

December 23, 1993

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

### **INTRODUCTION**

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

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

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

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

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

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

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

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

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

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

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

Among the key provisions of the Nickles-Stearns bill:

- ✓ **Insurance companies** could no longer exclude individuals, or charge them higher rates, because of pre-existing conditions. Their underwriting procedures, and hence premiums, could reflect only age, sex, and geography. But they could offer discounts to promote healthy behavior or for checkups and other steps taken to detect, prevent, or delay the onset of illness.
- ✓ **Individual tax credits** would replace the current "exclusion" for company-sponsored health plans. This means that instead of having, in effect, a tax deduction for the plan picked by his or her employer, a worker would be able to claim a sliding scale credit for the plan he chose, as well as for out-of-pocket expenses and contributions to a Medical Savings (medisave) Account.<sup>4</sup> The credits would be refundable, meaning that if the credit actually exceeded the family's tax liability, the government would pay the difference. The credits would be as follows:

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

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

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

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

- ✓ **Malpractice reforms** would, among other things, limit noneconomic damages to \$250,000.
- ✓ **The poor** would be helped by converting Medicaid Disproportionate Share payments, now used to reimburse hospitals for uncompensated care, into a grant for states for assistance to needy individuals in addition to the refundable credit.
- ✓ **Financing without a tax increase** is achieved in two ways. Most of the cost of the new tax credits is offset by the fact that they would replace the current tax exclusion and other minor health care tax deductions. Additional spending reductions in Medicare and Medicaid would offset the remaining costs of the new tax credit program. Based on a preliminary analysis by the respected health econometrics consulting firm of Lewin-VHI of the cost of the tax credits if implemented in 1994, the bill's sponsors project that the cost of the tax credits during the first three years of the program, 1997 through 1999, would be approximately \$454 billion. Eliminating the tax exclusion and other current health care tax breaks would offset the cost of the credits by an estimated \$321 billion during the same period. The remaining \$133 billion of additional tax relief under the credits during the same three-year period would be offset by spending reductions in Medicare and Medicaid. This means that Americans would receive an additional \$133 billion in tax relief for use in buying health insurance and medical care during the first three years the program is in effect.

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

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

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

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

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

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

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

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

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

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

## **WHY AMERICANS WANT GREATER HEALTH CARE SECURITY**

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

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

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

Why is most health care organized in this way?

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

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

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

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

cies (which they own) without new underwriting and resulting premium hikes or cancellation of coverage if their health declines.<sup>6</sup>

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

## Rethinking Health Care

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

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

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

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

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

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

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

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

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

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

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

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

## THE PROVISIONS OF THE NICKLES-STEARN'S BILL

### Tax Treatment of Health Care Expenses

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

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

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

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

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

