

Hawaii

Employment and Wage Data from Business Payrolls

1970 - 1992

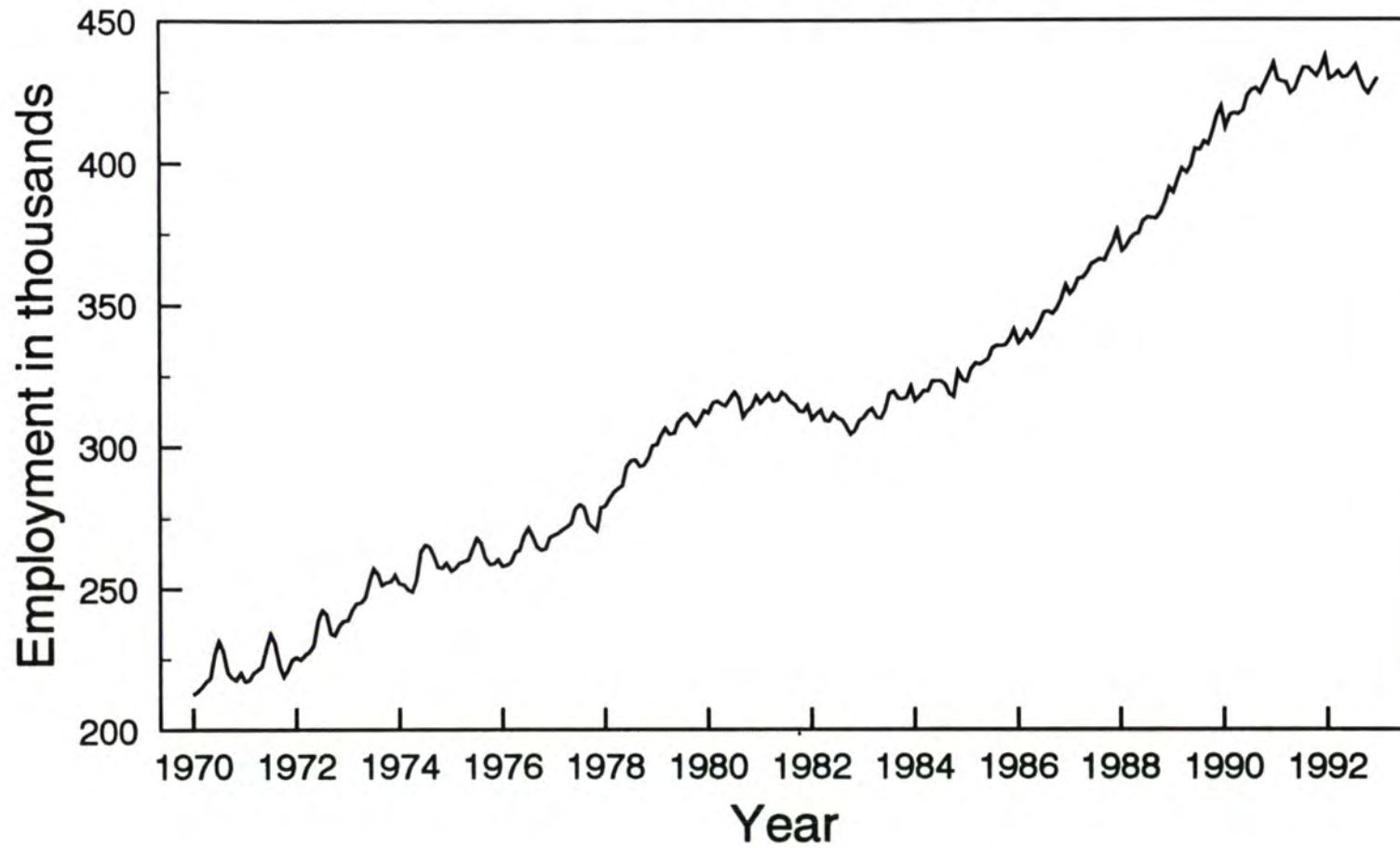


Bureau of Labor Statistics
U.S. Department of Labor

Section 1 - Hawaii Private Sector Employment Levels

- Total private nonfarm employment in Hawaii has trended steadily upward during the past two decades, increasing by more than 90 percent over the period 1970-1992. The corresponding U.S. employment expansion was 54 percent.
- Most of Hawaii's traditional private sector base, as well as its recent growth, have been in service- producing rather than goods- producing industries. The private service- producing industries represent over 85 percent of Hawaii's private nonfarm economy.
- Hawaii's long employment expansion period has continued nearly unabated even during U.S. economy-wide recessions. Hawaii's mostly services-based economy suffered only a mild employment decrease of 1.4 percent during the 1981-82 recession, which was largely confined to the goods-producing industries nationwide. The 1990-91 recession, which affected both the goods and service-producing sectors across the U.S., had no negative impact on Hawaii's employment; annual average employment actually increased 1.7 percent between 1990 and 1991.

Hawaii Total Private Employment



Hawaii

Source: Bureau of Labor Statistics
Current Employment Statistics Program

Note: Monthly data not seasonally adjusted

Section 2 - Total Nonfarm Employment Distribution by Industry Hawaii Compared to United States (1970-1990)

- While Hawaii has long been a services-based economy largely dependent on tourism, in recent years it has shifted still more towards the service- producing sector, slightly outpacing national trends for this phenomenon.
- In 1970 services comprised just under 20 percent of the State's total nonfarm employment; by 1990 it was nearly 30 percent of the total. For the U.S. as a whole, the share comprised of services grew from 16 to 25 percent over that same time period.
(Table 1)
- By contrast, while the number of manufacturing jobs in Hawaii between 1970 and 1990 was little changed (Table 2), the share of total employment they represented dropped by more than half, from 8.7 to 4 percent. At the national level, the number of manufacturing jobs was also little changed, while manufacturing's share of the national total declined from 27.3 percent in 1970 to 17.4 percent in 1990.

TABLE 1.
EMPLOYMENT BY INDUSTRY
(In percent)

INDUSTRY	1970		1980		1990	
	U.S.	HAWAII	U.S.	HAWAII	U.S.	HAWAII
Total Nonfarm	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Mining	0.9%	-	1.1%	-	0.6%	-
Construction	5.1%	8.8%	4.8%	5.9%	4.7%	6.1%
Manufacturing	27.3%	8.7%	22.4%	5.8%	17.4%	4.0%
T.P.U.	6.4%	8.2%	5.7%	7.7%	5.3%	8.0%
Trade	21.2%	23.6%	22.5%	26.1%	23.6%	25.7%
F.I.R.E.	5.1%	6.2%	5.7%	8.1%	6.1%	7.0%
Services	16.3%	19.5%	19.8%	24.4%	25.5%	29.2%
Government	17.7%	25.1%	18.0%	22.0%	16.7%	20.0%

TABLE 2.
EMPLOYMENT BY INDUSTRY
(numbers in thousands)

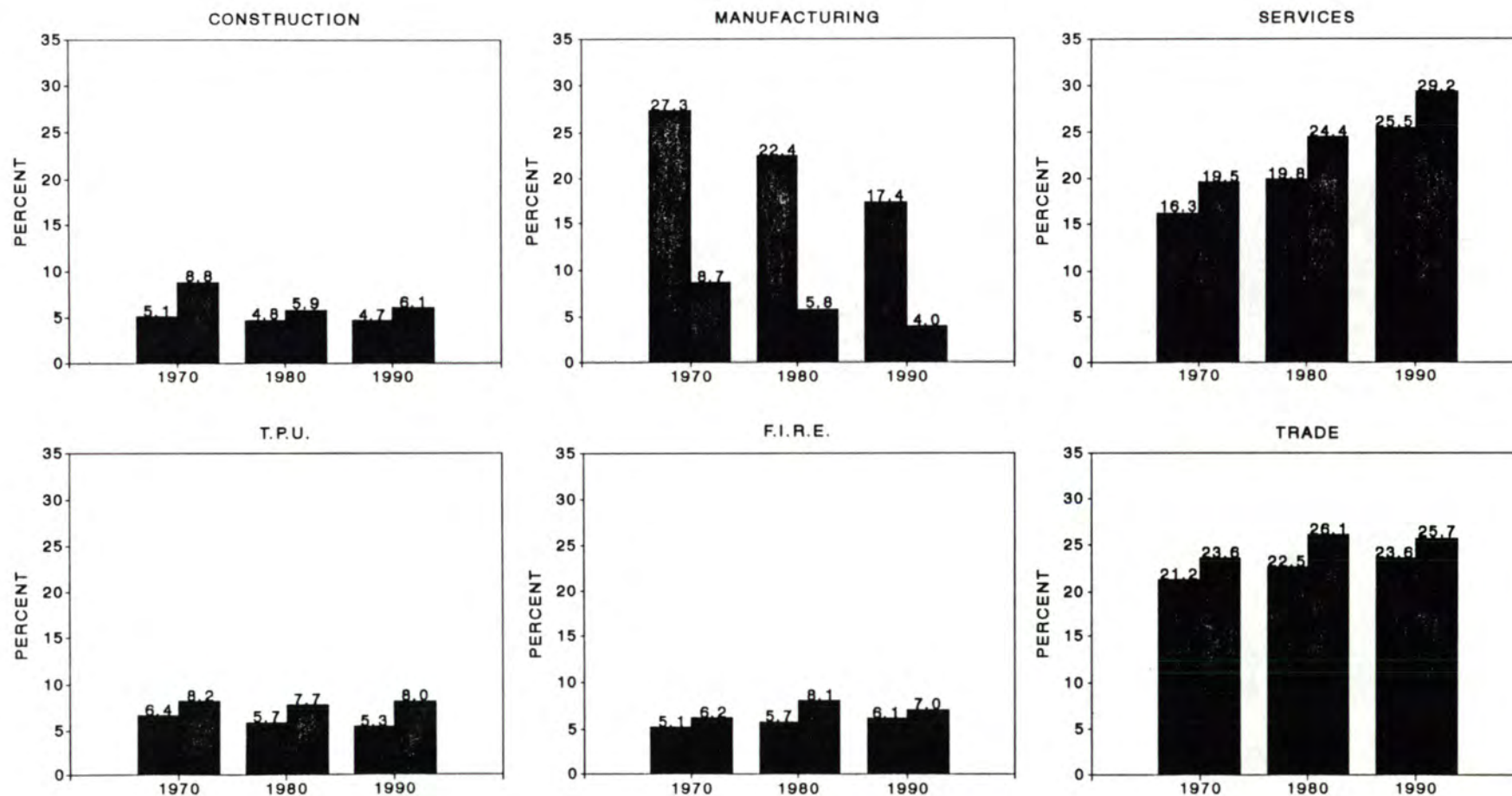
INDUSTRY	1970		1980		1990	
	U.S.	HAWAII	U.S.	HAWAII	U.S.	HAWAII
Total Nonfarm	70,880.0	293.7	90,406.0	404.0	109,419.0	528.4
Mining	623.0	-	1,027.0	-	709.0	-
Construction	3,588.0	25.7	4,346.0	23.9	5,120.0	32.3
Manufacturing	19,367.0	25.6	20,285.0	23.3	19,076.0	21.1
T.P.U.	4,515.0	24.0	5,146.0	31.2	5,793.0	42.2
Trade	15,040.0	69.3	20,310.0	105.3	25,774.0	136.0
F.I.R.E.	3,645.0	18.2	5,160.0	32.8	6,709.0	36.8
Services	11,548.0	57.2	17,890.0	98.5	27,934.0	154.4
Government	12,554.0	73.7	16,241.0	89.0	18,304.0	105.6

Source: Bureau of Labor Statistics,
Current Employment Statistics program.

