BRIEF ANALYSIS
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Two Cheers for Michel-Lott

House Minority Leader Bob Michel (R-IL) and Senator Trent Lott (R-MS) introduced an attractive health reform plan in August based on earlier proposals they had offered. The Michel-Lott plan builds on key reform ideas developed by the National Center for Policy Analysis. However, some benefits of the reforms would be diluted by unnecessary insurance regulations that should be dropped from the proposal.

First Cheer: Michel-Lott Is Not a "Clinton-Lite" Proposal. Unlike some other "moderate" proposals, Michel-Lott is not a me-too approach.

- There are no employer or individual mandates requiring people to purchase insurance whether they want to or not.
- There are no mandatory health alliances, giving the government control of the insurance marketplace.
- There are no price controls or global budgets that would inevitably lead to health care rationing.
- And unlike some other Republican proposals, the plan does not try to impose on the private sector managed competition or a government-defined benefits package.

Second Cheer: Michel-Lott Has a Number of Good Reforms. Among the most positive provisions are:

- Medical Savings Accounts (MSAs): People would be able to control most of their own health care dollars through personal MSAs, using third-party insurance only to pay catastrophic expenses.
- Tax fairness: People who purchase their own insurance would receive the same tax relief as those who obtain insurance through an employer.
- Positive insurance reforms: People could not have their insurance canceled or their premiums increased because they got sick.
- Health insurance vouchers: Low-income families not on Medicaid would qualify for subsidies to purchase private health insurance.
- Override of state regulations: Costly, premium-increasing regulations passed by state governments would be preempted.

Medical Savings Accounts. People would be allowed to select high-deductible insurance and deposit the premium savings tax free in a personal Medical Savings Account. The account would be the property of the individual or family, and the money would be available to pay medical expenses not covered by third-party insurance. Money not spent would earn taxable interest and would be available to pay postretirement medical expenses or to become part of the owner's estate. Funds could be withdrawn at any time, subject to income taxes and a 10 percent penalty.

Tax Fairness. The federal government currently "spends" about $84 billion a year in tax subsidies for health insurance, and state and local governments spend another $10 billion. These subsidies exist because employer-provided health insurance is excluded from employees' taxable income. At the same time, the self-employed, the unemployed and employees of small companies that do not provide health insurance must pay taxes first and buy health insurance with what's left over. This can make their health insurance cost twice as much as it would if an employer provided it.

The Michel-Lott proposal would, after a phase-in period, treat all individuals with the same income equally under the tax code by allowing those who purchase their own insurance a 100 percent deduction.

Positive Insurance Reforms. The Michel-Lott proposal establishes both portability and guaranteed renewability for all American workers. Once people are in the system, they cannot lose coverage through no fault of their own or be subjected to premium hikes because of an illness. Unfortunately, the plan proposes far more regulation than is necessary or desirable to achieve these goals. [See the discussion below.]

Vouchers for Low-Income Families. Individuals and families not on Medicaid with income up to 150 percent of the poverty level (185 percent for children) would be entitled to subsidies for the cost of insurance. The proposal could be improved by extending the vouchers to Medicaid beneficiaries as well as other low-income families. This would effectively privatize Medicaid, allowing low-income people to have the same private insurance coverage and health care as the middle class.

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Repeal of State-Mandated Benefits Laws. Currently, state-mandated health insurance benefits laws force people to purchase a Cadillac plan — loaded with extra benefits such as acupuncture and in vitro fertilization — or remain uninsured. The phenomenal increase in state-mandated benefits — from a total of eight in 1965 to over a thousand today — has priced many people out of the market for health insurance. The Michel-Lott proposal would abolish these state-mandated benefits requirements for all group health plans. This should be extended to individual insurance as well.

Why Michel-Lott Doesn't Get a Third Cheer. Although the Michel-Lott plan is a major step in the right direction, the plan could be much better. Its principal defect is its heavy emphasis on regulation of individual health insurance and insurance for small employers with up to 50 workers. These regulations include:

- Modified community rating: Everyone of the same age would be charged the same premium, regardless of health status.
- Guaranteed issue: Insurers would have to accept all applicants regardless of health status and pay for treatment of preexisting conditions after only a few months.
- Risk adjustment: State regulators would be required to transfer money from plans that have healthier enrollees to plans with less healthy ones.

Under this regulation, someone could remain uninsured for his entire life until he got AIDS. Yet, he would then be allowed to purchase health insurance for the same premium everyone else his age paid. Any group insurer would have to start paying his medical bills after six months at most; individual insurance policies would have to start paying after 12 months at most. Under either scenario, an insurance plan would be compelled to pay the vast majority of the person's medical expenses.

Here's the problem: *If people can obtain insurance after they get sick, they have an incentive to remain uninsured until they get sick.* For that reason, the insurance regulations are likely to increase the number of uninsured. Moreover, as sick people joined insurance pools and healthy people dropped out, premiums will rise. The higher costs would cause even more of the young and healthy to drop out, further increasing the number of uninsured.

When insurers are forced to sell to the sick and the healthy at the same premium they will find it in their self-interest to go to extraordinary lengths to attract the healthy and avoid the sick. The result is likely to be extreme adverse selection, in which a few health plans have disproportionate numbers of people with expensive health problems and healthy people leave those plans for lower-cost competitors.

To counteract this tendency, the bill calls for risk adjustment. However, risk adjustment regulation is unworkable and it could become a back door means for government control of health care. Regulators cannot know in advance what costs health plans will incur and, consequently, cannot rationally redistribute funds among insurers. At the time people join the plans. If the regulators wait until after costs have been incurred, they will be administering a cost reimbursement system. Health plans would agree to pay for high-cost care only if the risk adjustment regulators agreed to compensate them for it, and the regulators would end up telling insurers, doctors and patients what care could be paid for, provided and received.

Needed Change in the Michel-Lott Bill: Risk Pools Instead of Regulation. Surveys show that less than 1 percent of the population is uninsurable. The Michel-Lott plan attempts to solve the problems of the 1 percent by regulating the insurance of the other 99 percent. A much better approach would be to solve the problem directly through risk pools, as 28 states already have started to do.

Risk pools sell insurance at subsidized premiums to individuals who cannot obtain policies elsewhere. The losses are covered either from general tax revenues or by "taxing" insurers based on each insurer's market share. Properly established, high-risk pools could meet the needs of those who have been denied health insurance, because of a preexisting condition, while the free market meets the needs of everyone else. Studies indicate that risk pools could be extended nationwide to cover all who need them by an additional government subsidy that is less than one-tenth of 1 percent of the nation's annual health care bill.