice for consumers, 5) simplicity and reduced paperwork, and 6) that reform must make everyone responsible for health care.

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

The Clinton bill would require Americans to buy a standardized set of health benefits offered through typically three or four plans organized by a state-sponsored health alliance. The vast majority of employers would be required to pay—out of the compensation package for each employee—a fixed-dollar tax for each employee and send it to the alliance. This is the only part of health care costs that would be tax-free for the employee. Depending on the standardized benefit plan the employee picked, the family would be responsible for the remaining premium cost and out-of-pocket payments in after-tax dollars. If the employee wanted health benefits not in the standardized plan, the family would have to pay in after-tax dollars.[2]

Choice of Benefits. In the Nickles-Stearns bill, Americans would be able instead to choose the package of benefits that they consider best for their family, provided these include at least insurance protection against "catastrophic" medical costs. In other words, each family, not the government, would decide the medical services they could receive. Whichever plan chosen, the family would receive the same system of tax relief, in the form of a refundable tax credit. Moreover, and in stark contrast with the Clinton plan, the tax credit would apply also to out-of-pocket expenses, not just insurance, and to contributions to a "Medical Savings Account," which could be drawn down, free of tax, for any medical expense.

If the family was satisfied with the plan it already had through the place of work, the family could continue to be enrolled in it. But if a worker preferred a plan offered though another organization, perhaps though a union or even the family's church, the employer would be required to "cash out" the actuarial value of the worker's current benefits and give the money to the employee to use for another plan. Whichever plan the worker picked, the same system of tax credits would apply. If the worker became unemployed, the family would receive a refundable tax credit—a form of voucher—to offset the cost of the chosen plan.

Working Model. The Nickles-Stearns bill is based on the tax credit proposal first developed by The Heritage Foundation.[3] Unlike the President's plan, however, the Heritage plan and the Nickles-Stearns bill is not an untested theoretical construct. It is instead a modified and improved version of the Federal Employee Health Benefits Program (FEHBP), which currently gives federal workers the choice of a wide range of plans and benefits packages, and which during the last fifteen years has kept its average premium increases about one-third below those of other private health insurance plans. And the very existence of the FEHBP refutes the claim that Americans are unable to make an informed decision over health care benefits. "Many people say that the American people don't have the

2 For a comprehensive analysis of the Clinton plan see Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993.

3 See Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989). See also Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part I: The Debate Over Reform," Heritage Foundation *Talking Points*, February 12, 1992, and Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part II: The Heritage Consumer Choice Health Plan," Heritage Foundation *Talking Points*, February 28, 1992.

ability to make the choices that are required under [the Nickles-Stearns bill]," notes Alaska Republican Senator Ted Stevens. "I think the Federal Employees Health Benefits Plan shows they can."

Among the key provisions of the Nickles-Stearns bill:

✔ **Insurance companies** could no longer exclude individuals, or charge them higher rates, because of pre-existing conditions. Their underwriting procedures, and hence premiums, could reflect only age, sex, and geography. But they could offer discounts to promote healthy behavior or for checkups and other steps taken to detect, prevent, or delay the onset of illness.

✔ **Individual tax credits** would replace the current "exclusion" for company-sponsored health plans. This means that instead of having, in effect, a tax deduction for the plan picked by his or her employer, a worker would be able to claim a sliding scale credit for the plan he chose, as well as for out-of-pocket expenses and contributions to a Medical Savings (medisave) Account.[4] The credits would be refundable, meaning that if the credit actually exceeded the family's tax liability, the government would pay the difference. The credits would be as follows:

Health insurance premiums and unreimbursed medical expenses as a proportion of gross income	Percent Credit
Below 10 percent	25 percent
10 - 20 percent	50 percent
20 percent or more	75 percent
Contributions to a medical savings account	25 percent

Employers would have to offer employees the right to convert their current plan to an individual policy, which the employee would then own. Employers also would be required to add the value of their current coverage to the worker's wages, which each worker could then use to pay for the company-sponsored plan or to buy coverage from an alternative source. Employees thus would have the full security of owning their own coverage, which they could take with them if they changed jobs, and even during a spell of unemployment. And they would have greater choices and the incentive to pick the best value for money in plans.

To make the system simpler for employees, and to ensure regular payments, employers would be responsible for withholding premiums for the chosen plan from the employee's paycheck, whether or not that plan is sponsored by the employer, and sending the money to the plan. Employers also would adjust tax withholdings to reflect the credit available to the worker.

4 Contributions to a medical savings account would be eligible only for a 25 percent credit. Each household could contribute a maximum of $3,000 each year plus $500 for each dependent. Unused funds could be rolled over each year without affecting the limit for new contributions.

✔ **Malpractice reforms** would, among other things, limit noneconomic damages to $250,000.

✔ **The poor** would be helped by converting Medicaid Disproportionate Share payments, now used to reimburse hospitals for uncompensated care, into a grant for states for assistance to needy individuals in addition to the refundable credit.

✔ **Financing without a tax increase** is achieved in two ways. Most of the cost of the new tax credits is offset by the fact that they would replace the current tax exclusion and other minor health care tax deductions. Additional spending reductions in Medicare and Medicaid would offset the remaining costs of the new tax credit program. Based on a preliminary analysis by the respected health econometrics consulting firm of Lewin-VHI of the cost of the tax credits if implemented in 1994, the bill's sponsors project that the cost of the tax credits during the first three years of the program, 1997 through 1999, would be approximately $454 billion. Eliminating the tax exclusion and other current health care tax breaks would offset the cost of the credits by an estimated $321 billion during the same period. The remaining $133 billion of additional tax relief under the credits during the same three-year period would be offset by spending reductions in Medicare and Medicaid. This means that Americans would receive an additional $133 billion in tax relief for use in buying health insurance and medical care during the first three years the program is in effect.

The first way this additional tax relief is paid for is by capping the growth of federal Medicaid acute care funding in FY 1995 at 20 percent above the FY 1993 level and limiting growth in the capitated payment thereafter to one percent above the consumer price index (CPI) plus an adjustment for changes in the Medicaid population. Total federal acute care payments to a state for FY 1995 could not exceed the amount for FY 1993 plus 20 percent. In subsequent years, total federal acute care payments to a state could not exceed the previous year's payment plus CPI plus 2.5 percent. This achieves an estimated five-year savings of $72 billion.

The second financing mechanism is to eliminate Medicare payments to "disproportionate share" hospitals, reduce payments for indirect medical education costs, establish new copayment requirements for certain laboratory, home health, and skilled nursing services, and make small changes in prospective payments under Medicare. The House version differs slightly by not imposing these Medicare copayments. Instead it would achieve savings by making resident aliens ineligible for public assistance under various welfare programs.

These changes save an estimated $67 billion over five years.

