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October 26, 1994

THE CHAFEE-BREAUX "MAINSTREAM" PROPOSAL: NO BASIS FOR HEALTH REFORM IN 1995

INTRODUCTION

With the collapse of every version of the Clinton plan in the 103rd Congress, Americans are wondering what form of health care reform legislation will surface during the 104th Congress. The millions of Americans opposed to government control of the health care system hope that Congress will not repeat the mistakes of 1994 by trying to enact a watered-down modification of the Clinton plan. Unfortunately, many lawmakers intend to do just that.

It is very likely that the Clinton Administration and liberal members of Congress will attempt to revive the self-styled "Mainstream Group" proposal put forward in the closing days of the regular session by a bipartisan group of Senators led by John Chafee (R-RI) and John Breaux (D-LA) and use this as a starting point for discussion.[1] If this does become the basis for reform —instead of a proposal based on consumer choice and competition—it is imperative that the American people familiarize themselves with the details of the Mainstream proposal. If they examine the bill carefully, they will discover how strikingly similar it is to the original Clinton bill and the failed majority leadership bills. For example, the Chafee-Breaux Mainstream plan:

- ✘ Introduces community rating, which would artificially raise insurance costs for younger Americans while reducing them for older Americans.
- ✘ Creates a powerful new federal Health Commission, binding future Congresses to act or vote on its recommendations. Such a commission likely would propose an employer mandate and would determine the components of a standard basic benefits package.
- ✘ Establishes a federal government comprehensive standardized benefits package, forcing Americans to buy costly benefits they may not want.

1 The authors base this paper on an outline released by the "Mainstream Group" and dated August 24, 1994, 1:00 p.m. This is the most recent documentation available to the public outlining the intentions and goals of the group.

- ✘ Places new unfunded federal mandates on states, which would impose heavy costs on state taxpayers.
- ✘ Restricts the freedom of small employers, effectively forcing them to enroll their employees in government-sponsored health alliances with standardized plans.
- ✘ Imposes a new tax on employers offering more than a government-set ceiling on health benefits, encouraging many employers to cut benefits.
- ✘ Eliminates the tax exempt status of health care flexible spending accounts and other mechanisms used by employers to hold down costs and tailor benefits to employee needs.
- ✘ Creates a huge new welfare program in the form of a new health care subsidy. Because of its phase-out design, this would have the enormously destructive effect of imposing confiscatory combined marginal tax rates on millions of Americans, eliminating the incentive to increase earnings from work.

These "reforms" would not improve the U.S. health care system; they would undermine it. They were soundly rejected by the American people in 1994, and should not be the starting point in 1995.

PROBLEMS WITH THE MAINSTREAM PROPOSAL

Problem #1: The Proposal Introduces Community Rating.

While various forms of price controls were included in the bills that failed in 1994, one of the most damaging and pernicious is community rating, which requires that insurers provide guaranteed renewable coverage while simultaneously placing a tight legal limit on how much they may charge for their premiums. Community rating was a central feature of the White House and majority leadership bills. It is a core element of the Mainstream proposal.

Strict or "pure" community rating would allow insurers' rates to vary only by geographic area —the "community"—and by family type.[2] Everyone in a "community" is charged the same rate for health insurance regardless of the potential cost for the insurer. Many in Congress think community rating is "fair" because everyone pays the same price. But different individuals obtain very different levels of medical care for that same price, and this has several unfair and undesirable effects. Among them:

- ✘ Younger workers and families, who tend to have better health status but lower incomes, subsidize older workers and families with generally poorer health status but higher incomes.
- ✘ Many pay far more in premiums than their insurance is actually worth (when compared with buying medical services directly). This encourages younger families to drop coverage.

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2 American Academy of Actuaries, "An Analysis of Mandated Community Rating," Monograph Series on Health Care Reform, Monograph No. 3, March 1993, p. 1.

- ✘ Prudent health care consumers subsidize wasteful consumers.

- ✘ People who live in relatively low-cost areas can find themselves subsidizing those who live in high-cost areas. Individuals can be winners or losers depending on the "community" to which they are assigned. This makes the political process of defining community boundaries very contentious.[3]

Proponents of community rating tend to overlook the incentives and perverse effects that occur when insurers must offer community-rated plans in a "voluntary market" in which families or businesses do not have to buy coverage. The problems become even more pronounced when the law also calls for guaranteed issue of insurance policies, regardless of the buyer's medical condition. One effect is that companies with younger and healthier employees most likely will self-insure, if offered that option, as opposed to joining a community-rated purchasing pool in which a majority of the members are older and less healthy than the firm's employees. The result: higher community-rated provisions for those remaining in the insurance pool.

Should the self-insurance option prove to be impractical due to high taxes levied on such plans,[4] firms simply might decide not to purchase health insurance. The result: the number of uninsured Americans rises. This is likely to happen under the Mainstream proposal because its guaranteed issue provision forces insurers to cover any and all applicants.

When an insurer also must provide coverage without regard to medical condition, individuals and groups would have an incentive to postpone applying for coverage until they actually needed the health insurance. Premium rates for younger Americans also would increase dramatically. While many analysts have focused on New York State's recent experience with a mandated community-rated system where many younger workers dropped individual coverage, there has been little focus on employees who work for firms with 25 or fewer employees. Under the Mainstream proposal, such firms wishing to provide insurance to their employees would be pushed into regional alliances with community-rated government-approved health plans. A March 1993 report by the American Academy of Actuaries points out that millions of employees in these firms would be affected adversely.

