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WHAT TO DO ABOUT THE KASSEBAUM-KENNEDY BILL

INTRODUCTION

A conference committee soon will consider health care reform legislation passed by both the House and the Senate. In the House of Representatives, the Health Care Coverage and Affordability Act of 1996 (H.R. 3103), sponsored by the House congressional leadership, passed on March 28 by a vote of 267 to 151. In the Senate, the Health Insurance Reform Act of 1996 (S. 1028), sponsored by Senator Nancy Kassebaum (R-KS) and Senator Edward Kennedy (D-MA), passed on April 23 by a vote of 100 to 0.

The huge margins of support for these bills reflect the deep desire of Members of Congress from both parties to address the serious and continuing problems faced by workers and their families in getting and keeping health insurance coverage. Despite the voting margins, however, many Members are concerned about the impact of specific provisions which, though drafted with the best of intentions, could have unintended and seriously damaging consequences. As written, for example, this legislation most likely would increase the cost of health insurance by billions of dollars while decreasing both the affordability and accessibility of such coverage.

Congress has an opportunity to help millions of Americans gain access to affordable health insurance coverage, but it also has an obligation to do it right. As Members of the House and Senate meet in conference committee to resolve differences between the two bills, they therefore should consider key changes that would improve the health care system for all working families:

✓ **Keep medical savings accounts (MSAs) in the legislation.** MSAs are a big step toward tax equity for small businessmen and their employees, and for individuals and families without employer-based health insurance. The new tax benefits of MSAs would increase the affordability of health insurance, particularly for middle-class employers and employees.

- ✓ **Increase and broaden tax relief for working families.** Without tax equity for individuals and families in the purchase of health insurance, regardless of their status of employment, the reforms so widely promoted by supporters of this legislation would do little either to slow the growth in the ranks of the uninsured or to reverse the rate of uninsurance.

- ✓ **Sunset federal regulation of the individual insurance market.** Health insurance is one of the most highly regulated sectors of the American economy. These bills would impose an unprecedented level of federal regulation in an area of jurisdiction traditionally reserved to the states, increasing health care costs for working families. Congress should sunset these provisions.

- ✓ **Preempt all state mandated benefits as a condition of federal regulation of group insurance in the states.** State health insurance markets are a confusing tangle of rules, regulations, mandates, and price controls, all of which interfere with freedom of contract and drive up costs for workers and their families. If Congress is going to preempt state insurance regulation, it should at least begin to level the playing field for companies and insurers by preempting state mandated benefits.

- ✓ **Dump the costly mental health benefit mandate.** The Senate voted overwhelmingly to impose a parity requirement on health insurance, specifying that private insurance companies must provide the same benefits for mental illness as for physical illness. This would be the first time the federal government has imposed a benefit mandate on private health insurance. The Congressional Budget Office says this provision would result in substantial cost increases for workers and their families, as well as reductions in income, in affordable health insurance coverage for families, and even in federal revenues. It should be dropped.

- ✓ **Dump Clintonesque fines and penalties on doctors and allow private contracting in Medicare.** Both bills federalize criminal law governing health insurance fraud and abuse, with significant portions copied word for word from the Clinton health plan. Curiously, the applicability of certain sanctions does not extend to Congress's own plan: the Federal Employees Health Benefits Program (FEHBP). Members should go back to the drawing board and try again. They should reduce Medicare's paperwork requirements and allow doctors and patients to contract privately for medical services without being subjected to threats from federal bureaucrats.

- ✓ **Allow a rollover of funds in flexible spending plans.** Millions of working families already have tax-free flexible spending plans to offset routine health care costs, but they must use the money in any given year or lose it. Congress should allow them to roll over unused funds into the next year.

- ✓ **Tell workers and their families the truth about health care costs.** Too many Americans do not know how much their employer pays on their behalf for health insurance. Worse, far too many see company-based health insurance as a "free" fringe benefit that comes with the job. It is not. Households pay almost all the costs of health benefits in lower wages and other reductions in compensation. Congress should require full financial disclosure.

WHAT THE HOUSE AND SENATE BILLS WOULD DO

With the number of uninsured Americans rising by about a million a year, Congress is anxious to pass some type of health care reform legislation that begins to address the problem. One of the goals of the current debate is "portability," so that families do not lose their health insurance coverage if they lose or change jobs. According to the U.S. General Accounting Office, approximately 25 million Americans could take advantage of the portability provisions in the House and Senate bills.[1]

While Congress is addressing the serious and persistent problems that beset the employer-based health insurance market, it also should avoid policy decisions that could destabilize the already distorted health insurance market. The disappointing experience of states that have attempted complex insurance market reform shows that legislative mandates can drive up costs for working families and drive individuals out of the market, creating new problems that lead to even more aggressive government intervention.

Insurance Reform. Provisions in the current health care reform legislation designed to reform the health insurance market and guarantee portability of insurance coverage for workers include:

- **Guaranteed Issue.** With few exceptions, both bills would require insurers to offer group health insurance policies to eligible employers in the jurisdictions where they sell policies.[2] Under both bills, health insurers would be required to offer individual coverage to a person who 1) has had group coverage for at least 18 months; 2) is not eligible for coverage under any other group plan and 3) has exhausted his or her COBRA coverage, which currently allows most people to keep their employer group health insurance for 18 months after they leave a job; and 4) has never been denied coverage for fraud or nonpayment of premiums.

- **Limitations on Pre-Existing Condition Exclusions.** Both bills would restrict the ability of insurers to deny coverage to workers with pre-existing conditions if they have had continuous coverage.

- **Guaranteed Renewal of Policies.** Both bills would require health insurers to renew all group health plans, provided the insured individuals have paid their premiums and have not violated the insurance contract. Both bills also would allow individuals who leave a group plan to renew their policies on an individual basis.[3]

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1 Cited in Sharon McIlrath, "Senate Oks Insurance Bill," *American Medical News*, Vol. 39, No. 17 (May 6, 1996), p. 60.

2 State risk pools for the unhealthy or uninsured often are promoted as an alternative to a guaranteed issue rule for health insurance. But this popular alternative is burdened with practical and political infirmities: "A risk pool poses risk for abuse. One is that government may not sufficiently subsidize the pool and set premium caps on the insurance obtained by pool members, thus drying up the market for them. Conversely, there is a risk that the pool could be a step toward a government system. By expanding the entry criteria, and increasing the subsidy, the risk pool can be used increasingly to socialize the cost of insurance—and is likely then to be followed by the regulation that a government system necessarily entails." John Hoff, "Improving the System for Delivering Subsidies: Cap or Scrap the Exclusion?" paper presented to a conference on "A Fresh Approach to Health Care Reform" sponsored by the Galen Institute, Washington, D.C., March 25, 1996, pp. 19-20.

☞ **Premium Discounts.** The Senate bill would allow an employee health benefit plan or a health insurance company to offer premium discounts or modify co-payments or deductibles in return for patient enrollment in health promotion and disease prevention programs. This would make coverage more affordable for individuals and families who pursue healthy lifestyles.[4]

Tax Relief. Both the House and Senate bills contain limited tax benefits. The House bill would allow favored tax treatment for medical savings accounts. The Senate bill includes no such provision.[5]

Both bills also would help the self-employed purchase health insurance. The House bill would raise the tax deductibility of health insurance for the self-employed from 30 percent to 50 percent by the year 2003. The Senate bill would raise it from 30 percent to 80 percent by 2006. About 17 million self-employed workers and their families could benefit from this provision.[6]

Waste, Fraud, and Abuse. Many doctors will be surprised to learn that the House and Senate are considering enacting penalties curiously reminiscent of the sanctions proposed in the failed Clinton health plan. In fact, significant portions of the legislative language are strikingly similar to—and some were copied word for word from—language found in the Clinton bill.[7]

Both bills contain a confusing plethora of new fines, penalties, and jail terms for doctors, in addition to broadened investigative powers for federal agents. These provisions are designed to stop the leakage of the estimated 10 percent of Medicare dollars that is

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3 Both bills require insurers to renew policies in both the individual and group insurance markets.