These Medicaid and Medicare savings are roughly one-third of the proposed reduction in Medicare and Medicaid spending in the Clinton plan. The Clinton plan cuts spending in these programs by $188 billion over five years to help pay for health insurance and an additional $189 billion

to finance new Medicare drug and long-term care benefits, and part of the new insurance program's overhead and subsidies.

Different Vision. The Nickles-Stearns bill will allow a genuine debate to take place throughout America. This will be centered on two very different visions of how to assure a reasonable level of health care for all Americans and how to provide security for families with insurance who are anxious about losing their benefits in the future.

On one side of the debate is the Clinton plan. This would require all Americans to enroll in standardized plans with benefits selected by a national board in Washington. Only a handful of plans would be available to each family, organized through state-sponsored "regional health alliances." The state, in conjunction with these alliances, would impose price controls and tight restrictions on choices of plan and on doctors. The Clinton plan also would raise taxes by at least $150 billion over five years. And to achieve its budget, it would have to achieve savings in health costs through price controls at a faster rate than any country has ever achieved.

On the other side of the debate is the Nickles-Stearns bill, which would also achieve universal coverage and provide security. But it would allow Americans wide choices of benefits within many plans, just like the system available to Administration officials and Members of Congress. It would not impose destructive price controls, but achieve cost constraint through consumer choice in a competitive market—the dynamic which achieves cost control without sacrificing efficiency in the rest of the economy.

The Nickles-Stearns measure would not create powerful bureaucratic alliances, but would instead allow Americans to receive tax relief for plans offered through organizations they trust, such as their union, church, or farm bureau, as well as through their employer. The Nickles-Stearns bill also would not increase taxes. In fact it would provide additional and more equitable tax relief for medical costs. And although its sponsors assume that sharpening consumer incentives would trim future health costs, as consumer choice does in the federal employees' program, the budget estimates do not depend on projected savings in medical costs.

With these clear alternatives now in legislation, Americans at last can evaluate very different ways of achieving the health care goals they want. After that national debate has taken place, lawmakers can enact reforms with the confidence that their constituents have examined a full range of alternatives, with the costs and likely consequences for their medical care.

WHY AMERICANS WANT GREATER HEALTH CARE SECURITY

The reason why most Americans have been demanding health care reform is primarily because they worry that sometime in the future they will lose their current benefits or be unable to afford coverage. In addition, a minority of Americans lack even basic health insurance, even though most of these uninsured households do obtain some level of medical care, paid for by themselves or in the form of "uncompensated" care—the cost of which is added to other bills or paid by the taxpayer.

The root cause of this problem is that the only real access to comprehensive health care for the vast majority of working Americans is through a plan selected by their employer and—most important—owned by their employer. The coverage is not "paid for" by employers, as most Americans wrongly assume, but comes out of the worker's compensation package.

Most Americans are satisfied with the health care coverage they have through their employer. But they still feel insecure. The reason? When a worker changes jobs in America, or is laid off and must search for other work, that family does not lose its life insurance (which it owns), or its house and mortgage (which it owns). But the family does lose its health insurance (which the former employer owns). It must at the very least join a new plan and may become uninsured. It is little wonder that Americans crave security in their health care.

Why is most health care organized in this way?

While employer-sponsored insurance may make sense in many cases, the tax code today imposes heavy penalties on families who try to obtain medical care in any other way. If an employer uses part of a worker's compensation to buy an insurance policy which the employer then owns, that portion of the worker's compensation is made free of income and payroll taxes. But if a family uses its compensation to buy its own health insurance plan, or to pay directly for health care, that money is first fully taxed at all levels of government, including payroll taxes. Thus in practice it is very expensive for a family to obtain care in any other way than through an employer-sponsored insurance plan.

Even though there is no long-term security in such plans, because the employee does not own the plan, this huge tax penalty encourages working Americans to press for generous employer-sponsored insurance. More specifically, this artificial tax-favored system of coverage has a number of severe side-effects.[5] Among them:

- ✔ When employees move jobs, they lose coverage.
- ✔ Since there is generally no tax break for out-of-pocket expenses, employees tend to demand excessive insurance for routine, predictable medical expenses, even when it would be much cheaper if they paid directly rather than insuring against the cost. That increases the overhead cost of insurance.
- ✔ Families without employer-sponsored plans generally must pay for coverage in after-tax dollars. In many cases this makes the cost prohibitive and is a major cause of uninsurance.
- ✔ In large part because health insurance companies do not have a long-term contract with families, they typically change the cost of employer-sponsored premiums each year based on the medical experience of the group of employees. By contrast, families can purchase multi-year life insurance poli-

5 For a full explanation of the current tax treatment of health care and its consequences, see Butler, "A Policy Maker's Guide to the Health Care Crisis, Part I."

cies (which they own) without new underwriting and resulting premium hikes or cancellation of coverage if their health declines.[6]

- ✔ Because the employer is, in the first instance, responsible for the premium cost of an employer-sponsored plan, employees and their doctors have little or no incentive to consider the cost of an insured procedure or test. This is the principal reason why corporate health costs are so difficult to keep under control.

Rethinking Health Care

Lawmakers need to consider these structural problems when they ponder how to reform the health care system. And as they evaluate legislation, they would be wise to consider first what would constitute an ideal system. With this in mind, it becomes easier to design a practical solution.

Beyond the very general, nebulous principles advanced by President Clinton, most Americans would probably agree that an excellent reform should include at least the following elements:

Element #1: Tax benefits should not be restricted only to employer-sponsored health plans. If a family felt a plan offered through another organization, such as a union or church, or directly from an insurer, had more appropriate benefits or was better value for money, the tax system should treat it the same as an employer-sponsored plan.

Element #2: Whether a family obtained coverage through an employer or elsewhere, that family, not the employer or organization, should own the plan. With ownership comes security. In addition, the family, not their employer or the government, should have ultimate control over the money spent on the family's health care, because, as the proverb goes, "He who pays the piper calls the tune."

Element #3: Families should receive the same tax relief for medical costs however they pay for services, such as through insurance or by paying directly. That would let families pick the most efficient way to pay for health care.

Element #4: Each family, not employers or the government, ultimately should be able to decide what package of medical services that family will have in its health plan. Families should have control over this crucial decision affecting their lives.

Element #5: Rather than assistance in the current form of tax relief, which gives the biggest tax break to those with the highest incomes and the most generous health insurance, the tax system should give most help to those with modest

6 For an explanation of how health insurance works, see Edmund F. Haislmaier, "A Policy Maker's Guide to the Health Care Crisis, Part III: What's Wrong with America's Health Insurance Market?" Heritage Foundation *Talking Points*, August 7, 1992.

and low incomes who otherwise cannot afford the minimum acceptable level of care.

Element #6: Insurance rules should be changed to make insurance a two-way contract. Specifically, insurers should not be able unilaterally to cancel coverage or to avoid long-term risk by unilaterally increasing premium schedules because a family's health status unexpectedly changes. Health insurance should, in other words, become real insurance. In that way, a health insurance plan would give real security against future risk, as other forms of insurance do.

