AN ANALYSIS OF CONGRESSMAN MICHEL'S HEALTH PROPOSAL

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INTRODUCTION

The Congressional Budget Office (CBO) and the Joint Committee on Taxation have prepared this analysis of House Republican Leader Robert Michel's health proposal, the Affordable Health Care Now Act of 1994. The analysis is based on the text of the proposal as printed on August 10 and on subsequent revisions specified by the Leader's staff. It comprises a review of the financial impact of the proposal and a brief assessment of considerations arising from the proposal's design that could affect its implementation.

FINANCIAL IMPACT OF THE PROPOSAL

Congressman Michel's proposal would increase access to private health insurance through market reforms and would provide several financial incentives to purchase insurance. The proposal would subsidize insurance for low-income children and, if sufficient funds are available, for pregnant women and other low-income people. It would make health insurance premiums fully deductible for people who are self-employed and for those who have not recently been eligible for an employer contribution for health insurance. The proposal would also provide tax incentives for medical savings accounts. The new subsidies and tax deductions would be paid for largely by reductions in federal benefit programs.

The estimated federal budgetary effects of the proposal are displayed in Table 1 at the end of this document. According to CBO's estimates, the proposal would slightly reduce the federal deficit. An additional 2 percent of the population would eventually acquire health insurance coverage, primarily as a result of the subsidies for low-income children. The proposal would have a negligible effect on national health expenditures.

Measures to Reform the Market for Private Health Insurance

Most employers would be required to offer, but not contribute toward, coverage for all eligible employees under a health insurance plan having a specified actuarial value. They would also be required to give employees the option of having their share of the insurance premium collected through payroll deduction. The proposal, however, does not specify a standard benefit package. Health insurance plans would be limited in their ability to deny coverage based on a preexisting condition and would be prohibited from denying renewal of coverage based on a person's health status. Insurers that offered health insurance to any small employer in a state would be required to offer all individuals and small employers at least two insurance plans, including a standard plan with substantial cost sharing and a catastrophic health insurance plan. They could also offer a plan combining catastrophic coverage and a

medical savings account. Standard coverage would have to include a fee-for-service option as well as point-of-service and managed care options, if available.

The premium rate established by an insurer could not vary within each type of plan except by age group, geographic area, or family size. Individuals and small employers could band together in voluntary health purchasing arrangements. The proposal would require states to develop a reinsurance or risk-adjustment mechanism to spread the risk of insuring high-risk individuals and to ensure that small employers that chose to self-insure did not adversely affect the community-rated market. The proposal would also preempt many state laws governing medical malpractice, limit awards for noneconomic damages, limit contingency fees paid to attorneys, and require that most liability claims related to health care be subject to nonbinding arbitration before a civil suit could be filed.

Subsidies

Congressman Michel's proposal would make payments to states for subsidizing health insurance for low-income children. Children through age 19 who are in families with income up to 185 percent of the poverty level and who are not eligible for Medicaid would be eligible for full subsidies of their premiums, and those with income between 185 percent and 240 percent of poverty would be eligible for partial subsidies. Children in families with income below the poverty level would also be eligible for cost-sharing subsidies. The program would begin in 1997, and total spending would be capped at the following amounts:

Fiscal Year	Billions of Dollars
1997	4.7
1998	5.2
1999	6.5
2000	9.8
2001	12.3
2002	15.3
2003	20.0
2004	24.4

If money remained after subsidizing eligible children, states would be able to subsidize pregnant women with income up to 240 percent of the poverty level. If money still remained, states could cover other adults with income up to 150 percent of poverty.

CBO estimates that the available funds would be sufficient to provide subsidies to all eligible children who chose to participate in the program by 2000 and to all eligible pregnant women by 2001. In 2004, about 5 million children and about 2 million other low-income people would receive subsidies. About one-third of the subsidized children would have had employer-sponsored coverage in the absence of the subsidy program. Also, some of the increase in coverage for children would come at the cost of eliminating Medicaid coverage for most legal aliens. When the cuts were fully effective, about 1 million aliens would lose Medicaid coverage and would be ineligible to participate in the subsidy program.