4 S. 1028, Title I, Section 101(a)(2). This is similar to the health insurance premium discount contained in the Consumer Choice Health Security Act of 1993 (S. 1743 and H.R. 3698), based on the Heritage Foundation plan and sponsored by Representative Cliff Stearns (R-FL) and Senator Don Nickles (R-OK) and 24 Senate colleagues. See Stuart M. Butler and Edmund F. Haislmaier, "The Consumer Choice Health Security Act," Heritage Foundation *Issue Bulletin* No. 186, December 23, 1993.

5 Nonetheless, the original committee sponsors of the Senate measure indicate general support for the concept: "It is the sense of the Committee on Labor and Human Resources of the Senate that the establishment of medical savings accounts, including those defined in section 1301(b)(6)(B) of the Public Health Service Act (42 U.S.C. 300 e(b)(6)(B), should be encouraged as part of any health insurance reform legislation passed by the Senate through the use of tax incentives relating to contributions to, the income growth of, and the qualified use of, such accounts." See The Health Insurance Reform Act of 1995, Title III, Section 301(b).

6 McIlrath, "Senate Oks Insurance Bill."

7 A cursory review of the provisions shows this to be the case. For example, Section 201 of H.R. 3103, which establishes a new and comprehensive federal "Fraud and Abuse Control Program," is virtually identical to Section 5401 of the Clinton plan as delivered to Congress on October 27, 1993; the language in Title II establishing the "Health Care Fraud and Abuse Control Account" is remarkably similar to Section 5402 of the Clinton plan; the paragraph in Section 201(b) governing fines recovered in cases involving federal health care fraud is virtually identical to Section 5402(a)(1) of the Clinton plan; Section 242, which deals with health care fraud, mirrors Section 5431 of the Clinton plan, with slight changes; Section 243, which deals with theft and embezzlement, mirrors Section 5437 of the Clinton plan; Section 244, which deals with false statements, mirrors Section 5433 of the Clinton plan; and Section 249, which deals with forfeitures for "federal health care offenses," mirrors Section 5432 of the Clinton plan. For a fuller description of the fines and penalties in the congressional legislation, see Grace-Marie Arnett, "Cops and Doctors, Part II," Heritage Foundation *Physicians Council Report* No. 2, May 1, 1996. See also, "Crime," in Association of American Physicians and Surgeons *News*, Vol. 52, No. 6 (June 1996), p. 1.

lost each year to "waste, fraud and abuse," and to stop overcharges in private plans. While fighting Medicare fraud is a public necessity,[8] Congress also must recognize that doctors, hospitals, and patients today labor under more than 22,000 pages of Medicare rules, regulations, and guidelines[9] (including a cumbersome, counterproductive, and often silly system of price controls). Busy physicians, pressed for time and handling an ever larger caseload of elderly patients, can be fined $2,000 for a simple error in filing a claim or coding a treatment or medical procedure.

Under the current regime for coding of medical diagnosis and treatment, over 7,000 codes identify the specific medical services, treatments, or procedures deemed "appropriate" under conditions specified by officials of the Health Care Financing Administration (HCFA), the federal agency that runs Medicare. Even worse, Congress in recent years has deliberately increased the administrative burdens and pressures on physicians. Since 1989, Congress has ordered that all physicians, whether "participating" or not, must submit all claims for all Medicare beneficiaries and absorb the additional administrative costs of doing so. Doctors and patients who wish to contract privately to escape these intrusions are threatened with sanctions by HCFA.[10] Congress thus far has done nothing substantial to reverse either HCFA's bureaucratic excesses or the mounting paperwork burdens on doctors and patients under Medicare.[11]

Medicare's very structure, which allows contractors to process claims and reimburse doctors and other providers with large amounts of other people's money, is an open invitation to fraud, waste, and corruption. With this legislation, however, Congress is attempting to correct the system's inherent flaws without changing the structural dynamics that help to generate them. The best way to combat Medicare fraud is to reform the system as outlined in studies by the Heritage Foundation: to bypass contractors and providers altogether[12] and give each beneficiary a defined contribution. With appropriate consumer protections, this would allow seniors to select their own plans and doctors and pocket any savings from these personal choices. Moreover, direct patient payment and private contracting between doctors and patients through medical savings accounts, which enable patients to avoid the entire claims process for small bills, would add immeasurably to the honesty and integrity of health care transactions.

There is an urgent need to root out fraud and abuse in Medicare, but the sweeping language of both the House and Senate bills goes well beyond this one program. For example:

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8 For an overview of the nature and extent of Medicare fraud, see John C. Liu and Robert E. Moffit, "A Taxpayer's Guide to the Medicare Crisis," Heritage Foundation *Talking Points*, September 27, 1995, pp. 15-18.

9 Based on a 1993 estimate by the Progressive Policy Institute.

10 In *Stewart v. Sullivan*, 816 F. Supp 281 (1992), federal judge Nicholas Politan ruled that the Secretary of HHS had not articulated a clear policy against private contracting. Thus, there is a discrepancy between statutory and existing case law. Congress should clear up the confusion and allow patients the make the choice to contract privately.

11 During the 102nd Congress, then-Representative Roy Rowland (D-GA), developed an excellent series of recommendations to reduce the "hassle factor" for physicians in the Medicare program; but when some of his proposals were incorporated into broader legislation, they were watered down by liberals in Congress.

12 See Stuart M. Butler, John C. Liu, and Robert E. Moffit, "What To Do About Medicare," Heritage Foundation *Backgrounder* No. 1038, June 13, 1995. See also Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (Winter 1995), pp. 47-62.

✓ **New Federal Crimes.** Title II, Subtitle E, Section 241 of H.R. 3103 would create a new category of crime, "Federal Health Care Offenses," to include such offenses as embezzlement or criminal conspiracy related to a "health care benefit program." The House language describes a "health care benefit program" as "any public *or private* plan or contract, affecting commerce, under which any medical benefit, item or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract."[13]

✓ **New Federal Penalties.** Under Section 242 of the House bill, doctors or other providers could be sent to jail for 10 years if they misapply any assets used in health care, and could be sentenced to life in prison if their wrongdoing results in a death. They also would go to jail for five years if they obstruct a health care investigation. Under the federal criminal code, persons can be liable for criminal prosecution if they "knowingly and willfully" do something illegal, including such crimes as threats against the President of the United States, false claims for federal pensions, or destruction of an energy facility.[14] But under the House fraud and abuse language, doctors and other providers are not held to this standard. Officials of the American Medical Association and 37 other professional medical societies have been compelled to observe that "Vague and unfocused language could easily discourage appropriate behavior. Legitimate disagreements regarding medical judgment and treatment decisions should not be cause for imposing legal penalties."[15] Under Section 244, fines and jail terms would apply universally, not just to doctors: "Whoever, in any matter involving a health care benefit program" made false statements "knowingly" in connection with the delivery of or payment for health care benefits could be fined or imprisoned for up to five years.

