

HEALTH INSURANCE: THE PRO-COMPETITION PROPOSALS

ISSUE BRIEF NUMBER IB81046

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DATE ORIGINATED 03/18/81
DATE UPDATED 12/06/82

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ISSUE DEFINITION

For more than a decade, Congress and the Executive Branch have tried to stem spiralling health care costs through various regulatory actions at the Federal and State levels. Planning laws, for example, focus regulatory attention on the capacity of the health care industry to provide health services. Other laws have created programs to monitor and control the use of services provided to individual patients. Direct wage and price controls were applied to the health industry in the early 1970s, and in recent years Congress has debated whether to impose controls over hospital spending in the United States.

It has been suggested, however, that there are alternatives to such regulatory approaches and that it may be possible to increase efficiency and economy in our health system by fostering competition among insurers and the providers of health services, such as doctors and hospitals. Advocates of this so-called "pro-competition" strategy recommend that several steps be taken to achieve such competition. These include: changing Federal health laws and programs to encourage competing health plans and insurance arrangements, providing beneficiaries with informed choices among the competing alternatives, eliminating legal constraints on competition in the health area, and requiring consumer cost-sharing in the purchase of health services. Other proposals have been made to extend the pro-competition approach to public programs (see CRS IB81179, Health Insurance: The Medicare Voucher Proposals). Several legislative proposals containing these elements have been introduced in the 96th and 97th Congresses. In addition, the Administration began development of its competition strategy in the summer of 1981. In 1982, the Department of Health and Human Services approved a number of grants, contracts, and waivers of current reimbursement methods for the development of Medicare and Medicaid competition demonstration projects. (See Section 6 of this Issue Brief.)

BACKGROUND AND POLICY ANALYSIS

1. Competition vs. Regulation

Health care costs in the United States continue to soar, placing strains on publicly financed health care programs, on employers who provide health benefit coverage for workers and their dependents, and on individuals who must pay for medical care from their own personal resources. Health expenditures now represent almost 10% of the Gross National Product and account for more than 10% of the entire Federal budget. (See CRS Issue Brief IB77066, Health Care Expenditures and Prices.)

In recent years, some observers of the health care system in the United States, including several free-market economists, have suggested that the causes of runaway inflation in the health sector are the perverse incentives that promote overutilization of health services and unnecessary spending for health care. Specifically, they cite:

- The Third-Party Payment System. Most health care expenditures are paid for by third-party payment organizations (commercial health insurers, Blue Cross and

Blue Shield organizations, Medicare and Medicaid) that insulate the consumers of health care from the actual costs of care at the time it is provided. Health practitioners, aware that most bills will be paid for by some third-party, have few constraints on the types or quantity of the services they order or provide. The third-parties themselves also play a largely passive role in controlling costs.

- Fee-for-Service Payment to Physicians. Most independent physicians charge for their services on a service-by-service basis. Under this arrangement, the more services practitioners render, the more compensation they receive. Physicians determine both the quantity and the prices of the services they render. The consumer plays virtually no role in this process.
- Cost Reimbursement for Hospitals. Most third-party payments to hospitals are made on the basis of the costs to the institutions of providing patient services. As a result, there are no incentives to constrain spending, since lower costs mean lower revenues; on the other hand, more spending means greater revenues. There is virtually no price competition among hospitals and no shopping around for care by prospective patients. Physicians usually dictate the necessity of a hospital admission and where it will take place.
- Impact of the Tax Laws. The tax treatment of health benefits distorts the provision and purchase of health insurance by encouraging more coverage than warranted and thereby increasing the demand for health services.

Most of the public policy responses made in recent years to rising health costs have taken the form of economic regulation. Advocates of various regulatory steps to control health spending have held that the health care industry is inherently anti-competitive and have demanded responses, such as:

- Planning controls on hospital capacity through certificate-of-need programs that require prior approval before hospital expansion can be undertaken.
- Utilization controls over hospital services by requiring hospitals to develop hospital utilization review programs and by creating a national system of professional standards review organizations (PSROs) to review the appropriateness of hospital care financed by the Medicare and Medicaid programs.
- Establishment of limits on physician fees under Medicare and Medicaid, and by direct controls over fees during the economic stabilization program (of wage and price controls) during the early 1970s.
- Controls over hospital spending through a variety of means, such as limits to health reimbursements under Medicare and Medicaid, hospital rate-setting and budget review programs in various States, direct

controls during the economic stabilization program, and the 3-year effort of the Carter Administration to impose limits on annual increases in hospital spending.

These steps, free-market supporters argue, have not only failed to stem rising health care costs; they have actually helped raise costs to health consumers. What is needed instead, in their view, is a complete restructuring of the American health system in a direction away from regulation and toward greater competition.

