Who Won What in the Kassebaum/Kennedy Struggle?

BY JANE HIEBERT-WHITE

On August 2, 1996, one year to the day after the Senate Labor and Human Resources Committee unanimously passed the legislation popularly known as the Kassebaum/Kennedy bill, the full Senate unanimously passed the Health Insurance Portability and Accountability Act (HIPAA). The legislation was approved by the House of Representatives a day earlier by a 421-2 vote. This apparently high level of support came, however, after months of classic political wrangling, near defeat, and a resolution just hours before Congress left town for its August recess and political campaigning.

Although the legislation is but a modest effort to reform some health insurance practices, it represents the most significant piece of healthcare law in a decade. This column examines how this popular and important healthcare measure got intertwined with politics.

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An Important Incremental Step

The insurance reform legislation, cosponsored by Sens. Nancy Landon Kassebaum, R-KS, and Edward M. Kennedy, D-MA, is certainly modest in comparison with the failed comprehensive health reform efforts of 1994. It represents, however, an important incremental step and builds on the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986—the last significant health insurance reform legislation to be passed by Congress. (COBRA allows individuals who leave their jobs to continue their insurance coverage for up to 18 months under their former employer's group insurance plan, as long as they pay the premiums themselves.)

Both sponsors of the HIPAA battled all year to keep it alive and free from politically inspired amendments. It was the bill's incremental, modest nature that finally helped it win the bipartisan support necessary for passage. Kennedy, who has fought for insurance reforms and broader coverage for nearly three decades, was almost apologetic about the bill's limited nature. Kassebaum, who chairs the Labor and Human Resources Committee but is retiring from the Senate this fall, was vital to the transformation of what many saw as a "Democratic" initiative into a bipartisan achievement. "This bill is a nice tribute to Sen. Kassebaum," said Catholic Health Association (CHA) lobbyist Jack Bresch. "It epitomizes the human concern she brought to political deliberations."

The HIPAA's Features

The measure's primary features are as follows.

Portability The HIPAA will allow a worker to take his or her insurance coverage to a new job, without restrictions for preexisting medical conditions, if the worker has been continuously insured for 12 months under the previous employer's group insurance plan (this is the so-called group-to-group portability). In the case of a newly insured worker, coverage of preexisting conditions would begin after he or she has been on the job for 12 months. Economists claim this feature will alleviate "job lock"—that is, a worker's reluctance to leave one job for another for fear the new health insurance plan may not fully cover the worker or his or her dependents. The HIPAA also requires insurers to renew the policies of workers who become sick, including those with serious illnesses such as cancer or AIDS.

Individual Coverage A more controversial feature of the HIPAA is the "group-to-individual" portability requirement. This feature requires insurers to offer an individual policy to a worker who has at least 18 months of group insurance coverage under his or her former employer's plan and is not eligible for other coverage (e.g., under a spouse's plan or the COBRA requirements).

The Health Insurance Association of American (HIAA) fought this feature of the act, contending it would destroy the individual health insurance policy market by raising premium costs from 15 percent to 31 percent.[1] With such high premiums, fewer people would be able to afford individual policies, argued the insurer group. The American Academy of Actuaries, however, esti-

mated that premiums would increase by only 2 to 5 percent.[2] And a study by the Congressional Research Service predicted a 1 percent increase in the first year and a 3 percent increase overall.[3] At issue is how many individuals would take advantage of the coverage and whether they would likely be sicker and more costly to cover.

The insurance industry was also divided on portability for individuals. For instance, the Healthcare Leadership Council—whose members include such large insurers as Aetna, Prudential, and Cigna, and such health plans as Humana, Baylor Health Systems, Oxford Health Plans, and American Health Care Systems—expressly supported this provision of the legislation.

HIAA wanted to "segment" individual policies, offering some that would be tailored specifically for people moving from group to individual coverage. This action, however, might have led to excessively high premiums, thus negating the law's intended effect: to ensure portability of insurance. In a final compromise, the bill was amended to allow insurers to create special policies, but with limits on what they can charge for premiums.

The HIPAA also offers a tax break for individually insured self-employed workers. Under the act, such a person can, over a period of 10 years, increase the tax deduction for his or her health insurance premium costs from the current 30 percent to 80 percent. This brings the insurance tax break for self-employed people closer to the 100 percent tax exclusion now enjoyed by employers who offer group insurance benefits.

Medical Savings Accounts The legislation's biggest sticking point was its inclusion of medical savings accounts (MSAs). MSAs are tax-deferred accounts set up in conjunction with a less expensive "catastrophic" health insurance plan that has a very high deductible. Funds deposited in the MSA, either by employers or individuals, could be used to cover out-of-pocket healthcare costs.

The House version of the bill included MSAs; the Senate version did not. The compromise finally worked out between Republicans and Democrats—after much politicking—scaled the MSAs back to a four-year "experiment" limited to 750,000 policies.

Other Features The HIPAA also allows modest relief from long-term care costs by making the costs of nursing home care and home health care tax deductible, as are other medical costs. Long-term care insurance premiums are also deductible up to limits ranging from $200 per year for a person under age 40 to $2,500 per year for a person over age 70.