Note: T.P.U. = Transportation and Public Utilities
F.I.R.E. = Finance, Insurance, and Real Estate

Percent distribution of Total Nonfarm Employment 1970 - 1990

■ U.S. ■ HAWAII



Source: Bureau of Labor Statistics,
Current Employment Statistics program.

Note: F.I.R.E. = Finance, Insurance, and Real Estate
T.P.U. = Transportation and Public Utilities

Section 3 - Employment Trends: Total Private and Selected Industries Hawaii Compared to United States (1970-based index)

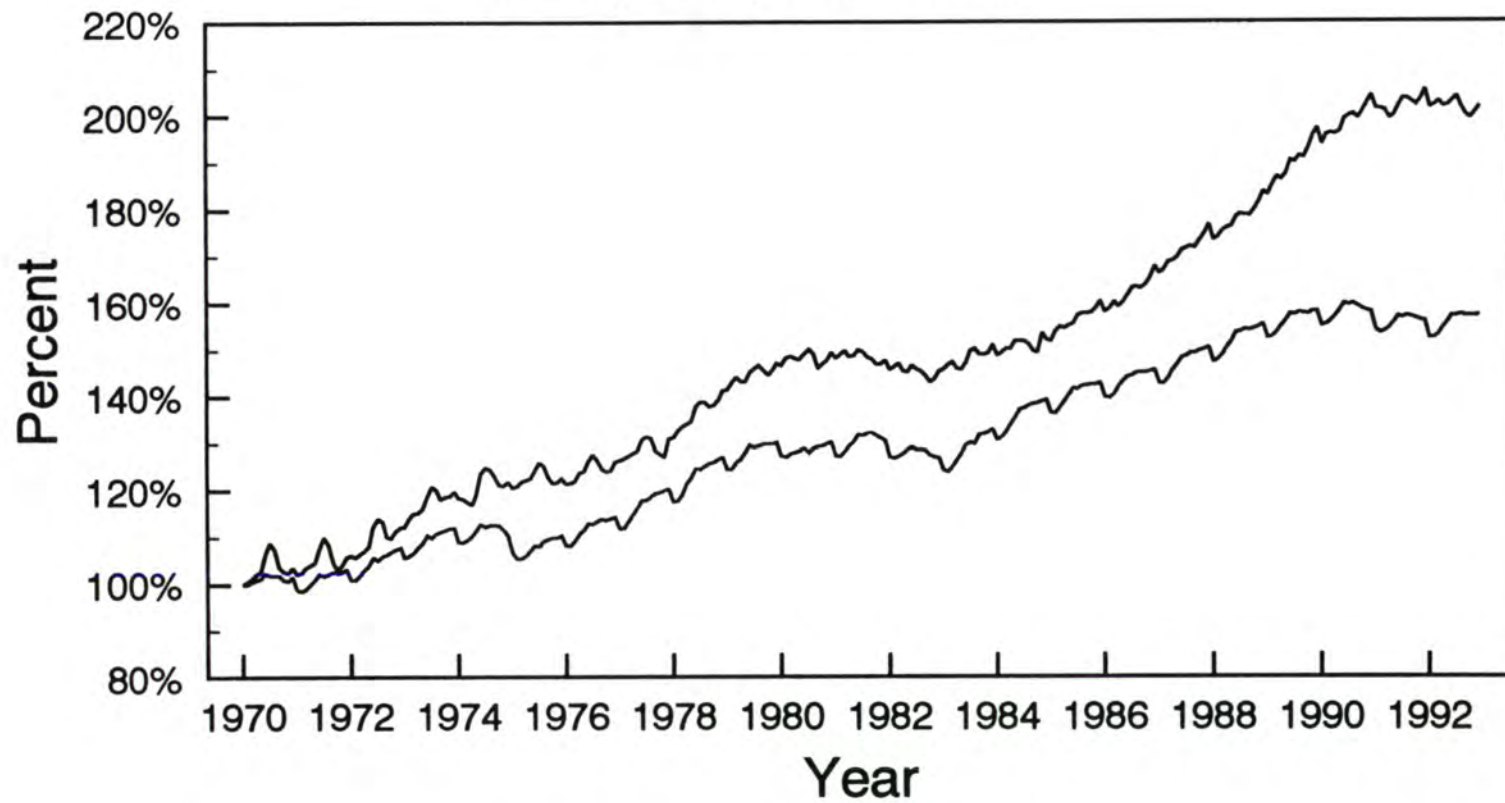
- Compared with the U.S. as a whole, Hawaii's employment growth has been significantly more robust over the past twenty years. This is shown in the following charts (described below), which use indexes of employment change based to 1970 to illustrate the comparison. (Use of index values rather than actual employment figures allows a more direct graphical comparison of the two series, which differ greatly in magnitude.)

- Total Private Employment: By 1990, the number of private sector jobs in Hawaii had almost doubled since 1970, and thus the employment index stood at about 200 percent. The national index value was considerably smaller at 160 percent.

-Major Service Sector Industry Divisions: Wholesale and Retail Trade, and Finance, Insurance, and Real Estate (F.I.R.E.) in Hawaii also doubled over the 20-year period. The index for the Services industry was close to 300 percent by 1992, indicating a near-tripling of the number of Services industry jobs since 1970.

Total Private Employment

Hawaii and United States
Index (January 1970 = 100%)



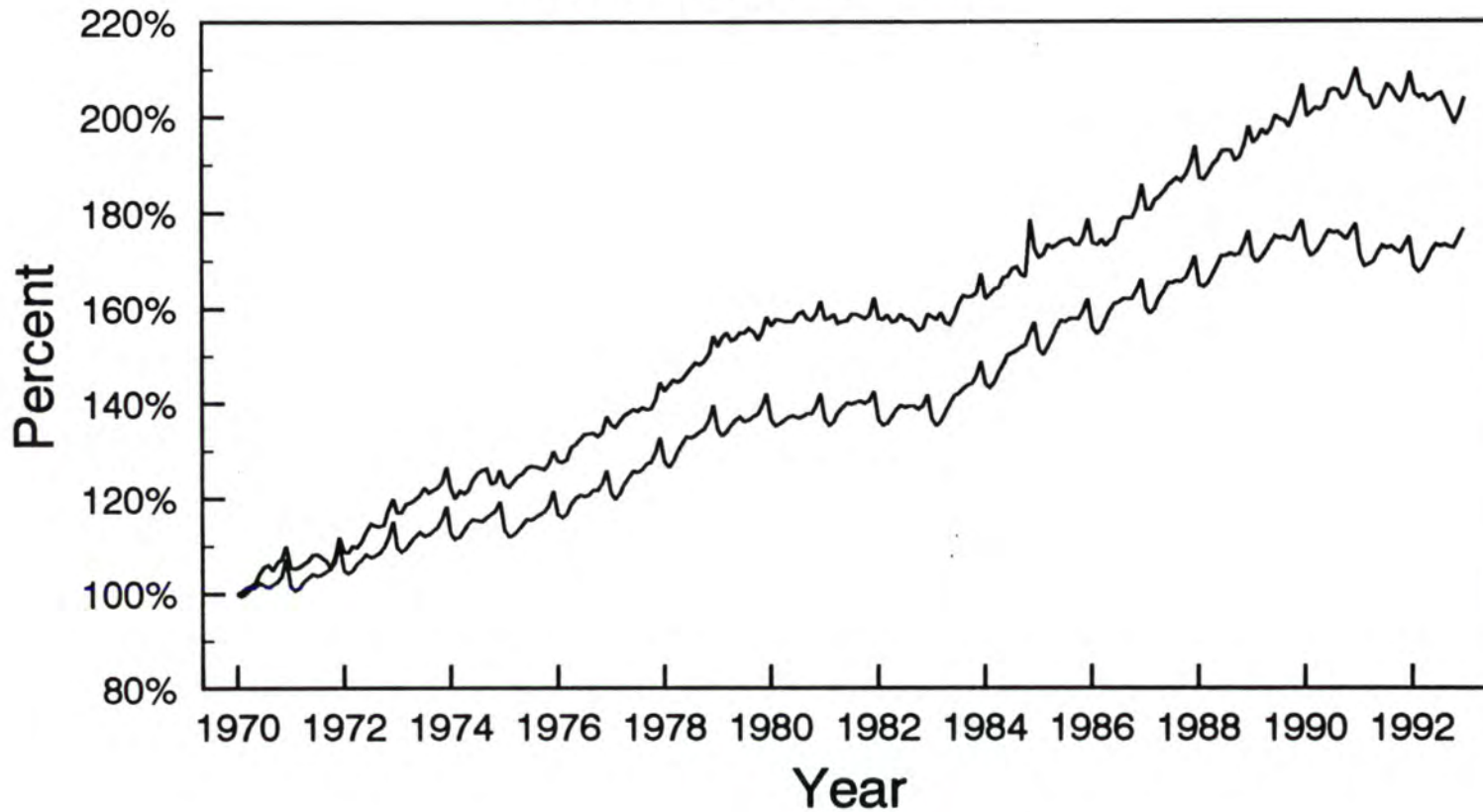
Hawaii United States

Source: Bureau of Labor Statistics
Current Employment Statistics Program

Note: Monthly data not seasonally adjusted

Retail and Wholesale Trade Employment

Hawaii and United States
Index (January 1970 = 100%)