Element #7: A major health reform ideally should be based on a model that actually exists — which can be studied and improved upon — rather than on an entirely new theoretical construct. The health care economy is highly complex, with millions of interrelated parts. It would be folly to assume, as the Clinton Administration apparently does, that a completely new system would work in the real world in the way it does on a White House computer.

The Nickles-Stearns bill constructs a health care reform guided by these elements.

THE PROVISIONS OF THE NICKLES-STEARNS BILL

Tax Treatment of Health Care Expenses

New Health Care Tax Credits. The legislation establishes new health care tax credits for individuals and families to offset the cost of their health expenses. This new credit system begins on January 1, 1997. The credits apply to all health expenses—health insurance premium payments as well as direct payments for deductibles and other out-of-pocket medical expenses.

Health insurance premiums and unreimbursed medical expenses as a proportion of gross income	Percent Credit
Below 10 percent	25 percent
10 - 20 percent	50 percent
20 percent or more	75 percent
Contributions to a medical savings account	25 percent

The basic tax credit would be 25 percent of health expenses. Thus, a family would pay $25 less in taxes for each $100 it spends on buying health insurance or paying deductibles or out-of-pocket medical bills.

Individuals and families whose health expenses (insurance premiums plus out-of-pocket costs) exceed 10 percent of their total income would receive more tax relief in the form of higher tax credits. For the share of health expenses that are between 10 and 20 percent of income, the tax credit would be 50 percent. For health expenses above 20 percent of income the tax credit would be 75 percent.

The tax credits are structured in this way to give all eligible individuals and families a basic level of tax relief on all of their health expenses, with greater tax

relief targeted to those individuals and families who, because of illness or below average incomes, face proportionately higher health expenses relative to their income.

Example: Consider a family with $30,000 of income and total health insurance and out-of-pocket expenses of $4,000. Ten percent of the family's income is $3,000. So the family would receive a 25 percent tax credit on the first $3,000 of health expenses, or $750 in tax relief. The remaining $1,000 of the family's health expenses is between 10 and 20 percent of the family's income. So the family would receive a 50 percent tax credit on the remaining $1,000 of their health expenses, or an additional $500 in tax relief. Thus, the family would pay a total of $1,250 less in taxes under the new tax credits.

The New Tax Credits are Refundable. The new tax credits also would be refundable. This means that if the value of the credits is more than an individual or family's tax liability, the government pays the difference. As employers currently do with the Earned Income Tax Credit (EITC), firms with one or more workers eligible for the refundable tax credits would reduce their quarterly employee tax payments to the IRS and provide the tax credit as additional income in the employees' paycheck, so they could purchase insurance and medical care.

Eligibility for the New Tax Credits. Individuals who have all or most of their medical care paid for by government health care programs would not be eligible to claim the new tax credits. Such individuals include: Medicare and Medicaid beneficiaries; members of the Armed Forces; veterans who participate in the VA health care system; and individuals served by the Indian Health Service. These Americans would continue to receive coverage under their current respective programs.

All other Americans would be eligible for the new tax credits for health expenses, provided they purchased coverage which, at a minimum, met the standards specified for a "Federally Qualified Health Insurance Plan"—which would provide catastrophic coverage (See section below on insurance provisions). Individuals not covered by a government health care program would be required to purchase coverage which at least meets the standards of a federally qualified plan. Individuals who failed to do so would not only be ineligible for the new tax credits, but would also be ineligible to claim any personal exemption amount for federal income tax purposes. They could escape this penalty by enrolling in a federally qualified plan by April 1 of any year.

Federal Workers and Dependents. Federal civilian employees, retirees, and their dependents who participate in the Federal Employee Health Benefits Plan (FEHBP), as well as military dependents and retirees who participate in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), would also be eligible for the new tax credits effective January 1, 1997.

Medical Savings Accounts. The bill would permit individuals to open Medical Savings Accounts (sometimes called medisave accounts or MSAs). These would be similar to Individual Retirement Accounts (IRAs), or to the flexible spending accounts available to many employees which can be used to pay for out-of-pocket medical costs. Each household would be permitted to have one Medical Savings

Account, and a taxpayer with an MSA would be permitted to make annual contributions to the account of as much as $3,000 plus $500 for each dependent. These limits would be indexed to increase annually for inflation. Contributions to an MSA could be made at any time. Deposits made between January 1 and the April 15 deadline for filing tax returns could be applied to either the current or previous tax year. Contributions to an MSA would receive a tax credit of 25 percent—the same as the basic tax credit provided for direct payments for health insurance premiums and out-of-pocket expenses.

The funds in a Medical Savings Account could be used to pay health insurance premiums, deductibles, and other medical bills not covered by a health insurance plan. However, payments for health insurance and medical care made from an MSA would not qualify for additional tax relief since the tax credit would be claimed up front when the money is deposited in the MSA.

Disbursements from MSAs for purposes other than the purchase of health insurance and medical care would be treated as taxable income and would be subject to an additional penalty of 10 percent, much like early withdrawals from an IRA. Funds deposited in an MSA are permitted to earn tax-free interest, and any unspent funds can be "rolled over" from year to year without penalty.

The MSA may be considered an improved version of a flexible spending account, available to millions of workers at their place of employment. But funds in a flexible spending account, which can be used, tax-free, for out-of-pocket expenses or additional insurance, cannot be rolled over from year to year but instead revert to the employer. The Clinton plan, incidentally, abolishes flexible spending accounts.

Reports on MSAs must be filed with the IRS by financial institutions maintaining MSAs in accordance with rules that currently apply to IRAs and annuities.

Existing Health Care Tax Breaks Replaced With New Tax Credits. When the new tax credits take effect in 1997, they would replace the health care tax breaks currently provided to individuals and families. Therefore, the tax exclusion for employer-sponsored health benefits, the medical expense deduction, and the partial deduction for health insurance costs for self-employed individuals would no longer apply after 1996.

Employers would continue to be able to deduct against corporate income tax, as a cost of doing business, all compensation paid to their employees, regardless of whether any of that compensation was earmarked for health benefits.

Insurance Provisions

Federally Qualified Health Insurance Plans. The legislation establishes standards for "Federally Qualified Health Insurance Plans." In order to claim the new tax credits for their health expenses, individuals and families would need to purchase health insurance coverage which at least meets the minimum requirements for a federally qualified plan. All Americans not covered by government health programs would be required to obtain coverage under a federally qualified plan.

A "Federally Qualified Health Insurance Plan" is one which:

- ✔ Provides benefits at least equal to those specified in the "Family Security Benefits Package";
- ✔ Provides guaranteed issue and guaranteed renewal of policies; and
- ✔ Meets other requirements related to premium rates and marketing practices.