Tax Deductibility of Health Insurance

Until 1994, self-employed people were allowed to deduct 25 percent of their health insurance costs from income for income tax purposes. The proposal would allow them to deduct 25 percent of their health insurance premiums in 1994 and 1995, 50 percent in 1996 and 1997, and 100 percent in 1998 and thereafter. In addition, people who have not been eligible to participate in a health plan with an employer contribution in the past three years would be permitted to deduct the same fraction of health insurance premiums without regard to the threshold for adjusted gross income required for other medical expense deductions, even if they did not itemize deductions.

The expanded deductibility of health insurance premiums would apply to both catastrophic and standard plans. A catastrophic plan would cover specified health care expenses that exceeded at least $1,800 a year for an individual or $3,600 a year for a family (in 1994 dollars). In addition, the current deduction for other out-of-pocket medical expenses that exceed 7.5 percent of adjusted gross income would continue to be available. The expanded deductibility of health insurance expenses would cost $51 billion over the 1995-2004 period.

Tax Treatment of Medical Savings Accounts

The proposal would allow a tax deduction for individual contributions to medical savings accounts (MSAs). The allowable deduction would be limited to 25 percent of the contribution in 1994 and 1995 and 50 percent in 1996 and 1997. The deduction would generally not be available to people over age 65 or, before 1999, to anyone eligible for an employer contribution for health insurance. Beginning in 1999, employer payments to MSAs would be excluded from an employee's income for purposes of income taxes as well as Social Security and other employment taxes. Total contributions could not exceed the difference between the price of a standard health insurance policy and that of a catastrophic policy.

Withdrawals from MSAs would be excluded from taxable income if they were used to pay the expenses of medical or long-term care. Withdrawals from MSAs for any other use would be subject to regular income taxes plus a penalty of at least 10 percent. Interest earned on balances in an MSA would not be taxed.

Few people would opt for a medical savings account before 1999, when people eligible for an employer contribution to health insurance would first be allowed to contribute. Even then, people would be likely to shift into the new accounts only gradually. The estimated loss in revenues would total $0.8 billion in 2004 and $3.6 billion over the 1995-2004 period.

Long-Term Care and Other Services

The proposal contains several revenue and spending provisions designed to encourage the purchase of insurance for long-term care. It also authorizes spending for several discretionary programs to increase access to health care services among the poor and in rural areas and to improve the efficiency of health care services.

Policies for long-term care insurance that qualified under the proposal would be treated as health insurance. Benefits would be excluded from income for tax purposes, and premium payments and other expenses for care would be deductible to the extent that total out-of-pocket medical expenses exceeded 7.5 percent of adjusted gross income. Alternatively, premiums and other long-term care expenses could be paid from an MSA. Deductible expenses would include those for a parent or grandparent, even if not a dependent of the taxpayer. These changes would reduce tax receipts by $3.4 billion over the 1995-2004 period.

The proposal would expand Medicaid coverage of long-term care services by permitting states to disregard a portion of the assets of a person who has a qualifying policy for long-term care insurance. The state could disregard either all of the individual's assets, if the long-term care insurance policy provided coverage for at least three years, or an amount of assets up to the limit on benefits that the policy would provide. This provision would increase federal Medicaid outlays by an estimated $4.1 billion over 10 years. The states' Medicaid outlays would also rise.