> If pure community rating were mandated, about 20 percent of the privately-insured, non-elderly population would receive premium increases of more than 20 percent.... For small employer groups under pure community rating, 20 percent of small employers (less than 25 employees) would receive premium increases of more than 20 percent. If coverage is not mandated there is a significant risk of adverse selection against the insurance system since younger and healthier individuals and employers are likely to migrate out of the system. A higher risk and more expensive population would remain in the system causing premium rates to increase.[5]

The Mainstream proposal includes a modified, not "pure," form of community rating. Insurance carriers would be allowed to take into account family size, geography, and age when deter-

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3 Edmund F. Haislmaier, "A Policy Maker's Guide to the Health Care Crisis, Part IV: The Right Road to Health Insurance Reform," Heritage Foundation *Talking Points*, November 5, 1992, p. 8.

4 Section 1504 of the Mitchell bill includes a risk adjustment mechanism that equates to a tax on large, experience-rated employers as well as community-rated plans.

5 American Academy of Actuaries, "An Analysis of Mandated Community Rating," p. 3.

mining the price of premiums. If insurers had complete freedom to vary premiums according to these factors, almost all the problems associated with pure community rating would be removed. But the proposal goes much further: it severely restricts an insurer's ability to vary age characteristics in assigning premium rates to individuals and groups by requiring a ratio of no more than 2:1. This means that any variation in premium rates by age may not result in a ratio of the highest age rate to the lowest age rate that exceeds 2:1. Thus, the inequities and perverse incentives largely remain. To illustrate how adversely the Mainstream proposal would affect the current insurance market, consider how a government-mandated 2:1 ratio would affect many younger Americans (see right).

AVERAGE PREMIUM COSTS

Age	Current System (Full adjustment by age)	Mainstream (2:1 ratio)
Single Male		
Age 27	$ 788	$1,111
Age 42	1,177	1,320
Age 57	2,407	1,979
Single Female		
Age 27	$ 977	$1,212
Age 42	1,565	1,528
Age 57	2,273	1,907
Age Only, No Gender Variation Allowed		
Age 27	$ 887	1,164
Age 42	1,382	1,429
Age 57	2,336	1,941

SOURCE: Health Insurance Association of America. HIIA cited an insurance company as the source, but declined to name the company.

The Mainstream proposal also requires insurance carriers to enroll subscribers on a continuous basis, rather than during an annual enrollment period like that in the Federal Employees Health Benefits Plan (FEHBP), which covers the President, Vice President, Members of Congress and their staffs, and all other federal employees. The problem with continuous enrollment is that it accentuates the risks to insurers associated with other reform provisions within the framework of a voluntary environment, such as guaranteed issue, guaranteed renewability, and pre-existing condition exclusion limitations. The aim is to make sure that insurers do not "cherry pick" (avoid enrolling high-risk individuals), but the result would be to make the insurance system far less stable. Explains Brookings Institution economist Barry P. Bosworth:

> [Y]ou just can't order insurers to cover everyone at the same dollar premium. Apart from the obvious problems of preventing insurers from finding every possible excuse from serving a high-risk clientele, there is also the issue of what economists call moral hazard. You can't allow people to decide when they want insurance; that gives them the option of waiting until they are very likely to become sick.[6]

Problem #2: The Proposal Creates a Powerful Federal Health Commission.

The original Clinton proposal contained a "National Health Board" which would have powerful regulatory authority over the American health care system, ranging from the pricing of health insurance premiums to the approval of benefits to be included or excluded in a government-approved standardized benefits package to the enforcement of public and private spending limitations at the state and national levels.[7] In response to growing public and congressional criticism of new government bureaucracies with overwhelming police powers and control, lawmakers attempted to soften the image of these federal agencies. For example, the bill in-

6 Peter Passell, "Economic Sense," *The New York Times*, September 1, 1994, p. D2.

7 Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993, p. 2.

troduced by Senator George Mitchell (D-ME) changed the name of the National Health Board to "National Health Care Cost and Coverage Commission." Like the original Clinton National Health Board, the Mitchell Commission would be established to "[m]onitor and make recommendations with respect to trends in health insurance coverage and costs. The Commission would consist of seven members to be appointed by the President and confirmed by the Senate."[8]

Members of the Mainstream group now are proposing a "Health Commission," but this turns out to be merely another variant of the Clinton proposal. While the name of this new federal commission has changed, many of its duties, responsibilities, and powers are not far removed from those of the Boards and Commissions established by the Clinton and Clinton-Mitchell bills.

Among the similarities of the two commission are the following:

MITCHELL[9]	MAINSTREAM[10]
• Demographics and unemployment status of the uninsured and reasons why they are uninsured	• Demographics of the uninsured, and findings on why those individuals are uninsured
• Structure of health delivery system	• Structure of health delivery system
• Status of insurance market reforms	• Status of insurance market reforms
• Development and operations of health insurance purchasing cooperatives (HIPCs/Alliances)	• Development of purchasing groups and other buyer reforms
• Success of market mechanisms in expanding coverage and controlling costs among employers and households	• Success of market and other mechanisms of controlling health expenditures and premium costs in the market area and nationally
• Success of high-cost health insurance premium tax in controlling costs	• Possible adjustments to tax treatment of benefits
• Success and adequacy of subsidy program in expanding coverage through employers and households	• Adequacy and possible adjustments of subsidies for low-income individuals

As the comparison shows, the similarities between the Mitchell and Mainstream proposals are striking. The Mainstream proposal requires expedited congressional consideration of the proposals of the new Health Commission.

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8 Executive Summary, "Senator Mitchell's Health Care Legislation," August 2, 1994, p. 4.