Hawaii United States

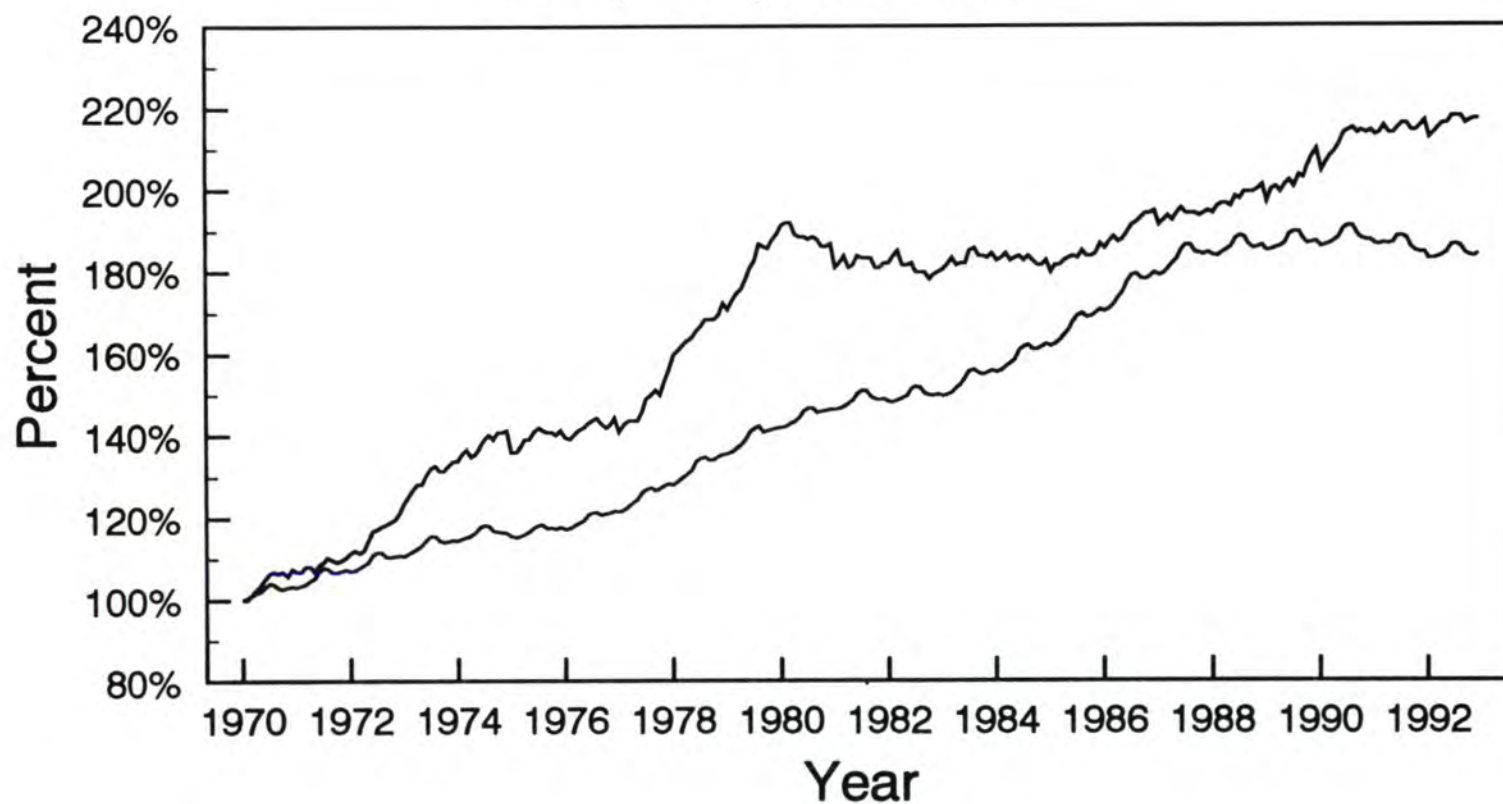
Source: Bureau of Labor Statistics
Current Employment Statistics Program

Note: Monthly data not seasonally adjusted

Finance, Insurance and Real Estate Employment

Hawaii and United States

Index (January 1970 = 100%)



Hawaii

United States

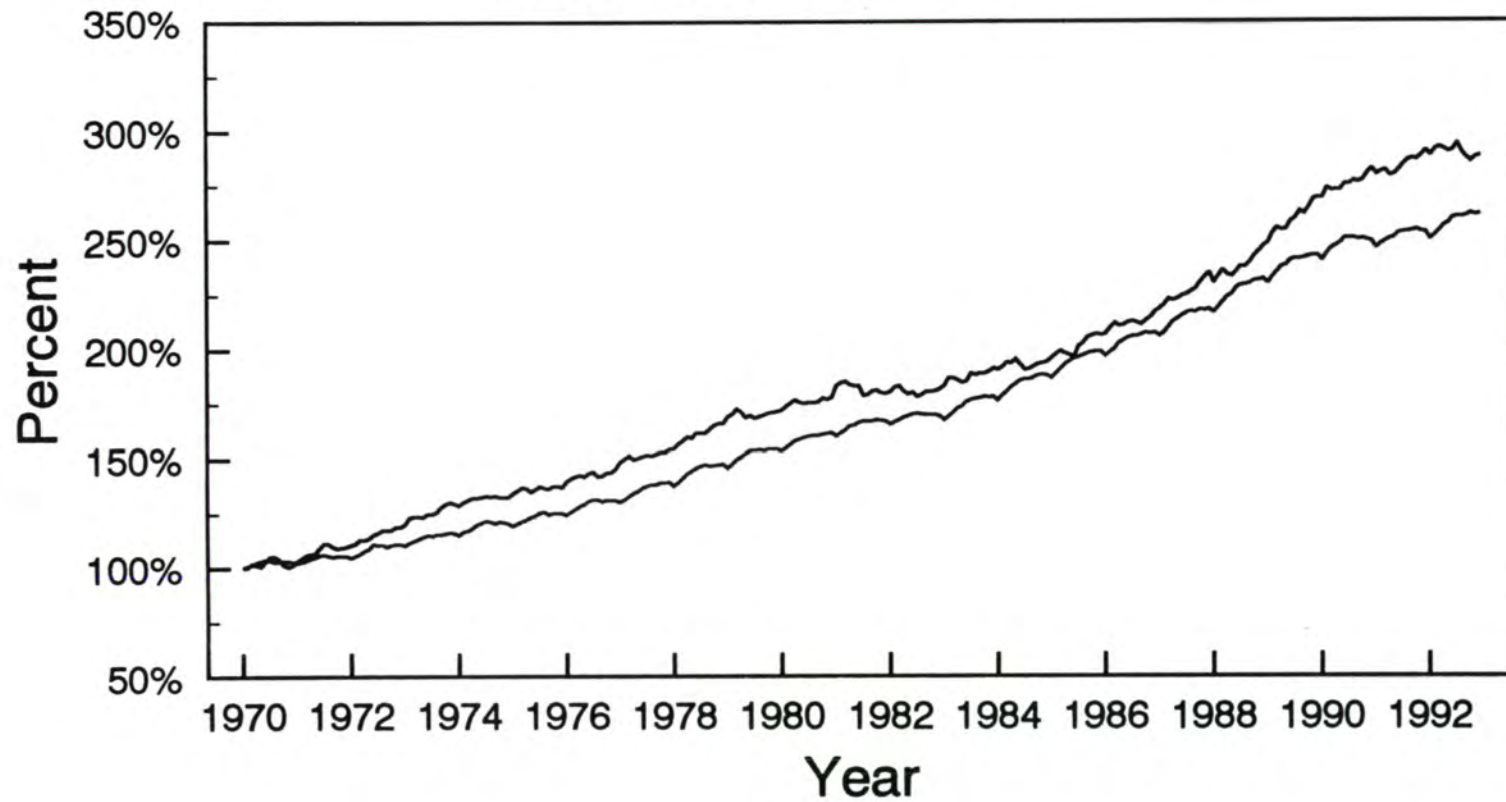
Source: Bureau of Labor Statistics
Current Employment Statistics Program

Note: Monthly data not seasonally adjusted

Services Employment

Hawaii and United States

Index (January 1970 = 100%)



Hawaii

United States

Source: Bureau of Labor Statistics
Current Employment Statistics Program

Note: Monthly data not seasonally adjusted

Section 4 - Health-Related Service Sector Industries

Hawaii Compared to United States (1975-based index)

(Note: Comparable data prior to 1975 do not exist for these industries)

-Health Services (SIC 80)

Employment in the health services industry has grown rapidly in Hawaii since 1975, increasing nearly two and a half times by the end of 1991 (and thus showing on the following chart an index value of nearly 250 percent by 1991). For the U.S. as a whole, the number of health services jobs doubled over the same time period (and therefore the index stands at 200 percent). The differential between growth rates in health services employment for the U.S. and Hawaii essentially mirrors the difference in their overall employment growth rates over the period.

