



The Heritage Foundation
Background
Executive Summary

No. 1158

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A PROGRESS REPORT ON THE CLINTON HEALTH PLAN

CARRIE J. GAVORA

“Now, what I tried before [enactment of the Clinton health plan] won’t work. Maybe we can do it in another way. That’s what we’ve tried to do, a step at a time, until we finish this.”

—President Bill Clinton,
speech to the Service Employees International Union,
Washington, D.C., September 15, 1997

Four years ago, Congress soundly rejected the Clinton health plan. Since then, however, it has quietly adopted many key elements of that plan. Now Congress is considering more elements.

It is time to take a different route. To ensure that its health care reform efforts meet the needs of the greatest number of Americans, Congress should measure the merits of proposals against a basic commonsense standard. Any plan that would create a new federal health care subsidy program, expand an existing program, or include mandated benefits or access should meet this overriding standard: It should empower individuals and families to decide for themselves which health care options to choose. They should not give that power to their employers or to the government—that would only help accomplish the vision of the original Clinton health plan.

The key step now is to end the bias in the tax code favoring employer-purchased health coverage at the expense of individual coverage.

Short of ending the tax exclusion for employer-provided health plans, there are several steps Congress can take to lay a solid foundation for a truly consumer-based health care system in America. Specifically, any new health care policy should:

- **Encourage** employers to disclose the value of their health benefits plan to employees.
- **Allow** individuals to opt out of their employer-provided health coverage. This could be done, for example, by requiring employers to give employees the chance to opt in or out of the employer-provided health plan when they are hired and giving employees who choose to opt out the same tax break they would have had under an employment-based plan, or by allow-

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Table 1 B1158

How Congress Is Advancing the Failed Clinton Health Plan

Goal of Clinton Health Security Act	Action So Far by Congress	Proposals Before Congress
Standardize Benefits	Standardization of Some Benefits	Several Mandated Benefits Proposals Pending
Create Government Purchasing Alliances	Government Purchasing Alliances for Uninsured Children	—
Increase Federal Insurance Regulation	Guaranteed Issue Regulations, etc.	Regulation of Managed Care, Genetic Information, etc.
Regulate Doctor–Patient Relationship	Restrictions in Medicare on Private Contracts	—
Increase Federal Data Collection	New Government Standards for Data Collection	—
Control Medical Practice	“Fraud and Abuse” Program	Tighter Control in Medicare and Medicaid
Federal Regulation of Quality	Federal Regulation of Quality in Medicare Program	Quasi-Governmental Council to Set “Minimum” Federal Health Plan Quality Standards

ing individuals who do not like the employer-provided health plan to cash out the tax-free value of their employer-provided health benefits and use that money to buy a health plan of their choice.

- **Require** that any health plan covering an employee who chooses to stay in the employer-provided health plan obtain the employee’s signature on a contract agreeing to the terms and conditions of the plan.
- **Allow** individuals who do not have health coverage through their place of employment to deduct the full cost of an individual health plan from their taxes.
- **Require** that limitations on type, duration, and scope of the covered benefits and providers are specified clearly in contracts with individuals.

- **Allow** individual workers in company-sponsored health care flexible spending accounts (FSAs) to roll over unused funds in these accounts, penalty-free, at the end of the year.
- **Remove** or raise limits on individual contributions to FSAs.

Congress took nine months to air the intricate and confusing details of the original Clinton health plan, and a resounding plurality of Americans registered their opposition to it. They saw it as a dramatic attempt to shift private dollars and decision-making authority away from families and individuals to the federal government. Under pressure from the Clinton Administration, recent legislation implements central elements of the Clinton plan. It is time for Congress to take a different direction.

—Carrie J. Gavora is the Health Care Policy Analyst at The Heritage Foundation.



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In 1994, Congress and millions of Americans soundly rejected the Administration’s proposed 1,342-page Health Security Act.¹ Today, these Americans might well be surprised to learn that over the past four years, by quietly adopting essential components of the original Clinton plan, Congress has been progressing, steadily and incrementally, toward the President’s goal of a federally supervised health care delivery system based largely on heavily regulated managed care networks. Essential components of the original Clinton plan gradually are becoming federal policy that covers important sectors of America’s health care economy.

The Drift to ClintonCare

Rather than engage the Clinton Administration in serious public debate about what kind of health care system Americans should have, the 104th Congress passed the Kennedy-Kassebaum Health Insurance Portability and Accountability Act (HIPAA) and several arcane provisions of the Balanced Budget Act of 1997. These provisions—a series of detailed health regulatory changes enacted at the urging of the White House—put in place the infrastructure for a health care system based on the Clinton vision of nationalized health care. The congressional calendar today is filling with proposals for new

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1. For a comprehensive description of the original Clinton plan, see Robert E. Moffit, “A Guide to the Clinton Health Plan,” Heritage Foundation *Talking Points*, November 19, 1993.



Table 2

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How Congress Is Advancing the Failed Clinton Health Plan

What the Clinton Health Security Act (H.R. 3600) Would Have Done	Has Congress Accomplished Clinton Health Plan Objective?	Public Law 104-191 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) or "Kennedy-Kassebaum"	Public Law 104-204 1996 VA-HUD Appropriations Bill	Public Law 105-33 The Balanced Budget Act of 1997	Proposed Legislation (Not a complete list)
Standardize Benefits (Title I, Sub. B, Sections 1101-1128)	Partially Achieved (for some benefits)	—	Mandates 48 hour maternity coverage; modified mental health parity.	Mandates new preventative health benefits for the Medicare beneficiaries. Requires states to either spend a specific amount or provide specific benefits for uninsured children.	H.R. 135, H.R. 164, H.R. 616, S. 143, S. 249 — all mandating length of stay for mastectomies; H.R. 815, S. 356 requiring coverage for emergency services.
Create Government-Run Purchasing Alliances (Title I, Sub. D, Sections 1300 to 1397)	Partially Achieved (for uninsured children)	—	—	Kidcare grants are made to state governments to secure health coverage for uninsured children (rather than individual families).	—
Increase Federal Insurance Regulation (Title I, Sub. E, Sections 1400-1414)	Partially Achieved (guaranteed issue, etc.)	Requires guarantee issue, guarantee renewal, and limits on pre-existing conditions for group-to-group and group-to-individual coverage.	—	—	H.R. 586, S. 449 gag clause restrictions; H.R. 211, H.R. 444 mandated portability for retirees health care; H.R. 306, H.R. 341, S. 89, genetic information use; H.R. 2606, S. 664, H.R. 1415, comprehensive managed care regulation.
Regulate the Doctor-Patient Relationship (Title I, Sub. E, Section 1406 (d) (2), prohibition on direct billing)	Partially Achieved (further limits in Medicare)	—	—	Requires doctors to stop accepting Medicare for two years in order to enter into private contracts, effectively prohibiting doctor-patient private contracting.	—
Increase Federal Data Collection (Title V, Sub. B, Sections 5101-5106)	Yes	Requires government standard setting for health info exchanges and individual health IDs (Title II, Sub. F, Section 261, 262)	—	—	—
Further Control Medical Practice through Fraud and Abuse Rules (Title V, Sub. E, Sections 5401, 5402, 5431-5437)	Yes	Creates a fraud and abuse control program, account, and establishes new fines and penalties for doctors. (Title II, Sub. A, Sections 201, 242-244, 249)	—	—	H.R. 1761, H.R. 2584, H.R. 362, S. 386, S. 865—all relating to combating Medicare/Medicaid fraud and abuse.
Federal Regulation of Quality Assurance (Title V, Sub. A, Sections 5001-5013)	Yes	—	—	Medicare Quality Assurance program	S. 795—creates quasi-governmental council to set "minimum" federal health plan quality standards.



federal mandates to regulate health care delivery in America.