✓ **New Federal Programs.** Both bills would create new federal programs to combat health care fraud and abuse through the coordinated efforts of the Attorney General, the Justice Department, and the Secretary of Health and Human Services (HHS). Section 201 of the House bill and Section 501 of the Senate bill would create a new "Fraud and Abuse Control Program" which would coordinate federal, state, and local law enforcement; conduct investigations, inspections, audits, and evaluations; and undertake enormous data collection on the financing and delivery of health care services in both the public and private sectors. Both bills would require the Attorney General

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13 See Health Coverage Availability and Affordability Act of 1996, Title II, Subtitle E—Revisions to the Criminal Law, Section 241, Definitions Relating to Federal Health Care Offense; emphasis added.

14 Memorandum to Senate Finance Committee, Hon. William V. Roth, Chairman, from Sidley and Austin, (Jack R. Bierig and David B. Toscano on behalf of the American Medical Association), concerning "Intent Requirement in Fraud and Abuse Provisions of Proposed Health Insurance Reform Legislation," April 18, 1996, pp. 7-8. Counsel for the AMA further noted that "We are not aware of any congressional efforts to have this standard deleted from federal criminal statutes. On the contrary, the standard serves a particularly salutary purpose when the proscribed conduct is not obviously evil or inherently bad. In particular, by limiting the stigma of criminality to conduct undertaken with knowledge that it is wrong, it helps to maintain the moral underpinnings of criminal laws and to assure that these laws are not used simply for routine regulatory purposes." *Ibid.*, p. 2.

15 Letter to the Honorable Newt Gingrich, Speaker of the U.S. House of Representatives, from the American Medical Association, May 1, 1996, p. 1.

and Secretary of HHS to issue guidelines to carry out this new program; these guidelines, however, would not be subject to the public notice and comment, public hearing, and record-keeping provisions that generally govern the issuance of federal rules under the administrative procedures statute in Title 5 of the U.S. Code.[16]

✓ **New Federal Funding.** Section 201 of the House bill and Section 501 of the Senate bill would establish a new "Health Care Fraud and Abuse Control Account" in the Hospital Insurance Trust Fund. This account would receive monies from fines, civil monetary penalties, or property forfeitures and would provide, over a period of seven years, $820 million to the HHS Office of Inspector General and another $330 million to the Department of Justice for additional prosecutors. If convicted of fraud, doctors and other providers would be required to pay stiff civil penalties, forfeit property, and pay for the investigations against them. Section 202 of the House bill and Section 502 of the Senate bill also would authorize a new "Medicare Integrity Program." Under this program, the federal government would enter into agreements with private contractors to police Medicare and review the practices of doctors, hospitals, and other providers in combating Medicare fraud and abuse, with contractors subject to limited liability for "actions taken to carry out a contract" under the program.

✓ **No Fraud and Abuse Sanctions for Congress's Own Plan.** Under both bills, Congress would apply federal "kickback" sanctions not only to doctors and providers in Medicare, but also to all "federal health care programs." Both bills define the applicability of new federal sanctions, but both also make a notable exception for the Federal Employees Health Benefits Program (FEHBP), which covers Members of Congress, congressional staff, and other federal workers and retirees. Section 204(a)(7) of the House bill specifies that "For the purpose of this section, the term federal health care program means (1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United states Government (other than the health insurance program under Chapter 89 of title 5, United States Code), or (2) any state health care program, as defined in Section 1128(b)."[17]

✓ **Bigger Fines on Doctors.** Fines for incorrect filing of claims or miscoding in Medicare currently are $2,000 per instance or error. Under Title II, Subtitle D, Section 231 of H.R. 3103 and Section 531 of S. 1028, doctors could be fined up to $10,000 for each time they deliver medically improper or unnecessary health care services. In the House bill, this dramatic increase in federal fines for incorrect coding or delivery of medically unnecessary services is accompanied by a clarification of the level of knowledge required for imposition of higher fines. Under Section 232, a doctor "should know" that he is submitting an incorrect or medically unnecessary claim if he acts in "deliberate ignorance of the truth or falsity of the information" or in "reckless disregard for the truth or falsity of the information." Remarkably, "no proof of spe-

16 According to the House bill's new Section 11128 c(a)(3)(A), "The provisions of section 553, 556 and 557 of title 5, United States Code, shall not apply in the issuance of guidelines." See Health Coverage Availability and Affordability Act of 1996, Title II; identical language is found in Section 501 of S. 1028.

17 Chapter 89 of Title 5 governs the Federal Employees Health Benefits Program (FEHBP). Identical language is found in the Senate bill; see S. 1028, Title V, Section 504.

cific intent to defraud is required."[18] Sponsors of the House bill, and staff representing them, claim these new anti-fraud provisions would improve the legal situation for doctors.[19] Meanwhile, physicians are forced to contend with often aggravating bureaucratic determinations of what constitutes medical necessity. In Medicare, as a practical matter, it is officials of the Health Care Financing Administration—not patients and doctors—who define what is "medically necessary," regardless of what a doctor or specialist, or even a professional medical society, may regard as necessary or appropriate.

✓ **Jail Time for Medicaid and Fines for Home Health Care Fraud.** Title II, Subtitle B, Section 217 of H.R. 3103 creates a new federal crime for citizens who "knowingly and willfully" dispose of assets to qualify for Medicaid. Offenders could be fined $25,000, jailed for five years, or both. Under Section 233, doctors also could be fined $5,000 or more for certifying that a patient who does not meet all the legal or regulatory requirements is eligible for home health services.

✓ **New Federal Standards.** Section 252 of the House bill would establish new standards for "administrative simplification" for public and private insurance and a massive data collection program. These standards would govern data, medical, and diagnostic codes, as well as codes for "any information, whether oral or recorded in any form or medium" that is "created or received by doctors or other health care providers" or a "health plan, public health authority, employer, life insurer, school or university or clearinghouse." Health information "relates to the past, present or future physical or mental health condition of an individual, or the past, present or future payment for the provision of health care to an individual."[20] The Secretary of Health and Human Services would be required to adopt "standards with respect to the privacy of individually identifiable health information" used, gathered, or transmitted in various health care transactions. Finally, a "General Penalty for Failure to Comply With Requirements and Standards" would give the Secretary of HHS the authority to "impose on any person who violates a provision of this part a penalty of not more than $100

18 See Health Coverage Availability and Affordability Act of 1996, Title II, Subtitle D—Civil Monetary Penalties, Section 232 (a)(2).

19 In the House report accompanying H.R. 3103, the sponsors write: "The current standard of 'knows or should know' is inconsistent with the Civil False Claims Act which applies to all other federal programs. Additionally, concerns have been raised that the standard currently applied by the Health and Human Services Department Office of the Inspector General may be less specific, and can result in the pursuit of allegations based on honest and simple mistakes where a provider had no knowledge of an alleged violation. The IG reports that the providers they generally pursue have shown deliberate patterns of abuse. Therefore, a modification in the intent standard should have no impact on the IG's ability to pursue offenders under this Act." *Report to Accompany H.R. 3103, The Health Coverage Availability and Affordability Act of 1996*, House Report No. 104-496, p. 96. Likewise, House Ways and Means Committee staff argue that Congress should make the standard for false claims under the Medicare law "consistent with false claims for all other sectors of the Government under the Federal False Claims Act." Under that standard, persons are liable for a violation if they "should know" that the claims they are filing are "false or incorrect."