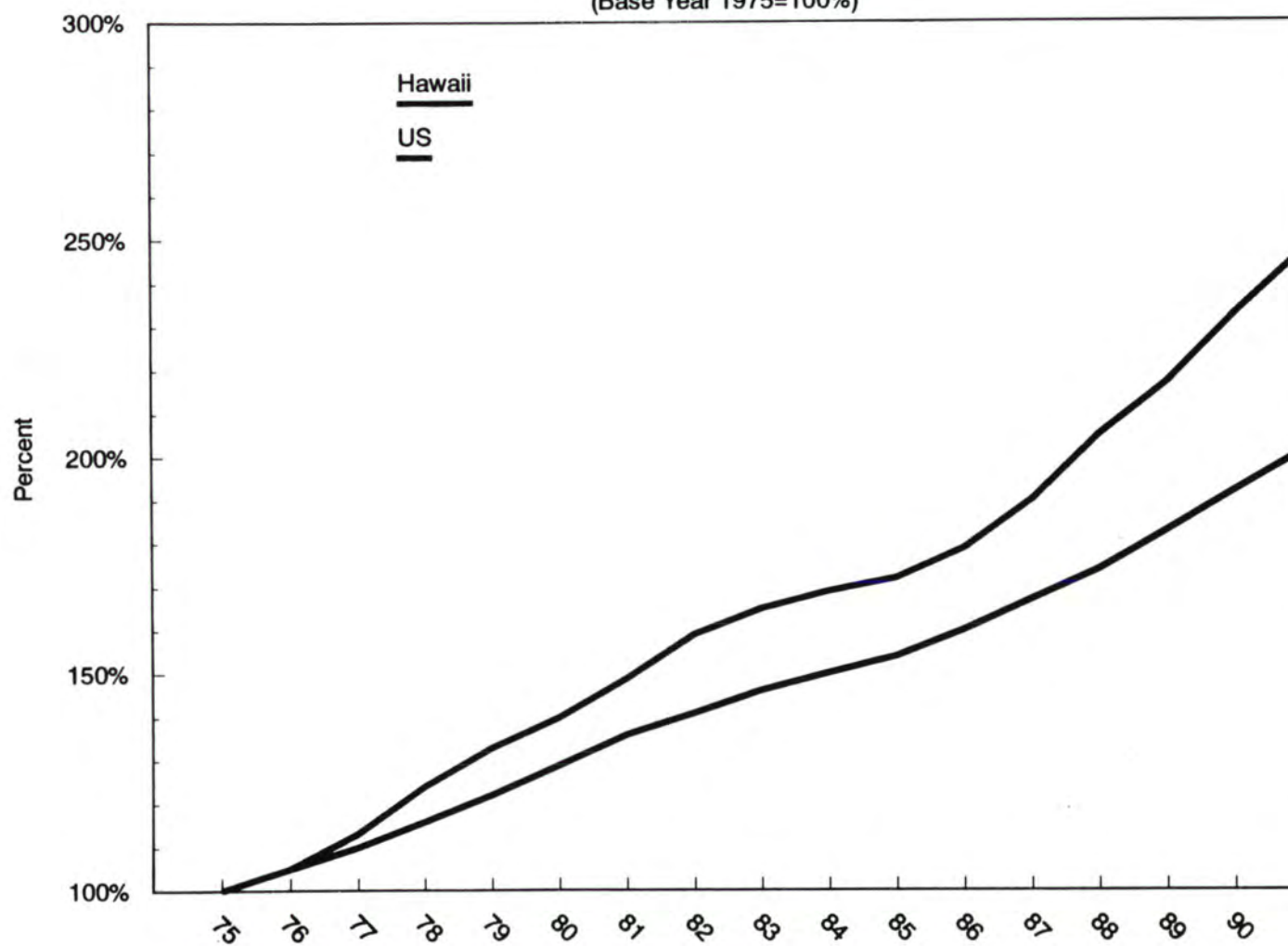
-Medical Insurance (SIC 632)

Medical insurance employment, in both Hawaii and the U.S., shows sharp percentage job gains since 1975. However, caution is in order in analyzing these figures for Hawaii, as the total employment base in this industry is very small (less than 1000 employees in 1975).

-Insurance Carriers (SIC 63)

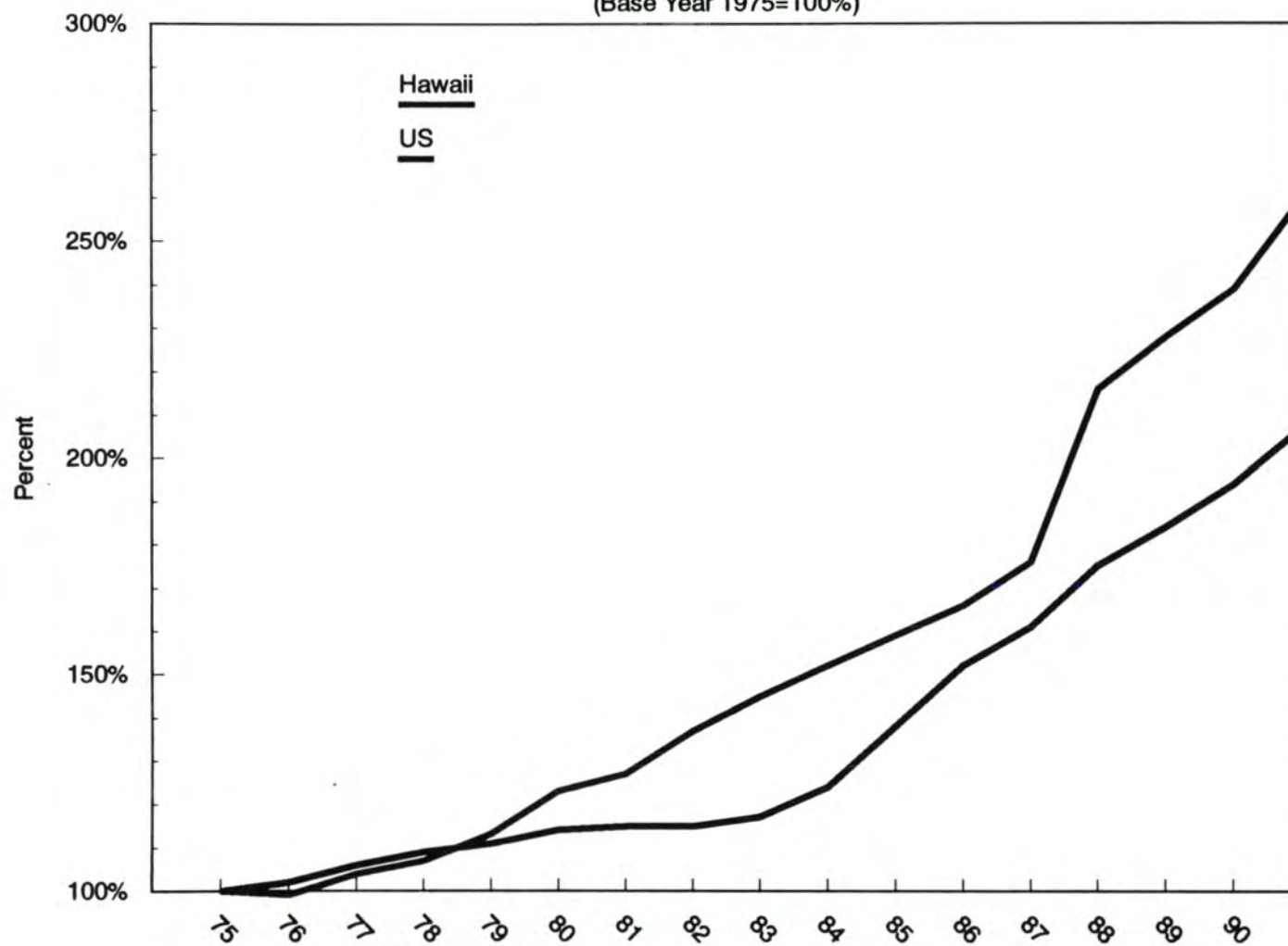
The growth rate of insurance carriers employment -- of which medical insurance carriers are a subset-- has been much less sharp in the U.S. and Hawaii than either total or health services employment. Jobs growth in this industry in both Hawaii and the U.S. was virtually flat in the first half of the 1980s; since then, industry employment in both areas has risen, with the growth in Hawaii outstripping that of the U.S.

Health Services Employment (SIC 80)
Hawaii and United States
Index of Annual Averages
(Base Year 1975=100%)



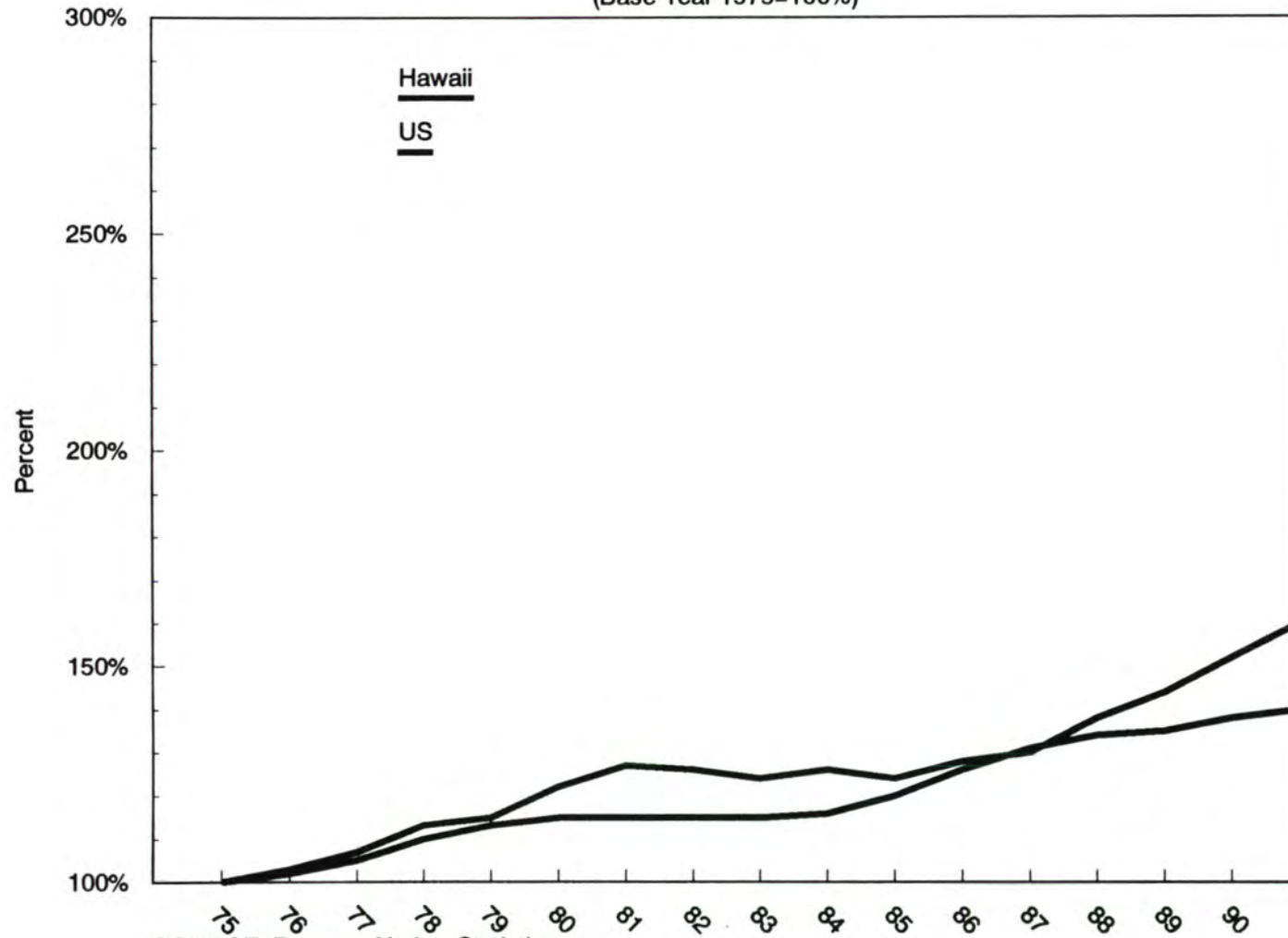
SOURCE: Bureau of Labor Statistics
Unemployment Insurance Covered Employment and Wages Program