9 *Ibid.*

10 Outline, Mainstream Coalition Proposed Agreement, August 24, 1994, p. 1-2.

The proposal also establishes a national goal for health insurance coverage: at least 95 percent of all Americans by the year 2002. If this goal is not met, the Commission must submit its recommendations to Congress for an up-or-down vote without amendment—even though the authors of the proposal themselves acknowledge that at best it will achieve only 92 percent coverage by 2002. Among the recommendations the Health Commission is to make to Congress is "A schedule of assessments or contributions to encourage employers who are not doing so to purchase coverage for their employees."[11] In other words, the Health Commission would be required by law to recommend that the future Congress consider an employer mandate despite overwhelming opposition by the public and Members of Congress from both sides of the aisle to an employer mandate in 1994.

Problem #3: The Proposal Introduces a Government-Approved Standardized Benefits Package.

Like the original Clinton bill and the majority leadership bills introduced by Senator Mitchell and Representative Richard Gephardt (D-MO), the Mainstream proposal includes a standardized health insurance package, requiring the Health Commission to develop and submit to Congress, within six months of the bill's enactment, a "clarification of the initial standard and basic benefits package."[12] The value of the standard benefits package must be actuarially equivalent to the Blue Cross/Blue Shield Standard Option plan currently available to federal employees.[13] Like the Mitchell bill, the Mainstream proposal gives either the Health Commission or Congress authority to dictate what type and level of benefits or services will be included in the standard benefits package.

While the concept of a "comprehensive standard benefits package" may sound appealing, the idea has many significant drawbacks.

First, as pointed out by the ERISA Industry Committee, which represents the employee benefits managers of 125 of America's largest employers, "the proposal effectively eliminates employer discretion with respect to many elements of health plan design, stifling further innovation [and] leading to increased costs."[14] This is also the view of the American Academy of Actuaries: "Uniform benefits will put an end to experimentation with different levels of coverage, which in turn will prevent the development of cost-saving or quality-enhancing changes in the benefits. Much of the reduction in cost as a result of advances in managed health care would not have been possible if a uniform benefit design had been mandated 20 years ago."[15]

Second, requiring all Americans to enroll in a comprehensive standard plan will make it difficult for employers and individuals to hold down the growth of health care spending without

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11 *Ibid.*, p. 2.

12 *Ibid.*, p. 4.

13 The authors advance no reason at all why the actuarial value of all health plans in America should be the same as the current Blue Cross/Blue Shield option. One assumes that the arbitrary choice was made merely because the plan is currently popular with many federal workers. These Members of Congress seem to assume that this option, or its actuarial equivalent, will always be popular with federal workers, regardless of changes in market conditions.

14 ERISA Industry Committee, "Preliminary Analysis: Revised Senate 'Mainstream' Health Reform Proposal Has Detrimental Impact on Employers' Plans, Workers," ERIC Legislative Bulletin, August 30, 1994, p. 2.

15 American Academy of Actuaries, "Actuarial Issues Involved in Evaluating a Guaranteed Benefit Standard Package Under Health Care Reform, Monograph Series on Health Care Reform, Monograph No. 5, March, 1994, p. 2.

rigid price controls or rationing. As the American Academy of Actuaries concludes in a recent study, "Designing a guaranteed benefit package within a limited health care budget is not an easy task. The ultimate design will depend upon the ability to balance the desire to provide affordable coverage to all with the reality of limited funding."[16] The Academy also notes that many Americans would prefer to purchase a leaner, lower-premium package with basic insurance coverage.[17] Based upon the public's outright rejection of the Clinton and Clinton-Mitchell standard benefits package, the Academy is correct in concluding, that "It is easier and less risky to enrich lean benefits after cost-saving goals have been achieved than to reduce rich benefits if the cost-savings goals are not being achieved."[18]

There are striking similarities between the benefits packages of the Mitchell bill and the Chafee-Breaux Mainstream proposal.

MITCHELL[19]	MAINSTREAM[20]
• Hospital services	• Inpatient and outpatient care, including hospital and health professional services
• Health professional services	
• Emergency and ambulatory medical and surgical services	• Emergency, incuding appropriate transport services
• Clinical preventive services	• Preventive services, including services for high-risk populations, immunizations, tests, and clinician visits
• Mental illness and substance abuse services	• Mental illness and substance abuse
• Family planning and services for pregnant women (abortion)	• Family planning and pregnancy-related services (abortion)
• Hospice services	• Hospice care services
• Home health services	• Home health services
• Extended care services	• Extended care services
• Ambulance services	• Appropriate transport services
• Outpatient laboratory, radiology, and diagnostic services	• Outpatient laboratory, radiology, and diagnostic services
• Outpatient prescription drugs	• Prescription drugs and biologicals
• Outpatient rehabilitation services	• Outpatient rehabilitation services

16 *Ibid.*, p. 18.
17 *Ibid.*
18 *Ibid.*, p. 4.
19 Executive Summary, "Senator Mitchell's Health Care Legislation," August 2, 1994, p. 8.
20 Mainstream Coalition Proposed Agreement Outline, August 24, 1994, pp. 4-5.

MITCHELL	MAINSTREAM
• Durable medical equipment, prosthetics, and orthotics	• Medical equipment, including orthotics and prosthetics
• Vision, hearing, and dental care under 22 years of age	• Vision care, hearing aids, and dental care for individuals under 22 years of age
• Investigational treatments	• Patient care costs pursuant to qualified investigational treatments

Instead of forcing every American into a single government-approved standardized benefits package, Members of Congress would be wiser to allow Americans at least the same freedom that lawmakers enjoy under the Federal Employees Health Benefits Plan. The FEHBP covers over nine million federal employees, retirees, and their dependents—including the President, Vice President, Members of Congress, and their staffs. With over 35 different health plans available to them under the FEHBP in the Washington metropolitan area, federal workers can choose the level of benefits and range of services they want and can afford. The Mainstream proposal, however, would impose standardized benefits on ordinary Americans.