20 See Health Care Coverage and Availability Act of 1996, Subtitle F—Administrative Simplification, Section 252.

for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000."[21]

✓ **Calling in the FBI.** The Federal Bureau of Investigation would be tasked with inspections, investigations, and prosecutions regarding health care matters and would receive $47 million in additional funding next year, and more in each succeeding year, for this purpose. This would supplement HHS's Medicare anti-fraud efforts, to be supported by more than $430 million in 1997, with increases each year thereafter.

Miscellaneous provisions. In the House-Senate conference, Members will make decisions on a variety of miscellaneous provisions covering such areas as medical malpractice reform, tax deductions for long-term care, administrative simplification of claims processing, and expansion of employer-based coverage under the Consolidated Omnibus Reconciliation Act of 1986 (COBRA).

ANALYSIS OF PROPOSED HOUSE AND SENATE REFORMS

The stated goal of many liberals in Congress is to create a government-run or government-managed national health care system. Knowing that it is politically difficult to sell such a policy, however, they favor making discrete regulatory adjustments in the current system so that large, more heavily regulated employer-based networks can evolve more easily into something that looks like the Canadian health care system. It is critical that conservatives who favor creating a new system based on consumer choice and competition have a clear idea of what they are doing and why they are doing it in any legislation designed to advance "incremental" reform. If they do not, they very easily could make the current system worse.[22]

The Need for a New Tax Policy. While the bills' tax changes are welcome, they do not go far enough—although, to its credit, the Senate does formally acknowledge the problem in its version.[23]

The best market reform Congress can devise is only as good as a person's ability to buy a policy. Without equity in the tax treatment of health insurance, the bills' insurance provisions alone, including the mandate for guaranteed issue of health insurance, are not likely to slow the growth in the numbers of uninsured. Moreover, the bills do little to provide meaningful tax relief for the millions of Americans who lack job-based coverage and who are not self-employed. Congress should recognize the current bills' inherent

21 New section 1176 (a) "General Penalty," created under Section 252 of Subtitle F of the Health Care Coverage and Availability Act of 1996.

22 For a timely discussion of the problem of incremental reform that is particularly apt in connection with consideration of the Kassebaum-Kennedy legislation, see Stuart M. Butler, John C. Liu, and Robert Rector, "How 'Incremental' Health Care Reform Would Make Things Worse: The Rowland-Bilirakis Bill," Heritage Foundation *Issue Bulletin* No. 203, September 26, 1994.

23 "It is the sense of the Senate that the Congress should take measures to further the purposes of this Act, including any necessary changes to the Internal Revenue Code of 1986 to encourage groups and individuals to obtain health coverage, and to promote access, equity, portability, affordability, and security of health benefits." See the Health Insurance Reform Act of 1995, Title III, Section 301 (b), "Sense of the Senate."

limitations and plan to broaden health care tax credits for individuals and families without employer-sponsored health insurance in the next phase of health care reform.

Neither bill adequately addresses the fundamental problems in the health insurance market. In large measure, these problems derive not from a lack of sound rules and regulations on the setting or purchasing of health insurance benefits, but from distortions in the market created by the federal tax treatment of health insurance. By eliminating or reducing tax-generated market distortions, Congress could promote equity among Americans purchasing health insurance, improve the efficiency of state health insurance markets, make health insurance more affordable, and improve access to quality health care for working families.

The Portability Problem. Federal tax policy excludes employer-provided benefits (unlike other compensation) from the taxable income of workers. Portability is logically inseparable from this tax discrimination. When a worker leaves a company that provides health insurance, he cannot take his policy with him because the employer, not the employee, owns it. True market portability, unlike legislated portability, comes from the worker's being able to own his health insurance policy—just as he typically owns his life, auto, or homeowner's insurance—so that he does not lose his and his family's health insurance if he loses his job. The only way to solve this problem is by changing the federal tax code to remove the disincentive against families' buying and owning the policies that best suit their own wants and medical needs.

The Equity Problem. Virtually every analysis of the current tax treatment of health insurance in the United States shows that the tax exclusion is profoundly regressive and inequitable.[24] The biggest breaks go to individuals and families who need them the least: well-paid, high-income families in large corporate health plans. Low-income workers in small or medium-size businesses, or those who purchase health insurance on their own, get relatively little help in terms of tax support. This is bad health policy, bizarre social policy, and terrible tax policy.

Without significant tax reform, federal insurance reforms could aggravate adverse selection and the segmentation of health risks in the individual health insurance market. Healthy individuals, lacking the same tax incentives available to healthy individuals within employer-based systems, will be more likely to decline insurance, while those who are sick will be more likely to purchase individual coverage.

For individuals and families having to pay the full range of federal and state taxes, and with only limited tax relief to offset the cost for the self-employed, the price of a health insurance policy that resembles a typical corporate employee health policy could still be more than 50 percent higher for a similar range of benefits.[25] Congress recently restored

24 For an excellent discussion of this problem, see Robert B. Helms, "The Tax Treatment of Health Insurance: Early History and Evidence," paper presented to a conference on "A Fresh Approach to Health Care Reform" sponsored by the Galen Institute, Washington, D.C., March 25, 1996.

25 "The difference in tax treatment creates a disparity that effectively doubles the cost of health insurance for those people who must purchase insurance on their own. For example, the family of a self-employed person earning $35,000 per year, having to pay federal and state taxes with only a 25 percent deduction, and having to pay social security taxes, must earn $7,075 to pay for a $4,000 health insurance policy. A person working for a small business that offers no health insurance would have

the limited tax deduction for the self-employed, increasing it to 30 percent. But even with this modest improvement, enacted last year, the disincentive remains. This disparity in price and tax treatment can be relieved only by making tax relief far more generous for consumers in the individual market, thereby giving young, healthy individuals and families an incentive to buy such policies. Otherwise, only those who intend to use their health insurance most aggressively to get a greater return on benefits than the cost of the policy are likely to take advantage of the portability provisions in H.R. 3103 and S. 1028.

The Problem of Choice. Today's federal tax policy undermines individual choice for those with job-based insurance because employers, not employees, make decisions about what kind of plan they have and what kinds of premiums, or prices, they pay for medical and insurance services. In other words, the customer (the employer) is distinct from the consumer (the employee) who uses these services. This anomaly, which exists almost nowhere else in the American economy, profoundly undermines the efficiency of market forces in the health sector and explains the often bitter antagonism between labor and management over the provision of company-based health insurance. It leads many companies to try to contain costs by forcing employees into less expensive managed care plans in which employees often lose their choice of a doctor or specialist or find themselves and their families subject to various insurance restrictions. Moreover, to the extent that managed care plans are less expensive than traditional fee-for-service plans, the companies, not the workers and their families, often pocket the savings from this transition. Congress would be well advised to be guided by one important principle: There is no normal market without consumer choice. And there can be no consumer choice unless providers are permitted to compete for consumer dollars.

The Inadequacy of Health Insurance Reforms. Legislative attempts to reform health insurance, at both the federal and state levels, are largely attempts to compensate for distortions of the health insurance market caused by tax policy. By focusing its efforts on legislating rules for health insurance in the individual and group markets without at the same time facing the consequences of the federal tax treatment of health insurance, Congress is addressing the symptoms, not the causes, of the problem in both markets.