The advocates of the pro-competition strategy recommend major changes in employment-based health benefit programs and in the overall tax treatment of such benefits. Some also suggest that the principles of competition be extended to the design of public health care programs as well. Among other things, these advocates support legislation that would eliminate much of the present regulation in the health industry and rely instead on competitive forces to produce an economic and efficient health care system. There are four principal elements to the pro-competition approach:

- Periodic Multiple Choice. Each consumer of health services should be offered periodically the opportunity to enroll in any one of several qualified health care plans.
- Fixed Dollar Subsidies Toward Benefit Protection. The amount of financial help that a consumer might receive toward the purchase of health plan membership (whether from an employer, Medicare, Medicaid or under the tax laws) should be in the form of a fixed dollar amount. Persons choosing more costly coverage would have to pay the extra cost themselves.
- Equal Rules for All Competitors. There should be a uniform set of rules, such as those governing minimum benefits, premium-setting practices, etc., for all health plans.
- Providers in Competing Economic Units. Physicians and other health care providers should be encouraged to join together in economic units (e.g., health maintenance organizations or other groups) that would compete to offer quality health services at the most competitive price.

2. Growth and Costs of Employment-Based Health Benefits

Advocates of the pro-competition approach would apply the principles described above to employment-based health benefits, the growth of which has been dramatic during the last 30 years. In 1950, health insurance premiums written by commercial health insurers and by Blue Cross and Blue Shield organizations amounted to almost \$2 billion. By 1979, the figure reached over \$66 billion. The majority of these premiums are for employment-based benefits. Several factors have contributed to this growth:

- Wage controls during World War II. Wage and price controls were imposed by the Federal Government during the Second World War in an effort to control inflation. However, fringe benefits, including insurance plans, were

excluded from these controls. Expanded benefits, including health insurance, were offered by many employers as a means of attracting and retaining workers.

- Collective bargaining. The Wagner Act (National Labor Relations Act of 1935) gave employees the right to organize unions and bargain collectively with employers over wages, hours and other conditions of employment. In 1948, the National Labor Relations Board ruled that the term "wages" included items such as pensions and insurance benefits. As a result, health benefits have become an important part of the collective bargaining process.
- Favorable tax treatment. Since World War II, much of the growth in health and other fringe benefits has been the result of the favorable tax treatment accorded such benefits when provided in a work setting (see 3 below).

Data gathered by the U.S. Chamber of Commerce indicates that health benefits are not only a significant portion of all employee fringe benefits, but also among the fastest growing as well. For example, all fringe benefits for workers, measured as a percent of payroll, rose from 26.6% in 1967 to 37.3% in 1981, an increase of about 40%. Employers' costs for insurance (including hospital, surgical, medical, major medical and a small amount of life insurance) grew from 3.2% of payroll in 1967 to 6.0% in 1981, an increase of 88%.

The tremendous increases in the costs of health benefits to employers have led many of them to adopt various steps to control expenditures for employee health programs. Employers have:

- Attempted to lower costs through tighter administrative controls, such as better claims review, and by self-insuring.
- Changed plan design to alter utilization of employee health services through, for example, employee cost-sharing, second opinions prior to surgery, hospital utilization review.
- Attempted to control the prices charged for employee health services by purchasing certain items in volume or by negotiating fees and discounts.

Most of these steps, however, have only had a marginal impact, if any at all, on rising health benefit costs for employers. Overall, employers seem to have had little success in controlling provider costs, have often met with employee resistance to many of the steps, and have addressed none of the underlying causes of health care inflation.

3. Tax Treatment of Health Benefits

Advocates of pro-competition proposals believe that major changes are needed in the current tax treatment of health benefits because present tax policies distort decisions about the kind and amounts of health coverage

purchased.

Tax treatment of health insurance, in a number of different ways, is favorable to insured individuals. This tax treatment includes the exclusion and deduction of premiums for employment-based health benefits, the medical expense deduction, and the health insurance premium deduction:

-- Employer Contributions Excludable From Taxable Employee Income. The most important tax subsidy found in the Internal Revenue Code regarding health benefits is the exclusion from personal income taxation of the payments made by an employer for a health plan (Sec. 106 of the Code). This so-called "employer exclusion" creates a tax-shelter for workers who receive part of their compensation in the form of health benefits rather than as wages that would be subject to personal income tax. Advocates of the competition approach argue that this tax feature lowers the net cost of the non-taxable fringe benefits and thereby creates more of a demand for the benefit than would exist in the absence of such an incentive. The value of this tax feature increases with rising marginal tax rates, i.e., the benefit is greater for those in higher brackets than for those in lower brackets.

