The House Compromise Health Bill: A Missed Opportunity

The Bipartisan Health Care Reform Plan of 1994 has been introduced in the House of Representatives by Roy Rowland (D-GA), Mike Bilirakis (R-FL), Jim Cooper (D-TN) and Fred Grandy (R-IA).

On the surface, the bill appears to include some key reform ideas developed by the National Center for Policy Analysis. In the fine print, however, it takes away many benefits of these reforms.

The bill looks as if it had been written by politicians who wanted to take advantage of the popularity of Medical Savings Accounts (MSAs) but make sure the private sector never actually uses them. Although the sponsors pay lip service to the idea of tax fairness, the bill fails to give meaningful tax relief to either self-employed people or employed people who buy their insurance on their own.

And although the bill aims to solve problems in the health insurance marketplace, harmful regulations might cause the number of uninsured people to rise rather than fall.

Good Feature: The Bill Avoids the Worst Aspects of the Clinton Plan. The bipartisan plan is not a me-too approach.

- There are no employer or individual mandates requiring people to purchase insurance whether they want to or not.
- There are no mandatory health alliances, giving the government control of the insurance marketplace.
- There are no price controls or global budgets that would inevitably lead to health care rationing.
- And the plan does not impose managed competition on the private sector.

What’s Wrong With the Bill

- The Medical Savings Accounts (MSAs) are so restricted that few people would want one.
- Employed people who purchase their own health insurance would receive only a 25 percent income tax deduction.
- MSA funds could not be used to pay health insurance premiums while a person is between jobs.
- Insurance regulations would encourage people to remain uninsured until they get sick.

Good Feature: The Bill Has a Number of Positive Reforms. Among the most important provisions are:

- Medical Savings Accounts: People would be able to control some of their own health care dollars through personal MSAs, using third-party insurance only to pay larger medical bills.
- Tax fairness: People who purchase their own insurance would receive some tax relief.
- Positive insurance reforms: People could not have their insurance canceled or their premiums increased because they got sick.
- Vouchers for low-income families: States would be allowed to partially privatize Medicaid by moving patients into managed care, and low-income families would qualify for subsidies to purchase private health insurance.
- Override of state regulations: Costly, premium-increasing regulations passed by state governments would be preempted.

Bad Feature: The Rules On Medical Savings Accounts Are Too Restrictive. Employers would be required to offer their employees, but not necessarily to pay for, two options: a high-deductible plan and a standard plan. If employees selected the high-deductible insurance, their employers would be able to deposit the premium savings in tax-free Medical Savings Accounts. An account would be the property of the individual employee, and the money would be available to pay medical expenses not covered by third-party insurance. Money not spent would earn taxable interest and would be available to pay postretirement medical expenses or to become part of the owner’s estate.
So far so good. But in the fine print we discover that the difference in premiums for the high-deductible and the standard plans could not exceed 20 percent. That severely limits the height of the deductible and the size of the MSA contribution. If a standard plan cost $4,500, a high-deductible plan would have to cost at least $3,600 and the MSA deposit could be no more than $900. That is less than half of what many private employers routinely deposit under the current system.

Moreover, the withdrawal provisions are draconian. The interest on the MSA deposit would be fully taxable, but if the funds were withdrawn before age 65 for a nonmedical purpose, they would be subject to twice the normal tax. Under these provisions, very few people would find MSAs attractive.

Finally, the bill appears to have no mechanism for people who purchase their own insurance to establish Medical Savings Accounts.

Bad Feature: The Bill Does Not Achieve Tax Fairness. Currently, employer-provided health insurance is excluded from employees' taxable income. Yet the self-employed, the unemployed and employees of small companies that do not provide health insurance must pay taxes first and buy health insurance with what's left over. This can make their health insurance cost twice as much as it would if provided by an employer.

The bipartisan plan would, after a phase-in period, allow the self-employed to take a 100 percent deduction. But others who purchase their own insurance would receive only a 25 percent deduction. Thus a wealthy trial lawyer would get four times the tax break given to a waitress. And even the self-employed would not get the relief that recipients of employer-provided coverage do from the 15.3 percent FICA tax, which for most people is a heavier burden than the income tax.

Bad Feature: The Bill Fails to Encourage Portability. An important potential advantage of Medical Savings Accounts is that they would provide people with the funds to pay their insurance premiums when they are between jobs. MSA funds could be used to continue coverage under a previous employer's plan (the COBRA option) or to purchase another policy. Indeed, considering that most people are uninsured only for short periods, if MSAs were universally utilized the number of people uninsured at any one time would probably be cut in half.

The compromise plan, however, forbids people to use MSA funds to pay insurance premiums. The bill also discourages the genuine portability that would exist if individuals owned their own insurance policies. Instead, it continues to heavily subsidize employer-provided insurance and provides only minimal tax relief to employees who buy their own insurance.

Bad Feature: The Bill Would Encourage the Healthy To Be Uninsured. A principal defect of the bill is that its insurance regulations could actually make the health care system worse. Regulations include:

- Modified community rating: Variations in premiums could reflect only age, family size and geographical location, and health status could not be considered.
- Guaranteed issue: Insurers would have to accept all applicants regardless of health status and pay for treatment of preexisting conditions after only a few months.
- Risk adjustment: State regulators would be required to transfer money from plans that have healthier enrollees to plans with less healthy ones.

What would be the consequence of these regulations? Suppose a man remains uninsured for his entire life until he gets AIDS. Under the bipartisan plan, he could then purchase health insurance for the same premium paid by everyone else his age. Payment of his medical bills would begin immediately if he bought insurance during a 60-day state amnesty period or the annual 30-day "open season." His insurers would have to start paying his medical bills after six months, at most.

Here's the problem: If people can obtain insurance after they get sick, they have an incentive to remain uninsured until they get sick. For this reason, the bill might cause the number of uninsured people to rise, not fall, even though it generously subsidizes health insurance for low- and moderate-income families.

On Balance: Pluses and Minuses Cancel Out. Unlike the Clinton plan and the versions of that plan sponsored by the House Democratic leadership, the House compromise bill promised to solve problems by empowering individuals and leaving markets free to solve problems. Unfortunately, it fails to deliver on that promise.

Note: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any legislation.