State Experience. Congress is on the threshold of imposing unprecedented levels of federal regulation on state insurance markets. Members should realize that, at the state level, the results of similar reform have been mixed at best. In some states, they have been disastrous, and ambitious measures overhauling state health insurance markets, as in Minnesota and Washington State, have been scaled back.[26]

State health care reform efforts are inherently limited. States can change insurance regulations, the rules governing health benefits, and the licensing of doctors and hospitals and other medical providers. They can impose various counterproductive rate regulations. But because they cannot change the federal tax treatment of health insurance—the very

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to earn $8,214 to pay for that $4,000 policy." Michael D. Tanner, *Getting off the Critical List: A Prescription for Health Care Reform in Georgia*, Georgia Public Policy Foundation, 1992, p. 74.

26 See Charles Baker, Ken Heithoff, M.D., and Representative Phil Dyer, "Lessons on Reforming Health Care at the State Level: Massachusetts, Minnesota, and Washington State," *Heritage Lecture* No. 548, June 13, 1995.

thing that drives and shapes the insurance market—they cannot alter the basic dynamics of the health care system. Only Congress can do that.

Guaranteed Issue. Insurance reforms of the sort found in the House and Senate bills are popular, but there are legitimate concerns among economists about group-to-individual market portability provisions in both bills. The concern is that the individual market will become the insurance pool of last resort for the sickest and most unhealthy citizens. A disproportionate number of sicker enrollees would drive up health insurance costs, making it more difficult for both insurers and enrollees to market or buy affordable policies. The best remedy is more generous tax relief for individuals and families so that greater numbers of younger and healthier people can enter the individual market. Without significant reform of the tax treatment of health insurance, guaranteed issue could be troublesome in the individual health insurance market.

With a guaranteed issue requirement, an increase in the cost of individual health insurance is likely. But estimates of the impact vary. The American Academy of Actuaries, which represents the actuarial profession in matters of public policy, says that costs in the individual market would rise only a modest 2 to 5 percent.[27] Likewise, Rand Corporation analysts estimate that premiums under the Senate bill would rise anywhere between 1 and 5.7 percent.[28] Health insurers are far less optimistic. For example, the Health Insurance Association of America (HIAA) projects that guaranteed issue would result in premium increases ranging over time from 10 and 30 percent in the individual market.[29]

For many, including supporters of H.R. 3103 and S. 1028, the problem of rising premiums is a real one; for others, however, it merely presents an opportunity to impose a federal regulatory agenda on the health care system that was thwarted by opponents of the Clinton health plan and its various congressional incarnations. Notes David S. Broder, veteran political columnist for *The Washington Post*: "Although the Clinton Administration supports the [Senate's] Kassebaum-Kennedy Bill, some of its health care experts privately agree that the measure as it stands would create 'significant instability' in the insurance market—and a need for new regulation."[30]

Unintended Consequences. One disturbing feature of this year's health insurance debate is that the primary Senate sponsors see the legislation as a stepping-stone to actions that many Americans would find unacceptable.

Commenting on this likelihood, Senator Nancy Kassebaum (R-KS) revealed that some Senators were seriously considering price controls on health insurance premiums to deal with the anticipated problem:[31] "That's why we gave the states so much flexibility....A number of us thought that capping premiums would be a good idea, but we chose not to

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27 According to health care expert Grace-Marie Arnett, Vice President for Information Marketing at The Heritage Foundation, this estimate did not account for the behavioral impact of the guaranteed issue requirement.

28 "Kassebaum Kennedy Bill Would Have Little Effect on Rates, Rand Says," Bureau of National Affairs *Daily Report for Executives*, April 17, 1996, p. 4.

29 *BNA Health Care Policy Report*, Vol. 4, No. 9 (February 26, 1996), p. 341.

30 David S. Broder, "Kennedy-Kassebaum and the Law of Unintended Consequences," *The Washington Post*, April 28, 1996.

31 For an in-depth discussion of this recurrent issue, see Edmund F. Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Costs," Heritage Foundation *Backgrounder* No. 929, March 8, 1993.

do it and instead let the states decide how to handle the problem."[32] But if premiums rise and states resort to Clinton-style caps, the inescapable result will be huge market distortions.

Liberals in Congress and elsewhere, who have a clear vision of their goal of a government-run and government-managed health care system, would seize on any regulatory problem created by this legislation as an excuse to extend federal regulation. Nick Littlefield, an aide to Senator Edward Kennedy, who is a long-time supporter of national health insurance and cosponsor of the Senate bill, says: "It may be that the ultimate effect of our bill is to lead the government to take further steps to increase coverage and control costs of health care. My boss still wants universal coverage with cost containment, so from his point of view, the foot in the door is a good thing."[33]

Fines and Penalties. Congress should refrain from imposing extensive federal standardization of private insurance markets, replete with ambitious and intrusive data collection, fines, or penalties. H.R. 3103 and S. 1028 would create a new series of federal crimes, imposing fines and penalties on doctors and other providers that resemble the most oppressive features of the discredited Clinton plan. Not surprisingly, these provisions were enacted with little fanfare—and with little apparent appreciation of their content, particularly in the more conservative House of Representatives.

Federal fines and penalties are an understandable response to fraud, particularly in the Medicare program. Extensive policing is endemic to bureaucratic systems of health care delivery. A system of central planning and price controls requires tighter and tighter rules to stop the gaming that the system itself encourages, with regulators trying to close an ever-growing number of escape hatches for providers. The way to stop this escalating spiral is not by further federalizing and criminalizing health care, but by giving individual consumers more direct control over decisions about their health coverage. The free market is the best anti-fraud measure ever devised.

WHAT CONGRESS SHOULD DO

Congress should not enact health insurance reforms without simultaneously enacting significant reforms in the tax treatment of health insurance, because such reforms can be successful only if coupled with significant changes in the federal tax code. Changes in the federal tax code will subject insurance companies and those providing medical services to the discipline of consumer choice and competition, and thus make both health insurance and health care services more affordable for working families.

Given the strengths and weakness that exist in both H.R. 3103 and S. 1028 as currently written, Congress should retain key features of both bills and substantially modify or eliminate others. Specifically:

32 Broder, "Kennedy-Kassebaum and the Law of Unintended Consequences."

33 *Ibid.*

❶ **Give all American families the right to have medical savings accounts.** MSAs are a major contribution to health care reform; they empower patients and allow both doctors and patients to avoid the burdensome bureaucracy of highly regulated third-party payment systems for routine medical services. MSAs would help people regain control over their own choices, provide greater insight into the full cost of medical bills, and give people incentives to act on their own to restrain costs. Best of all, individuals and families would be able to keep the savings from making prudent health care choices. Estimates of the number of persons who would choose an MSA vary. According to estimates of the Joint Tax Committee, middle-class families most likely would choose this option. Of the projected number of taxpayers who would participate in an MSA option, 51.5 percent would be making between $50,000 and $75,000 per year; and almost 78 percent of the total of those participating in such an option would be making $75,000 per year or less.[34]

Medical savings accounts would engender intense competition among providers and health plans, and thus introduce unprecedented levels of economic efficiency into the American health care system. But the principal reason Congress should adopt MSAs is that they restore to individuals and families a measure of personal freedom, the highest value in the American political tradition.