Medical Insurance Employment (SIC 632)
Hawaii and United States
Index of Annual Averages
(Base Year 1975=100%)



SOURCE: Bureau of Labor Statistics
Unemployment Insurance Covered Employment and Wages Program

Insurance Carriers Employment (SIC 63)
Hawaii and United States
Index of Annual Averages
(Base Year 1975=100%)



SOURCE: Bureau of Labor Statistics
Unemployment Insurance Covered Employment and Wages Program

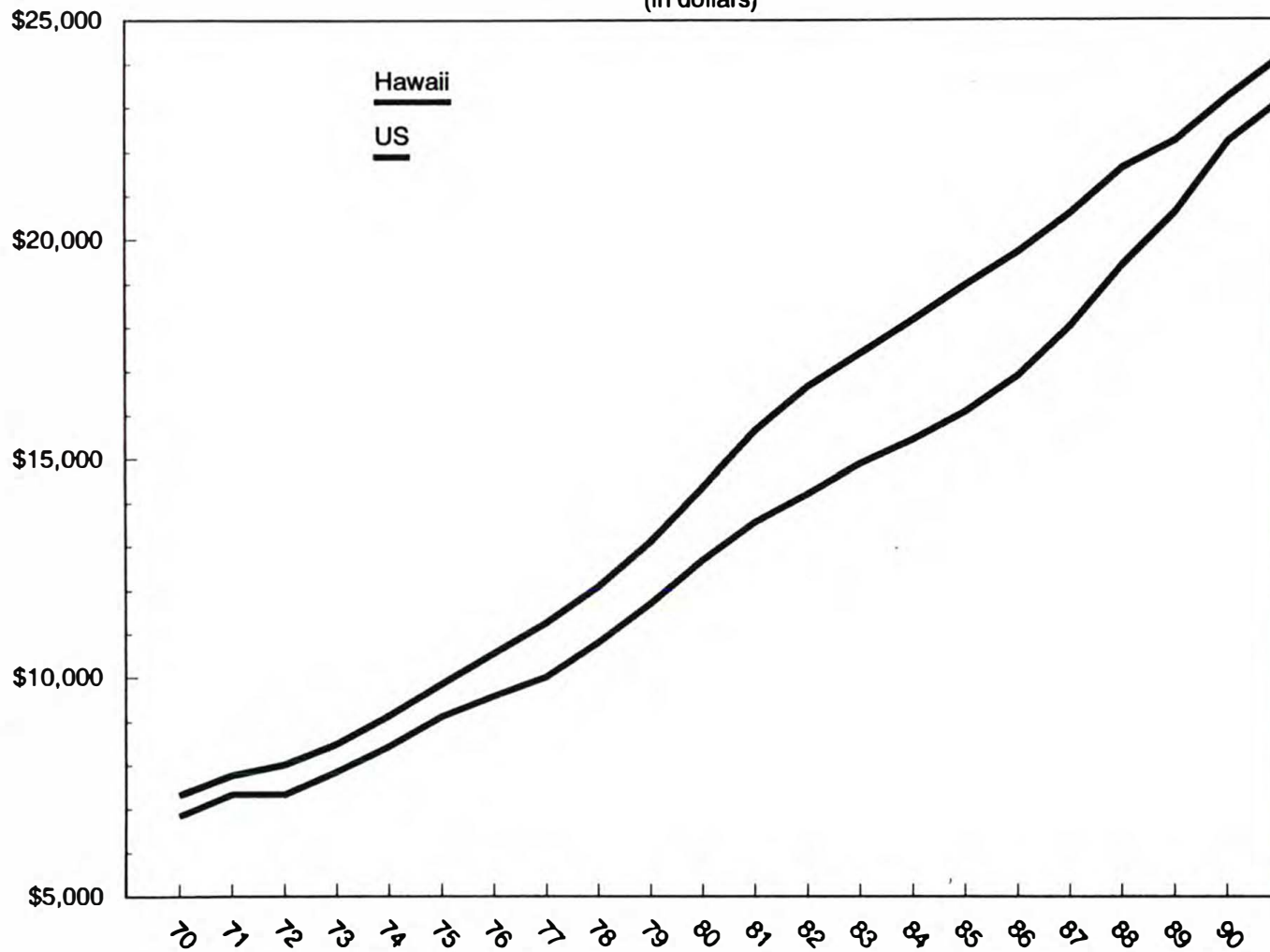
Section 5 - Annual Wage Trends

Hawaii Compared to United States

- Annual wages in Hawaii have consistently averaged somewhat less than the U.S. as a whole, probably due to the heavy service sector concentration of employment. What was a narrow gap in the 1970s widened during the 1980s, but the gap has begun to narrow again during the last three years, as Hawaii's average annual pay has increased more rapidly than the national average since 1989. (Note: these data are in current dollars and are not adjusted for inflation.)

-Note: These data are derived from unemployment insurance records filed by employers to State employment security agencies. Average annual pay is computed by dividing the total annual pay of employees on the payroll by the average monthly number of employees. Included in annual payroll data are bonuses, the cash value of meals and lodging when supplied, tips and other gratuities, and, in many states beginning in 1985, employer contributions to certain deferred compensation plans such as 401(k) plans.

Total Private Average Annual Pay Hawaii and United States (in dollars)



SOURCE: Bureau of Labor Statistics
Unemployment Insurance Covered Employment and Wages Program

Section 6 - Number of Unemployment Insurance Reporting Units (1972-1991)

Hawaii Compared to United States

- The closest approximation the Bureau of Labor Statistics has readily available to the number of employers in the U.S. and Hawaii is the number of "reporting units."
- Reporting units are usually business establishments located at one physical site, although occasionally reporting units may be composed of more than one establishment.
- A reporting unit is the most detailed economic unit reported by an employer as required by State Unemployment Insurance laws.
- Changes in the number of reporting units may sometimes be due to administrative rather than economic reasons. In 1991, for example, employers reported their data at a finer level of detail than in previous years. This reporting change caused an artificial increase in the number of units for both the United States and Hawaii. Hawaii also showed a large increase in reporting units in 1986 primarily due to the introduction of a new computer system which led to improved reporting unit counts.

Table 3.

Average Annual Reporting Units, 1972 - 1991
Private Ownership Totals for the United States and Hawaii with
Year to Year Percentage Change.

YEAR	UNITED STATES		HAWAII	
	REPORTING UNITS	PERCENTAGE CHANGE	REPORTING UNITS	PERCENTAGE CHANGE
1972	3,698,026	-	14,569	-
1973	3,896,568	5.4%	15,363	5.4%
1974	3,921,247	0.6%	15,913	3.6%
1975	3,881,690	-1.0%	16,284	2.3%
1976	3,988,700	2.8%	16,700	2.6%
1977	4,078,000	2.2%	17,381	4.1%
1978	4,283,800	5.0%	18,463	6.2%
1979	4,431,800	3.5%	19,330	4.7%
1980	4,544,800	2.5%	19,770	2.3%
1981	4,617,600	1.6%	20,106	1.7%
1982	4,697,200	1.7%	20,158	0.3%
1983	4,802,000	2.2%	20,684	2.6%
1984	4,951,500	3.1%	21,114	2.1%
1985	5,116,400	3.3%	21,775	3.1%
1986	5,238,800	2.4%	25,625	17.7%
1987	5,481,600	4.6%	24,672	-3.7%
1988	5,617,400	2.5%	24,777	0.4%
1989	5,718,600	1.8%	25,940	4.7%
1990	5,871,100	2.7%	26,929	3.8%
1991	6,162,600	5.0%	29,805	10.7%

Source: Bureau of Labor Statistics,
UI Covered Employment and Wage program.

DataWatch

Small Business And The National Health Care Reform Debate

by Jennifer N. Edwards, Robert J. Blendon, Robert Leitman,
Ellen Morrison, Ian Morrison, and Humphrey Taylor

Many of the legislative proposals to address the growing problem of uninsured Americans to date have focused on improving access to health insurance for small businesses. This focus is sound for three reasons. First, the impact could be quite large—over 53 percent of the uninsured work for small businesses, and many more are dependents of someone who works for a small firm.¹ Second, these reforms retain our current employment-based system of providing health insurance—a system that is favored by a large number of employers and employees. Third, the reforms expand access to health insurance without requiring that the federal government raise taxes.

Proposals targeted at covering employees of small businesses have taken two forms. The first, reforms of the small-group insurance market, attempt to address many of the problems small businesses face in offering health insurance to employees: high costs, rising rates, policy cancellations, lack of access to a policy due to insurance policies such as "redlining" (that is, excluding) specific industries, exclusions of certain individuals or illnesses, and lack of information about rates.² Such proposals retain the voluntary nature of health benefits and only attempt to regulate the sale of policies by insurance companies. The second group of proposals focuses on providing access to insurance for small businesses as part of a comprehensive program to cover all of the uninsured. Universal access proposals fall into three categories—employer mandates, "play-or-pay" proposals, and single-payer programs—and the effect of any policy on small businesses will depend on the financing levels set in the legislation.³ A variety of tax rates and subsidy levels are being considered.

Jennifer Edwards is deputy director of the Harvard Program on the Future of Health Care. Robert Blendon is chairman of the Department of Health Policy and Management, Harvard School of Public Health. Robert Leitman is senior vice-president and Humphrey Taylor is president and chief executive officer of Louis Harris and Associates in New York City. Ellen Morrison is associate director of the Health Care Program at the Institute for the Future in Menlo Park, California; Ian Morrison is director of the program and the institute's president.

Here we explore the likelihood of each proposal's success in covering the employees of small businesses. To do so, we report the results of our national survey of small businesses, which asked about the decision to purchase health insurance and attitudes toward health care reform. We then discuss the implications of current health care reform proposals for small businesses and their employees, drawing on this survey and others.