Financing Provisions

The foregoing provisions would be financed by an increase in the premium for Medicare's Supplementary Medical Insurance (SMI) for high-income people and by a variety of reductions in spending for federal benefit programs. The Postal Service would be required to prefund the health benefits of its annuitants. Most legal aliens

would be made ineligible for Supplemental Security Income (SSI) and Medicaid benefits. The program for the distribution of pediatric vaccines established by the Omnibus Budget Reconciliation Act of 1993 (OBRA-93) would be repealed. SSI benefits for drug and alcohol abusers would be limited. Medicaid's payments to disproportionate share hospitals would be cut by 12 percent in 1995 and 1996 and by 25 percent thereafter. Medicare's secondary payer provisions enacted in OBRA-93 would be extended through 2004, as would the provision setting the SMI premium at 25 percent of program costs.

OTHER CONSIDERATIONS

Like other proposals to reform the health care system, Congressman Michel's would require many changes in the current system of health insurance. Some of these changes could have unintended consequences.

Adverse Selection and Risk Adjustment

Several features of the proposal--including the community-rating provisions, the requirement for insurers to offer standard and catastrophic plans, the availability of the catastrophic-plus-MSA option, and the voluntary nature of health insurance--could result in rising premiums for standard policies and adverse selection among types of plans and insurers. These problems would be compounded by the provision allowing small firms (those with more than 1 but fewer than 51 employees) to self-insure. The proposed risk-adjustment mechanisms would be difficult to design and implement and would be unlikely to address effectively many of the potential problems of adverse selection.

The proposal does not specify a standard benefit package. Rather, standard benefits would be determined in the marketplace. A plan would meet the criterion for a standard policy if its actuarial value was within 5 percentage points of a target actuarial value that could vary by geographic area. The target would be "the average actuarial value of a representative range of the different types of health benefits provisions (which include cost-sharing) typically offered as standard coverage in the small employer health coverage market." Similar provisions would apply to catastrophic plans.

The proposal does not require that insurers restrict the difference in premiums between catastrophic and standard policies to reflect the difference in the actuarial value of the two policies for a standardized population. Rather, it explicitly applies the community-rating provisions separately to each type of plan. Insurers wishing to focus primarily on catastrophic insurance, therefore, could price their

standard policies at levels designed to discourage enrollment in those plans. If the catastrophic and the catastrophic-plus-MSA options proved to be attractive to healthy individuals and to small firms with relatively healthy employees, people currently purchasing standard policies might drop out of the standard pools, thereby raising risk levels in those pools and causing premiums for standard policies to rise across the board.

Effective mechanisms for adjusting premiums among health insurers for the actuarial risk of their enrollees would be essential in community-rated health care markets in which insurers had both incentives and opportunities to select favorable risks. Under the proposal, states would be required to develop a mechanism to compensate plans enrolling large numbers of people with preexisting conditions in the initial 45-day open-enrollment period, during which there would be amnesty for preexisting conditions. The Secretary of Labor would also develop and implement mechanisms to compensate fully insured plans in the small-group market for any deterioration in the risk pool resulting from the provision allowing small firms to self-insure. In addition, states would be required to establish programs for reinsurance or for allocating risk to compensate health insurers that enroll high-risk individuals. As with all health care proposals, however, risk-adjustment mechanisms would be difficult to develop and implement since neither the technology nor the data currently exist. The lack of market structure and standardization in this proposal would compound those problems.

The Option of Catastrophic Coverage and a Medical Savings Account

Congressman Michel's proposal would facilitate a new type of insurance coverage that would combine a high-deductible (or catastrophic) insurance policy with a tax-favored medical savings account. Contributions to an MSA would be deductible or excludable from taxable income, expenditures from the account for medical care would be tax exempt, and in this proposal, interest earned on funds in the account would not be taxed. The availability of the catastrophic-plus-MSA option would exacerbate the problem of adverse selection.

Catastrophic insurance would cost less than standard insurance but would leave the purchaser exposed to the risk of higher expenses for health care. Because of the phase-in of the deduction for contributions to MSAs and the delay of eligibility for people with employer contributions, few people would choose the option before 1999. Thereafter, it would probably become increasingly popular. In any given year, more than half of the people under age 65 spend less on medical care than they would be likely to save in premiums by switching to the catastrophic-plus-MSA option, and many would do so. Nonetheless, some people who could expect to gain financially based on their normal medical spending would be unwilling or

unable to bear the risk of added out-of-pocket expenses and would choose standard coverage instead.