Problem #4: The Proposal Imposes New Responsibilities and Mandates on the States.

Like the original Clinton and Mitchell bills, the Chafee-Breaux proposal places costly new responsibilities upon the states. The August 24, 1994, outline of the proposal says the states are not forced to set up a specific process or bureaucracy to implement the Act's requirements, but they nevertheless will have to carry out their new responsibilities within a federally defined set of guidelines.[21] Among the general responsibilities of state governments:[22]

✓ Certifying insured health plans;

✓ Establishing community-rated areas;

✓ Establishing procedures for setting up and operating purchasing cooperatives;

✓ Preparing standardized information concerning certified health plans;

✓ Administering a risk adjustment program for community-rated health plans;

✓ Specifying an annual general open enrollment period and an initial enrollment period for community-rated plans;

✓ Establishing state programs by January 1, 1996;

✓ Submitting to the Secretary of Health and Human Services, at intervals determined by the Secretary, a report on compliance with the above requirements.

While the states already regulate and monitor health insurance companies within their boundaries, the additional federal requirements inevitably would strain existing state resources.

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21 Mainstream Coalition Proposed Agreement Outline, August 24, 1994, p. 14.

22 *Ibid.*, pp. 14-15.

To establish community-rated areas, for instance, would be enormously difficult and subject to political abuse because of its cost implications for each neighborhood. The incentive to engage in gerrymandering and redlining would be great. Depending on how a community-rated area is defined, individuals who live in lower-cost areas could end up subsidizing residents who live in higher-cost areas. Dealing with such issues would be a political nightmare for the nation's governors and state legislators.

As another example, the Mainstream proposal, like the Mitchell bill, requires the states to administer a risk adjustment program for community-rated health plans (so that insurance plans with generally healthy enrollees subsidize plans with sicker enrollees). But this would be no simple task. In its analysis of the Mitchell proposal, the Congressional Budget Office (CBO) explains:

> The risk-adjustment mechanism in this proposal is more complex than those in other proposals analyzed by CBO.... As discussed below, implementing the risk-adjustment process would be a major undertaking for the states.[23]

The Chafee-Breaux proposal, again like the Mitchell bill, would have the states operating a risk-adjustment system which takes into account the differences between community-rated and experience-rated plans. Generally, a risk-adjustment system is designed as a way to reduce the effects of inadvertent or intentional risk selection so that insurance carriers in a competitive market can compete on the basis of quality of service and care.[24]

The difficulty associated with operating a risk-adjustment system in an area that includes both community-rated and experience-rated plans is the wide discrepancy between premium prices and underlying risk. The more factors that insurers are prohibited by law from taking into account in the underwriting process, the more complicated the risk adjustment must be. For example, if the insurer is prohibited from underwriting on health status alone, the risk adjustment is fairly simple. However, in a community-rated system where the insurer is prohibited from underwriting on the basis of age, gender, health status, and possibly even geography, more factors are involved, therefore further complicating the risk-adjustment mechanism. Besides being difficult to organize, such a requirement would end any semblance of a true health insurance market. The reason: the average premiums between the two insurance pools would be significantly and artificially narrowed.[25] The Mainstream proposal thus imposes yet another deliberate distortion on the health insurance market, compounding the existing distortions.

Problem #5: The Proposal Treats Small Employers Unfairly.

Under the Chafee-Breaux Mainstream proposal, small employers (defined as 100 or fewer full-time employees) would be prohibited from self-insuring. As a result, small employers would be forced to purchase plans from health insurance purchasing cooperatives (HIPCs) in state-defined community-rated areas. Small firms with a relatively young and healthy work-

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23 CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal," August 9, 1994, p. 8 [hereinafter cited as CBO Analysis].

24 American Academy of Actuaries, "Health Risk Assessment and Health Risk Adjustment—Crucial Elements in Effective Health Care Reform," Monograph Series on Health Care Reform, Monograph No. 1, May 1993, p. 1.

25 John C. Liu, "Health Care Debate Talking Points #1: The Heavy Burden on States," Heritage Foundation *FYI.*, September 7, 1994, p. 6; citing CBO Analysis, p. 2.

force most likely would be forced to pay premiums higher than they pay today and higher than they would pay if they were allowed to self-insure. Faced with this, many probably would opt to provide no coverage at all.

The primary reason to self-insure, especially among smaller firms, is the significant savings to be realized. As long as a self-insured plan is in compliance with the federal Employee Retirement Income Security Act (ERISA), for example, it can avoid the many absurd and costly state insurance regulations which have fueled the increase in health insurance premiums. Small firms also can avoid state insurance premium taxes, the need to maintain a reserve fund of an arbitrarily specified size, and the wide range of state laws mandating the benefits health insurance plans must provide.[26] Prohibiting smaller firms from self-insuring would deny them these savings.

Problem #6: The Proposal Places an Arbitrary Tax Cap on Employment-based Premiums.

According to the outline of the Chafee-Breaux Mainstream proposal, changes in the tax code would limit the amount of employer-sponsored health benefits that could be excluded from taxable employer income. Specifically, the proposal caps the employer's deduction for contributing to employees' health plans at 110 percent of the average premium in the community-rated market. Employers in experience-rated plans may choose between the 110 percent cap or the plan's actual cost for 1997. If an employer chooses the plan's actual cost for 1997, the deductible amount is permanently locked into place, and no deviation or adjustments are allowed on a year-to-year basis.[27] This effectively bars any adjustments by employers in experienced-rated plans who realize escalating health costs due to an older and sicker workforce.