In a few discrete areas, Congress did enact reforms that expanded consumer choice instead of regulation and bureaucracy. The Kennedy-Kassebaum bill, for example, enables a limited number of individuals and small businesses to make tax-free deposits into medical savings accounts (MSAs) for their future health care needs. For the self-employed, the deductible amount for the cost of health plan purchases has been increased to 100 percent, to be phased in by the year 2007. Both of these changes removed tax barriers for Americans who want to exercise greater discretion in choosing their health care. Congress also made important headway last summer, in the Balanced Budget Act of 1997, by allowing new and different types of private health plans to contract with Medicare so that senior citizens will have available a greater range of private coverage options. But these preliminary steps in the right direction are overshadowed by the breadth of new regulatory controls that Congress has enacted over the past four years.

Implementing ClintonCare in Stages

The goal of the Administration's health policy, elucidated by the President in his speech to the Service Employees International Union in 1997, is to create new federal programs for different portions of the American population in order to build a broad government-controlled system.

The first major step in this plan was passage of the Kennedy-Kassebaum bill. The next was approval of the President's "KidCare" program as part of the Balanced Budget Act of 1997, which

established a \$24 billion government health care program for low-income children. More recently, the President has proposed a laundry list of new programs and mandates: (1) allowing seniors who are 62 to 64 years old, and anyone over 55 years of age who was forced into retirement, to buy into the Medicare program; (2) providing an additional \$900 million over five years to states for outreach efforts to enroll children in Medicaid; and (3) the recently announced extension of a number of "patient protection" measures to federally financed health insurance coverage. Young adults between the ages of 18 and 24 who are vulnerable to becoming uninsured also appear to be the likely targets of the next attempt to expand the reach of ClintonCare.² Those efforts, added to the growing list of legislative proposals to further regulate private health insurance, offer Congress still more opportunities to expand the federal health care system.

This quiet reversal of the Administration's past failure to secure approval of its health care plan can be attributed to several factors:

First, employer-based health coverage is eroding as (and because) public programs are expanding.³

Second, the ranks of the uninsured are growing, aggravated by federal and state policies that discourage individuals and families from obtaining affordable private insurance policies.

Third, managed care, once touted by the President as the predominant model for health coverage and delivery, is now criticized by conservatives and liberals alike for routinely doing what it says it

2. David Nather, "Clinton, Democrats Face Challenge in Mapping Next Steps for Coverage," Bureau of National Affairs (BNA) *Daily Report for Executives*, September 30, 1997, p. C1.
3. A growing body of evidence suggests that expansion of public programs, such as Medicaid, leads to a phenomenon called "crowding out," or expansion of eligibility for publicly financed programs into the working poor population, which induces some employers to drop dependent coverage or coverage for all their workers, or employees to drop dependent coverage because of higher premium requirements. The Congressional Budget Office estimates, for example, that of the 3.4 million children it expects the new federal program for uninsured children to cover, approximately 1.4 million, or 40 percent, will have been insured previously. See Congressional Budget Office, "Budgetary Implications of the Balanced Budget Act of 1997," *CBO Memorandum*, December 1997, p. 54.



will do—lowering the cost of health care by controlling utilization.

Together, these factors encourage the creation of new programs to fill ever-widening gaps in health insurance coverage, as well as new federal regulations to “protect” consumers from managed care plans that limit and restrict access to certain doctors and health services.

Confusing the Agenda. The Clinton Administration and its allies on Capitol Hill are adept at exploiting genuine consumer insecurities. Their significant successes in implementing health care policy are the direct result of a unified commitment to a clear and consistent agenda based on a highly regulated health care system. This agenda—directly at odds with free-market ideals of consumer choice and competition—permeates just about every area of health care policy, from insurance regulation to measures guaranteeing quality assurance. By contrast, members of the majority leadership in Congress appear to lack a clear vision of the health system’s problems and the possible remedies for those problems. As a result, they often have seemed unable to respond effectively to real consumer insecurities, such as what to do for individuals or families who have lost their job-based health coverage or who have no direct access to a physician of choice.

Most conservative policymakers are hesitant to meddle with what they see, however mistakenly, as a real “market.” And they are empathetic to their constituents’ legitimate concerns about the state of their health care coverage or lack thereof. A direct result of this conundrum is that Congress has become increasingly complicit in the Administration’s efforts to impose government dictates on the structure and financing of health care.

Misdiagnosing the Problem. In the United States, health insurance markets are distorted by a federal tax policy that offers unlimited tax breaks to individuals and families for the purchase of health insurance if they purchase that insurance through their employers. This tax policy divides Americans into two unequal camps: (1) those fortunate enough to receive generous federal tax breaks through their places of work and (2) those

who receive little or no tax relief for the purchase of health insurance and must buy health insurance policies on an individual basis with after-tax dollars. Policies are burdened with unequal legal treatment and state-mandated benefits, and therefore often are less affordable for individuals and families.

The exclusivity of tax treatment for employer-based health insurance, unlike virtually every other form of employee compensation, lies at the root of the problems plaguing the current health care system. Inequitable tax treatment not only distorts the health insurance market, but also undermines personal choice of plan and benefits, creates perverse incentives in the market for medical services, and aggravates cost increases in the health care system. These problems then generate other related problems, such as gaps in insurance coverage and the rising numbers of uninsured Americans. The proper policy response is to attack the problem at its roots, not to treat its symptoms and create cumbersome bureaucratic structures in the process.

The Right Prescription. To eliminate the health insurance market’s current distortions, Congress should replace the inequitable tax treatment of health insurance with tax relief for individuals and families: for example, tax credits for those who pay taxes (or vouchers for those who do not) to offset the cost of health insurance premiums and out-of-pocket expenses, or to open a medical savings account. Tax relief should never be exclusive—that is, given for only one form of health care delivery system. It should be neutral and thus compatible with consumer choice and competition.

This kind of policy change would sharply reduce the level of uninsurance among working Americans. It would expand access to health care insurance for individuals and families, and enable them to own their health insurance policies just as they own automobile, life, or homeowner’s insurance. Most important, it would put individuals and families in charge of their own health care decisions—not insurance companies or distant executives of government-sponsored purchasing



cooperatives, or even more distant federal or state government officials.

