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THE SHADEGG HEALTH BILL: EXPANDING ACCESS AND CHOICE

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Various Members of Congress are taking serious steps to help American families gain access to quality health care. Most recently, Representative John Shadegg (R–AZ) introduced the Patients' Health Care Choice Act of 1999 (H.R. 1687), which includes a number of proposals designed to improve access to health insurance. If Congress is intent on reducing the ranks of the uninsured and providing a higher quality health delivery system for all, it should examine the policies in this legislation.

Today's employer-based health insurance system does not serve the needs of all working families. A product of the 1940s, when employers competed for scarce workers by offering health benefits, the system grew rapidly, largely because of its favorable tax treatment: An employer's contribution to an employee's health insurance premiums is tax-free for both employer and employee. The same tax treatment is *not* granted to individuals who must, or wish to, purchase health insurance outside the employer-based system. This disparate tax treatment is unfair; it discriminates against the unemployed and those who work for small businesses by making them pay for health insurance with after-tax dollars. The policies in H.R. 1687 address this inequity by creating five vehicles for the purchase of health insurance:

1. Tax Credits. A refundable tax credit would be created for the purchase of health coverage. It would cover 100 percent of the cost of coverage up to $500 for individuals and $1,000 for families. It would be restricted to workers whose employers make no contributions for individual or family coverage, and to the unemployed.

2. Individual Membership Associations (IMAs). An affinity group, such as the American Bar Association, the University of Arizona Alumni Association, or any other bona fide group in existence for at least five years, would be exempted from state mandates and allowed to offer health benefits packages to its members, regardless of state of residence. A member of an IMA—even one who might change jobs frequently—could buy the IMA's health plan without fear of losing it when he or she changed jobs. The member could use the tax credit toward the cost of such coverage.

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3. HealthMarts. A HealthMart is a private organization, similar in concept to a supermarket, to which employers and employees within a certain area would go to purchase health insurance. Under H.R. 1687, a HealthMart would have to offer the same insurance policies and prices to all employers and employees, regardless of health, and would act as a kind of clearinghouse for insurers to sell their products, reducing administrative costs.

Employers, if they so chose, would offer employees the ability to opt out of employer-provided insurance. An employee would be given a voucher by the employer in an amount equivalent to what the employer would contribute to his or her employer-provided health plan (actuarially adjusted). The employee could use that voucher at a HealthMart to purchase a desired health plan. The value of the voucher would be excluded from the employee's taxable compensation, just as employer-sponsored insurance is excluded today. If the employee bought coverage that cost less than the value of the voucher, the extra money could be placed in a medical savings account (MSA).

4. Association Health Plans (AHPs). H.R. 1687 would enable small-business trade associations to band together across state lines to purchase health insurance policies just as big *Fortune* 500 companies do. Small-business owners and their employees in, say, the National Federation of Independent Business (NFIB) could access health insurance plans offered through NFIB regardless of their state of residence, much like the identical plans General Motors offers its employees in multiple states. An extension of the Employee Retirement Income Security Act of 1974 (ERISA) would enable trade associations to do this without having to deal with different state mandates. Many small-business owners today cannot afford the expense, in time or money, to seek out and offer appropriate insurance plans for their employees. As a result, a significant number of the uninsured are people who work for small businesses. Allowing small-business owners to offer plans in this manner would extend health coverage to many working but currently uninsured Americans. An individual could use the tax credit toward the cost of this coverage.

5. Expanded Medical Savings Accounts. H.R. 1687 expands access to medical savings accounts by repealing the artificial limit on the number of MSAs and other restrictions, and allowing all employers to offer them, not just small employers. The best feature of an MSA is that the patient is free to visit any doctor, anywhere and at any time.

The primary problem for patients is that they do not own their health insurance policies. In this unique employer-based system, employers choose what plans to offer their employees. These choices do not always conform to what is in the best interest of each employee. Because the current tax system is weighted so strongly in favor of employer-provided insurance, it is rare for employees who are offered insurance at work to choose to purchase health insurance on their own. The result: an insurance market in which plans are responsive to the needs of the employer, not the consumer.

Tax credits would begin to reduce the inequity in the tax code. Shifting decision-making power to individuals would allow people to buy plans that meet their personal needs. Consumer choice empowers employees to "fire" a poorly performing health plan. Such choice would eliminate many of the arguments for a "patients' bill of rights," because individuals and families would be able to pick better and less restrictive plans. The policies embodied in H.R. 1687 would offer working families an expanded array of choices, and with choice comes empowerment: the ability of people to pick the health insurance plans and physicians they want without incurring tax penalties for choosing wisely.

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