-- Medical Expense Deduction. Certain non-reimbursed and itemized expenses for medical care can be deducted from gross personal income. Present law (Sec. 213 of the Code) permits such deductions to the extent that they exceed 3% of the adjusted gross income (AGI). Drug expenses in excess of 1% of AGI may be counted to determine whether the 3% threshold is reached. These criteria are intended to establish that the taxpayer has had "extraordinary" health care and drug expenses that reduce the ability to pay taxes. The value of this itemized deduction, like all deductions, also rises with income. The deduction can be taken only by persons who itemize their personal tax returns. Section 202 of P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982, amends this provision by raising the floor for deductible medical expenses from 3% to 5% of AGI, effective after Dec. 31, 1982. In addition, the 1% floor for drug expenditures is eliminated and only drug expenses for prescribed drugs or insulin will be allowed, effective after Dec. 31, 1983.

-- Health Insurance Premium Deduction. The medical expense deduction feature of the present tax code contains a provision (also in Sec. 213) which allows the individual taxpayer to deduct one-half of any health insurance premiums paid by an individual, up to \$150 a year. This includes premiums paid by an individual to a group benefits plan, if such contributions are required, and any premiums paid for a plan purchased on an individual basis. Any premiums not counted under this test may be included in the amounts added up to determine whether the "extraordinary" expense (3% of AGI) test can be met. Effective after Dec. 31, 1982, Section 202 of P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982, eliminates this deduction. However, amounts paid for insurance may be counted toward the medical expense deduction (5% of AGI).

-- Employer Contributions as Deductible Business Expenses. The Internal Revenue Code permits employers to deduct as business expenses contributions to employee health plans regardless of the design or features of such plans (Sec. 162(a)). Some of the sponsors of pro-competition legislation would permit continued employer deductibility of such contributions only if certain requirements were met.

The amount of Federal subsidy through the tax code represents "tax expenditures," which are revenue losses to the Treasury arising from a

provision in the tax code that extends special or selective relief to certain groups of taxpayers. According to the President's FY83 Budget Proposal, FY83 tax expenditures for health will amount to about \$16.4 billion for the employer exclusion and an additional \$4.2 billion for the medical expense deduction (including the deduction for health insurance premiums). In addition, the tax subsidies for health benefits also result in further losses to State income taxes and lower Social Security revenues, totaling approximately \$10 billion. As a result, tax subsidies for health benefits comprise one of the largest Federal programs to finance health care.

4. The Elements of Pro-Competition Proposals

There are several elements that can be found in the various pro-competition proposals. These elements fall into two broad categories:

- Those which make changes in the way in which employers provide health benefits to their employees, and
- Those which change the tax treatment of health benefits.

Limit the Employer Contribution to a Maximum Amount. One of the elements contained in pro-competition proposals places a limit or cap on the amount an employer could contribute toward the premium cost of a health plan. Contributions in excess of that limit would be included in the employee's gross taxable income. Advocates of such a limit argue that:

- Employees would become more cost-conscious in the selection of their health plans if the employer contributions were limited,
- Limits on the amount of the employer contribution that is deductible as a business expense would decrease the amount of Federal subsidy toward the purchase of private health insurance.

Some problems have been raised about proposals to limit the employer's contribution:

- A national flat limit would not take into account the differences in the cost of providing benefits in one geographic area as opposed to another,
- A limit would discriminate against employment groups with a high proportion of older workers or less healthy workers whose health costs are greater,
- A limit on the employer's contribution could reduce an employer's incentive to be concerned about health care costs

if he is presently at or above the limit,

- A limit might increase the possibility that some employers would decrease or "roll-back" existing benefits for employees now receiving contributions greater than the limit.

Require a Choice of Plans and an Equal Employer Dollar Contribution to Each. Another element of pro-competition proposals is a requirement that the employer offer a choice of plans or plan options, with an equal dollar contribution by the employer to each plan or option offered. Presently, the majority of employers offer a single health insurance plan to their employees. In addition, many pro-competition proposals provide financial incentives for employees to choose lower cost health plans or options. The incentives would take the form of rebates to the employees who select lower cost coverages.

The intended effects of the multiple choice option, the equal employer contribution requirement, and the rebate are that:

- Employees should have the opportunity to choose among various plans, with an economic incentive to choose a lower cost plan or option,
- These requirements would potentially promote greater competition among insurers to offer the most attractive low-cost option,
- Health care providers, such as doctors, would be encouraged to organize themselves into competing economic groups in order to offer the most attractive low-cost option.

Some problems which have been raised with the multiple choice provision include:

- The administrative costs to the employer would probably be increased by having to offer more than one plan or option,
- By requiring an employer to offer more than one plan, less efficient carriers might be assured a market they do not now have.

Require Plans to Contain Cost-Sharing Features. Patient cost-sharing requirements in health insurance plans are defined as any requirement that covered individuals pay some portion or share of their covered medical expenses. Patient cost-sharing could include deductibles, which are the dollar amounts the patient must pay initially before the insurer will assume any liability for the remaining covered services; coinsurance, or a percentage of the eligible expenses for which the patient is liable; and copayments, or flat dollar amounts required per unit of service or unit of time.

