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John S. Hoff

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Kassebaum-Kennedy: No Slam Dunk

by John S. Hoff

Health care reform this year means the Kassebaum-Kennedy bill. But, as is always the case with health care reform, it is never as simple as it looks at first blush.

The Kassebaum-Kennedy bill started off on the theory that insurance could easily be reformed to provide portability of coverage and ban exclusions in insurance policies that bar coverage for preexisting conditions. The theory was that these reforms were easy to make and would be widely supported. It quickly became apparent, however, that the reforms were neither so simple nor noncontroversial.

Concern was raised that people who lose employer-provided coverage would buy individual coverage only when they become sick, thus raising the price of individual coverage. The estimates on the extent to which premiums in the individual market would increase varied from 3 to 30 percent. Only time will tell.

At the same time, the bill was expanded in several ways beyond this (supposedly) noncontroversial reform. A host of new fraud and abuse elements and penalties were added. These elements made an incomprehensible web of proscriptions even more obscure. At this point, no one can determine all the conduct that is outlawed (other than real fraud, for which no new law is necessary).

Some changes are understandable. Anyone who obtains the money or property of a health plan by false representations or promises can be jailed for ten years, for twenty years if serious bodily injury results, or for life if the violation results in death. Also, property that is indirectly derived from money "traceable" to the commission of certain offenses can be forfeited—a doctor's car, his office, a hospital?

The Senate added a requirement that if mental health benefits are included in a policy, they must be treated in the same way as benefits for physical disease. That federal mandate would make insurance more expensive and reduce the number of employers and individuals who would buy insurance—the exact opposite of what the bill was intended to do. The mental health provision was vigorously opposed by business interests that had previously favored the bill.

The bill was further complicated by the addition of a provision for medical savings accounts. The bill provided that employer payments to a medical savings account would be excluded from the employee's taxable income, just as payments for insurance premiums are. It also provided that individuals who do not receive an MSA payment from their employer may deduct their own contribution to the MSA.

MSAs are intended to give people money to make their own health care purchasing decisions for the upfront costs of care, rather than relying on insurance. Insurance would kick in for expenses above the MSA amount ($2,000 for an individual/$4,000 for a family). The hope is that this will give individuals choice, make them economically more sensitive in their health care choices, and so bring economic discipline to the system. MSAs also are supported on the grounds that they will give individuals who are in a managed care plan the freedom to choose their providers (at least at the beginning of an illness). The downside of MSAs is a fear that only the healthy will use them, thus raising the cost of noncatastrophic insurance for the sick.

The effects of MSAs are not known because the idea is new. Some MSAs now exist, but without a tax subsidy. A handful of employers contribute to an MSA account with after-tax dollars. The purpose of the bill is to treat out-of-pocket payments made through MSAs in the same way as employer-provided insurance—both would be excluded from the employees' tax.

While the discrimination that now exists between the tax treatment of employers' contributions to insurance premiums and out-of-pocket payments through MSAs would end, the question is whether there should be a tax subsidy at all. The tax exclusion for employer-provided insurance is regressive, inflationary, and fails to direct public subsidies to those who need them most. A vital way to "reform" the health care system is to eliminate the exclusion and recycle the increased tax revenues through a voucher that could be given to those who need help in purchasing insurance. This would be more equitable, moderate health care inflation, and target subsidies to those who need them.

The new MSA legislation, therefore, was at the focus of cross-currents of reform. It increased individual choice, essential to a market system, and it provided equitable treatment for out-of-pocket payments compared to insurance. However, it retained and expanded the current tax treatment, which is a major problem. Consequently, people were ambivalent as to whether the MSA proposal advanced or retarded reform. This was another reason the reaction to the bill was ambivalent and its course more difficult than had been predicted.

John S. Hoff is ACCC legal counsel in Washington, D.C.