Family Security Benefits Package. The "Family Security Benefits Package" specifies the minimum coverage that a federally qualified plan must provide. The "Family Security Benefits Package" would cover medically necessary acute medical care, defined as coverage that includes:

- ✔ Physician services;
- ✔ Inpatient, outpatient, and emergency hospital services and appropriate alternatives to hospitalization; and
- ✔ Inpatient and outpatient prescription drugs.

Under the "Family Security Benefits Package," beneficiary cost-sharing for covered services would be limited to:

- ✔ Maximum, annual deductibles of $1,000 for an individual and $2,000 for a family;
- ✔ Maximum, annual cost-sharing (the total of deductibles plus any coinsurance or other copayments) of $5,000 for an individual or family.

These amounts would be indexed to inflation in future years. Moreover, these out-of-pocket amounts would be eligible for the new refundable tax credit, and so the after-tax, out-of-pocket expenses for a family would be less—and much less in the case of low-income families with high medical costs as a proportion of their income (whenever the 50 percent or 75 percent credits would apply).

Furthermore, the package could not exclude coverage for selected illnesses or selected treatments that are consistent with medically acceptable practices. However, a plan would not be required to include coverage of abortion services.

Rating Practices. Insurers would be permitted to vary premium rates only on the basis of age, sex, and geography. Furthermore, insurers would be required to charge the same rates to both existing policyholders and new applicants with the same age, sex, and geographic characteristics.

However, insurers would be allowed to give individuals discounts as an incentive to participate in a program designed to promote healthy behavior, prevent or delay the onset of illness, or provide for screening or early detection of illness, provided such a program was approved by the applicable state insurance regulator. There is nothing in the legislation that would prevent an approved wellness or prevention program from being sponsored by someone other than the insurer, such as an employer or a community group.

Guaranteed Issue and Pre-Existing Conditions. Insurers would be required to provide guaranteed issue of federally qualified health insurance policies at standard rates to all applicants. This means insurers would not be permitted to exclude coverage of any pre-existing medical condition of any applicant who switches from one insurance plan to another or of any currently uninsured person who first applies for coverage during 1997, the year the legislation first takes effect.

Guaranteed Renewability. Insurers would be prohibited from canceling or refusing to renew coverage of a federally qualified health insurance policy except for nonpayment of premiums, cases of fraud, or misrepresentation.

Marketing Practices. The legislation would prohibit insurers from engaging in marketing practices which have the effect of encouraging insurance agents to discriminate in selling health insurance on the basis of an applicant's age, sex, occupation, health status, previous claims experience, or geographic location.

Certification of Federally Qualified Plans. The bill directs the Secretary of Health and Human Services (HHS), in consultation with the National Association of Insurance Commissioners (NAIC), to develop model acts and model standards for certifying plans as federally qualified health insurance plans. States that have established regulatory programs approved by the Secretary of HHS may certify plans as federally qualified. The Secretary would certify plans in states that fail to establish such regulatory programs.

Development of Additional Insurance Standards. The legislation also directs the Secretary of HHS, in consultation with the NAIC, to develop "model acts and regulations" pertaining to state regulation of health insurance. These model acts and regulations would address:

- ✔ Health insurer solvency standards and guaranty funds;
- ✔ A mechanism for insurers to report to the Internal Revenue Service on the acquisition and termination by individuals of health care coverage;
- ✔ Procedures for the partial "passback" of claims and premiums from one insurer to another in the cases where an individual decides to change health insurance carriers while undergoing treatment for a pre-existing condition; and
- ✔ State-administered risk adjustment or reinsurance programs designed to compensate for the potential occurrence of disproportionate distributions of above-standard or below-standard insured risks among health insurance carriers.

The Secretary of HHS also is directed to develop, in consultation with the NAIC, non-binding recommendations to the states for standards of premium rating practices and guaranteed renewability of coverage which is more generous than the minimum required for federally qualified health insurance plans.

Employer Provisions

General Employer Requirements. The bill would require employers to withhold premiums from their employees' paychecks and to send these premiums to the insurer from whom the employee has chosen to obtain coverage. However, there is nothing in the legislation that would prevent employers, insurers, or state or local governments from establishing clearing houses to better facilitate the transfer of premium payments.

Employers also would be required to notify their employees when they are first hired, and at the beginning of each year, of their eligibility to claim the new, refundable tax credits for health expenses.

Conversion of Existing Employer-Sponsored Plans. The legislation sets out transitional rules for employers and insurers in order to permit workers who currently have employer-sponsored coverage to retain and become owners of their existing plans, while making that coverage portable.

Under these transitional rules, insurers are required to convert existing group plans into portable individual and family policies by the end of 1996. The new rates for those policies could vary only on the basis of age, sex, and geography. Furthermore, the combined total of the rates charged for the individual and family policies with a firm's work force could not exceed the total premium previously charged for those same individuals and families when they were covered as a group.

Employers would be required to notify their employees of their right to convert their current benefits to portable policies. Furthermore, employers would be required to notify each employee of the actuarial value (as computed by the insurer) of the employer's contribution to the employee's health insurance, to add such amount to the cash wages of the employee, and to pay the employer's share of Social Security payroll taxes on that amount. Employees then would have the option of retaining the coverage that they had been receiving through their employer or of using their money to purchase a different policy elsewhere.

In the case of a self-insured plan, or a plan which an insurer no longer wished to sponsor, the plan could, during the transition period, be sold, transferred, or assigned to another insurer or entity willing to sponsor the plan and convert it into portable policies. However, any such transfer would have to be approved by two-thirds of the employees covered by the plan.

The legislation would also amend provisions of COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) relating to continuation of coverage under employer-based health insurance plans, so as to ensure that currently insured workers did not lose their coverage prior to the January 1, 1997, effective date of the legislation.

Including Federal Employees. The legislation would establish a commission to recommend to Congress increases in federal civilian and military pay and retirement benefits so as to allow families covered by FEHBP or CHAMPUS to "cash out" the value of their current benefits and buy coverage elsewhere if they so chose. The bill would instruct the President to appoint as members of the commis-

sion individuals with experience in health insurance and federal pay and benefits, and Congress must approve or reject the commissions findings without amendment.

State Plan Requirements

The legislation would require states to establish a program for the provision of health insurance coverage at least equal to that of the federally qualified health insurance plans to residents who refused to purchase such coverage privately. States would provide supplemental assistance to low-income people through a new federal-state program established under this bill (See Medicaid section.) States would enroll other uninsured individuals in any federally qualified plan of the state's choice and assess whatever premium the state deems appropriate in view of the individual's ability to pay. Such individuals would be permitted to switch to coverage under a federally qualified plan of their own choice at any time without penalty.

The legislation would also preempt state laws which:

- ✔ Require health insurance policies to cover specific diseases, services, or providers;
- ✔ Limit the ability of managed care plans to selectively contract with health care providers; or
- ✔ Limit the ability of managed care plans to impose higher cost-sharing provisions on treatment obtained from providers outside a plan's network.