Several reasons are suggested by pro-competition advocates for including patient cost-sharing requirements in health insurance plans:

- Cost-sharing requirements would motivate the insured person to be more careful about incurring health expenses, since he must pay a portion of his medical bills,
- Patient cost-sharing establishes limits on the insurer's liability and, as a result, limits the premium cost of the insurance.

However, critics of patient cost-sharing requirements point out that:

- It is unclear whether economics is the overriding factor in matters of health care, even more important than psychological, personal, and family considerations, or the other influences that may affect how individuals seek or use medical care,
- Deductibles and coinsurance can be made large enough to deter most persons from obtaining care, but some question whether this should be one of the goals for health insurance,
- Postponement of needed treatment may lead to complications or other conditions that ultimately require even more expensive treatment later on,
- Usually the choices about type and quantity of the health services used are determined not by insured patients but by physicians and other practitioners who are not significantly influenced by patient cost-sharing requirements.

Repeal the Tax Deduction for Health Insurance Premiums. The health insurance premium tax deduction allows taxpayers to deduct one-half of their health insurance premiums, up to a limit of \$150. This deduction is a tax subsidy designed in part as an incentive for the purchase of health insurance. There are various reasons given for eliminating the health insurance premium deduction:

- The deduction may encourage people to buy more health insurance, further stimulating health care spending,
- The deduction provides greater benefit not for the low-income, but for upper-income taxpayers. This happens because persons who do not itemize deductions, a group that includes most low-income persons, cannot benefit from it. Also, tax savings depend on taxpayers' marginal rates, which increase with rising taxable income. Taxpayers with higher taxable incomes

receive higher subsidies for each dollar of deductible expenses. (This tax deduction was eliminated, effective after Dec. 31, 1982, by Section 202 of H.R. 4961, the Tax Equity and Fiscal Responsibility Act of 1982.)

Include Employer Contributions as Employee Income. The exclusion of employer health contributions from employees' taxable income provides a considerable incentive for employees to bargain for, and for employers to offer, more health benefits coverage. It has been argued by the pro-competition advocates that the exclusion thus encourages employees to purchase more insurance than may be necessary, leading to inefficiency and excessive cost in the use of health services. With extensive insurance coverage, there is little reason for the employee or the health care provider to be cost-conscious about the type or quantity of health care provided.

The exclusion of employer-provided health contributions is used as a means of "encouraging" employers to offer health plans which are consistent with the pro-competition approach. For example:

- The exclusion could be made available only if the employer-provided health plan meets certain standards, such as cost-sharing requirements, minimum benefits, multiple choice of plans, or an equal employer contribution to each,
- The exclusion could be made available only if the employer did not exceed a limit on the amount of employer contribution to a health plan; in other words, contributions in excess of the limit would not be excluded from employee income.

One of the problems with eliminating the exclusion is that employees could be penalized for an employer's failure to comply with any plan requirements.

Increase or Eliminate the Medical Expense Tax Deduction. The medical expense tax deduction allows taxpayers to deduct unreimbursed medical expenses exceeding 3% of adjusted gross income. The deduction is a tax subsidy designed to cushion the impact of medical costs not covered by health insurance.

Raising the deduction level would reduce the revenue losses from the provision and provide the tax subsidy only to those taxpayers with very large medical outlays which are unreimbursed by insurance. Raising or eliminating the deduction could introduce an element of cost-consciousness in those taxpayers who can avail themselves of this tax provision. (The 3% floor on this tax deduction was raised to 5%, effective after Dec. 31, 1982, by Sec. 202 of H.R. 4961, the Tax Equity and Fiscal Responsibility Act of 1982.)

Convert the Medical Expense Tax Deduction to a Tax Credit. Another element sometimes included in considerations about changing incentives under the tax laws which affect health benefits would change the medical expense deduction to a tax credit. Reasons given for the change:

- It would then be possible for all taxpayers to receive the same rate of subsidy for each dollar contribution to a health plan, regardless of their income,

- Since the tax subsidy would be fixed and would not vary with the price of the health insurance option chosen, it should encourage employees to purchase less expensive health plans,
- The subsidy would be available to all taxpayers, not just those who itemize their deductions.

5. Problems and Concerns

A number of questions have been raised in connection with some of the elements of the pro-competition proposals:

Adverse Selection. The principle behind adverse selection is that people who obtain insurance or increase their coverage are generally those who want or need it the most, usually those who represent a greater-than-average probability of risk. Though adverse selection is a problem in any insurance scheme, it may be particularly troublesome if individuals are not only permitted to choose among plans or plan options but are also strongly encouraged to do so by means of certain incentives, such as cash rebates. If employees are offered a choice between a low-cost option, which might contain more patient cost-sharing or fewer benefits, and a more costly, more comprehensive plan with little or no patient cost-sharing, those employees who expected few medical expenses in the near future could be expected to pick the low-cost plan. Those employees who expected substantial medical expenses might be expected to join or, if given the opportunity to change their enrollment, might switch to the more comprehensive plan until their medical needs were taken care of. If all the high medical risks shifted to the more comprehensive plans, the costs of the comprehensive plans would soar, and the benefits of spreading risk among all members of a group with varying levels of health care needs would diminish.