Methods. In January and February 1991, Louis Harris and Associates, in conjunction with the Institute for the Future and the Harvard School of Public Health, conducted a national telephone survey of 501 small businesses about their purchase of health insurance and attitudes toward health care reform. The respondent at each firm was the chief executive officer or the senior executive most knowledgeable about the company's policy on health benefits. The sample was drawn randomly from the Dunn and Bradstreet U.S. Enterprise and Establishment Microdata File.⁴ The sample was stratified by three sizes of firms: one to five employees, six to twenty-five employees, and twenty-six to one hundred employees. Forty-nine percent of small businesses who were contacted completed the survey.⁵ While response rates of 49 percent are generally subject to significant nonresponse bias, the survey does represent a relatively high response rate for this population.

Health Benefits In Small Firms

Six findings from our survey and other studies enhance our understanding of the likelihood that small businesses will provide health insurance in the future.

Wage and benefit policies of small firms. Small businesses are less likely than large businesses to provide health insurance and all types of fringe benefits to their employees, and they pay lower wages than large firms. We found that half of firms with one to five employees offer health insurance to all or some employees; three-fourths of firms with six to twenty-five employees do so; and nine out of ten firms with twenty-six to one hundred employees offer benefits. Most small firms pay at least half the cost of the policy for the employee.

Through the 1980s, the share of jobs in small businesses increased slightly. In 1980, 48 percent of all jobs were in firms with fewer than 100 employees; by 1990, the proportion had increased to 51 percent. Small firms as a percentage of all businesses held steady at 98 percent throughout the decade. Large firms pay, on average, 35 percent more in wages and provide a more comprehensive range of fringe benefits (Exhibit 1).⁶

Health insurance is the most widely offered fringe benefit in small firms, and yet one-third of all small businesses do not provide health insurance coverage for employees. Our study found that the primary

Exhibit 1
Full-Time Employees Participating In Selected Employee Benefit Plans,
By Firm Size, 1990

Benefit	Small independent private businesses	Medium and large private establishments
Health insurance	66%	92%
Life insurance	57	94
Retirement plan	35	81
Dental insurance	23	66
Short-term disability	23	43
Long-term disability	14	45
Maternity leave (paid and unpaid)	19	40

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Small Establishments, 1990* (Washington, D.C.: BLS, June 1991).

reason was pragmatic: 54 percent of respondents believe that the cost is too high. A survey conducted by the National Federation of Independent Business (NFIB) found additional, more philosophic reasons. Not only are small firms concerned about costs, but a majority (64 percent) also reported that they do not believe that employers have a responsibility to provide health insurance for their employees.⁷

The other reasons given by small employers in our survey for not providing insurance are less significant when compared with cost. These include: (1) employees are generally covered under a spouse's or parent's policy (23 percent); (2) the business cannot qualify for a policy (3 percent); (3) employee turnover is too high (3 percent); or (4) the business has no trouble hiring without offering benefits (2 percent). Another factor that may affect their decision is that small employers are able to get insurance for themselves and their families without covering their employees. Two-thirds of respondents who do not provide insurance for their employees reported having coverage for themselves.

There is considerable evidence that size alone is not a good explanation of why small firms do not provide insurance. The Health Insurance Association of America (HIAA) has found that wages are a good predictor of a small firm's decision to provide insurance benefits. Firms in which a majority of workers earn more than \$10,000 a year are three times more likely to provide health benefits than are firms with workers earning less than \$10,000 a year.⁸ There are also differences in the demographics of small firms that provide insurance and those that do not. Firms not offering insurance are more likely to have higher proportions of part-time, female, and low-wage workers.⁹

Small business trade associations have reported that their members are not profitable enough to provide health insurance.¹⁰ However, our review of the literature did not turn up any data that support this claim.

The difficulty in assessing this claim is that a good measure of a firm's ability to provide insurance has not been developed. Accounting principles blur the distinction between a firm's profitability and the earnings of the owner. Charles Brown and colleagues point to data that cast doubt on the belief that many small employers cannot afford to provide health insurance.¹¹ The incomes of owners of small firms compare favorably with those of large-firm owners; and families who own small businesses have incomes almost twice as high as the income of the average U.S. family and own assets more than five times as large.

Reduction of future benefits. As a result of rising premium rates, small businesses are considering reducing their health insurance coverage in the future. The cost of benefits is a major concern for small firms now providing insurance benefits. Nearly two-thirds (62 percent) of small business respondents reported that they perceive their health care costs to be out of control. If insurance costs continue to rise 20 percent or more a year (a reasonable forecast for this segment of the market), more small-business respondents anticipate more cost shifts and cut-backs in benefits for their work force. Small businesses often do not have the option to shift more costs to their employees because some insurance companies require the employer to pay for the bulk of coverage to obtain a small-group policy. Because of the high cost of insurance, 30 percent of small firms reported that they are likely to eliminate company-paid health benefits in the future. This is consistent with recent behavior of small businesses; 13 percent of firms in our survey reported having dropped their health insurance benefits in the past three years.

Incentives to cover workers. For small employers not now covering their employees, it would take a very large reduction in the current cost of health insurance to induce them to offer coverage. To understand what public policy changes might improve coverage for the uninsured, we queried small businesses that do not provide benefits about what incentives would lead them to offer benefits to their employees. They were given four choices of health plans: a stripped-down insurance policy (one devoid of state-mandated benefits), a health maintenance organization (HMO), a plan with limited choice of providers, or a public plan such as Medicaid. Each option was offered at three price discounts. Respondents were more willing to purchase the plan that was offered at the lowest price, regardless of the type of plan (Exhibit 2).

The Robert Wood Johnson Foundation's Health Care for the Uninsured program reported similar findings. In nine demonstration sites, new insurance products or subsidized existing products were made available to uninsured small businesses at premiums ranging from 9 to 60 percent below those of other health insurance products in their respective local markets. According to estimates made by the independent

Exhibit 2**What Would Induce A Small Business Not Currently Offering Insurance To Buy A Policy?**

Type of policy offered	Percent of companies very likely to purchase ^a
A stripped-down, no-frills policy	
At 15 percent less	19%
At 30 percent less	36
At 50 percent less	46
HMO coverage with several choices of providers ^b	
At 15 percent less	17
At 30 percent less	32
At 50 percent less	44
A plan with limited choice of providers	
At 15 percent less	10
At 30 percent less	20
At 50 percent less	36
A publicly run program such as Medicaid	
At 15 percent less	12
At 30 percent less	27
At 50 percent less	36

Source: Louis Harris and Associates, *Small Business Survey*, 1991.^a n = 151.^b HMO is health maintenance organization.

project directors, fewer than 25 percent of the eligible businesses have chosen to buy the policies.¹²

Dissatisfaction with the health care system. Perhaps because of the serious cost problems they face, small businesses reported being highly dissatisfied with the U.S. health care system—much more dissatisfied than are large employers (Exhibit 3). On average, three out of ten small-business respondents believe the health care system has so much wrong with it that it needs to be completely rebuilt. About half of small businesses want to see fundamental changes, and 16 percent think only minor changes are needed. Small-business owners are less supportive of fundamental change than nonowners are. About a third (32 percent) of owners believe the system needs to be completely rebuilt. Compared with senior executives of large companies, as reported in a nationally representative survey of large businesses (over 100 employees) conducted in 1990 by Louis Harris and Associates, small-business owners are much more likely to favor completely rebuilding the system.¹³

Support for universal access. Two-thirds of small businesses would support changing from the current health system to one providing universal access. Unlike larger businesses, almost half of small businesses prefer an all-governmental system. When given a choice of a single-payer all-governmental system, mandated employer coverage with an

Exhibit 3
Attitudes Of Business Toward The U.S. Health Care System, 1991

	Large business	Small business	
		Owners ^a	Nonowners ^b
On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better	21%	17%	15%
There are some good things in our health care system, but fundamental changes are needed to make it work better	69	47	57
The health care system has so much wrong with it that we need to completely rebuild it	10	32	26
Not sure	0	4	2

Sources: Louis Harris and Associates, Small Business Survey, 1991; and Louis Harris and Associates, "Survey of Corporate Health Plans, 1990," in *System in Crisis: The Case for Health Care Reform*, ed. R.J. Blendon and J.N. Edwards (Washington, D.C.: Faulkner and Gray, 1991).

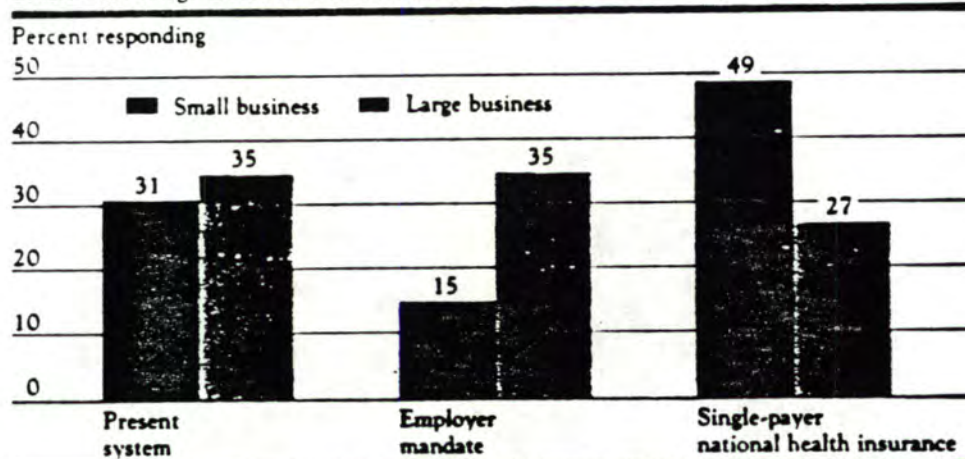
^a n=239

^b n=246

expanded public program, or the present system, about half of small businesses support a single-payer system, one in six prefer an employer mandate, and three of ten prefer the present system (Exhibit 4). Companies not offering insurance are more likely to prefer an all-governmental system (56 percent) than are those who offer insurance (45 percent).