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Costs and Benefits

The long-term care feature is actually the most expensive aspect of the legislation. Because of it, experts say, the federal government will forgo $7.8 billion in tax revenue over the next decade. Tax revenue lost because of the expanded tax break for the self-employed is projected to be $6.3 billion over the decade. MSAs will cost about $3 billion in lost taxes, according to estimates.

The bill's sponsors claimed that as many as 25 million Americans would benefit from the new legislation. This is probably an overstatement, and even Kennedy acknowledged that the projected benefit was hard to quantify.

The General Accounting Office (GAO) had estimated that up to 25 million Americans are affected by job change or loss. However, the protection afforded by the new law will not be needed by all of these 25 million. Some workers will take new jobs with employers who offer health insurance plans without restrictions for preexisting conditions. And some workers live in states, that already have laws protecting policy-holders from such restrictions.

Public Ignored the Debate

A survey conducted between June 20 and July 9, 1996 showed that most Americans (56 percent) had neither heard nor read about the Kassebaum/Kennedy insurance reform debate and that 69 percent didn't know about MSAs.[4] When they were read a description of the proposed reforms and the arguments for and against them, 31 percent of those surveyed supported the reforms and 12 percent opposed them; 57

THE HIPAA'S MAIN FEATURES

The primary features of the Health Insurance Portability and Accountability Act are:

- **Portability.** Workers can take their insurance from one job to another, and insurers are limited in their ability to restrict coverage because of preexisting conditions.
- **Individual coverage.** Workers who leave a job that provided group coverage must be allowed the opportunity to purchase individual coverage.
- **Medical savings accounts.** In an "experiment" limited to 750,000 policies, workers may set up tax-deferred accounts, along with a catastrophic insurance plan with high deductibles.
- **Other features.** The HIPAA also allows some tax deductions for the costs of nursing home care and home health care and the premiums on insurance for long-term care.

percent said they needed more information in order to make a decision. Of the 43 percent who *had* followed the debate, 47 percent favored the reforms and 14 percent opposed them.

The survey found higher negative reactions to the MSA experiment, varying according to the proposed size of the deductible. After they were read a description of MSAs and the arguments pro and con, 28 percent favored and 36 percent opposed MSAs linked with a catastrophic insurance policy with a $2,000 deductible. When the interviewers raised the proposed deductible to $5,000, only 18 percent of respondents said they favored MSAs, whereas 42 percent said they opposed them.

The telephone survey (designed by the Kaiser Family Foundation, Harvard University, and Princeton Survey Research Associates [PSRA] and conducted by PSRA) did find that public interest in healthcare issues is on the rise again. Respondents said that healthcare ranked third, behind economic concerns and candidate characteristics, as an important issue in the upcoming presidential election.

The HIPAA's Political Importance

Although the HIPAA will help but a relatively small segment of the U.S. population and apparently stirs little public interest, it has tremendous political importance in congressional and presidential politics. Both Republicans and Democrats immediately took credit for its passage. Republicans wanted to show they could deliver on healthcare reform, even if it was modest. Their opponents contended that the Republicans finally adopted what were essentially Democratic goals because they feared voters would be angry if they did not. President Bill Clinton also claimed some credit. The only political actor left out, was Republican presidential nominee Bob Dole, who in April resigned as Senate majority leader without forcing action on the bill.

The political ups and downs of the Kassebaum/Kennedy bill demonstrate classic Washington politicking and show how some relatively modest policy ideas can be held hostage to political goals. For example, after the bill was approved by the Senate Labor and Human Resources Committee, it was blocked for months by secret "holds" by unnamed conservative senators. Clinton then urged action on the bill in his January State of the Union message. Analysts feared that this direct appeal by a Democratic president to a GOP-led Congress would further jeopardize the bill. Neither Republicans nor Democrats wanted the other side to get credit for healthcare reform. In the end, a compromise made it possible for both sides to take credit. It remains to be seen, however, how voters will judge the outcome.

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The MSA Stumbling Block

The House finally passed its version of the bill on March 25 by a vote of 267 to 151. It included a tax exemption for MSAs. House Republicans, led by Ways and Means Committee Chairman Rep. Bill Archer, R-TX, strongly supported MSAs as a tool that would bring more individual responsibility and consumer choice into healthcare and thus help control costs.

In the Senate, however, Kennedy was adamantly opposed to MSAs. Democrats and moderate Republicans fought off an amendment to add MSAs to the Senate version. When the Senate finally voted April 23, it passed the Kassebaum/Kennedy bill without MSAs, but with the controversial provision for mental health parity.

Senate conferees agreed to drop the mental health parity provision, and it was the MSA provision that caused the most disagreement. Archer was absolutely committed to including MSAs, whereas Clinton threatened to veto the bill if it allowed them. Kennedy took some political heat for tying up the legislation until he was convinced it would not include full-scale MSAs. Archer and Kennedy agreed on the limited MSA experiment on July 25.