Under the House bill, if an individual received health insurance through an employer, the employer could contribute up to $2,000 a year ($4,000 a year for a family) to the employee's medical savings account. An individual whose employer did not provide insurance, who was uninsured, or who was self-employed could contribute to his own MSA and deduct the amount deposited (up to $2,000 for an individual and $4,000 for a family). Money spent for medical expenses is considered pre-tax; otherwise, it is subject to income tax plus a 10 percent surcharge, just as withdrawals from an individual retirement account (IRA) are penalized. Money left in the account can be carried over from year to year with tax-free buildup of reserves.[35]

MSAs have been endorsed by many health care economists as a way to reduce administrative costs. Doctors see them as a way to protect the integrity of the doctor-patient relationship. Among prominent Members of Congress, Senate Minority Leader Thomas Daschle (D-SD) and five colleagues signed a September 8, 1992, letter[36] nicely outlining the case for MSAs:

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34 "Anticipated MSA Participation, Percentage of Taxpayer Returns By Income Class," Joint Committee on Taxation, U.S. Congress, April 1996. The analysis was made in connection with the MSA provisions of the House bill and is based on assumptions about classes of taxpayers who might be offered an MSA as an employer-provided plan or who might elect to participate in an MSA. The committee estimates that of persons choosing to participate in an MSA, the highest usage would be among "high middle income classes."

35 Another prominent alternative is to set up MSAs with after-tax dollars, with tax credits provided to individuals to assist in the purchasing of catastrophic health insurance. For a description of this approach, see Mark V. Pauly and John C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs*, Vol. 14, No. 1 (Spring 1995), pp. 125-139.

36 "Dear Colleague" letter on the Medical Cost Containment Act of 1992 (S. 2873) signed by Senators John Breaux of Louisiana, Richard Lugar of Indiana, David Boren of Oklahoma, Daniel Coats of Indiana, Thomas Daschle of South Dakota, and Sam Nunn of Georgia.

> Unlike many standard third party health coverage plans, Medical Care Savings Accounts would give consumers an incentive to monitor spending carefully because to do otherwise would be wasting their "own" money. That is, money that they would otherwise be able to save in their account for future needs.
>
> Once a Medical Care Savings Account is established for an employee, it is fully portable. Money in the account can be used to continue insurance while an employee is between jobs or on strike. Recent studies show that at least 30 percent of the uninsured are uninsured for four months or less.
>
> Today, even commonly required small dollar deductibles (typically $250 to $500) create a hardship for the financially stressed individual or family seeking regular, preventive care services. With Medical Care Savings Accounts, however, that same individual or family would have this critical money in their account to pay for the needed services.

Likewise, House Minority Leader Richard Gephardt (D-MO) included an MSA option in his own comprehensive health care reform legislation in 1994, noting during a broadcast interview on the subject of health care reform legislation that "This is an idea the Ways and Means Committee has worked on for three or four years. It's very popular. A lot of people like this option and I think it will be in the final bill. I think it's a great option."[37]

In forging the final health care reform legislation, Congress should retain the House guarantee that MSAs would be available to everyone. It is a step toward tax equity and a major component of middle-class tax relief.

❷ **Be even more generous to working families by further liberalizing tax breaks for health insurance.** As noted, the tax benefits from purchasing health insurance are far from the same for all Americans:

- ☞ The self-employed can deduct only 30 percent of the cost of their health insurance premiums.
- ☞ Those who are not self-employed and do not have employment-based health insurance can deduct the cost of health insurance only when their insurance and medical bills exceed 7.5 percent of their adjusted gross income.
- ☞ The federal tax code allows only those with job-based health insurance to receive all of their health insurance tax free.

Both the House and Senate bills take a first step toward recognizing this inequity, but Congress must go further if portability for the individual insurance market is to work.

The ideal policy, outlined in detail by analysts at The Heritage Foundation, would be a national and comprehensive system of tax credits, as well as vouchers for low-income persons, available to all American families and individuals, regardless of their place of work or even their status of employment.[38] Far short of this would be tax equity—100

37 Interview with Mary Matalin on "Equal Time," CNBC, Tuesday, August 3, 1994.

percent deductibility for health insurance—for all Americans, regardless of their status of employment. At a minimum, Congress should focus first on assuring greater equity in tax benefits to help more working families buy health insurance to protect themselves against the financial devastation of serious illness.

❸ **Sunset federal regulations in the individual market.** Both bills would impose new federal regulations (including guaranteed issue and renewability requirements) on the individual health insurance market, making these rules a normal part of doing business. Over time, as employers, employees, and insurance companies became accustomed to them, these new rules would become part of the culture of the industry. If Congress does approve such a measure, it also should specify a date certain—say, after seven years—for the return of health insurance regulation to the states. Such a sunset provision would accord well with the principles of federalism.

❹ **Use tax policy to create a level playing field for health insurance plans.** The various health insurance market reforms in both bills, particularly the guaranteed issue requirement, concern health insurers, who feel that forcing them to offer policies to individuals who move from the group market to the individual market would destabilize the market for individual health insurance. They believe that this "group-to-individual mandate" would cause premiums to rise for everyone, prompting the healthiest and the less wealthy to drop coverage. Critics point to the experience of several states that have tried similar legislation.[39] In Washington, for example, the cost of some insurance policies increased by 34 percent, and some insurers are pulling out of the market altogether.[40]

Any negative impact caused by a guaranteed issue requirement, including rising premiums, should be softened by strengthening consumer choice and competition in the individual market. This can be done by creating a level playing field between consumers in the individual market and those enrolled in employer-based health insurance. Specifically, Congress can give younger, healthier individuals an incentive to purchase such a policy by giving them the same tax breaks now reserved for workers who have employer-based insurance. Failure to establish tax equity in this manner, on the other hand, could lead to higher premiums and even, as Senator Kennedy's aide indicated, to a Clinton-style regulatory solution.

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38 For a description of the Heritage Consumer Choice Health Plan, see Stuart M. Butler and Edmund F. Haislmaier, *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); 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; Stuart M. Butler and Edmund F. Haislmaier, "The Consumer Choice Health Security Act," Heritage Foundation *Issue Bulletin* No. 186, December 23, 1993.

39 The Council for Affordable Health Insurance, a Virginia-based group advocating free market health care reforms, notes that because of guaranteed issue and community rating reforms, 350,000 people dropped coverage in New York; premiums for families in New Jersey doubled; and insurance rates in Kentucky, which expanded state mandated benefit coverage, also skyrocketed. Bureau of National Affairs *Daily Report for Executives*, April 10, 1996.

40 *BNA Health Care Policy Report*, Vol. 4, No. 4 (January 22, 1996), p. 112.

❺ **Preempt all state mandated benefits in the reform of the small group insurance market.** With few exceptions, health insurance is subject to a myriad of state rules and regulations. Among the most costly are state mandated benefits, invariably a product of successful lobbying in the state legislature by special-interest groups and medical practitioners seeking coverage for particular medical conditions or specialties. There are more than 1,000 of these mandated benefits at the state level, forcing insurance carriers to cover everything from alcoholism treatment and hair transplants to psychological services and in vitro fertilization. Moreover, the states impose special taxes on health insurance premiums. This combination of mandatory coverage and premium taxes drives up the cost of health insurance for workers and their families, especially those employed in small businesses. A 1988 study of the economic impact of mandates suggested that approximately 44 percent of firms without health insurance did not offer it because of the higher costs imposed by state mandated benefits. As observed by Professor Michael A. Morrisey of the University of Alabama, this "suggests substantial price sensitivity on the part of these workers and their employers."[41]

Large companies that self-insure can escape the burden of complying with state mandated benefits through the Federal Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, such companies are exempt from state mandated benefit laws and state regulation, and required to comply only with federal law. They also can avoid paying state premium taxes on their health insurance—yet another powerful incentive to self-insure. Congress, of course, has exempted its own health plans in the Federal Employees Health Benefits Program (FEHBP) from state premium taxes.[42]

Small businesses that do not self-insure are not so fortunate. They must comply with all state regulations, including mandatory benefit coverage requirements and extra tax burdens, making it doubly difficult for them to afford health insurance for their workers. Moreover, small employers lack the economies of scale and the power to bargain with health insurance companies, and thus cannot control the cost of policies as effectively as large companies. In effect, the state insurance market is operating under two sets of rules, with an uneven playing field between large and small businesses. For small businesses and their employees, this is a serious problem. Both House and Senate reformers would remedy this problem by creating pooling arrangements for small employers and thus imposing federal regulation, supposedly less onerous than state regulation in governing these relationships. In setting up these pooling arrangements, the House bill is superior to the Senate bill.[43]

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41 See Michael A. Morrisey, *Price Sensitivity in Health Care: Implications for Health Care Policy* (Washington, D.C.: National Federation of Independent Business Foundation, 1992), p. 3.