Medicaid Reforms

Capitated Payments. The legislation provides that, beginning in fiscal year 1995, federal Medicaid payments to states for acute care would be distributed on a per capita basis. The capitated amounts would be set at 20 percent above the FY 1993 level in FY 1995. In subsequent years, the capitated payment would rise by one percent above the Consumer Price Index (CPI). Total federal Medicaid acute care payments to a state in FY 1995 could not exceed the payment for FY 1993 plus 20 percent. In subsequent years, the total federal acute care payment to any state could not exceed the previous year's payment plus CPI plus 2.5 percent. These reductions in federal Medicaid payments to the states would be more than offset by reductions in state and local government spending on community hospitals and increased state revenues. Because the legislation provides universal coverage, states and localities would not need to spend as much as they currently do to support community hospitals which now treat uninsured persons. Also, most states would receive an income tax windfall as a result of the legislation eliminating the tax exclusion for employer-sponsored health insurance.

New Medicaid Waiver Program. The bill would require the Secretary of HHS to establish an expedited waiver process under which a state may apply for waivers of any federal Medicaid requirement to establish innovative and cost-effective programs for furnishing acute care services to Medicaid-eligible individuals. Waivers would be granted for five years and would be renewable for subsequent

five-year periods unless the Secretary determined that the state had committed fraud or failed to furnish acute care services.

New Low-Income Assistance Program. The legislation would terminate federal Medicaid payments for disproportionate share hospitals, effective October 1, 1996. However, these federal funds previously allocated to disproportionate share payments would be provided to the states under a new program designed to assist low-income individuals who are not eligible for Medicaid coverage.

Under the new program, federal funds would be distributed to states according to a formula that takes into account a state's poverty population and tax base. States would be required to continue matching federal contributions to the program. The program would target assistance to individuals who are not eligible for Medicaid, who have incomes less than 150 percent of poverty, and whose unreimbursed payments for health insurance premiums and medical care, net of federal tax credits, exceed 5 percent of adjusted gross income.

States could also use program funds to:

- ✔ Provide eligible individuals with supplemental vouchers on top of their federal tax credits for the purchase of health insurance and medical care;
- ✔ Provide services directly to eligible individuals;
- ✔ Deliver outpatient primary health services in underserved areas;
- ✔ Provide increased funding for community and migrant health centers;
- ✔ Improve the availability and quality of emergency medical services and trauma care;
- ✔ Transport victims of medical emergencies, including air transportation in rural areas; and
- ✔ Enhance telecommunications between rural medical facilities and medical facilities in urban areas.

Medicare Provisions

New Option for the Elderly. The legislation directs the Secretary of HHS to conduct a study of the feasibility of permitting future Medicare beneficiaries, when they become eligible for Medicare, to elect to retain private health insurance coverage and receive, in lieu of Medicare benefits, vouchers for use in purchasing private health insurance coverage.

In order to help fund the new tax credits, the legislation contains a number of provisions which would reduce Medicare spending. The legislation would:

- ✔ Eliminate, beginning in FY 1995, the disproportionate share adjustment for hospitals in Medicare's prospective payment system;
- ✔ Reduce, beginning in FY 1995, payments for the indirect costs of patient care that are related to hospitals' teaching programs;

- ✔ Require, beginning in FY 1995, 20 percent coinsurance payments on clinical laboratory services, home health care services, and skilled nursing facility services; and

- ✔ Shift the update for all payment rates under Medicare's hospital insurance program from October 1 to January 1 beginning in FY 1995, and continue Medicare's transition to prospective payment rates for facility costs in hospital outpatient departments.

Health Care Liability Reform

The legislation would institute a number of reforms in the area of medical malpractice and health care liability law. Specifically, the bill would:

- ✔ Require that malpractice awards which exceed $100,000 be paid in periodic increments;

- ✔ Reduce the amount of damages paid in a medical malpractice case by the amount of other payments (such as public or private disability insurance payments or employer wage continuation program payments) made to the injured party for medical care or lost wages;

- ✔ Modify the statute of limitations for the filing of malpractice claims;

- ✔ Limit attorney fees in medical malpractice actions to 25 percent of the first $150,000 award or settlement and 15 percent of any additional award or settlement;

- ✔ Limit noneconomic damages in medical malpractice cases to $250,000;

- ✔ Make each defendant liable only for the amount of noneconomic loss and punitive damages allocated to such defendant in direct proportion to such defendant's percentage of responsibility;

- ✔ Grant punitive damages only if the claimant established by clear and convincing evidence that the harm suffered was the result of conduct manifesting conscious, flagrant indifference to the health of the claimant or to the health of persons who might be harmed by the health care product; and

- ✔ Limit the liability of manufacturers or sellers of health care products approved by the Food and Drug Administration (FDA), except in cases where the manufacturer or seller withheld or misrepresented information to the FDA or bribed an agency official.

Administrative Reforms

The legislation would give the Secretary of HHS the authority to require all health care providers to submit claims to health insurance companies in accordance with standards developed by the Secretary, if providers are not voluntarily complying with the standards. The Secretary also would be directed to adopt standards relating to data elements for use in paper and electronic claims processing of health insurance claims, uniform claims forms, and uniform electronic transmission of data. Furthermore, the bill would preempt state laws which re-

quire medical or health insurance records to be maintained in written, rather than electronic, form.

The bill also authorizes the Secretary of HHS to provide grants to states to develop information systems regarding comparative health values. Such information would include the average prices of common health care services and health insurance plans, and would measure the variability of these prices within the state or other market area.

Anti-Fraud Measures

The legislation would enhance federal criminal penalties established against health care providers and insurers who knowingly defraud persons in connection with a health care transaction.

Anti-Trust Provisions

The bill would create "safe harbors" from federal anti-trust laws for: certain groups of providers; medical self-regulatory entities that do not operate for financial gain; certain joint ventures for high technology and costly equipment and services; and certain hospital mergers.

It would also direct the Attorney General to create additional "safe harbors" for health care joint ventures that would increase access to health care, enhance health care quality, establish cost efficiencies from which consumers would benefit, and otherwise make health care services more effective, affordable, and efficient. The Attorney General would also be required to establish a program through which certain providers may obtain certificates exempting from anti-trust laws activities relating to the provision of health care services.

Long-Term Care

The legislation would change the laws on IRAs such that funds withdrawn from IRAs and 401(k) pension plans for long-term care insurance would be excluded from income for tax purposes. The bill also would exempt from taxation certain exchanges of life insurance policies for long-term care insurance policies, and amounts paid or advanced from a life insurance contract to a terminally or chronically ill individual who is confined to a hospice or nursing home.