Desire for Insurance. Will people choose to have less health insurance coverage? Experience under the Federal Employees Health Benefits Program and other programs indicates that most people seem to have a preference for more comprehensive, low-deductible coverage. Will rebates or other types of incentives change people's ideas about how much insurance coverage they think they need?

Incentive Not to Insure Adequately. Will offering incentives, such as cash rebates, to choose low-cost insurance options encourage certain persons to purchase less health benefits coverage than they or their dependents might need?

Information Costs. For a competitive market to work, it is necessary that buyers of health care be reasonably well-informed about the alternatives they are considering in order to make intelligent choices for themselves. Health care and health insurance are very complex fields, very difficult for the average person to understand fully. What must be done to make it easier for the average health care consumer to understand his purchase of health care services or health insurance? What would be the cost to the system of any changes or education process that might be necessary? Do health care consumers want to become better informed and shop around for health care and health insurance?

Cost Containment. Will there be actual cost savings under the

pro-competition approaches, or would costs merely be shifted to another part of the health care system? For example, would consumers end up paying a greater portion of their health bills? Would bad debts increase, forcing providers of health care to shoulder more of such costs?

Pressure on Providers of Health Care to Lower Prices. Probably the most important question is whether by changing insurance incentives, it follows that provider pricing behavior can be influenced. Armed with low-option health plans, will patients then shop around for the hospital or doctor charging the least expensive prices? Can the pro-competition approaches generate enough or the right kind of market pressure on providers to lower the prices of health care services? Would an incentive for providers to lower prices lead to any decreases in the quality of care?

6. Recent Administration Activity

In 1982, the Department of Health and Human Services awarded a number of grants, contracts, and waivers of Medicare reimbursement methods for the development of Medicare and Medicaid demonstration projects in the area of competition. Contracts and/or waivers were awarded in October 1982 to 21 organizations for the development of Medicare competitive health care systems in 24 cities across the country. The demonstration projects were designed to encourage competition among insurers and providers by allowing Medicare recipients a choice of alternative health plans which would compete for beneficiaries by providing more attractive benefits at reduced costs. Included in the projects are a broker model, where the broker will perform centralized enrollment and marketing activities for all the Medicare beneficiaries in a county, and preferred provider organizations, which are panels of providers which provide services according to negotiated fee schedules, usually at a discount.

Grants were awarded in August, 1982, for the development of Medicaid competitive health care systems in Florida, Minnesota, Missouri, New Jersey, and New York. The projects are designed to measure potential savings in health costs by paying a fee in advance for Medicaid enrollees rather than the traditional fee-for-service payments. Some of the concepts to be tested include: consumer choice models, where beneficiaries will be offered various choices of prepaid health care options; competitive bidding to determine the most cost effective providers from which beneficiaries can then select; vouchers for the purchase of health insurance; and case management, where primary care physicians will be given responsibility for the management of a patient's care.

LEGISLATION

The major pro-competition proposals introduced in the 97th Congress include:

S. 139 (Hatch) (Identical to S. 1590 introduced by Sen. Schweiker in the 96th Congress)

Comprehensive Health Care Reform Act. Federal Tax Benefits. Prohibits the exclusion of employer health plan contributions from employee taxable income and the deduction of employer health plan contributions as business expenses unless the employer meets the requirements of this legislation.

Copayment Option. Requires employers to offer their employees, if such plans are available, at least one group health benefit plan for inpatient hospital services having an annual copayment for hospital services of at least 25%, which would be paid by employees. Specifies that the copayment would not apply when the employee and his family incurred, during a calendar year, out-of-pocket medical expenses which exceed 20% of the family's combined earnings. Specifies that if employees are represented by collective bargaining or other employee representative, the offer of the copayment option plan must first be made to such representative and, if accepted, would then be made to employees. Employer Contribution and Employee Rebates. Requires employers who pay for group health benefit plans for their employees to make the same payment per enrolled employee toward each plan offered, regardless of the actual premium cost of a plan. If the employer's payment is more than the premium cost of the health plan selected by the employee, specifies that the employee would receive the excess amount in cash or other benefits from the employer. Provides that this excess amount would not be considered taxable income to the employee. Prohibits employers from lowering the amount of their payments per employee for health plans after the effective date of the bill, except to comply with the requirement that employers pay for a health benefit plan no more than the premium cost of the most costly health plan offered by the employer in which at least 10% of his employees are enrolled. Multiple Choice of Health Plans. Requires employers having at least 200 full-time employees to offer a choice to employees of not less than three qualified health plans, offered by different carriers, to the extent that such plans are available. Catastrophic Illness Insurance. Prohibits the exclusion of health plan contributions and the employer deduction, for employers with 50 or more full-time employees, for contributions to health plans which do not include catastrophic benefits, coverage of dependents, and coverage continuity as described in this legislation. Requires health benefit plans to pay for medical expenses for the covered employee and family, without any cost sharing, when the employee and family have incurred in a calendar year out-of-pocket medical expenses which exceed 20% of the family's combined earnings. Requires all carriers (including voluntary associations, corporations, partnerships or other non-governmental organizations which provide, pay for, or reimburse health services, including health plans sponsored by employee organizations) to enter into arrangements in each State where they do business in order to provide catastrophic insurance and preventive care coverage to individuals in the State who are not eligible for (a) group health benefit plans providing qualified catastrophic and preventive coverage and (b) government programs of health care. Prohibits any carrier failing to meet these requirements from participating in any health benefits program paid for with Federal funds. Establishes catastrophic benefits under the Medicare program. Preventive Care. Prohibits the exclusion of health plan contributions and the employer deduction, for employers with 50 or more full-time employees, for contributions to health plans which do not include certain preventive care services.