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

43 For a discussion of the comparative advantages of the House bill, see John C. Liu, "Why the House Health Insurance Reform Bill Would Help Achieve True Health Care Reform," Heritage Foundation *Backgrounder Update* No. 271, March 26, 1996.

Under both bills, the new business pooling arrangements would be exempt from state insurance rating laws and benefit mandates, but not from state premium taxes.[44] While this federal exemption from state insurance rating laws is designed to rectify the imbalance between large and small businesses in the small group health insurance market, it does not eliminate the uneven playing field. Under the House bill, for example, small employers would be able to join multiple employer welfare arrangements (MEWAs), such as those sponsored by trade or industry associations, or Voluntary Health Insurance Associations (VHIAs). Moreover, church and religious institutions also would be able to sponsor health insurance plans. Heritage Foundation scholars have long favored the dramatic expansion of group insurance options outside of the place of work, including plans offered by trade and professional associations, union and employee organizations, and even church and religious institutions. Such a broadening of health insurance options expands both consumer choice and real market competition.

Under the House bill, these associations would be exempt both from state laws that prohibit experience rating and from state mandated benefit laws. Because of the inequities of the current regulatory structure, they would enjoy an artificially competitive advantage over commercial insurance companies, which still are burdened by state regulation, state mandated benefits, and state premium taxes. In other words, by favoring one group of insurers over another, Congress would distort the state insurance markets even further with new legal and regulatory changes.

The health insurance market already is a regulatory mess, with some insurers throttled by state regulations and others operating under less onerous ERISA rules. Congress should not add another layer of regulation without forcing a net deregulation of the already overregulated health insurance market. The answer to competitive imbalance among insurers is not to maintain or increase regulation, but to extend deregulation. Therefore, congressional preemption of all state mandated benefits should be the condition for any new federal regulatory role. The only benefit condition imposed should be a requirement that insurers offer catastrophic coverage to protect workers and their families from the financial devastation of serious illness. Beyond that, insurers should be able to offer a variety of benefit packages, including those with high deductible plans. Since this is a federal preemption of state authority, albeit designed to broaden the access to health insurance, it should not be permanent. Congress, after a period of a few years, should sunset this preemption.

Such a measure would go a long way toward leveling the playing field among insurers, substantially reducing the costs of health insurance in the several states and making health insurance more affordable for workers and their families. If Congress does not preempt costly state mandated benefits, however, it will merely perpetuate the current unevenness in the nation's health insurance markets, aggravating the current distortions in these markets and adding to the cost of health insurance for American workers and their families.

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44 An earlier version of the House bill also included a preemption of state premium taxes. It was dropped in committee before HR 3103 passed the House of Representatives.

❻ **Drop the costly mental health mandate.** Broad and painful experience with the several states has shown that imposing mandates for specific health services has expensive secondary effects, including driving up the cost of health insurance and making it less available to individuals and families, particularly in small businesses. Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) added an eleventh-hour provision to the Senate bill that would require insurers to provide the same benefits for mental health coverage as for other illnesses.

This has profound significance: It is nothing less than an attempt by members of the U.S. Senate to impose a mandated benefit on private health insurance. People should be able to get medical care and insurance coverage for all illnesses, mental or physical. But whether to cover treatment for mental illness is an insurance contract issue, not an area for congressional intervention. Individuals and families (with tax relief to help offset the cost) should be able to purchase comprehensive catastrophic health insurance that covers all major illnesses, including mental illness, without imposing high costs on the private health insurance plans of other workers and their families.

Mandating this benefit for private insurance would impose huge new costs on America's working families. According to the Washington-based Association of Private Pension and Welfare Plans, the Senate amendment would raise company-based insurance premium costs by 8 to 11 percent.[45] The nonpartisan Congressional Budget Office (CBO) has estimated that premiums for traditional fee-for-service plans would increase by 5.3 percent because of this provision alone, while managed care plans would see an extra increase of 4 percent.[46] Recognizing that workers and their families, rather than employers, invariably bear the real cost of any mandated benefits, the CBO says that many employers would respond simply by dropping benefits—or even health insurance altogether—for employees and their families.[47] For employers who retained the congressionally mandated package, the higher costs would simply be passed back to employees in lower wages. This reduction in family income also would mean a reduction in federal tax revenues of approximately $9.3 billion between 1997 and 2002.[48]

This federal mandate would affect the costs of some federal programs. The CBO notes that the language of the Senate amendment also would apply to the hundreds of private plans currently competing in the Federal Employees Health Benefits Program, the consumer-driven system that covers Members of Congress, federal workers and retirees, and their families. The CBO projects that the Senate mandate would impose $432 million in additional costs on the FEHBP between 1996 and 2002, rising to $739 million by 2005.[49] And this probably is a conservative estimate.

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45 Albert G. Holzinger, "Final Health Care Bill Could Be Good or Bad," *Nation's Business*, June 1996, p. 6.

46 Letter from June E. O'Neill, Director of the Congressional Budget Office, to the Honorable Nancy Landon Kassebaum (R-KS), April 23, 1996, p. 1.

47 *Ibid.*

48 *Ibid.*

49 *Ibid.* There is historical precedent for a discussion of this mandate in terms of federal employees. When the Reagan Administration decided to order a round of benefit cutbacks in 1982 to deal with a $440 million shortfall in the FEHBP,

The CBO notes that it is not at all clear whether the Senate mandate would apply to Medicare or Medicaid. If it did, Medicare outlays could increase by almost $80 billion between 1997 and 2002, and Medicaid costs could rise by another $35 billion during the same period.[50] Most of these extra costs also would be borne by working families.

As long as employers, rather than employees, own private health insurance policies and are on the receiving end of such government mandates, the political dynamics of the system will foster the imposition of these mandates and their increased costs. The only brake on these dynamics is employee ownership of health insurance policies, in which the high costs of these mandates are direct, rather than indirect, and transparent to workers and their families.