In the long run, the existence of any type of catastrophic-plus-MSA option that would be attractive to a large number of people could threaten the existence of standard health insurance. When such an option was first offered, healthier people would be more likely to choose it than would less healthy people because they would have a smaller risk of added out-of-pocket medical expenses. After the people with low health expenditures left the standard insurance pool, the premiums for standard insurance would have to increase to compensate insurers for the higher average rate of claims that would result. In turn, higher premiums for standard coverage would increase the incentive for the healthiest people remaining in the standard pool to opt for the catastrophic-plus-MSA option. The process could continue until the differential between premiums in the two plans exceeded the difference in deductibles. If that happened, even people who were sick would find it advantageous to elect the catastrophic-plus-MSA option. Because most families have limited savings, those without an employer contribution to an MSA could then face unmanageable out-of-pocket expenses.

Under this proposal, the problem of adverse selection would most threaten the small-group and individual markets, because the proposal would require insurers in those markets to offer a choice of standard and catastrophic insurance. Larger employers that continued to offer standard insurance could avoid adverse selection by not offering catastrophic insurance. However, because workers with low income and those without employer-sponsored coverage predominate in the small-group market, a weakening of the demand for standard coverage could imperil the small increase in insurance coverage that might otherwise occur under the proposal.

The contribution of the catastrophic-plus-MSA option to containing health care costs is uncertain. The option would increase the incentive to shop prudently for medical care by eliminating insurance coverage of routine care. In recent years, several firms that offered workers cash bonuses in exchange for reduced insurance coverage have reported sizable reductions in medical spending. However, such experience is limited, the results have not been scrutinized, and the outcomes may not be typical. Research conducted by RAND provided a more controlled test of how spending for insured medical care responds to changes in cost sharing. The RAND experiment found that people with higher cost sharing that was similar to the higher costs associated with the catastrophic-plus-MSA option reduced their spending for insured medical care by between 7.5 percent and 15.0 percent.

The potential for curbing national health spending promised by the catastrophic-plus-MSA option, however, would be weaker than the RAND experiment implies, for two reasons. First, the gains from increased cost sharing in that

experiment were achieved strictly within the fee-for-service insurance market, whereas the catastrophic-plus-MSA option might attract people out of group- and staff-model health maintenance organizations (HMOs). These people would no longer benefit from the efficiencies of HMOs. Second, although the option could reduce spending for insured medical expenses, it might increase spending for uninsured medical expenses. Uninsured expenses are now purchased with after-tax income but would become tax-exempt expenditures with an MSA. Such expenses include those for eyeglasses, orthodontic work, and some psychiatric care.

The effect of the catastrophic-plus-MSA option on the administrative cost of insurance coverage is also uncertain. By reducing the extent of insurance coverage, the option would cut the costs that insurance companies incur for processing claims, but it would bring new costs for monitoring the accounts to ensure that withdrawals for nonmedical spending were taxed.

Apportionment of Subsidies to States

Under the formula for allocating the available funds to the states, those that had done the most to expand coverage for children under Medicaid would benefit the least. A state's share of the funds for children's subsidies would be based on the proportion of all children eligible for subsidies nationwide who lived in the state. Children who were eligible for Medicaid under the state's plan at the time the act was passed would generally be ineligible for subsidies. Consequently, states that have significantly expanded their Medicaid programs for children in families with income above the poverty level would be at a distinct disadvantage; the funds those states would receive under the program would be disproportionately low relative to their actual numbers of low-income children. States with a large population of aliens would also be at a disadvantage.