S. 139 was introduced Jan. 15, 1981; referred to Committee on Finance.

H.R. 850 (Gephardt/Stockman) (Identical to H.R. 7527 introduced in the 96th Congress)

National Health Care Reform Act of 1981. Actuarial Categories and Healthcare Areas. Requires the Secretary (of Health and Human Services) to establish actuarial categories (an aged and disabled category, and other categories based on age, sex, marital status, and dependents) in order to determine healthcare contributions and premium charges under this

legislation. Also requires the Secretary to divide the country into healthcare areas (urbanized and nonurbanized). Healthcare Contributions. Entitles all U.S. residents who are either citizens or lawful resident aliens to a healthcare contribution. Specifies that the contribution could take several forms: (1) for employees whose employers pay amounts towards the premiums of qualified health plans, an exclusion from income subject to Federal tax equal to the amounts paid by the employers; (2) for individuals who purchase qualified health plans, a refundable tax credit equal to the amount paid for premiums; (3) for aged or disabled individuals, a voucher enabling such individuals to purchase qualified health plans as an alternative to the Medicare program; and (4) for certain low-income individuals, a voucher enabling such individuals to purchase qualified health plans (if the individual's State has elected not to participate in the Medicaid program). Excludes employer health plan contributions from gross employee income only if certain conditions are met, including: the employer has determined, before the employee's selection of a qualified plan and without regard to the health plan selected or the premium of such plan, the maximum amount of contribution the employer will make toward the premium of a health plan selected by an employee; the employer agrees to pay each employee an amount equal to any amount by which the premium of the qualified plan enrolled in by the employee is less than the maximum payment amount agreed to by the employer (rebate), up to a limit of \$500 increased or decreased by changes in the GNP deflator; and continuity of coverage requirements. Sets a limit on the maximum amount an employer may contribute to a health plan, equal to the larger of (1) in 1984-1986, the Federal healthcare contribution for aged individuals, and in 1987 or later, the weighted average of premiums of qualified plans for similar actuarial categories and healthcare areas, increased or decreased by changes in the GNP deflator; (2) the amounts paid on behalf of the employee by the employer for medical or hospital costs which were excluded from gross employee income during 1980; or (3) the amounts paid by the employer on behalf of the employee for medical or hospital costs under terms of a collective bargaining agreement agreed to before Jan. 1, 1981.

Qualification of Plans. Requires the Secretary to certify health plans as qualified if they meet the following requirements: provision of specified basic health care services; membership by written agreement with the enrollee; enrollment of local residents only; periodic open enrollment; enrollment of spouse and dependents of an enrolled individual; establishment of annual premiums in each healthcare area, for each actuarial category, including any copayment amounts not to exceed \$2,900 (changed in subsequent years according to the percentage increase or decrease in the Gross National Product deflator), except for low-income individuals with vouchers, who cannot be charged for any out-of-pocket expenditures; reporting requirements concerning enrollment, changes in coverage, and financial information; preparation and distribution of detailed brochures describing plan coverage and other plan information; and the plan agrees to permit members to refuse the provision of a health care service by a person designated by the plan to provide that service, and permits health personnel to refuse to deliver a modality of health care service for professional, ethical, or moral reasons.

Other Health Plan Provisions. Establishes the rights of qualified plans and health care deliverers. Establishes the actions for which a qualified plan could be disqualified, such as reduction of services, increase in out-of-pocket expenditures beyond the limits of the legislation, and anti-trust violations. Requires the Secretary to prepare and distribute pamphlets describing the qualified plans in each health care area.