The Mainstream proposal also prohibits employers who currently contribute to plans that do not conform to the federal government's standard benefits package from deducting their contributions. Meanwhile, those who do offer the federal government's standard benefits package are allowed to deduct their contributions to the extent that the premiums are less than 110 percent of the average premium in their community-rated area. This is a powerful incentive to drop plans designed to meet the needs of employees and replace them with standardized plans.

The elements of this tax policy are very similar to the tax provisions contained in the "Managed Competition Act" offered by Representative Jim Cooper (D-TN). Like the ill-fated Cooper bill, the Mainstream proposal unfairly penalizes employers who provide health benefits that are more generous than the average cost plan in the geographic area. The end result will be millions of Americans forced into a government-approved standardized benefit package offered only through new state-run purchasing cooperatives.[28] The only alternative is to be insured under a health plan with no tax relief for the employer. And for employers contributing in excess of the 110 percent limit, this proposal is an incentive to pare down the health benefits of their employees. Even if employers do opt to pay the tax, it is really a tax on workers whose health plans are more generous than the average employee's, since studies show that almost 90 per-

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26 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 14, 1992, p. 17.

27 Mainstream Coalition Proposed Agreement Outline, August 24, 1994, p. 29.

28 Robert E. Moffit, "A Guide to 'Clinton-Lite': The Cooper-Grandy 'Managed Competition' Health Care Reform Proposal," Heritage Foundation *Talking Points*, March 28, 1994, p. 5.

cent of any new tax or cost of providing fringe benefits to workers is passed on in lower worker compensation.[29]

Problem #7: The Proposal Eliminates Popular and Proven Mechanisms to Contain Costs and Tailor Compensation.

Another remarkable change in the current tax treatment of employment-based health insurance in the Chafee-Breaux Mainstream proposal is the plan to eliminate the tax-exempt status of health insurance offered through a flexible spending account (FSA). A flexible spending account permits employees to set aside a pre-determined amount of their income, free of taxes, for certain health care expenses not included in the employer's health insurance plan. Certain other expenses, such as child care, receive similar tax advantages.

Including flexible spending accounts in employees' taxable income would generate revenue for the federal treasury and thus help finance the Mainstream proposal, but it also would roll back many of the gains employers have made in holding down health care costs and giving wider compensation choices to their employees. According to the Employee Benefit Research Institute, "The continuing evolution of the American family is likely to increase the attractiveness of flexible work practices and choice in benefit plans throughout the next decade. Employers have responded to changing employee needs...."[30] Instead of eliminating the current tax break for flexible spending accounts, Members of Congress should encourage the use of FSAs, by eliminating the "use-it-or-lose-it" rule and allowing workers to roll over unused funds each year tax-free. This would lead more Americans to choose to pay directly for a greater proportion of their medical care instead of using insurance to pay for minor services. This, in turn, would make families more sensitive to the cost of care and more inclined to challenge the cost and necessity of minor treatments and tests. It would also allow Americans to choose their own tax-free health insurance and medical services.

Recent surveys show that FSAs are increasingly popular among employers and employees. In a poll conducted by EBRI and The Gallup Organization, "Forty percent of respondents indicated that if they had a choice between two jobs with the same salary and benefit level, one that provides choice and one that does not, the choice in benefits would have a great deal of influence on their decision."[31] Employers adopt flexible spending accounts for various reasons: for example, to attract and recruit new employees when competing with other firms for skilled workers, to provide their employees with a choice among benefits, and to hold down health care expenditures.

Problem #8: The Proposal Would Lead to a Huge Increase in the Welfare State and Eliminate Work Incentives.

The Chafee-Breaux proposal also would create a very strong incentive for employers to drop health insurance coverage for employees while triggering a huge expansion of the welfare state. This problem is caused by the design of a new subsidy program intended to help lower-income families afford insurance.

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29 *Ibid.*, p. 6.

30 Employee Benefit Research Institute, "Flexible Benefits, Choice, and Work Force Diversity," EBRI Issue Brief Number 139, July 1993, p. 3.

31 *Ibid.*, p. 6, citing EBRI/Gallup Poll, 1992.

The incentive coverage would arise because the amount of the proposed federal subsidy to employees would be reduced, dollar-for-dollar, by the amount of any employer contribution to employee health costs. Thus, any firm could achieve considerable savings by abandoning its health coverage and allowing the government to pay for low- and moderate-wage worker's coverage.

True, any firm wishing to eliminate its health coverage would have to eliminate it for all employees, not just for lower-wage workers. But for higher-wage workers who would not receive government subsidies, the firm could convert current coverage into cash wages, permitting these employees to purchase their own care.[32] Moreover, firms deciding to retain health benefits for employees would have a very strong incentive to contract out most functions performed by lower-wage employees to other firms which did not provide coverage. The likely bottom line: few low- or moderate-wage employees would continue to receive employer-provided health coverage.

However, the most devastating problem with the subsidy program would be a massive expansion of the welfare state. Piling huge new welfare and health benefits on top of dozens of already existing welfare programs, the bill would obliterate the rewards of work, the motivation to work, and the incentive to gain education for over one-third of U.S. families by establishing extraordinarily high combined marginal tax rates on most families earning less than $40,000 per year.[33]

In examining the subsidy provisions of the original Mitchell health care bill, which are similar to those of the Mainstream proposal, CBO declares:

> In 2000, the effective marginal tax rate on labor compensation (wages and benefits) could increase by as much as 30 to 55 percentage points for workers with family income in the phaseout range. Moreover those levies would be added to the explicit and implicit marginal taxes that such workers already pay through the income tax, the payroll tax, and the phaseout of the earned income tax credit. In the end, some low-wage workers would keep as little as 15 cents of every additional dollar they earned.[34]

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32 Non-subsidized employees who had their health coverage converted into wages would be subject to income and Social Security taxes on the wage increase. The employer could compensate for this by providing a wage increase with a post-tax value at least equal to the cost of the health insurance formerly provided to the employee. Many, if not most, employers would be able to finance such wage increases through the considerable savings generated by allowing the government to pay for coverage of lower wage employees.