A Policy Failure. To date, most conservatives in Congress have focused their efforts on articulating the need for medical savings accounts. They have failed to address the broader issues: the damaging impact of federal tax treatment of health insurance on the efficient functioning of the market, the consequent absence of consumer choice, tax inequality for individuals and families, and politically designed limitations on access to affordable health coverage.

Advocating MSAs is important, but it does not, by itself, constitute an effective health care agenda. In fact, the hard-fought battle to attain favorable tax treatment for MSAs—to the virtual exclusion of other free-market reforms—resulted in, at best, a Pyrrhic victory: The huge concessions made to achieve this goal far outweigh the end result. Indeed, the data now indicate a disappointing start to the MSA pilot program initiated under HIPAA at the beginning of 1997. As of June 30, 1997, the Internal Revenue Service reported that only 22,000 accounts had been opened out of a possible 750,000.⁴

What the health care policy debate needs is an honest discussion of how policymakers can create a truly consumer-driven U.S. health care market. Before implementing any new policies, Congress must address the structural problems of the insurance market, especially the driving force behind most of these problems—the tax code's current exclusion for employer-provided health coverage. If Congress does not find a way to fix this structural defect and replace it with a progressive tax credit, the Administration's health care agenda will triumph, and Americans and their physicians will find themselves forcibly enrolled in a system that steadily grows more and more restrictive and bureaucratic.

THE NEW COMPONENTS OF BUREAUCRATIC CONTROL

Congress already has acted to implement components of the President's failed 1994 Health Security Act. The major components include: (1) federally standardized benefits; (2) centralized health care purchasing alliances; (3) federal regulation of insurance; (4) limits on individual choice and regulation of the doctor-patient relationship; (5) federal data collection; (6) the expansion of federal fraud and abuse authority; and (7) federal regulation of quality and consumer protections.

Federally Standardized Benefits

Perhaps no issue is more important to the advocates of central planning than making all health plans look alike by allowing the federal government to define the type and scope of health benefits coverage without regard to individual needs or resources. The Clinton plan met this challenge in excruciating and rigid detail. Comprehensive health benefits, ranging from standard physician and hospital services to a full complement of mental health and substance abuse counseling and benefits, were spelled out in the proposed statute, which included even the "periodicity schedules" that determined the frequency of certain covered benefits. Most notably (and controversially), the Clinton plan told women between 40 and 50 years old that they would be covered for breast cancer screening (mammograms) every other year, and women over 18 years old that they would be covered for uterine cancer screening (pap smears) once every three years. Even supplemental benefits packages would be tightly regulated and would have to be approved by the Secretary of Health and Human Services (HHS).

In addition, any changes in the required standard benefits package would have to be approved by a National Health Board, a new federal agency that would be responsible for setting standards for health benefits, information gathering and dissemination, quality assurance, and cost controls, as

4. Nancy Ann Jeffrey and George Anders, "Medical Savings Accounts Are Struggling to Catch On," *The Wall Street Journal*, December 12, 1997, p. A1.



well as for approving all state plans to ensure that they met its own standards. Insurers would be required to cover any new benefits the Board approved; they also would be subject to strict mandates requiring them to control costs and live within the budget established for the regional alliance.

The Clinton Administration's strategy for selling its health plan to the public hinged on the ability to convince people (1) that current health coverage could be maintained or improved and (2) that an additional 37 million uninsured individuals could be insured, all at no additional cost. In fact, however, the price would include the costs associated with the new benefits that Americans would be required to include in their health plans, as well as the money needed to pay an estimated 98,146 new federal, state, and alliance bureaucrats to manage the program.⁵ And this would require, in turn, that the cost burden be shifted to employers through a mandate that they pay 80 percent of the premium costs for their employees in a health alliance pool.

In the end, the American people were not convinced. In assessing polling data on the public's perception of the Clinton plan, Robert Blendon of the Harvard School of Public Health noted that, "In designing its plan, the Clinton administration aimed to improve the health care arrangements of most Americans and lower their future costs. Thus, it is startling to find how few people

believed, by April 1994, that the reform plan would actually do this."⁶

Undeterred by this failure, the advocates of central planning pushed forward—with a significant degree of success—in their quest to level Americans' private health benefits through individual benefit mandates. Employers and individuals participating in state-regulated insurance plans are familiar with health plan standardization through individual benefit and provider mandates. In 1996, there were no fewer than 976 state laws specifying benefits coverage, provider coverage, or persons to be covered—56 more mandates than in 1995.⁷ In addition, 177 state laws regulated managed care, ranging from mandated coverage for emergency services and maternity stays to mandatory point of service options and access to specialists in managed care plans.⁸

Because these mandates affect privately purchased health insurance, they appear to be free. But this is not so, according to the Congressional Budget Office (CBO), which reports that mandates on benefits force employers to pass their costs on to employees in the form of lower wages or in reductions in other covered, and possibly more desirable or needed, benefits.⁹ The U.S. General Accounting Office (GAO) estimates that state mandated benefit laws account for 12 percent of the claims costs in Virginia, which has 29 benefit and managed care mandates, and 22 per-

5. "Study Estimates Clinton Plan Would Require 98,146 New Employees," *BNA Daily Report for Executives*, March 9, 1994; estimate based on a March 1994 study conducted by Multinational Business Services, Inc., a Washington-based regulatory consulting firm.
6. Robert Blendon, Mollyann Brodie, and John Benson, "What Happened to Americans' Support for the Clinton Health Plan?" *Health Affairs*, Vol. 14, No. 2 (Summer 1995), p. 9.
7. Susan S. Laudicina *et al.*, *State Legislative Health Care and Insurance Issues: 1996 Survey of Plans*, BlueCross BlueShield Association, December 1996.
8. See "Roundup of state managed care laws," *On Managed Care*, Vol. 2, No. 10 (October 1997), p. 6.
9. Regarding one such proposed mandate, "CBO estimates that the proposal would initially raise private group health insurance premiums by about 0.06 percent. In response, employers and employees would reduce coverage or drop benefits for other services. Because of these reactions, we assume that employer contributions for health insurance would rise by only 0.02 percent. Most of that increase would be passed back to employees in lower wages." Congressional Budget Office, "Federal Cost Estimate, S. 969, The Newborns' and Mothers' Health Protection Act of 1996," July 17, 1996, p. 2, attached to letter to Honorable Nancy Landon Kassebaum, Chairman, Committee on Labor and Human Resources, U.S. Senate; by facsimile.



cent in Maryland, which has 36 mandates.¹⁰ A similar study conducted by the actuarial firm of Milliman and Robertson for the National Center for Policy Analysis found that the costs of the 12 most common state mandated benefit laws added as much as 30 percent to the cost of insurance.¹¹

Since 51 percent of people with employment-based health coverage (based on 1995 data) are in self-insured plans exempt from state regulation of health plan benefits design under the Employee Retirement Income Security Act (ERISA), the effort to mandate specific benefits has moved to the federal level.¹² In 1996, as part of the Veterans Administration and Housing and Urban Development (VA-HUD) appropriations bill, Congress required all private health plans to cover mothers and their newborn children for at least two nights in the hospital after a normal birth and at least four nights after a cesarean section. In addition, the bill prohibited private health plans from placing restrictions on mental health coverage (such as lifetime or annual payment limits) that they do not also place on medical or surgical coverage.