Different House Provisions

The House version of the legislation, H.R. 3698, differs in a few respects from the Senate version. Specifically, the House version:

- ✔ Does not include the Senate provisions imposing copayments for laboratory and home health services under Medicare.
- ✔ Would, instead, reduce federal spending by generally making resident aliens ineligible for public assistance under numerous welfare programs.
- ✔ Permits the Secretary of HHS to provide increased assistance to community and migrant health centers using any funds identified by the Director of OMB as residual savings to the federal government generated by this legis-

lation during the five year period following enactment, up to a maximum total of $13.1 billion.

✔ Provides for a different schedule of limits on attorney fees in medical malpractice actions than those in the Senate version, namely: 40 percent of the first $50,000 of any award or settlement, 33 ⅓ percent of the next $50,000, 25 percent of the next $500,000 and 15 percent of any additional award or settlement.

CONCLUSION

President Clinton recognizes that the main reason Americans demand health care reform is not that they are concerned about the quality of health care services, or even the features of their current insurance. It is because they worry about losing their employer-sponsored coverage. Others worry about having no coverage through their current employer. That feeling of insecurity stems from the design of today's system, which itself is the product of perverse incentives in the tax code. Clinton would deal with this problem by radically changing health care in America, creating a vast new bureaucracy in each state and imposing heavy regulation, price controls, and rationing. The Nickles-Stearns bill would solve the same problem by giving Americans control over the ownership and financing of their health care benefits, and assisting them where needed to pay for basic care, enabling families to select from a wide range of benefits as well as plans, offered through their place of employment or another organization. And the bill would use sharper incentives for consumer choice, not price controls, to moderate costs.

With these very different approaches to reforming the health care system, a national debate can now take place between clear alternatives, so that lawmakers can enact reforms that genuinely reflect the choice of the American people.

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APPENDIX A

The Nickles-Stearns Bill and the Clinton Bill: A Comparison

Clinton	Nickles-Stearns
Assures universal health care for all Americans.	Assures universal health care for all Americans.
Based on a theoretical model.	Based on the working health system now used by Members of Congress and Administration officials.
Americans must buy a standardized plan designed by a board in Washington. It will be illegal to buy most existing insurance plans.	Americans can pick plans with benefits they want. They can retain their current insurance.
Relies on price controls and regulation to control costs.	Relies on competition and consumer choice.
Severely limits choice of doctor.	Guarantees choice of doctor.
Introduces a national health budget, leading to rationing.	No national health budget.
Sets up powerful, monopolistic "health alliances" in each state to select plans Americans allowed to buy.	No health alliances.
Alliances can fine insurer plans that exceed budget allocation. Insurers must pass on fines to doctors and hospitals.	No such powers to fine.
Families must obtain plans through health alliances.	Families can obtain plans through employers, unions, churches, farm bureaus, and other organizations of their choice.
Imposes a health tax on employers to part-fund health alliance plans.	Imposes no such tax.
Workers happy with their existing company-sponsored plans generally must change them.	These workers can keep their own plans.
Throws 1-3 million out of work, according to leading econometrics firm. White House admits 600,000 jobs will be lost.*	No jobs will be lost, according to same firm.
Will raise taxes by $160 billion over five years, according to White House.	Cuts federal taxes by $133 billion over five years.
No tax relief for out-of-pocket medical expenses. Flexible spending accounts abolished.	Tax relief for out-of-pocket expenses, and for contributions to Medical Savings Accounts (improved, portable versions of flexible spending accounts).

* See Peter J. Ferrara, "The Jobs Impact of Health Care Reforms," Heritage Foundation *FYI*, July 6, 1993. See also June E. O'Neill and Dave M. O'Neill, *The Impact of a Health Insurance Mandate on Labor Costs and Employment — Empirical Evidence* (Washington, D.C.: Employment Policies Institute, September 1993.)

APPENDIX B

QUESTIONS AND ANSWERS ON THE NICKLES-STEARNS BILL

Q. The Nickles-Stearns bill expects ordinary Americans to choose their own health benefits, not just where they get their plan. Isn't choosing health care too complicated for average families?

A. Apparently not for federal workers. The Nickles-Stearns bill assumes ordinary Americans are just as smart as federal workers and Members of Congress, who every year can pick plans incorporating different benefits. And if a family can choose a college for their child, a car or house for their family, or a mutual fund for their savings, they can probably pick a health plan for themselves.

Q. Still, aren't there going to be some people who are just unable to make that decision because they are confused by health care?

A. Of course. But they can do two things under the Nickles-Stearns bill. They can simply avoid making any decision and stay with their current coverage provided through their employer. Or if they are unhappy with their current coverage (or do not have any) they will be able to go to an organization they trust that offers plans—perhaps their union, or their church—and take a plan suggested by that organization.

In other words, they do not have to decide on specific benefits, but they can choose a trusted organization to do that for them. Today the only group that can make those decisions for them is their employer.

Q. Doesn't the Nickles-Stearns bill eliminate employer-provided coverage, even though most Americans are fairly satisfied with that?

A. No. But it would allow workers who are dissatisfied with their employer-sponsored coverage to pick an alternative plan. Moreover, it would give greater security to Americans with coverage provided through their employer. Nobody would be forced out of a plan offered through their employer.

The reason the bill would give greater security to workers with employer-sponsored coverage is that, today, an employer-sponsored plan belongs to the employer, not the worker. So when the worker changes jobs, he or she loses the coverage. And in the case of self-insured plans today, the employer can change or even terminate benefits and coverage and the employee can do nothing about it. But under the Nickles-Stearns bill, an employer-sponsored plan would become the employee's own plan. The employer could not change it. If the employee switched jobs, he or she could take that plan along, without interruption and without any hike in costs.

Q. What if someone wanted an alternative to their company-sponsored plan?

A. They would be able to pick any other plan they wanted. It would work as follows. If a worker wanted to switch to another plan, the employer would be required, by law, to "cash out" the value of the benefits he or she receives. That money would be added to the worker's paycheck.

This cash value would be based on the actuarial value of the benefits now provided by the employer, based on age, sex, family status, and geographic location. The worker could take this money and enroll in the plan of his or her choice, such as one offered, perhaps, through their union.

The only requirement on the employee is that he or she must at least buy catastrophic coverage.

Q. How does the Nickles-Stearns bill enforce the requirement that I buy at least a catastrophic plan?

A. Workers would be legally required to demonstrate to their employer that they and their dependents were covered by such a plan. Each head of household would have to show proof of coverage when filing the annual tax return. Failure to show coverage would lead to a loss of the personal exemption—in effect, a fine. Finally, states would be required to identify and enroll individuals who refused to voluntarily purchase coverage in a federally qualified plan of the state's choosing. The state could also charge such individuals for all or part of the cost of the required coverage.

Q. What if my chosen plan didn't want to cover me, because I had a heart attack last year?

A. Your chosen plan could not turn you down, or charge you extra because of your medical condition. You would be charged a premium based only on your age, sex, family status, and geographic location.