Plan Membership Provisions. Authorizes individuals to act as healthcare agents for eligible individuals, or groups of 25 or less eligible individuals. Prohibits Federal payments to States under titles III (Unemployment Compensation) or IV (Aid to Families with Dependent Children and Child

Welfare Services) of the Social Security Act unless the State makes payments only to individuals who are members of qualified plans. Authorizes payments under title XVI (Supplemental Security Income for the Aged, Blind and Disabled) and the Food Stamp Act of 1977 only if the individual is a member of a qualified plan. Repeals authorization for the Federal Employees Health Benefits Program, requiring the Federal Government to make contributions in specified amounts toward the premium cost of a health plan chosen by the employee. Plan Administrative Provisions. Authorizes the Secretary to permit Federal guarantees of policies of insurance or reinsurance issued to qualified plans or self-insurance programs of qualified plans. Establishes within the Treasury Department a Health Benefits Assurance Corporation to provide financial certification and review of qualified plans and to establish a protective fund, composed of per capita contributions from all qualified plans, to assure the provision of health services to members of qualified plans that are unable to meet their financial obligations. Authorizes the Secretary to make payments to healthcare service deliverers that have furnished basic health care services to individuals who are not qualified plan members and have not been able to collect payment for such services. Arbitration and Criminal Penalties. Establishes procedures for arbitration of claims. Establishes a United States Health Court and Health Court of Appeals to have jurisdiction over all civil claims and disputes arising under this legislation. Specifies criminal penalties for violations under this legislation. Miscellaneous Provisions. Authorizes the Secretary to make grants or contracts to compensate entities that are not educational institutions for not more than 70% of the direct cost of providing graduate medical education and training for health care professionals. Preempts all State and local laws, regulations and administration actions which interfere with the implementation of this legislation. Authorizes such sums as may be necessary to carry out this legislation. Amends the Internal Revenue Code to eliminate the deduction for health insurance premiums. Requires specified maintenance of effort by States which elect to have healthcare contributions made to their low-income population in lieu of Medicaid assistance. Repeal of Existing Laws. Repeals the following provisions of the Social Security Act: Professional Standards Review Organization (title XI, part B); uniform reporting (section 1121); capital expenditure limitations (section 1122); hospital utilization review plans and hospital by-laws with respect to staff or physicians under the Medicare program (section 1861(e), paragraphs (3) and (6), and section 1861(k)); Medicare customary charge limitations (section 1814(b)(1)); and Medicare reasonable cost limitations which limit reimbursement to health facilities (section 1861(v)(1)(A)). Repeals the following provisions of the Public Health Service Act: health maintenance organizations (title XIII, other than section 1308(e)); health planning (title XV); and health resources development (title XVI, other than sections 1602(d) and 1622). Provides that if more than 50% of persons eligible for Medicare choose to receive a healthcare voucher instead, legislation authorizing the Medicare program would be repealed. Effective Dates. In general, provides that this legislation would be effective on or after Jan. 1, 1984.

H.R. 850 was introduced Jan. 16, 1981; referred to Committees on Ways and Means, Energy and Commerce, the Judiciary, and Post Office and Civil Service.

S. 433 (Durenberger, Boren, Heinz) (Identical to S. 1968 introduced in the 96th Congress.)

Health Incentives Reform Act of 1981. Employer Contributions to Health Benefit Plans. Amends the Internal Revenue Code to provide that any employer contributions to an employee health or dental benefit plan which exceed the

limitations established by this legislation would be included in the employee's gross income. Specifies that the limitations in 1982 are the following amounts, increased or decreased in subsequent years by percentage changes in the medical care component of the Consumer Price Index: \$50 for employee only coverage, \$100 for employee and spouse, \$125 for employee and family, and amounts to be determined by the Secretary (of Health and Human Services) for self-insured employers. Amends the Internal Revenue Code to provide that if an employer fails to comply with any requirements of the legislation, any contribution the employer makes toward an employee health plan would be non-qualified and included in the employee's gross income.

Multiple Choice of Plan Options. Requires that any employer having more than 100 employees covered under a health benefit plan at any time during a calendar year must provide that such plan includes at least three options, each offered by a separate carrier, which meet requirements pertaining to continuity of coverage, coverage for employee's family, minimum benefits, and catastrophic expense protection.

Equal Contribution Requirements. Provides that if an employer offers more than one health benefit plan option, the amount of the employer's contribution could not depend on which option an employee chooses. Requires that, if the contribution amount selected by such employer exceeds the cost of the option chosen by the employee, the employer must contribute the difference to the employee in the form of cash (if the employee so wishes) or other compensation or benefit (the rebate).

Continuity of Coverage. Provides that, in order for an employer's contribution to be qualified, the contribution must be to a plan or plan option that provides: (1) continued group coverage for 30 days in the event of death, separation from employment or divorce, with the employer continuing his contribution during that period; (2) continued group coverage for an additional 180 days if the employee pays the premium rate; and (3) for the right of the employee to convert during the 30-day or 180-day period to an individual health benefit plan or option which contains specified minimum benefits and catastrophic expense protection, without regard to prior medical condition or proof of insurability.