33 Marginal tax rates determine the actual economic benefit of earning more money. A simple marginal tax rate describes the net income loss to the government in explicit taxes for each additional dollar earned. For example, an individual who faces a marginal tax rate of, say, 40 percent would receive a net, take home increase in income of only $60 for each extra $100 earned. A "combined marginal tax rate" shows the combined effects of both explicit taxes and the benefit reduction rates (BRR) of government aid and subsidies. The rate at which benefits are reduced as income rises is, in effect, a tax. For example, an individual might face marginal taxes (such as income and Social Security taxes) of 30 percent on earned income, but may also receive government welfare benefits which are reduced by 40 cents for each dollar of added earnings. Such an individual thus would face a combined marginal tax rate of 70. For each added $100 earned, he would receive a net increase of just $30 in total income.

34 CBO, "A Preliminary Analysis of Senator Mitchell's Health Proposal," p. 16.

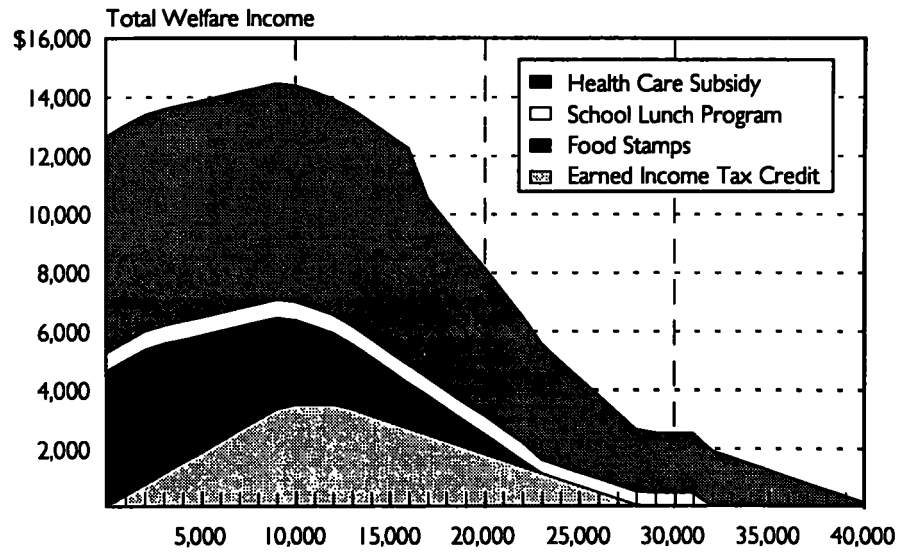
CBO adds that once the health care subsidies were fully phased in, marginal tax rates for some workers could reach 95 percent.[35]

Analysis of the Mainstream proposal by Heritage Senior Policy Analyst Robert Rector indicates confiscatory combined marginal tax rates similar to those of the original Mitchell bill. The results of this analysis are presented in Charts 1 through 3.[36]

Chart 1 displays the welfare benefits which would be available to a family of four under the Mainstream proposal.[37] In addition to the proposed health benefits, families with incomes of less than $20,000 per year also would receive aid from at least three existing welfare programs: food stamps, the earned income tax credit (EITC), and the school lunch program. These three programs form the broad foundation of the current welfare system. Most working families with children and incomes below $20,000 per year are eligible for aid from these programs and currently receive benefits from them. Many families receiving aid from these programs also receive benefits from other welfare programs such as AFDC, public housing, and the Women, Infants and Children food program (WIC). However, because various fiscal and legal restrictions limit the number of low-income families participating in them, these programs have not been included in Charts 1-3. If they had been, the combined marginal tax rate problems would be even more severe than those presented.

Chart 1

Proposed Health Subsidies and Welfare Benefits



Source: Heritage Tax Model, based on U.S. Government data.

35 *Ibid.*

36 The assumptions used in the analysis are presented in the appendix to this paper.

37 Charts 1, 2, and 3 illustrate what would happen if the provisions of the proposal were fully implemented in the year 1995. In reality, the proposal phases in its health care subsidies during a period leading up to the year 2004. The phase in of health care subsidies creates even larger marginal tax rate problems in the intervening years.

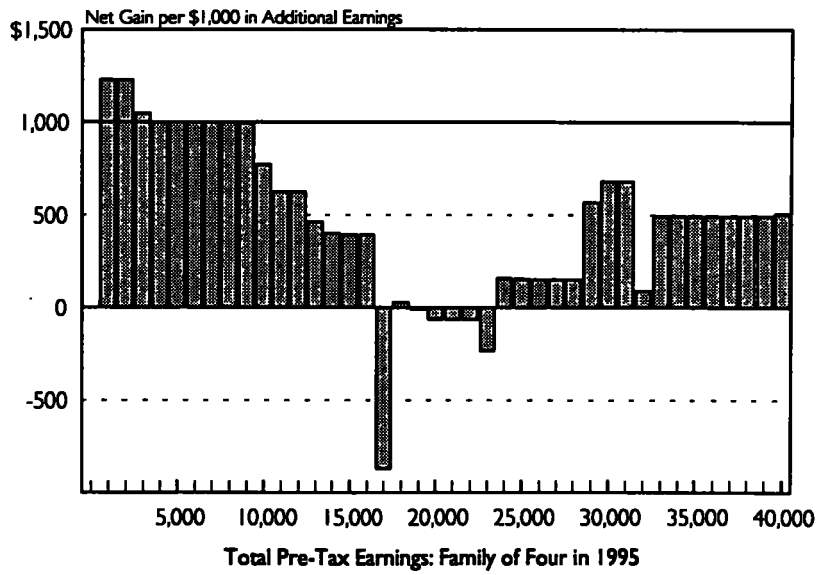
As Chart 1 shows, under the Mainstream proposal, a family of four earning $10,000 per year would receive over $14,000 in welfare once the proposed health benefits were added to food stamps, the EITC, and school lunch subsidies.[38] The combined post-tax income for this family from earnings and welfare would be around $23,000. As earned family income rises, welfare benefits are reduced. Overall, there would be a reduction in welfare benefits of roughly $500 to $600 for each $1,000 in extra earnings in the $15,000 to $30,000 range.