Similar legislation has been introduced to require 48-hour hospital stays for women undergoing mastectomies, to prohibit contractual “gag” clauses on physician communication with patients, and to impose mandatory coverage of emergency room services—and the list goes on. Not only are these mandates costly for consumers, who must pay the price of mandated benefits, but they make health insurance even less affordable for

the uninsured. They also represent the disturbing trend toward a pollster-prescribed health reform “incrementalism” by which Members of Congress make politically expedient decisions about the type, scope, and appropriateness of certain types of care—determinations the majority of lawmakers are not trained to make.¹³

Congress recently took specific steps to mandate comprehensive benefits coverage for certain groups of Americans. While Members were proposing, in the Balanced Budget Act of 1997, to expand consumer choice in the Medicare system and allow new types of private health plans to contract with Medicare, they also introduced and passed new restrictions on health plans and consumer choice by requiring that new preventive health benefits be covered in the Medicare basic benefits package. Ideally, the government should make a defined contribution to private health plans contracting with Medicare so that, for the same amount of money spent on traditional Medicare benefits (or even less), they can provide seniors with more coverage than the traditional program offers today, such as prescription drug coverage. Each new benefit that Congress adds to the traditional program, however, translates into new costs for taxpayers and beneficiaries in private plans, and therefore limits the program’s ability to provide extra benefits.¹⁴

The debate over creating a federal program for uninsured children demonstrated the desire of liberal policymakers to impose one-size-fits-all health

10. U.S. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance*, GAO/HEHS 96-161, August 19, 1996.

11. John Goodman and Merrill Matthews, *The Cost of Health Insurance Mandates*, National Center for Policy Analysis (NCPA) *Brief Analysis* No. 237, August 13, 1997, p. 1.

12. Derek Liston and Martha Patterson, “Analysis of the Number of Workers Covered by Self-Insured Health Plans Under the Employees Retirement Income Security Act of 1974, of 1993, and of 1995,” for a KPMG Peat Marwick LLP survey prepared for the Henry J. Kaiser Family Foundation, August 1996.

13. The GAO reported that maternity stay requirements “may be giving the public a false sense of security.” Researchers found that shorter stays can be as safe as or safer than the required 48-hour stays. For additional information on this issue, see U.S. General Accounting Office, *Maternity Care: Appropriate Follow-up Services Critical with Short Hospital Stays*, GAO/HEHS 96-207, September 11, 1996.

14. For more on this subject, see Carrie J. Gavora, “The Budget Deal’s Medicare Benefits Inflation,” *Heritage Foundation Backgrounder* No. 1114, May 12, 1997.



care on Americans at almost any cost. The budget bill made \$24 billion available to states in block grants to provide health coverage for low-income uninsured children. The Senate-passed KidCare bill would have required that benefits be equivalent to the benefits federal employees receive in the standard BlueCross BlueShield plan, which is estimated to cost \$800 a year per child. The House bill, on the other hand, defined basic health services that must be included in a benefits package without explicitly defining the benefits, thereby allowing the states greater flexibility to tailor benefits packages to population needs and resources. For example, some states that already operate health programs for children, such as Florida's Healthy Kids program or Vermont's Dr. Dynasaur program, provide comprehensive health insurance coverage for between \$446 and \$612 a year per child.¹⁵ The more flexible House bill would allow these programs to continue as long as they provide basic health services.

Given KidCare's fixed budget, it was clear that Senate policymakers were willing to forsake the goal of providing basic health coverage to as many children as possible so that fewer children might possibly receive more comprehensive standardized benefits—benefits that would not necessarily reflect individual health needs and family resources. The KidCare legislation that eventually became law, however, does not define benefits explicitly; instead, it is a confusing compromise between the House and Senate positions.¹⁶

Centralized Health Care Purchasing Authority

Another key feature of the Clinton plan is the centralization of health insurance purchasing in large, mandatory insurance purchasing cooperatives known as regional health alliances. These

regional alliances could be administered directly by state agencies or by nonprofit entities contracting with state governments. Health alliances would be responsible for collecting federal and state subsidy payments and employer and beneficiary premiums, contracting with health plans that are certified as eligible to participate, enrolling families in plans, and obtaining and disseminating information on health plan options. They also would be responsible for calculating the premiums owed by employers and families, determining which families and employers were eligible for subsidies, establishing the fee schedule for the mandatory fee-for-service plans, and enforcing National Health Board cost controls on health plans that contract with the alliances. Large corporations (those with 5,000 or more employees and certain multi-employer group plans) were exempted from participating in the health alliance structure and allowed instead to form their own "corporate alliances."

Similarly, the KidCare proposal approved in the Balanced Budget Act could lead to the creation of state-level health alliances for uninsured children. States must submit plans to HHS either to expand Medicaid coverage or to create new state-based programs for uninsured children. States choosing to receive funds in a block grant would be required to establish a program to expand health coverage for eligible children, determine the benefit package they want to offer families, and establish sliding-scale premium and cost-sharing requirements. States may base their cost-sharing requirements on income, except for children in families whose income is below 150 percent of the poverty level. These families would fall under the state's Medicaid cost-sharing requirements. Out-of-pocket costs for all families would be limited to 5 percent of annual family income. States must use

15. Anne Gauthier and Stephen Schrodell, *Expanding Children's Coverage: Lessons from State Initiatives in Health Care Reform* (Washington, D.C.: The Alpha Center, May 1997), pp. 18, 24. This study was produced as part of the Robert Wood Johnson Foundation's program on State Initiatives in Health Care Reform.

16. States must ensure that health plans covering uninsured children offer one of three "benchmark" benefit packages, or the aggregate actuarial value of one of those packages.



90 percent of their KidCare block grant dollars for health insurance (instead of purchasing health services directly from providers).

The defining similarity between the two approaches is who controls the health subsidy dollars. Like the government subsidies and employer-mandated premiums paid to the Clinton plan's proposed health alliances, KidCare grants will be made directly to state governments, not to individual families in need of assistance. States that decide to use these funds to expand their Medicaid programs will be choosing to expand a highly restrictive federal entitlement program that directly increases federal and state government control of coverage and benefits determination for families. States that choose to take the funds in the more flexible block grant could use the money to set up large state-based purchasing programs with significant financial and regulatory obligations, affording them direct control of private health benefits and plan options for their residents. In many cases, this means the state's role as licensor and regulator of private health plans would be elevated to one of direct purchaser of private insurance for families with uninsured children—thereby controlling not only the type of benefits that families must have, but also the type and number of insurers that may compete for subsidy-eligible enrollees. Most states are choosing one or a combination of these approaches to cover uninsured children.

This does not have to be the case. States choosing to receive federal KidCare funds in a block grant will have considerably more flexibility than they would have either under the health alliance structure in the Clinton plan or under Medicaid today. Under KidCare, states could offer eligible families tax credits or vouchers to purchase a child health policy that meets plan standards. This approach would give low-income families both the incentive and the resources they need to purchase private coverage and control their own health care.