Coverage for Employee's Family. Provides that, in order for an employer's contribution to be qualified, the contribution must be to a plan or plan option that covers an employee's spouse and qualified children and allows such children to convert to an individual plan or option without regard to prior medical condition or proof of insurability.

Minimum Benefits. Provides that, in order for an employer's contribution to be qualified, the contribution must be to a plan or plan option which at least provides coverage for the same types of services covered by title XVIII of the Social Security Act (Medicare), without regard to Medicare's requirements for deductibles, copayments, and provision of covered services by particular persons or facilities.

Catastrophic Expense Protection. Provides that, in order for an employer's contribution to be qualified, the contribution must be to a plan or plan option that provides for payment of 100% of the cost of minimum benefits provided to a covered individual during a catastrophic benefit period. Defines a catastrophic benefit period as beginning when an individual and his family incurs out-of-pocket expenses for minimum benefits in excess of \$3,500 and ending at the end of that calendar year.

Effective Date. Jan. 1, 1984.

Special Rule for Employment Taxes. Specifies that employer contributions to health plans that exceed the limitations and to health plans that do not meet the qualifications specified in this legislation would be included in the gross income of the employee and would be treated as paid in cash to the employee, not as paid under a health plan of the employer. Provides that the rebate, if paid in cash, would not be subject to Social Security, Railroad Retirement, and Federal Unemployment taxes, but would be subject to personal income tax.

Coordinated Administration. Requires the Secretary of the Treasury to coordinate with the Secretary of Health and Human Services in

determining whether health plans or options meet the requirements of this legislation related to minimum benefits and catastrophic expense protection.

S 433 was introduced Feb. 5, 1981; referred to Committee on Finance.

HEARINGS

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"Serial no. 96-79"

----- Proposals to stimulate competition in the financing and delivery of health care. Hearings, 97th Congress, 1st session. Sept. 30, Oct. 1, and Oct. 2, 1981. Washington, U.S. Govt. Print. Off., 1981. 749 p.
"Serial no. 97-24"

U.S. Congress. Senate. Committee on Finance. Proposals to stimulate health care competition. Hearings, 96th Congress, 2d session. Mar. 18-19, 1980. Washington, U.S. Govt. Print. Off., 1980. 462 p.

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At head of title: Committee print.

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U.S. Congress. Joint Committee on Taxation. Description of proposals to restructure the incentives for coverage under employer health plans. Washington, U.S. Govt. Print. Off., Feb. 22, 1980. 23 p.
At head of title: Joint committee print.

----- Description of S. 1968 and other proposals to restructure the incentives for coverage under employer health plans. Washington, U.S. Govt. Print. Off., Mar. 15, 1980. 19 p.
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CHRONOLOGY OF EVENTS

- 07/15/82 -- Committee on Ways and Means tentatively approved a voluntary Medicare voucher system (Sec. 112 of H.R. 6878) which was later deleted by House-Senate conferees during the conference on H.R. 4961, the Tax Equity and Fiscal Responsibility Act of 1982.
- 10/02/81 -- Representatives Gradison and Gephardt introduced H.R. 4666 (the Voluntary Medicare Option Act).
- 09/30-10/02/81 -- Hearings held by House Ways and Means Committee on pro-competition proposals.
- 02/05/81 -- Senator Durenberger introduced S. 433 (identical to S. 1968 introduced in 96th Congress).
- 01/16/81 -- Representatives Gephardt and Stockman introduced H.R. 850 (identical to H.R. 7527 in 96th Congress).
- 01/15/81 -- Senator Hatch introduced S. 139 (identical to S. 1590 in 96th Congress).
- 06/09/80 -- Representative Jones (Oklahoma) introduced H.R. 7528.
- 06/09/80 -- Representatives Gephardt and Stockman introduced H.R. 7527.
- 03/18-19/80 -- Hearings held by Senate Finance Committee.
- 02/25/80 -- Hearings held by House Ways and Means Committee.
- 02/04/80 -- Representative Martin introduced H.R. 6405.
- 11/01/79 -- Senator Durenberger introduced S. 1968.
- 10/30/79 -- Representative Ullman introduced H.R. 5740.
- 09/25/79 -- Carter Administration bill (H.R. 5400/S. 1812) introduced by Representative Rangel and Senator Ribicoff.
- 09/06/79 -- Senator Kennedy introduced S. 1720 (same bill, H.R. 5191, introduced by Representative Waxman).
- 07/26 79 -- Senator Schweiker introduced S. 1590.

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- S. 139 -- The Comprehensive Health Care Reform Act. In remarks of Orrin G. Hatch. Congressional record [daily ed.] v. 127, Jan. 15, 1981: S179-S182.
- S. 433 -- Health Incentives Reform Act of 1981. In remarks of David Durenberger. Congressional record [daily ed.] v. 127, Feb. 5, 1981: S1096-S1098.
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