Q. But if premiums can be varied in this way, couldn't it still cost me a lot more?

A. No. If you switch from your employer's plan, you receive the value of your current plan, based on the same actuarial considerations as your new plan. So if you were older, and generally faced higher premiums, you would get more in your paycheck to pay for the higher premiums and benefits in your chosen new plan.

In addition, you would be eligible for a tax credit based on your total health expenses—insurance, out-of-pocket expenses, and contributions to a Medical Savings Account. That means that if you have unusually high costs, such as a great deal of routine costs, you will receive more help through a larger tax credit.

Q. **What if I "shop wisely" and find an alternative plan that gives me the benefits I want at a lower cost than my company-provided plan today—who gets the sayings?**

A. You do. If you economize today, your employer gets to keep most of the savings. But under the Nickles-Stearns bill, the money you spend—or don't spend—on health insurance is yours, and you keep any money you save. That incentive is what helps to control costs.

Q. **What if I buy more than the basic catastrophic coverage. Do the additional benefits qualify for the credit?**

A. Yes, unlike the Clinton plan, where only your employer's contribution to a standard plan is free of tax to you. The Clinton plan also will not let you deduct out-of-pocket costs. Under the Nickles-Stearns bill, whatever you decide to spend on insurance, contributions to a Medical Savings Account, or out-of-pocket costs is eligible for the tax credit.

Q. **What if I get sick during one year? Does that mean the insurer can drop my coverage or hike my premiums, like they often do today?**

A. No. Under federal law you would have the right to renew your chosen plan, and your insurer could not change your premium because of any change in your health.

Q. **Doesn't individual health insurance have higher administrative costs than employer group coverage?**

A. Not necessarily. There is little difference between individual and employer group insurance in the cost of processing claims. For example, in an employer group plan covering 100 people, the insurer must still maintain separate records on the claims, deductibles, copayments, of 100 different individuals.

There is a small difference in the cost of collecting prompt premium payments from 100 separate individuals versus a single premium for a group of 100. However, under the Nickles-Stearns bill employers would still withhold workers' premiums and send them to their chosen insurer or a clearing house established to facilitate premium payments. Consequently, there would be little, if any, difference from the present system in the administrative cost of collecting premiums. In this regard, it should be noted that under the FEHBP system each worker chooses from a menu of plans and OPM acts as a clearing house for transferring the premiums to the appropriate insurer, all at very little cost.

Q. But don't insurers still have higher marketing costs for individual plans than for group plans, with those costs passed on in the form of higher premiums?

A. Yes, that is true today. But under the Nickles-Stearns bill, marketing costs—the expenses an insurer incurs in finding new business through advertising, and paying agents' commissions—would also be reduced. Obviously, when groups of individuals apply for coverage together, the insurer saves on marketing costs and can pass those savings on to policy holders. But these savings, through what is in effect "wholesale purchasing," can be achieved regardless of whether, say, 100 people purchase one policy to cover all of them or 100 separate policies.

Consequently, individuals could still get these "wholesale purchase" savings by banding together in groups. Under the Nickles-Stearns bill these groups could be employment-based, unions, farm bureaus, chambers of commerce, or other associations. This is similar, for example, to the way members of some associations can today get discounted individual auto insurance or life insurance policies.

It is important to note that in one respect the current system artificially increases the marketing costs of individual insurance. This is because while employer group plans are tax free, Americans who buy health insurance on their own usually get no tax relief. The result: people tend to drop individual insurance whenever they get the chance to participate in a tax-free employer group plan. This, in turn, forces individual insurers to constantly spend huge amounts on advertising and agents' commissions to get new business—which increase the cost of indiviual coverage. Indeed, today, 40 percent of people who buy individual coverage don't renew their policy for even a second year.

The Nickles-Stearns bill would change this by giving equal tax relief to all plans. This would lead individuals and families to pick plans they liked, either their current employer plan or some other, and keep their plan for as long as they are satisfied with it. The result would be much less turnover in the health insurance market and much lower marketing costs.

Q. Still, isn't group insurance cheaper than individual insurance because group insurance spreads the cost of illness among a bigger risk pool?

A. No. Many people have the mistaken impression that by participating in an employer group plan their claims costs (that is the costs of their illnesses), are spread over a much larger group of people, or risk pool, than if they have an individual policy. In fact the opposite is almost always the case. People who buy individual insurance are actually placed into groups, or risk pools, which are larger than almost any single employment based group.

To understand how this is the case, imagine a company with 100 employees, each of whom has homeowner's insurance. Imagine further the

the risk pool is limited to just those 100 employees. If one worker's house burned down, the insurer would need to charge those 100 employees in the group an enormous premium to cover such a loss, since it is spread over such a small group.

Of course, in reality, workers purchase their homeowner's insurance individually, and are placed by the insurer in a much larger group of tens of thousands of similar policy holders. Consequently, a few house fires a year make little difference in premiums since the cost of those losses is spread over a very large group of individual policy holders.

Furthermore, under the kind of reformed system the Nickles-Stearns bill would create, individuals and families could be expected to keep policies they liked for many years. This would enable insurers to spread claims costs more over time (like life insurance), instead of just over a group.

Q. I have a flexible spending account though my employer, so that I can pay deductibles and copayments in pre-tax dollars. How does the Nickles-Stearns bill affect those accounts?

A. It improves on them, while the Clinton plan eliminates them. Under the Nickles-Stearns bill, you would be able to set up your own form of flexible spending account— even if your employer didn't provide one today—and contributions would be eligible for the credit. Under this new Medical Savings Account, you could roll over unused account funds to the next year (unlike flexible spending plans, where your employer gets your unused balance). And if you go to another job, your account goes with you. Moreover, since out-of-pocket costs also are eligible for the credit, you would not even have to set up an account to get tax relief for deductibles and copayments.

Q. What does the Nickles-Stearns bill do to encourage preventive care?

A. Several things. First, you could now select a plan with preventive care in it if you wanted to do so. Today many employer-sponsored plans don't include it. Second, you would get tax relief for routine preventive care paid for out of your own pocket, unlike today. Third, because you would have the right to renew your plan each year no matter if your health deteriorated, your insurer would have a strong incentive to "invest" in your long-term health to keep the insurer's long-term costs down. That would lead to far more plans including immunization, screening, and other preventive measures to reduce the plan's probable outlays on acute care in future years. In addition, the Nickles-Stearns bill would encourage preventive care by permitting plans to offer a discount to families agreeing to a course of preventive care.

Q. Let's say I opt to tell my employer to cash out my current plan so I can enroll in a plan my union offers. Do I get that cashed-out amount each year?

A. The cashed-out amount becomes part of your permanent base salary or hourly wage. Your total compensation, which is the sum of cash and benefits, remains unchanged, except that more of it is now in cash and less is in fringe benefits. In future years that total compensation must be renegotiated, as it is today. But unlike today, when an employer can unilaterally reduce your health benefits, that plan now belongs to you and cannot be changed by your employer.