The states' ability to pursue these types of innovative programs to cover uninsured children, how-

ever, depends largely on how the Health Care Financing Administration (HCFA) interprets the new law. At a National Governors' Association meeting last fall, state health commissioners (many of whom are familiar with HCFA's foot-dragging with regard to Medicaid waiver approval) expressed concern at the agency's indication that it would look unfavorably on states that seek waivers to try different approaches to cover their uninsured children. For example, some states want to assess cost-sharing on families with incomes below 150 percent of poverty in excess of the Medicaid cost-sharing limitations, and others want to use funds to cover uninsured families—not just children—when it is more cost-effective to do so. States would need a federal waiver to pursue these options. Yet HCFA has stated that it would rather the states gain experience operating programs under the new law before seeking waivers.¹⁷

Even as Congress has worked to encourage government-controlled purchasing alliances and to grant new regulatory authority to state governments on behalf of uninsured children, there have been other efforts to allow individuals to pool their resources voluntarily and circumvent onerous state insurance mandates and regulations. These efforts are opposed by those who view such freedom of choice as a threat to the states' bureaucratic hold on the private insurance market. For years, the self-employed and small business owners have sought ERISA protection for the voluntary pooling of resources to purchase health insurance. Representative Harris Fawell (R-IL) is sponsoring the Expansion of Portability and Health Insurance Coverage Act (H.R. 1515), which would give the self-employed and small employers the regulatory relief they need to purchase affordable private health insurance on a voluntary basis.

Federal Regulation of Insurance

The Clinton plan would have preempted state laws regulating commercial insurance. It required all health plans contracting with the regional alliances (1) to accept all those who apply for insur-

17. "HCFA Releases More Guidelines on Law as State, Federal Officials Wrap up Talks," *BNA Health Care Policy Report*, Vol. 5, No. 37 (September 22, 1997).



ance, regardless of health status (“guarantee issue”); (2) to offer to renew an insurance contract (“guarantee renewal”); (3) to charge everyone in a health plan the same premium regardless of age, sex, or health status (“community rate”); and (4) to prohibit limitations on pre-existing conditions. In fact, the Clinton plan would prohibit health plans from canceling health coverage for any reason, even if enrollees failed to pay premiums. When individuals or employers failed to pay premiums to the alliance, the alliance would adjust other payers’ premiums to reflect the loss of revenue. Because everyone would be required to purchase the same package of benefits, with premiums and co-pays strictly regulated by health alliances, the ability of insurers to compete within the alliances for business would be substantially limited.

When reforms combine guarantee issue requirements with community rating in a voluntary market, the result will be a rise in average premium rates, because insurers must accept all applicants, including the chronically ill, but will be unable to vary premiums based on health status or age. Some healthy individuals, seeing no extra value in the significantly higher premiums under community rating, would drop out of the insurance market altogether. This would create a sicker risk pool that needed to be insured, and would trigger spiraling costs.

Many states, like Kentucky, New York, Vermont, and Washington, have passed some or all of these restrictions on commercial insurance and also have experienced dramatic increases in premium

rates, particularly in the individual market. The result: Many insurers decided to quit issuing policies.¹⁸ With the passage of HIPAA, federal law requires that each market insurer guarantee issue to individuals and families who leave group health plans (although premium rates may vary in accordance with state law). The original estimates of the cost of guarantee issue requirements on premiums varied from 2 percent to 20 percent.¹⁹ More recently, the GAO reported for working families covered under the new law, “Premiums for some portability products may be substantially higher than for standard products. Of the five different carriers whose rates we reviewed, only one charged the standard rate to HIPAA eligibles. The remainder charged or anticipated charging 29, 40, 85 and 125 percent above the standard rate.”²⁰ In addition, some states are reporting problems with large numbers of individual insurers leaving the marketplace.²¹

Even if coverage were mandated so that people could not drop it when it became too expensive, prohibiting insurance underwriting only masks the costs of coverage. One of the arguments the President put forth for mandatory universal coverage was that it would bring overall health spending down by ending the cost-shifting that occurs when doctors and hospitals inflate bills for people who have private coverage to cover the cost for those who have no coverage. If everyone is forced to purchase insurance, if insurers are required to accept individuals regardless of health risk, and if premiums are determined by the community rate,

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18. To learn more about the adverse consequences of state health care reforms in Kentucky and Washington, see Rachel McCubbin, “The Kentucky Health Care Experiment: How ‘Managed Competition’ Clamps Down on Choice and Competition,” Heritage Foundation *State Backgrounder* No. 1119/S, June 6, 1997, and Robert Cihak, M.D., Bob Williams, and Peter J. Ferrara, “The Rise and Repeal of the Washington State Health Plan: Lessons for America’s State Legislators,” Heritage Foundation *State Backgrounder* No. 1121/S, June 11, 1997.
19. The American Academy of Actuaries predicted overall premium increases of 2 percent to 5 percent, while the Health Insurance Association of America predicted premium increases of 10 percent to 20 percent.
20. U.S. General Accounting Office, *Early HIPAA Implementation Concerns*, GAO/HEHS-97-200R, letter and report from William J. Scanlon, Director, Health Financing and System Issues, General Accounting Office, to the Hon. James M. Jeffords, Chairman, Committee on Labor and Human Resources, United States Senate, September 2, 1997, p. 5.
21. “Federal, State Regulators Convey Early Implementation Snags with HIPAA,” *BNA Health Care Policy Report*, Vol. 5, No. 38 (September 29, 1997).



the argument goes, the result will be economies of scale that create efficiencies and reduce costs.

A closer look at this type of insurance regulation suggests that this argument is false. In the end, community rating does not reduce costs; nor does it encourage the efficient use of health care services. It simply redistributes the burden of payment. As summarized by Stephen Entin and Norman Ture of the Institute for Research on the Economics of Taxation, "Mandating universal coverage is a mistaken solution to the problem. It doesn't eliminate cost shifting; it merely shifts the identity of those to whom the cost is to be shifted. Instead of shifting the cost of unpaid care to paying customers, this cost is to be shifted to one or another group of taxpayers and to young and healthy policy holders."²²

The last thing the insurance market needs is more regulation. Most regulation merely breeds new regulation, further complicating the dual regulatory structure that already exists in today's private health insurance market. Under HIPAA—as would have been the case as well under the Clinton health plan's unmanageable rules regarding state and health alliance responsibility for enforcing decisions of the National Health Board—state and federal regulators are finding it difficult to balance the competing desires for federal and state regulatory control of the private health insurance market. Paul Olenick, director of insurance standards for HCFA's Center for Medicaid and State Operations, in reporting on HCFA's work with the states to implement HIPAA's federal "fall-back" standards if the states fail to put forth their own plans, described the patchwork of federal-state responsibilities as "not consumer-friendly."²³ Furthermore, even though the Act went into effect on July 1, 1997, Representative Bill Thomas (R-CA), Chairman of the House Ways and Means Subcom-

mittee on Health, asked a witness during a September hearing on implementation of the Act to submit suggested "technical corrections" that would address certain ambiguities and "abuses" occurring in the insurance markets in various states.²⁴

Limiting Individual Choice and Regulating the Doctor-Patient Relationship

The Clinton plan would require all Americans to have health insurance. Health alliances would be responsible for contracting with insurance plans that meet all the rigid cost and benefit guidelines established by the legislation and the National Health Board. Individuals would not have an opportunity to purchase a less expensive package of health benefits, and any supplemental benefits packages would be strictly regulated by the health alliances. New benefits or changes in the timetable placed on certain benefits (like mammograms) would have to be approved by the Board.