However, working families in this income range also must pay federal income, state income, and Social Security taxes. The effect of these taxes, combined with the phase-down schedule of welfare benefits, would be to reduce the net return to labor to nearly zero for millions of families.

Chart 2 displays the combined effect of taxes and welfare under the Mainstream proposal by showing the net increase in total family income that would result from an extra $1,000 in family earnings. For example, a family raising its earnings from $25,000 to $26,000 would achieve a net increase in total income of only $151. In many cases, the reduction in welfare actually exceeds the gain in post-tax earnings, creating a net loss in family income from added pay. Another family whose earned income increased from $16,000 to $17,000 would lose roughly $1,500 in welfare. The result: $1,000 in additional earnings generates a loss of $869 in net family income.

Chart 2

The Mainstream Bill's Effect on Income: Earning More Means Keeping Less



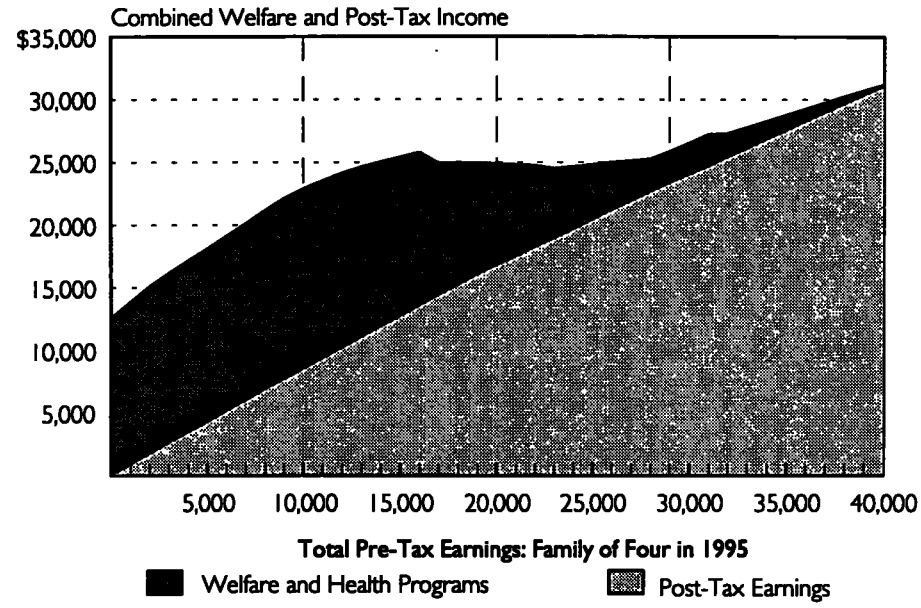
Source: Heritage Tax Model, based on U.S. Government data.

38 Throughout the text, and in Charts 1 through 3, the term pre-tax earned income means the nominal wages plus the so-called employer share of Social Security tax which the employer deducts form the worker's wages. Liberal and conservative economists agree that both shares of Social security tax are in fact direct taxes on worker's wages. See Joseph A. Pechman and Benjamin A. Okner, *Who Bears the Tax Burden?* (Washington, D.C.: The Brookings Institution, 1974), pp. 25-43.

Chart 3 shows the overall effect of the Mainstream proposal on family incomes. Once the proposed health benefits are piled on top of existing welfare programs (EITC, food stamps, and school lunches), the proposal would produce a dramatic income leveling for families with earnings between $15,000 and $40,000 per year. In this income range, the bill either entirely obliterates or drastically shrinks the rewards for improved education, greater work effort, and higher productivity.

Chart 3

Eliminating the Rewards of Work and Education



Note: Welfare and Health Programs include the Earned Income Tax Credit, Food Stamps, School Lunch Benefits and the proposed health care subsidies.
Source: Heritage Tax Model, based on U.S. Government data.

Overall, for families within the affected income range of $10,000 to $40,000, the proposal creates a combined marginal tax rate of roughly 75 percent. Thus, an increase in annual earnings of over $10,000 will generate, on average, an increase in net financial well-being of only $2,500. For certain segments of the population, the effects are even more severe. For example, a family of four which earns $16,000 per year would end up with a net income of $25,818, combining post-tax earnings with welfare. By contrast, a family which earns $29,000 would have a net income of $25,873. Thus, an extra $13,000 in earnings would yield an increase of only $55 in overall family income.

This subsidy system would have immediate, devastating effects on the economy. In families making less than $40,000, workers would have every incentive to stop overtime work. Women in dual-earner, married couple families would leave the work force, since their employment would result in no income gain for the family. Husbands making $35,000 per year or less would discover that they could obtain almost the same net income from working half a year as from working a full year. Millions of these workers would begin to work part-time or part-year.