Both the Democrats and Republicans finally compromised to break the logjam. Said CHA's Bresch, "Republicans wanted MSAs to be permanent and available to up to 100 million Americans. Democrats would have preferred not to have them at all." Bresch said timing helped spur action. "They were coming up on the August recess and hadn't done anything in healthcare. They hadn't done Medicare reform. They hadn't done Medicaid reform." Lawmakers on both sides of the aisle desperately wanted to show voters that they had accomplished something as they left for a month of campaigning back home, Bresch said.

Once the conferees were named after the Archer/Kennedy compromise, they quickly worked out the final compromise bill, which then sped through Congress. The House passed it Thursday, August 1, and the Senate on Friday, August 2, just before the August recess began.

The MSA Debate

MSAs appealed to Republicans as a way to bring more individual responsibility and truer market incentives into healthcare. University of

Pennsylvania economist Mark Pauly and leading MSA proponent John Goodman explained the conservative policy thinking on the proposal: "Political decisionmakers must resist the temptation to engineer choices for other citizens, even at the cost of seeing people make choices that the decisionmakers would not make for them or that they think are unwise."[5]

Proponents also argue that MSAs will contain healthcare costs. Having invested in MSAs and a catastrophic insurance plan with high deductibles of $2,000 per individual or $4,000 per family, people would have a bigger incentive to purchase no more healthcare than was necessary. Under comprehensive insurance, on the other hand, people are encouraged to consume more healthcare, since they are insulated from the true cost of it. Some analysts argue, however, that the cost-saving potential of MSAs will be overshadowed by managed care's ability to do the same. Experience in California and other areas with high managed care penetration shows that employers are vigorously negotiating about prices with insurers and managed care plans and are driving historic price increases back down.

Some analysts estimated that, under the House version, as many as 40 million Americans might be attracted, for their health coverage, to an MSA combined with a catastrophic insurance plan. As Urban Institute analysts Linda Blumberg and Len Nichols explain, "MSAs would appeal to healthy persons because catastrophic premiums are lower than comprehensive premiums, and healthy persons often will conclude that the amount they would have to pay out of pocket with an MSA would be less than the higher cost of more comprehensive coverage. MSAs also would appeal to unhealthy persons who currently have no stop-loss provision and to persons who chafe at the restrictions of managed care plans."[6] However, MSAs would draw off the healthy risks, leaving only the sickest in comprehensive health insurance plans. "In a nutshell, MSAs would reduce the implicit cross-subsidy in all risk-pooling arrangements for comprehensive policies that overcharge healthier persons to transfer current funds to less healthy persons," concluded Blumberg and Nichols, who both worked at the Office of Management and Budget (OMB) before joining the Urban Institute.

Since there has been little experience with MSAs to date, an experiment may prove prudent. Said CHA's Bresch, "CHA has some concerns about the MSA concept. Now we get to see how it works." The MSA experiment will begin January 1, 1997; the rest of the law will take effect July 1, 1997.

Recent experience shows that small and incremental is the name of the game in American healthcare politics.

One country that has experimented with MSAs is Singapore. But even after a decade of experience, interpretations of the results are mixed. Writes Harvard professor William Hsiao: "The well-executed Medisave scheme in Singapore could not contain costs, so it is unlikely that such a scheme could do so here. In the current ideologically driven health policy debate, we can avoid costly mistakes by examining the experiences of other nations."[7] On the other hand, two other analysts studying Singapore reached the opposite conclusion. "With Medisave as a key element of its strategy, Singapore has developed a very sophisticated health care system over the past decade at much less than the world market price. While this does not prove the cost-effectiveness of MSAs, it certainly makes it difficult for us to dismiss the concept," write Thomas Massaro, of the University of Virginia, and Yu-Ning Wong, a medical student at the Robert Wood Johnson Foundation Medical School.[8]

If a nation's decade-long use of MSAs has not led to conclusive results, what can we expect from a very limited four-year experiment? Probably not much. But at least it is a step forward. If there is one thing to be learned from the healthcare reform failure of 1994, it is that small and incremental is the name of the game in American healthcare politics. □

NOTES

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2. American Academy of Actuaries, *Comments on the Effect of S. 1028 on Premiums in the Individual Health Insurance Market*, Washington, DC, 1996.
3. Congressional Research Service, *Letter to the Senate Labor and Human Resources Committee*, Washington, DC, 1996.
4. Kaiser-Harvard Program on the Public and Health/Social Policy, "Public Not Following Battles in Washington over Kassebaum/Kennedy and Medical Savings Accounts," July 30, 1996.
5. Mark V. Pauly and John C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs*, Spring 1995, pp. 126-139.
6. Linda J. Blumberg and Len M. Nichols, "First Do No Harm: Developing Health Insurance Market Reform Packages," *Health Affairs*, Fall 1996.
7. William C. Hsiao, "Medical Savings Accounts: Lessons from Singapore," *Health Affairs*, Summer 1995, pp. 260-266.
8. Thomas A. Massaro and Yu-Ning Wong, "Positive Experience with Medical Savings Accounts in Singapore," *Health Affairs*, Summer 1995, pp. 267-271.