Furthermore, alliances could exclude any health plan whose premiums exceeded 20 percent of the average plan's premiums. Because of federal health spending targets established by the Board, caps placed on premium contribution, and beneficiary cost-sharing outside the price-controlled mandatory fee-for-service health plan, it is likely that only large managed care companies would be able to submit bids to the alliances that are low enough to participate in the health system. Such bids therefore would limit an individual's choice of and access to health plans and doctors.

Consumer choice and the doctor-patient relationship can be impeded in two specific ways: directly by governmental prohibitions on access and choice and indirectly through governmental policies and regulations that act as a wedge

22. Steve Entin and Norman Ture, "Health Care Reform: Why Not Try Real Insurance?" Institute for Research on the Economics of Taxation, presented to a conference on *A Fresh Approach to Health Care Reform* sponsored by the Galen Institute, March 25, 1996, p. 6.

23. "HHS Enters California to Enforce Federal HIPAA Standards, NAIC Told," *BNA Health Care Policy Report*, Vol. 5, No. 38 (September 29, 1997).

24. "Federal, State Regulators Convey Early Implementation Snags with HIPAA," *op. cit.*



between consumers and insurance companies, and between patients and doctors. As already noted, federal tax policy that subsidizes employer-based health insurance at the expense of individual tax relief is one of the greatest impediments to consumer choice. Government-imposed price controls and fee schedules also undermine consumer choice and access. The fee-for-service coverage option in the Clinton health plan promised unlimited choice of doctors, but this would have been a hollow promise because of restrictions on premium payments and fee schedules placed on physicians.

In this respect, the Clinton proposal mirrors today's Medicare program for senior citizens. In Medicare, a doctor's value is not measured by assessing the quality or appropriateness of care provided, or even by patient satisfaction. It is measured by a complicated formula called the resource-based relative value scale (RBRVS). Measures from this scale are converted to a fee schedule, which is the amount Medicare will provide to reimburse doctors for services rendered. Excessive and unsustainable cost growth in Medicare has caused Congress to ratchet back physician and hospital payments to the point that Medicare now pays physicians, on average, 60 percent or less of their actual costs of care. The natural and predictable response to this type of system is for doctors either to limit the number of Medicare patients they will see or to choose not to see them at all.

The Doctor-Patient Relationship. Federal policy also places direct prohibitions on patients' ability to establish private contractual relationships with physicians. A provision in the Clinton health plan prohibiting physicians from billing patients directly for services covered by the mandatory benefits package has been interpreted by policy experts as prohibiting patients from paying cash for services and thereby establishing private contractual relationships with doctors of their own choosing.

This is similar to Medicare policy adopted in the 1997 Budget Act, under which doctors who want

to enter private contracts with their Medicare patients for benefits covered under the mandatory Medicare benefits package must give up their entire Medicare practice for two years. Because most physicians could not afford to do this, the effect of this policy is to prohibit most Americans over age 65 from spending their own money to secure the medical services or treatments they want on terms mutually agreed upon with physicians of their choice. In this respect, doctors and patients participating in Medicare have less personal and professional freedom than they would have under the British National Health Service (NHS), which allows its physicians to treat patients on a private basis without giving up their NHS practice. Representative Bill Archer (R-TX) and Senator Jon Kyl (R-AZ) have introduced legislation (H.R. 2497 and S. 1194, respectively) to counter the Medicare policy in the Budget Act and allow physicians and patients to contract privately without having to leave the Medicare program.

Federal Data Collection

The Clinton plan would give the National Health Board broad authority to collect and use individual patient information from health records for a variety of purposes. The Board would be responsible for collecting, reporting, and regulating the collection and dissemination of health care data, including clinical encounters and administrative and financial transactions between health plans, providers, employers, and individuals. Nor would the Board's intrusiveness be limited to evaluating cost and quality; it would have almost open-ended authorization to collect information on "any other fact that may be necessary to determine whether a health plan or a health care provider has complied with a Federal statute pertaining to fraud or misrepresentation...."²⁵ In addition, the Clinton plan would require each insured individual, employer, health plan, and health care provider to be given a "unique identifier" for the database. The Board would be responsible for ensuring that this unique identifier was not used to connect individually identifiable infor-

25. Health Security Act, Title V, Section 5101(e)(11).



mation “except in cases where the National Health Board determines that such connection is necessary.”²⁶ Regional clearinghouses would be responsible for storing patient information, and the National Health Board would be responsible for developing privacy standards to govern use of this information.

Under the seemingly innocuous title of “Administrative Simplification,” HIPAA requires the Secretary of Health and Human Services to establish a standard for electronic transactions and use of personally identifiable health care information. Like the Clinton plan, this Act authorizes assigning each patient a unique identifier number. It also requires that Congress enact privacy legislation within two years; if Congress fails to act, HHS must promulgate privacy standards for the network. As required by HIPAA, HHS Secretary Donna Shalala forwarded to Congress a set of criteria for the new data collection and privacy standards. Included is a list of “allowable disclosures” for which patient consent is not needed, such as research, law enforcement purposes, oversight, and audits of quality assurance, as well as issues pertaining to public health.

There are legitimate reasons to share certain kinds of health information. Undoubtedly, the use of computers and the Internet will create new challenges in ensuring the privacy of health information that is stored and transmitted for patient care purposes online. Lawmakers must proceed with extreme caution and recognize that the interests of the individual whose information is being collected are paramount. James Rule, professor of sociology at the State University of New York at Stonybrook, has outlined a potential solution to the problem of unauthorized use of personal data:

Existing privacy protection legislation has been plagued by problems characteristic of regulatory efforts—the extreme diffi-

culty for any government agency in monitoring activities that are widespread, well-financed and easily concealed. By contrast, instituting property in personal data would create no new government bureaucracy. Instead, ordinary citizens would be empowered to act on their own interests in controlling the use and misuse of data about themselves.²⁷

Lawmakers in Washington need only look at the neighboring state of Maryland for an example of what not to do when developing policy guidelines regarding this highly sensitive and volatile issue. In 1993, Maryland passed a law establishing the Health Care Access and Cost Commission (HCACC) and, among other things, authorized it to collect patient-specific health care data from Marylanders without their informed consent. Toward the end of 1995, *The Baltimore Sun* reported that “Hundreds of thousands of patient records already have been collected this year without patients’ knowledge. Experts say Maryland is on the way to having the nation’s biggest computerized health profile of patients and doctors.”²⁸ By July 1996, according to another article in *The Sun*, about 40 percent of Maryland patients already were in the government’s data base.²⁹

The Secretary’s recommendations for health information disclosure without patient consent could set a dangerous precedent that should not be glossed over in the name of efficiency or administrative simplification. All patients, after consulting with their doctors, should have the right to authorize the use of their health records before they are used for any other purpose.