The Chafee-Breaux health proposal, like the very similar Rowland-Bilirakis bill and the original Mitchell health care bill, thus is among the most destructive pieces of legislation ever considered by the U.S. Congress. If enacted, the Mainstream proposal would impose a straitjacket

on U.S. society, leveling out economic rewards for nearly a third of the U.S. population and sending a very clear message: working hard, striving for a promotion or a better job, and studying in school will provide little or no financial return. This is a message the U.S. government cannot afford to send.

CONCLUSION

Over 85 percent of Americans today have health insurance. In general, they are satisfied with their level of coverage, their doctors, and other health care providers. What has generated such fierce debate, and rightly so, is the fear among insured Americans that they will lose the security and protection that private health insurance provides. Americans want the peace of mind that comes from knowing that should they lose their jobs, change jobs, move across the country, or suffer from a pre-existing condition, the choice of health benefits and plans will be theirs. They do not want the key decisions to be made by their employers, their unions, by a faceless commission in Washington, D.C., and especially by the U.S. Congress.[39]

Reforming America's enormous health care system is not an easy task. Members of Congress now realize this. Health care represents one-seventh of the U.S. economy and is one of the most complex sectors of that economy. Because the health insurance industry already is one of the most regulated industries in the United States, changes to broaden the insurance pool must be made precisely and carefully.

The 104th Congress will have plenty of lessons to learn from the health care debacle of the 103rd. Aside from the fact that the Clinton Administration and the majority congressional leadership from the start were far too partisan in their approach, Members of Congress must bridge this gap and explore alternatives that win bipartisan support but also are based on sound public policy. In particular, instead of moving the health care market closer to a government-controlled system, Congress should adopt an approach based on the consumer's right to choose in a competitive environment.

The main reason health care costs have risen at unsustainable rates and millions of Americans are uninsured is simple: the market has not been allowed to work. With the federal government responsible for 44 percent of each dollar spent on health care in this country, lawmakers should wake up and realize that less government involvement is needed, not more. It also is time to challenge the conventional wisdom that health insurance must be employment-based. The current tax system makes employment-based coverage the only real option for most working Americans, but this leads to the insecurity that flows from families not owning their own insurance or choosing their own benefits. Congress should end the tax bias against non-employer group coverage by granting tax relief to Americans who choose to purchase health insurance outside of their place of employment and to own their own plans. With that move alone, portability of health insurance would become a reality for millions of Americans who no longer would be dependent on their employer for health insurance plans.

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39 Fabrizio, McLaughlin & Associates, survey conducted in October 1993. Approximately 85 percent of respondents answered that they would want to decide on their own health plans, thereby determining the services they want included or excluded.

Moving in this direction during the 104th Congress would address the real concern of most Americans—security—without huge new bureaucracies, standardization of health benefits, and much greater government control of the medical system. Unfortunately, the Chafee-Breaux Mainstream proposal would take America in the opposite direction, down the road favored by the Clinton Administration and rejected by the American people.

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TECHNICAL NOTE ON CHARTS 1-3

Computations for the income effects and marginal tax rates for the Chafee-Breaux Mainstream proposal demonstrate, for purposes of illustration, the results which would occur if the proposal's provisions were fully in effect in the year 1995. (The proposal actually phases its health care subsidies in over time, completing the phase-in by 2004. During the phase-in period leading up to 2004, the combined marginal tax rate problems would be as great as or greater than those presented in the charts).

Under current law, and in the Mainstream proposal, the poverty threshold, tax brackets, welfare benefits, and health benefits that determine the combined marginal tax rates discussed in the text are all indexed to inflation. Thus, in constant dollars, the marginal tax rates presented in the text will not change over time. The income data and combined marginal tax rates in 2004 (when the Mainstream proposal is fully implemented) will be exactly the same as those shown in Charts 1-3, except that nominal incomes will likely be some 20 percent higher due to inflation.

All computations in the charts represent a family of four: husband, wife, and two children. Welfare benefits included in the calculations are food stamps, school lunch subsidies for two children, and the EITC. The EITC is set at the full rate of 40 percent of earnings, scheduled to come into effect in 1996 under current law.

Taxes incorporated in the calculations include federal income tax, the employee share of Social Security tax, the employer share of Social Security tax, and estimated state income taxes. State income taxes are based on Ohio, which levies about the average tax rates for the relevant income range.

The family of four is assumed to be eligible for a subsidy to purchase health insurance which would have a maximum value of $6,177 in 1995. This figure represents the CBO estimate for the average cost for families of community- and experience-rated plans providing the level of coverage specified in the proposal. The family would be required to choose between a subsidy for health insurance coverage for the entire family and a separate subsidy for coverage of the children alone. The full family subsidy is phased down linearly as family income rises above 100 percent of poverty, reaching zero when family income reaches 200 percent of poverty.

The children's subsidy is estimated to equal one-third of the maximum value of the full-family subsidy and is phased down linearly as family income rises above 185 percent of poverty, reaching zero at 240 percent of poverty. The family is assumed to choose the children's subsidy in lieu of the full family subsidy whenever the value of the children's subsidy exceeds that of the family subsidy. For a family of four, this would occur at annual earned income levels above $29,000.

According to the proposal, families with earnings below 100 percent of poverty would receive an extra cost-sharing subsidy for out-of-pocket medical expenses. This cost-sharing subsidy is estimated to be worth 20 percent of the health insurance premium.

In all calculations, the family is assumed to pay for the portion of the health insurance premium which is not directly subsidized by the government. According to the proposal, the family would receive an income tax deduction equalling 100 percent of the cost of this self-purchased portion of the health insurance premium. The calculations assume that wage earners would be employed in firms which do not provide employer health coverage.