Q. Will I have to wait until the end of the year, when I file taxes, to get the credit? I can't wait that long.

A. No. Your employer will factor that into your tax withholdings, so the credit will show up in each paycheck. The employer will make the same kind of adjustment as for any other tax benefit you are entitled to.

Q. Will I have to send a check each month to the plan I pick?

A. No. You will normally direct your employer to make a payroll deduction for you and send the money to your chosen plan, just as employers often do for contributions to 401(k) pension plans. State or local governments, employer coalitions, or insurers could also establish clearinghouses to facilitate premium payments and publish information on the cost and benefits of various insurance plans.

Q. I'm a small business owner and I don't offer a plan today. Must I now do so?

A. No. All you will have to do is adjust the withholding of your employees to reflect the value of their credit, like you do now for other tax breaks they are entitled to, and you will have to deduct money from their paycheck and send it to their chosen plan.

Q. If I am laid off and unemployed, do I lose my coverage?

A. No, unlike today, and you will get help to pay for your coverage. If you became unemployed for a spell, you would not lose your health insurance, any more than any other insurance policy would be terminated. If your unemployment lasted more than a short spell and you registered for unemployment, your available tax credit would go to the unemployment office and be sent, with an appropriate amount from your benefits, to the plan to continue coverage. Since your income would fall, you would be eligible for a larger credit during your unemployment. Since this change in paying for your care would take time for the unemployment office to organize, regulations accompanying the Nickles-Stearns bill are expected to

make it illegal for insurance companies to drop your coverage while the paperwork is being completed.

Q. I work part-time. What does the Nickles-Stearns bill mean for me?

A. If you are a spouse or other dependent family member in a household, your income would be added to the household income in calculating the credit you are entitled to for family coverage. Since you are working part-time, your household income would be lower than if you were working full-time, and so the credit likely would be larger.

If you are the head of household working part-time, your relatively low income would entitle you to a larger percentage credit to offset your household insurance and out-of-pocket costs. You would, of course, have the same right as a full-time worker to pick the plan that suits you best.

Q. I'm self-employed. What will the Nickles-Stearns bill do for me?

A. Exactly as much as it does for other Americans. Until the end of 1993, you only receive a tax deduction for 25 percent of your premium costs. The 1993 tax bill ended even this deduction after 1993. Moreover, because you are not part of a large employment group, you probably pay more for coverage. Worse still, if you have had any medical problem you may be unable to get insurance at any reasonable price.

The Nickles-Stearns legislation gives you the same refundable tax credit as any other American receives, for insurance, out-of-pocket costs, or contributions to a Medical Savings Account. And you can join a large group to get less expensive coverage through administrative savings, such as a church or union plan. Moreover, the plan you obtain will have to charge a premium based only on your age, sex, family status, and geographic location — not your health — so you will be able to obtain insurance just like anyone else.

Q. Under the Nickles-Stearns bill, will my health costs and taxes go up, or down?

A. Under the Nickles-Stearns bill, families "lose" the current tax break for any employer-provided insurance, but they "gain" a tax credit for out-of-pocket expenses and Medical Savings Account contributions as well as insurance. If you decide to cash out your current plan, you will receive a "pay increase" but you will be responsible for buying your own plan. The net effect on each family will vary, depending on their own decision. Preliminary calculations by Lewin-VHI, a leading firm specializing in health spending analysis, indicate that the vast majority of middle-class Americans will, after they have made their decision, be significantly better-off financially. High-income families generally will pay a little more in taxes, chiefly because they will cut back on "Cadillac" health plans and

opt to receive more in taxable income. Lower-income families generally will pay less on health than they do today, and will have portable insurance.

Q. I don't see any cost controls in the Nickles-Stearns bill.

A. If by "cost controls" you mean price controls, you are right. Price controls, such as those in the Clinton plan, have never succeeded in holding down costs and are being abandoned all over the world by socialist governments.[7] On the other hand, the Nickles-Stearns bill has the most powerful tool to moderate costs without rationing or reducing quality—consumer choice in a competitive market. Under the Nickles-Stearns bill, the strong incentive to choose value for money in health plans and benefits will keep costs down more effectively than regulation and price controls.

We know already that works in the consumer choice plan available to Members of Congress and other federal employees. The rate of FEHBP premium increases has averaged one-third less than private employer-provided plans during the last fifteen years.[8] Next year, the average FEHBP rate premium increase will be just 3 percent, and 40 percent of federal workers will enjoy lower premiums.

Q. I'm retired and in Medicare. Does the Nickles-Stearns bill affect my medical care?

A. No, you would still be covered for the same medical services as you are today. However, you would have to pay a 20 percent copayment for certain laboratory, home health, and skilled nursing services. In the House version, the copayment would apply only to skilled nursing services.

Q. I'm going to retire in a couple of years. What does the Nickles-Stearns bill do for me?

A. It will create a commission to consider precisely how to give you a new option. This new option will work as follows. When you turn 65, you will be able to go into Medicare as you will do under current law. But if you want to—and only if you want to—the legislation will enable you to opt at 65 to keep the same private health plan you were happy with at 64. You will be able to do this because Medicare will be permitted, at your direction, to "cash out" your share of Medicare benefits (based on your age, sex, and geographic location) and you will be able to use this money toward the cost of your current plan.

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7 See Edmund F. Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Care Costs," Heritage Foundation *Backgrounder* No. 929, March 8, 1993.

8 Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation *Backgrounder* No. 878, February 6, 1992.

Q. What happens to the homeless, and other low-income people not in the work force, under the Nickles-Stearns bill?

A. Very low income individuals who do not qualify for Medicaid would be eligible for a generous voucher under the Nickles-Stearns bill, together with other assistance provided through the state. The legislation would create a new grant to states to supplement the refundable tax credits available to very low income individuals not covered by Medicaid. This grant would be funded by Medicaid Disproportionate Share money currently allocated to hospitals to help pay for the uninsured. States would have wide latitude in how they used this grant. They could, for instance, provide some households with supplementary assistance to buy insurance. A state might also use grant funds to finance clinics for migrant families or in homeless shelters, or to provide other services directly to those families for whom the refundable tax credit is insufficient.

Q. I am a veteran and get free care from the VA. How does the Nickles-Stearns bill affect me?

A. It has no effect on you.

Q. I work for the federal government. How does the Nickles-Stearns bill affect me?

A. Under the Nickles-Stearns bill, Members of Congress and federal workers like yourself would be treated just like anyone else. That means you would actually have even wider choice of plans and benefits than today, as would your neighbors who do not work for the government. So you would be able to keep the plan you now have and, as today, be able to switch plans without facing pre-existing condition problems.

What would change would be the method by which the federal government subsidizes your chosen plan. A commission would be set up to determine how best to figure the value of your existing benefits. That money would be added to your paycheck or retirement annuity. Thereafter you would pay the full amount of the premium for your selected plan yourself, with help from the extra money you receive.