We find two reasons why small businesses are more likely than large businesses to favor a governmental solution. First, small businesses lack

Exhibit 4
Small And Large Business Preferences For U.S. Health Care System



Sources: Louis Harris and Associates, Small Business Survey, 1991; and Louis Harris and Associates, "Survey of Corporate Health Plans, 1990," in *System in Crisis: The Case for Health Care Reform*, ed. R.J. Blendon and J.N. Edwards (Washington, D.C.: Faulkner and Gray, 1991).

the capacity for exploring the health insurance choices that large businesses enjoy. Possessing smaller staffs and less-specialized roles within the firm, small businesses do not spend much time investigating their insurance options (most small businesses spend fewer than ten hours a year investigating health insurance). Most small firms that offer insurance rely on insurance agents when they contract for insurance and use the agent as the primary source of information about their options. The second reason may be a limitation of our question: We did not state the size of the tax burden on small businesses of an all-governmental health plan. Our results suggest that small businesses will choose the lowest-cost insurance option, even if it is an all-governmental plan. The NFIB reached a similar conclusion in a recent analysis of Health America, the proposal of the Senate Democratic leadership. The federation reported that under this particular plan, firms that pay employees less than \$12.50 per hour would find it cheaper to pay the tax than to provide insurance.¹⁴

If there is to be a national health plan, small employers have a preference for how it is to be financed (Exhibit 5). Our survey shows that small businesses prefer to finance expansions in coverage through hidden taxes such as alcohol and tobacco taxes (70 percent) or a premium paid by the people covered (64 percent). Only 31 percent favor an employer payroll tax, and 24 percent would choose an income tax. Small-business owners are more likely to oppose an employer payroll tax

Exhibit 5

Small Business Support For Different Ways Of Financing Expanded Coverage And Controlling Costs, 1991

Financing options	Favor strongly	Favor somewhat	Oppose somewhat	Oppose strongly	Not sure
Higher taxes on alcohol and tobacco	44%	26%	11%	17%	2%
Premiums paid by people covered	24	40	19	14	2
Employer payroll tax	5	26	30	38	1
Income tax	3	21	26	49	1
Cost-control options					
Controls on prescription drug prices	50%	31%	9%	8%	2%
Hospital price controls	50	25	12	12	1
Physician price controls	43	27	12	16	2
Limits on high-technology services	13	24	34	27	2
Longer waits for non-urgent care	7	29	33	27	4

Source: Louis Harris and Associates, Small Business Survey, 1991.

than respondents who are not owners (49 percent versus 26 percent). Owners also oppose income taxes more strongly than nonowners. Most national proposals now acknowledge a need to control health care costs while expanding access. Small businesses prefer governmental cost controls on hospitals, doctors, and prescription drugs over limiting access to major medical technology or increased waiting times for nonurgent care.

Political concerns. Although most small businesses are concerned about high health care costs, health care reform is not a salient political issue for most of them. Our survey shows that most respondents' votes in state and national elections would not be strongly influenced one way or the other by a candidate's position on health system reform (Exhibit 6). However, it appears that politicians who support employer mandates or who advocate no change at all face the most political risk, especially in the eyes of those voters whose vote would be influenced one way or the other by health system reform issues. These negative attitudes could carry over into the agendas of the small-business trade associations and their campaign contributions. Seven political action committees explicitly represent small business, and dozens more trade and industry groups speak for concerns of small business. The committees' total contributions are about 60 percent of the size of large businesses' contributions and thus have significant potential to influence political outcomes.¹³

Policy Implications

Our primary finding is that it will be difficult to get small employers to buy health insurance for their employees unless a very large subsidy is offered. Even with a reduction as large as 50 percent, only half of small

Exhibit 6
Small Business Support For Political Candidates Favoring Various
Health Care Policies

Health care policy	Would a political candidate supporting each of the following policies make you much more likely, more likely, less likely, or much less likely to support him/her?			
	Much more likely	Somewhat more likely	Somewhat less likely	Much less likely
All-governmental health insurance	13%	36%	26%	21%
Expand Medicaid to cover all of the poor	8	39	31	16
No change in the current system	7	26	42	17
Employer mandate	6	22	3	38

Source: Louis Harris and Associates Small Business Survey, 1991.

firms that do not now insure their workers are likely to elect to buy insurance. The results of our study suggest that the government will have to mandate coverage or subsidize the cost of a policy to induce small businesses to offer insurance. We found that offering a 30 percent government subsidy (and likewise a 30 percent reduction in price) is not enough to persuade most firms to buy insurance. If policymakers choose instead to provide a tax credit or subsidy to small firms to help defray the cost of providing insurance, it will be important to take into account the findings of Brown and colleagues, which suggest that some small businesses are able to afford to pay for coverage.¹⁶ We recommend developing an indicator of a business's financial ability to provide benefits and using it as a means test to determine the size of the subsidy given to each small business to apply toward its health insurance purchase. The measure should take into account the profitability of the firm and the wages of employees. A means-tested subsidy of this nature could significantly reduce the cost of a subsidy to the government.

Given the resistance to purchasing a policy and the size of the subsidy that would be needed, a mandate (or play-or-pay option) may be the only route to achieving broad insurance coverage of small business workers and their families. However, this will not be achieved without some cost to politicians in political support (in the form of votes and contributions from the national organizations that represent small business).

Finally, for those who have suggested that the best policy may be to muddle through with only small, incremental changes, our analysis suggests that the number of uninsured workers in small businesses will continue to grow. If our survey proves true, in the years ahead, 30 percent of small businesses currently providing insurance will drop their insurance coverage because of the high cost. This will leave our system with more uninsured people who lack a regular source of care, greater uncompensated care burdens on hospitals, and more pressure on large firms to pay for the care of the uninsured in their communities.

The authors gratefully acknowledge assistance received from Ann Hendricks and Deborah Garnick (Harvard School of Public Health) and Daniel Campion (Alpha Center) in developing the survey instruments. Partial support for this work was provided by The Pew Charitable Trusts and The Robert Wood Johnson Foundation. The perspectives presented here are the sole responsibility of the authors and do not reflect in any way the views of the funders.

NOTES

1. "Regulating Health Insurance in the Small-Group Market: Proposals to Increase Availability and Affordability," National Health Policy Forum Issue Brief no. 581 (November 1991).
2. Proposals to reform the small-group market by the Health Insurance Association of America; Blue Cross and Blue Shield Association; National Association of Insurance Commissioners. Reps. Dan Rostenkowski, John J. Rhodes and Tim Johnson, Fortney (Pete) Stark, and Henry A. Waxman; Sens. Lloyd Bentsen, Dave Durenberger, Jay Rockefeller, and George J. Mitchell; and over fifteen states are summarized in "Regulating Health Insurance in the Small-Group Market" and in *State Health Notes* (7 October 1991), published by the Intergovernmental Health Policy Project at The George Washington University.
3. Employer mandates require that all employers offer insurance to their employees. Pay-or-pay proposals give employers the choice of providing health insurance or paying a tax so that their employees can get coverage through a public plan. Single-payer systems centralize the purchase of health insurance in a single national insurance system.
4. The Dunn and Bradstreet database is the most complete publicly available source of data on small business and has been used by the U.S. Department of Commerce.
5. The margin of error on responses ranges from ± 4 percent when the total sample is used ($n=501$) to ± 9 percent when just the uninsured businesses' responses are reported ($n=151$). The response rates vary by firm size: 44 percent for the smallest firms (one to five employees), 47 percent for medium firms (six to twenty-five employees), and 57 percent for the larger firms (twenty-six to one hundred employees). We expect that firms that do not provide benefits are likely to be underrepresented.
6. C. Brown, J. Hamilton, and J. Medoff, *Employers Large and Small* (Cambridge: Harvard University Press, 1990).
7. C.P. Hall, Jr., and J.M. Kuder, *Small Business and Health Care* (Washington, D.C.: NFIB Foundation, 1990).
8. Health Insurance Association of America, *Providing Employee Health Benefits: How Firms Differ* (Washington, D.C.: HIAA, 1990).
9. Data from Alpha Center, in "Regulating Health Insurance in the Small-Group Market."
10. G. Borger, "Small Business Pulls the Strings," *U.S. News and World Report*, 20 January 1992.
11. Brown et al., *Employers Large and Small*.
12. Alpha Center, personal communication, February 1992. It should be noted that the insurance products offered to small businesses through these nine demonstration projects varied considerably in price, benefits, and plan design, and price may not have been the only factor in employers' purchasing decisions.
13. I.J. Morrison, E.M. Morrison, and J.N. Edwards, "Large Employers and Employee Benefits: Priorities for the 1990s," in *System in Crisis: The Case for Health Care Reform*, ed. R.J. Blendon and J.N. Edwards (Washington, D.C.: Faulkner and Gray, 1991).
14. National Federation of Independent Business, "It's Cheaper to Pay than It Is to Play" (Press release, October 1991).
15. Brown et al., *Employers Large and Small*.
16. Ibid.

DataWatch

Small-Business Health Insurance: Only The Healthy Need Apply

by Wendy K. Zellers, Catherine G. McLaughlin, and Kevin D. Frick

Several private and public programs and countless proposals have targeted the estimated twenty-two million full-time workers and their dependents who lack health insurance.¹ Most of these programs rely on financial incentives designed to encourage employers to provide health benefits to their employees. Unfortunately, because of existing insurance company underwriting practices, incentive-based programs would miss a significant proportion of uninsured workers. This is particularly true for employees of small businesses, which are more susceptible to these practices.²

To date, reports of the barriers faced by small businesses have been based largely on anecdotal information about the underwriting practices of health insurance companies. In our study of health insurance benefits in small businesses, undertaken as part of our evaluation of The Robert Wood Johnson Foundation's (RWJF's) Health Care for the Uninsured Program, we surveyed health insurance companies and agents. We found strong evidence to support the assertions made by several small-business interest groups that insurance companies routinely use a variety of underwriting techniques to control the amount of financial risk to which they may be exposed in the small-business market. One of the largest companies doing business in this market summarized its underwriting guidelines: "Insurability is determined by many factors, including the nature of the business . . . , and most importantly, the good health of all employees and dependents."

Redlining. Enrollment of high-risk firms is limited through a practice known as redlining, in which specific types of industries are considered ineligible for enrollment, at any premium. Redlined industries include those characterized by an older work force (over age fifty-five) or high employee turnover, those engaged in seasonal work or exposed to hazardous working conditions, those lacking an employer/employee rela-

Wendy Zellers is a senior research associate, Catherine McLaughlin an associate professor, and Kevin Frick a research assistant in the Department of Health Services Management and Policy, University of Michigan School of Public Health.

tionship, and those "known to present frequent claims submissions." In some insurance companies, a plan is available to high-risk firms, but with substantial premium surcharges added or with various restrictions on enrollment or coverage imposed.