❼ **Drop the Clinton-style fines and penalties on doctors.** Medicare fraud is obviously a disgrace. The bills' rewards to patients for reporting it should be retained. But new fines and threats of fines for filing incorrect claims or performing medically unnecessary procedures, especially when added to the mountain of regulatory paperwork that already burdens physicians, would be even more confusing for doctors and patients who still have trouble keeping track of HCFA's rules. Faced with stiffer fines, and with no standard of willful intent required as a basis for determination of physician liability, doctors would have to spend even more time trying to keep abreast of the latest federal decisions on what constitutes correct coding or medically necessary or appropriate treatment. Other medical providers, as well as nurses and health plans, would be forced to focus even more closely on whether they are filing claims correctly or complying properly with statutory provisions, waiting all the while for the next avalanche of regulations, interpretations, and guidelines born of changes in federal law. Health care costs for workers and their families inevitably would rise as doctors, hospitals, and medical facilities were forced to devote even more resources to defensive and necessary paperwork, or to produce information to justify themselves to government bureaucrats.

Congress should establish clearly both the nature and extent of the fraud problem in the private sector before legislating in this area[51] and usurping yet another responsibility of state law enforcement. If they do so, they can fashion effective legislation that has the benefit of full-scale full hearings and deliberation, especially with respect to the character and extent of fraud in private sector plans.

With respect to Medicare, Congress should address the fraud issue in conjunction with the administrative burden on both doctors and patients in the program. First, lawmakers should stop the practice of imposing civil monetary penalties on Medicare

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private carriers included in those cutbacks a reduction in mental and nervous coverage for federal workers and retirees. In response, liberals in Congress proposed to legislate a mandatory mental health benefit in the FEHBP, bypassing the normal process of sensitive negotiations between OPM and private carriers. But when the extra costs of such a mandatory benefit became apparent to liberal congressional staff, particularly the extra costs to be borne by federal workers and retirees, the effort died quietly.

50 *Ibid.*, p. 2.

51 The General Accounting Office has done extensive and solid research in the area of Medicare fraud, but much less so in the area of private sector fraud. This would be a fruitful enterprise for GAO investigators.

physicians who do not know that their coding of treatments or use of certain procedures is prohibited. As officials of both the American Medical Association and the American Hospital Association have observed:

> Coding health care services for purposes of Medicare billing often is subjective, and more than one code may be appropriate. Variations in coding generally do not constitute fraud, yet under provisions in the House and Senate bills, innocent coding decisions could trigger civil monetary penalties. Likewise, a determination of whether services are "medically necessary" is by nature a subjective judgment, and should not be challenged as fraud (unless there is a specific intent to defraud the system).[52]

Second, lawmakers should reaffirm the intent of Congress that Medicare beneficiaries have the right to enter into private contracts with their physicians if they choose to do so and can pay their physicians out of pocket for the services they want without submitting claims for these services to Medicare.[53] Under a private contracting arrangement, no Medicare reimbursement claims would be filed because no such claims would be sought by either doctor or patient. This exercise in personal freedom would impose no cost on the taxpayers.

In any case, after resolving the specific issues raised by these bills, Congress should undertake an aggressive review of the entire regulatory system governing Medicare, including the application of the DRG system for hospitals and the RBRVS for physician reimbursement, especially the transactional costs to doctors and hospitals of complying with Medicare's regulatory regime and its indirect costs to the private sector.

It is ironic that at the very time Congress is concerned about the shortage of doctors serving the elderly, and about trying to rein in federal regulation and devolve more power to the states, it is thinking of adding to the confusion and paperwork already imposed on doctors and patients by the Health Care Financing Administration. Even worse, it is thinking of broadening the federal power to go after doctors, hospitals, and health plans in the private sector—power eerily similar to that exercised by the Internal Revenue Service.

❽ **Allow rollover of existing flexible spending accounts.** Current law allows millions of American workers and their families to deposit money tax free in a spending account to help pay for routine medical services. Under these Section 125 flexible spending plans, however, employees who put tax-protected money into these accounts must use it before the end of the year or lose it. Allowing workers to roll over any unspent money from one year to the next would provide an incentive for more cost-consciousness, would enable them to build up accounts to protect themselves

52 Letter to Members of the U.S. House of Representatives and U.S. Senate from the American Hospital Association and the American medical Association, May 17, 1986, p. 2.

53 In trying to rectify the current inequities and end bureaucratic threats from HCFA officials, Senator Jon Kyl (R-AZ), and 12 Senate colleagues have introduced S. 1289, the Senior Citizens Health Care Freedom to Contract Act.

and their families against unexpected medical bills, and would help fund their health insurance premiums in the event they lose or change jobs.

⑨ **Forget the COBRA extension.** Section 121 of the Senate bill would expand coverage under the Consolidated Omnibus Reconciliation Act of 1986 (COBRA). Under COBRA today, workers in a firm with over 20 employees can remain insured between jobs by continuing their enrollment in the company health plan and paying the full premium for up to 18 months after leaving the company. In the event of a worker's death or divorce, company-based coverage can remain in effect for up to 36 months for his spouse and children.

The Senate wants to extend COBRA coverage an additional 11 months for individuals with disabled family members or individuals who have become disabled under their initial COBRA extension period. While COBRA is a popular law, Congress should realize that any extension increases the cost of health insurance to employers, and that this increased cost is passed on to workers and their families. While healthy ex-employees may decline COBRA coverage, forgoing full payment for the company's benefit package, unhealthy or disabled ex-workers are likely to sign up for the extension. But while the ex-employees pay the premiums, the higher claims costs are passed back to the firm and its pool workers and their dependents. Direct tax relief to families with higher health care costs is a much better solution to the problem than imposition of yet another mandate on small business.

⑩ **Tell workers and their families the truth about who pays for health care.** A major obstacle to serious health care reform is that too many Americans still think their employer is paying for their health care. Under an employer-based system, the employer transmits the payment for health benefits to the insurance company, and receives a tax benefit for doing so, but 100 percent of the cost is borne by households. Health benefits, like wages, are part of total compensation, and any increase in health benefits is largely offset by a decrease in wages and other compensation. As C. Eugene Steuerle and Gordon Mermin of the Urban Institute note, "Even to this day... few employees get regular statements with their paychecks on how much health insurance is costing them. They then have little understanding of how to bargain with employers to receive higher wages in lieu of a still more generous health care plan."[54]

Congress can close this knowledge gap by requiring, as a condition of tax deductibility, that every employer include a periodic statement on the employee's pay stub specifying the amount the employer has paid in health benefits and the corresponding amount by which the worker's wages and other compensation have been reduced.

54 See C. Eugene Steuerle and Gordon B. T. Mermin, "A Better Subsidy for Health Insurance?" paper presented to a conference on "A Fresh Approach to Health Care Reform" sponsored by the Galen Institute, Washington, D.C., March 25, 1996., p. 5.

CONCLUSION

In disposing of the many different provisions of the Senate and House bills, Congress will make major decisions that affect the lives of millions of Americans. It is a profound mistake to view incremental health care reform legislation as a series of statutory technical adjustments in health insurance rules, upon which all are vaguely agreed, and which have only neutral philosophical significance. That is not, and indeed cannot, be true. Every specific incremental reform of the complex American health care system can take Congress and the American people either closer to a genuine system of consumer choice and competition, one in which patients are free to make the key decisions that affect their lives, or closer to a more highly regulated system in which the key decisions are made by corporate or government bureaucrats.

Health insurance reform is not tantamount to reform of the health care system. Health insurance reform can make life better for millions of workers and their families, but it also has an enormous capacity to make matters significantly worse, especially in terms of high prices for insurance, greater restriction of the kinds of care and services workers and their families can get, and even reduced access to affordable health insurance coverage for America's workers and their families.

Robert E. Moffit
Deputy Director of Domestic Policy Studies[55]

55 Grace-Marie Arnett and Elizabeth Kern contributed to this paper.