The Expansion of Federal Fraud and Abuse Authority

There are significant similarities between the Clinton health plan and the HIPAA in the area of health care fraud and abuse. Among other things,

26. Health Security Act, Title V, Section 5104(b).

27. James B. Rule, “Our Data, Our Rights,” *The Washington Post*, October 7, 1997, p. A17.

28. John Fairhall, “State Collects Files on Medical Patients,” *The Baltimore Sun*, December 9, 1995, p. 1A.

29. Jennifer A. Katze, M.D., “Who’s Seeing Your Files?” *The Baltimore Sun*, July 15, 1996, p. 1F.



the Clinton plan proposed creating a health care fraud and abuse program to coordinate auditing and investigating activities between the Federal Bureau of Investigation and the Departments of HHS, Justice, and Labor. It also proposed a fraud-and-abuse control account with revenues derived from assessing fines and penalties on hospitals and doctors. These revenues would be used to prosecute and audit health programs and providers. Both provisions are almost identical to provisions of the HIPAA. The Clinton plan's proposed fines and penalties for false statements, theft, and embezzlement are also reflected in HIPAA provisions. There is an important distinction, however, between the Clinton plan and HIPAA's standard as to what constitutes health care fraud. The Clinton plan defines fraudulent behavior as behavior which is entered into "knowingly"; the HIPAA standard defines fraud as a "knowing and willful" attempt to deceive or defraud.

The most comprehensive audit of Medicare conducted last year revealed that billing errors or outright fraud and abuse accounted for approximately \$23 billion in overcharges in 1996—or 14 percent of all program expenditures.³⁰ Combating Medicare fraud and abuse is now one of the Administration's top health care priorities, with more funds directed to investigators and auditors and a moratorium placed on approval of new home health agency Medicare contracts. Last year, Senator Tom Harkin (D-IA) put a hold on the confirmation of President Clinton's nominee for HCFA director until the Administration agreed to spend an additional \$50 million on anti-fraud efforts.³¹ Others in Congress want to use evidence of over-billing or billing errors to discredit physicians for excessive greed and as an excuse not to allow physicians to establish private contracts with their patients. Representative Pete Stark (D-CA), for example, has charged that "In 1995, Medicare paid 393 doctors

more than \$1 million for services; 3,152 doctors received between \$500,000 and \$1 million. Now a greedy few want more."³² Outright fraud in Medicare or any other government program obviously must be rooted out; fraudulent behavior, however, should be distinguished from honest mistakes made by those who work under the 22,000 pages of rules and regulations governing the Medicare program.

Because of the government's renewed interest in cracking down on fraud, many hospitals have hired compliance officers to ensure that they will not be targeted with sanctions, fines, or criminal charges. This can be both expensive and perplexing for those who try to operate carefully by the rules. According to Sister Pat Eck, chairperson of Bon Secours Health System in Maryland, "The regulations are so complex that organizations can make errors just because of the complexity."³³ And while the editorial page of *The New York Times* is not known for anti-regulatory rhetoric, it also has observed: "The truth is that the Health Care Financing Administration, the Federal oversight agency for Medicare, has neither the financial means nor the ability to tightly supervise the numbingly complex system."³⁴

Federal Regulation of Quality and Consumer Protections

The Clinton plan sought to establish a comprehensive "quality management" program to evaluate the quality, appropriateness, and effectiveness of health care plans and services. To oversee quality issues, a quasi-governmental entity would be created: the National Quality Management Council, made up of 15 members appointed by the President to serve three-year terms. The Council would be tasked with developing measures of quality performance for all health plans. In addition, it would update those performance measures annually, col-

30. Robert Pear, "Major Audit of Medicare Finds \$23 Billion in Overpayments," *The New York Times*, July 17, 1997, p. A1.

31. Amy Goldstein, "Harkin Puts 'Hold' on Medicare Nominee," *The Washington Post*, October 3, 1997, p. A26.

32. Representative Pete Stark, Extension of Remarks, *Congressional Record*, September 23, 1997.

33. George Anders, "Hot New Job in Health Care: In-House Cop," *The Wall Street Journal*, September 18, 1997, p. B1.

34. Editorial, "Fraud and Waste in Medicare," *The New York Times*, August 1, 1997, p. A26.



lect specified quality data from the health alliances, report its findings to Congress, and perform periodic consumer surveys. When the Council determined that “sufficient information and consensus exist” regarding performance measures, it would recommend that the National Health Board establish national performance goals for health plans and providers.

Similarly, a number of bills have been introduced or are being crafted to define and regulate quality in health care plans. This legislation spans a spectrum of issues, from information disclosure requirements on health plans, to creating Clinton-like national boards to set and enforce quality and information standards, to allowing greater direct federal regulation of private insurers. Senator Joseph Lieberman (D-CT) has introduced legislation designed to monitor the quality of health plans contracting with the federal government. Like the Clinton plan, the Federal Health Care Quality, Consumer Information and Protection Act (S. 795) would create a Federal Health Plan Quality Council whose members would be appointed for fixed terms by Congress and the President. The Council would license the entities charged with certifying contracting health plans, contract with an independent entity to conduct certification and quality audits, and establish minimum criteria to be used by the certifying entity in evaluating health plans. Senator James Jeffords (R-VT) is crafting legislation for this session of Congress that would impose similar—and probably more rigorous—federal quality and accreditation standards on all private health plans.

Although the idea of requiring health plans to meet certain quality measures or provide special access for certain services might seem reasonable, such requirements can lead to serious unintended consequences. Once the federal government takes on the role of setting rigid quality standards and access requirements for private health plans, there will be many cases in which official Washington standards do not reflect local health care service conditions. In many areas, such as poor inner-city

urban areas or rural settings, otherwise good and solvent health plans could be prohibited from offering coverage because they do not meet all national standards. *The New York Times*, in an editorial advocating Medicare reforms modeled after the successful Federal Employees Health Benefits Program (FEHBP), described the federal government’s ability to address quality issues in sobering terms: “The agency [HCFA] can do very little to oversee the quality of care that Medicare recipients receive. An agency that cannot even check whether the services it paid for were actually provided can hardly be expected to tackle the much harder problem of guaranteeing that the services are medically appropriate.”³⁵

MORE RED TAPE FROM CONGRESS?