Economic Effects

Congressman Michel's proposal would have little net effect on total employment or the overall economy. But like the other health reform proposals, it would redistribute insurance costs within the economy and could therefore have significant consequences for some small firms and their employees. Insurance costs would be redistributed because insurance in the small-group market would be subject to a modified form of community rating. Depending on the extent of catastrophic coverage and the success of states' risk-adjustment efforts, small employers with relatively sicker workers (or those in higher-risk industries) could pay less for insurance than under current policy. Those gains would ultimately translate into higher wages--and broader insurance coverage--for their workers. At the same time, small employers

in low-risk industries or those with relatively healthy workers might pay more for insurance, ultimately reducing the wages or insurance coverage of their workers. For the overall labor market, however, the redistributions among workers could largely even out.

Other features of the proposal are also unlikely to have much of an effect on the economy. For example, although phasing out the subsidies for children in families with income between 185 percent and 240 percent of the poverty level would implicitly tax the economic advancement of those families, the effect on the overall labor market would be small because few subsidized families would have income in this range. In addition, the proposal would have little effect on national saving. As discussed earlier, the federal budget deficit (that is, government dissaving) would remain largely unaffected, and private saving would not change much either. Indeed, the proposal would generate only small, temporary effects on private saving. On the one hand, some households might save less because they would face a reduced risk of becoming uninsured. On the other, some households who chose catastrophic health plans might save more to cover their potentially larger out-of-pocket expenses.

Table 1. Estimated Federal Budgetary Effects of Congressman Michel's Proposal
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
	Revenues									
Deduction for health insurance expenses	-1.1	-1.3	-2.2	-3.4	-5.6	-6.2	-6.8	-7.5	-8.2	-9.0
Medical savings accounts	a	-0.1	-0.2	-0.2	-0.3	-0.4	-0.4	-0.6	-0.7	-0.8
Increase Medicare Part B premium for high-income individuals	0.2	0.4	0.5	0.7	0.9	1.1	1.4	1.8	2.3	3.0
Clarify tax treatment of premiums for long-term care insurance	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Treat qualified long-term care services as deductible medical expenses	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4
Other revenue proposals	a	a	a	a	a	a	a	a	a	a
Total	-1.1	-1.3	-2.2	-3.2	-5.4	-5.9	-6.2	-6.7	-7.0	-7.3
	Outlays									
Mandatory spending										
Low-income subsidies	0	0	4.7	5.2	6.5	9.8	12.3	15.3	20.0	24.4
Medicare health maintenance organizations	a	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Prefund Postal Service retiree health contributions	0	-2.4	-2.5	-2.6	-2.6	-2.8	-2.8	-2.9	-3.0	-3.1
Protection of assets for Medicaid long-term care	0	0.1	0.2	0.4	0.4	0.5	0.5	0.6	0.7	0.7
Limit Supplemental Security Income and Medicaid for aliens	-0.1	-3.2	-3.6	-3.9	-4.3	-4.7	-5.1	-5.7	-6.2	-6.9
Repeal vaccine program	-0.3	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
Limit SSI for drug abusers	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Reduction in payments for disproportionate share hospitals	-1.1	-1.1	-2.5	-2.7	-3.7	-4.2	-4.7	-5.2	-5.7	-6.3
Extend Medicare secondary payer provisions	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Extend Part B premium	0	0	0	0	-1.2	-3.4	-5.9	-8.9	-12.7	-16.0
Other mandatory spending	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	a
Discretionary spending	0.2	0.5	0.6	0.7	0.8	0.9	0.9	0.9	0.9	1.0
Total	-1.2	-6.2	-3.2	-3.2	-5.5	-6.0	-7.0	-8.1	-8.5	-8.7
	Deficit									
Mandatory	-0.3	-5.5	-1.6	-0.7	-0.9	-1.0	-1.7	-2.4	-2.4	-2.3
Total	-0.1	-4.9	-1.0	a	-0.1	-0.1	-0.8	-1.4	-1.5	-1.4

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

a. Less than $50 million.