It is in the ill-defined areas of health policy known as “quality assurance” or “consumer protections” that the next legislative battle for health care reform will be fought. The debate most likely will center on H.R. 1415, the Patient Access to Responsible Care Act of 1997 (PARCA) introduced by Representative Charles Norwood (R-GA), which has 223 co-sponsors. Senator Alfonse D’Amato (R-NY) has introduced a companion bill in the Senate. H.R. 1415 would impose an unprecedented level of federal regulation on private insurance, including mandatory point-of-service options for managed care plans, with a requirement that additional premiums for point-of-service be “fair and reasonable” as determined by the state; mandatory coverage of services determined by a “prudent layperson” to be emergency services; mandatory access to specialty care without referral for the chronically ill; and efforts to coordinate care and control costs for the chronically ill that would not “create an undue burden” for them, as defined by the state. In addition, the bill includes anti-discrimination language that has been interpreted to require guarantee issue and community rating of all managed care health plans.

The Norwood bill, like other proposals that attempt to address the problems people face

35. *Ibid.*



accessing health care, seeks to address legitimate concerns about how working-age Americans obtain health care insurance. It addresses the danger patients feel when a plan selected by their employer fails to deliver promised benefits. Nevertheless, the key to quality and consumer protection in health care is the fundamental issue of control and ownership of health coverage. Real ownership and choice by the family would enable Americans to “fire” plans that did not serve them well. To the extent that federal legal protections also are needed, it is to supplement family ownership and control with the right to sue for breach of contract.

As already noted, Congress has made some headway toward the goal of individual ownership by allowing a limited number of individuals and families to make tax-free contributions to MSAs, and by allowing the self-employed to deduct more of the costs of purchasing health coverage. However, the majority of Americans today have employment-based health insurance and therefore do not own, control, or choose the type of health plan or the scope of benefits they want and need. The contract exists between the employer and the health plan, not the employee and the health plan. The employer diverts employee wages to purchase health benefits tax-free, but the employee still has no ownership rights.

Managed care, by definition, means that control of health care utilization and treatment decisions is no longer the province of doctors and their patients. The trade-off for this loss of autonomy and decision-making authority is lower-cost health coverage. But the debate must not center on whether this is an appropriate medical insurance model; it must center on who is makes the trade-off decision—the employee or the employer—and what are the different incentives that drive this a decision?

Consumer choice is linked inextricably to a rationally functioning market in health care. If the true goal of policymakers is to promote and preserve a private health care system with minimal regulation, policies promoting individual control and ownership of health coverage must be part of

their reform plans. Lawmakers can shift the locus of the debate and pursue their own brand of incrementalism by allowing those dissatisfied with their employer-provided health coverage to opt out with the tax-free value of their employer-purchased plan; by giving the 55-year-old American who was forced to retire or a family with an uninsured child who lacks the means to purchase private coverage a tax credit or voucher to purchase coverage of their choice; and by giving senior citizens in Medicare the same private health coverage choices and options that Members of Congress and their families enjoy in the FEHBP.

HOW TO AVOID CLINTONCARE IN SMALL STEPS

Whether the purpose of any health care reform is to expand coverage to those who currently do not have employer-provided coverage or to provide options and choice to those who currently are dissatisfied with their employer-provided coverage, every health care reform proposal should be measured against basic standards. The most important of these standards is individual control and ownership.

The acid test for any proposal that would let government create a new federal health care subsidy program, expand an existing program, or mandate benefits or access should be whether it would allow individuals and families—not government or employers—to make their own health care decisions. Health care policies that strengthen the power of government to make decisions that directly affect health care consumers create new levels of bureaucratic control and help accomplish the vision of the original Clinton health plan. The best way for Congress to keep this from happening, and to maximize personal choice, would be to end the tax code’s bias in favor of employer-provided health coverage at the expense of individual coverage.

With that in mind, there are several steps Congress can take, short of ending the tax exclusion for employer-provided health plans, which could serve as the foundation for a truly consumer-based



health care system. Specifically, any new health care policy should:

- **Encourage** employers to disclose the value of their health benefits plan to employees. This is a critical first step in developing employee awareness of how much of their wages is being diverted each year to tax-free health benefits.
- **Allow** individuals to opt out of their employer-provided health coverage. It is essential that individuals be able to exercise choice and withdraw from a health plan that does not meet their needs without suffering a tax penalty. A new health care policy should include such steps as requiring employers to allow employees to opt in or out of the employer-provided health plan at the time they are hired and, if they choose to opt out, give them the same tax break (exclusion) that they would have had under an employment based plan, or allowing individuals to cash out the tax-free value of their employer-provided health benefits and use the money to buy a health plan of their choice.
- **Require** a health care plan covering an employee who chooses to stay in the employer-provided health plan to obtain the employee's signature on a contract agreeing to the terms and conditions of that health plan. No individual should be bound by a contract he or she did not sign; if an employee chooses to stay in his or her employer's health plan, that employee should be a party to the insurance contract.
- **Allow** individuals who do not have health coverage through their place of employment to deduct the full cost of an individual health plan from their taxes. This is essential to providing tax equity between employer-provided and individually purchased health coverage. It also, for the first time, would allow access to affordable health insurance to those who work for employers who do not offer coverage.
- **Require** that limitations on type, duration, and scope of the covered benefits and providers are specified clearly in contracts with individuals.

Individuals who enter a contractual agreement need to be informed of its terms and conditions. This does not mean that every specific benefit and treatment must be laid out in excruciating detail; it does mean, however, that where benefit and coverage determinations are subject to utilization review determinations by a managed care company, the plan should state this clearly in the contract with the individual.

- **Allow** individual workers in company-sponsored health care flexible spending accounts to roll over unused funds in these accounts, penalty-free, at the end of the year.
- **Remove** or raise limits on individual contributions to FSAs. FSAs have many of the advantages of MSAs. They allow employees to choose their own doctors and medical specialists, and they introduce a cost-saving incentive into the physician-patient relationship. "Carry-over" FSAs will encourage efficient utilization of medical benefits and better enable employees to deal with natural fluctuations in their health care needs. Also, in case of a job change, refunding employee contributions to FSAs tax-free will provide a measure of portability to employer-based health insurance.

CONCLUSION

The Clinton health plan has been characterized as one of the most significant attempts to impose government control of the American economy since Franklin Roosevelt's New Deal. It was defeated soundly in 1994. In other areas of public policy, Congress has been moving decisively in the opposite direction. Congress made history last year when it repealed one New Deal social policy, the 60-year-old federal entitlement to welfare benefits, and Americans can see the beginnings of a dialogue on the challenges facing policymakers who hope to reform another entitlement program, Social Security. So, too, must the growing trend toward counterproductive health care policy-making be halted, if not reversed.

After nine months of listening to the intricate and confusing details of the Clinton health plan, a resounding plurality of Americans recognized it



for what it was: a dramatic attempt to shift private dollars and decision-making authority away from families and individuals to the government. Since then, however, Congress has been moving incrementally toward Clinton's goal of a nationalized health care system. Congress's recent incremental moves are no less threatening. Anxiety and dissatisfaction with the current health care system cannot be remedied by imposing more regulation and government control.

Lawmakers who believe in the power of the free market and the individual's ability and freedom to

make choices in that market must find their voices and articulate the need to reform the tax code. Reforming the tax code is the best solution, because it will give individuals and families—not their employers or the government—the means to purchase and own their own health coverage.

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