Preexisting conditions. Enrollment by high-risk individuals is curtailed through the imposition of preexisting condition exclusions. These generally apply when one or more individuals in a group have a chronic, potentially expensive condition at the time of application or have had an illness thought to predict future costly use of care. The insurer can refuse health insurance to the whole group, impose a substantial surcharge on the premiums of all members in the group, or refuse to write a policy for the high-risk individual(s). Many insurers restrict coverage by stipulating that benefits for conditions for which an individual required medical treatment within a specified time period prior to initial enrollment (usually six or twelve months) will not be payable until the individual has been enrolled for six to twelve months. Some of these rules can be applied whether the policy is a new contract or simply a renewal of an expiring prior agreement.

Redlining and preexisting condition exclusions constitute a major problem for many small firms; approximately 15 percent of small firms fall into industries that are routinely redlined.³ Preexisting condition exclusion—particularly excluding an entire firm because of one employee's health status—is a practice reserved almost exclusively for small businesses (those with fewer than ten or fifteen workers).⁴

Study Methods

Using a semistructured telephone interview, we surveyed forty-five insurance companies and thirty-seven agents in July and August 1991. We surveyed ten of the largest national companies in the small-business health insurance market and a sample of health insurance companies and agents in four sites: Pima County, Arizona (Tucson); Hillsborough County, Florida (Tampa); Genesee County, Michigan (Flint); and Denver/Boulder, Colorado. These sites were four of the nine areas where a project sponsored by The Robert Wood Johnson Foundation marketed a health insurance plan designed specifically for small businesses. We had surveyed small businesses (that is, firms with two to twenty-five persons working at least seventeen hours per week) in these four locales the previous summer as part of a larger evaluation of the RWJF Health Care for the Uninsured Program.

The sampling frames for the insurance companies and agents were provided by several sources, including Chartered Life Underwriters, the Association of Health Insurance Agents, state insurance offices, local

Chambers of Commerce, and individuals familiar with the local small-business health insurance market. We also received a list of the ten insurance companies with the largest small-business market share nationwide. We contacted all of the health insurance companies and random samples of agents on the various lists we received.

Only nine of the fifty-four insurance companies we contacted refused to respond. Flint, Michigan, the smallest of the four sites, has few insurance companies selling small-business health plan policies. Four of the local companies represented Blue Cross and Blue Shield plans. Of the eleven companies responding to our survey in Tampa, five do not sell health insurance benefits to companies with fewer than twenty-five employees. Approximately half of the agents we contacted participated in the survey.⁵

The interviews averaged twenty minutes and addressed such issues as (1) how long they had been writing health plan policies in general and for small businesses in particular; (2) the minimum and maximum size of businesses to which they sell policies; (3) the types of plans available to small businesses; (4) employee eligibility criteria; (5) compulsory employer contributions; (6) differences in the premiums charged for large and small businesses; and (7) whether the respondent believes small businesses have difficulty purchasing health insurance and why. These questions led to discussions about restrictive enrollment standards that could result in preexisting condition exclusions and redlining.

We also received marketing materials and underwriting guidelines for thirty-two companies. For thirteen companies, this material included information on industry redlining and restrictions. Two of these companies did not list firms or businesses that would be ineligible but rather provided a list of businesses they call "restricted." For several types of businesses, a precise definition of the restrictions was not included. One company specified a list of businesses to which premium surcharges apply. In addition to giving general preexisting condition rules, which were explained in all cases, four of the company's pamphlets included lists of specific preexisting conditions.

Results

Redlining. Barriers for small businesses in the health insurance market are quite pervasive. The overwhelming majority of company representatives (91 percent) and agents (73 percent) that we interviewed indicated that small businesses face problems when trying to purchase a health benefit plan. Approximately two-thirds of the company representatives and virtually all of the agents said that their company excluded certain industry types. Several respondents gave general catego-

ries of excluded industries, most frequently "high-risk" and "hazardous," but over two dozen specific industries were named by fifty-seven of the respondents as examples of industries excluded by their company or plan for small-business health insurance.⁶ The two most frequently mentioned were lawyers (too litigious) and physicians (high utilization) (Exhibit 1).

In addition to examples provided in the interview, thirteen of the plan descriptions that we received included specific types of businesses considered either ineligible or restricted. The types of businesses most frequently excluded illustrate the underwriting practices of most insurers. For example, hair salons were described to us as representing a "triple threat"—high employee turnover with little interest in long-term employment, a high proportion of women of child-bearing age, and a high proportion of homosexual men. Bars, taverns, and liquor stores, considered ineligible by ten of the plans, are perceived as bad risks because of high employee turnover and hazardous or unhealthy working conditions. In some cases, the risk being avoided is quite obvious. For example, one company writes health insurance policies for bakeries and confectioners but considers them ineligible for dental coverage.

Exhibit 1
Health Insurance Industry Redlining Practices

Industry	Number of plans listing industry as		Number of respondents listing industry as ineligible
	Ineligible	Restricted	
Bars and taverns	10	3	12
Entertainment businesses	9	4	7
Mining and quarrying	9	3	7
Bus, limousine, and taxi services	8	3	0
Hair salons	7	3	16
Fishing industries	7	0	0
Logging and sawmills	7	3	0
Barber shops	6	4	3
Detectives, security guards, and collection agencies	6	3	0
Explosives manufacturing and distributing	6	2	2
Hospitals	6	5	2
Liquor stores	6	2	2
Government agencies and municipalities	5	5	0
Junkyards and salvage firms	5	4	1
Law firms	5	2	19
Nursing homes	5	4	0
Trucking firms	5	6	5
Restaurants	3	3	14
Physician groups	2	6	19

Source: Survey of insurance companies and agents, 1991.

Even when considered eligible for coverage by some plans, this kind of industry is often labeled as "restricted." These restrictions normally include a sizable surcharge and sometimes include limits on coverage (for example, only a high copayment option) or employee eligibility (for example, coverage may be available on a "management only" or "office/clerical only" basis). In certain instances, the difference between ineligible and restricted was not clear (one insurer considers hair salons an ineligible industry and barber shops a restricted industry, with a note to "contact your Customer Service Representative for details").

Small businesses' access to health insurance is compromised not only by explicit underwriting guidelines but also by implicit reluctance on the part of insurers and agents to market plans to certain small businesses. Several respondents made the distinction between offering a plan and marketing a plan. In addition, agents pointed out that quoting an exorbitantly high premium was one way to eliminate undesirable applicants without having to deny coverage.

Included in virtually every pamphlet's discussion of eligibility was the caveat that these lists are not inclusive and that the insurance company reserves the right of refusal to any application not meeting underwriting criteria. In some cases, firms are denied coverage because one or more employees or their dependents have a preexisting condition. When asked why small businesses have difficulty obtaining health insurance, 80 percent of agents and 67 percent of company representatives cited preexisting conditions or "health problems."

Preexisting condition exclusions. All of the twenty-two plans for which we received application information required every employee to fill out a detailed personal and family medical history and, in some cases, to submit to a physical examination. Company policies regarding preexisting condition exclusions were summarized in the literature we received from some respondents. All of these respondents mentioned several conditions that could result in denial of the application of an individual or firm: acquired immunodeficiency syndrome (AIDS) and AIDS-related conditions, cancers (blood, lymph, bone, soft tissue, and organ malignancies), heart disease (including aneurysm, myocardial infarction, and bypass surgery), and degenerative nerve disorders (multiple sclerosis and muscular dystrophy). All of the plans had provisions for preexisting condition rules, with the standard time window of twelve months before enrollment for defining a preexisting condition and twelve months after enrollment for establishing coverage eligibility. Some policies, however, specified certain conditions that would never be covered; one plan labeled these "unacceptable medical conditions," for which no coverage can be provided. This plan mentioned twenty-one conditions but specified that this list was not all-inclusive.

Our survey revealed some disparities in the underwriting practices between national company headquarters and local company offices. For example, several national companies stated that they did not exclude applicants because of type of business or preexisting health problems, yet the local offices gave us a list of exclusions. In several cases, the differences between national and local practices were the result of state-based variation in insurance laws. About half of the states have passed laws that prohibit insurance companies from enforcing preexisting condition rules on individuals who are renewing a current policy or transferring from one insurance company policy to another.

Policy Implications

Underwriting practices may discourage small employers from shopping for a better insurance value or employees from shopping for a better job. In addition, hiring practices of small employers may be influenced by whether or not the health status of a job applicant could threaten the premium rate for or the insurability of all the people in the firm, leaving some perceived "uninsurables" also unemployable.

Because of current underwriting practices, some small businesses would find it difficult to respond to any financial incentives or government mandates to provide health benefits to their employees. According to representatives interviewed, seven of the nation's ten largest insurers in the small-business health insurance market routinely exclude certain types of small businesses, and all of them exclude, where state law permits, individuals or their firms because of preexisting conditions. Approximately 15 percent of small businesses fall into categories that are considered ineligible or restricted. No estimate is available of the number of businesses and individuals denied coverage because of the adverse health problems of an employee.

Although most health insurance companies reject the applications of specific types of firms and individuals, some do not. Also, not all companies identify the same high-risk firms or conditions. Therefore, even though a small business may face difficulties finding insurance, plans are almost always available to that business. However, for some high-risk businesses, the price they face as a result of premium loading represents an effective obstacle to the purchase of a health benefit plan.⁷

Top advisers in the Bush administration are proposing changes in the regulation of small-business insurance as part of their health reform strategy. Most of the reform proposals being discussed recommend eliminating preexisting condition exclusions. However, few recommend eliminating an insurer's ability to consider a particular type of business ineligible based on perceived risk.⁸ Even if underwriting practices are

altered, the premium loading that is assessed most "high-risk" businesses represents a form of de facto exclusion. It is likely that substantial financial incentives for these businesses will have to accompany any legislation that mandates employer-based health insurance.

This paper is based on research funded by The Robert Wood Johnson Foundation.

NOTES

1. P.F. Short, A.C. Monheit, and K. Beauregard, *A Profile of Uninsured Americans*, National Medical Expenditure Survey Research Findings 1, DHHS Pub. no. (PHS)89-3443 (Rockville, Md.: U.S. Public Health Service, September 1989); and R.J. Blendon and J.N. Edwards, "Caring for the Uninsured: Choices for Reform," *Journal of the American Medical Association* (15 May 1991): 2563-2565.
2. National Federation of Independent Business, "NFIB News: Small Businesses Will Choose Layoffs, Shutdowns if Forced to Offer Health Benefits, Survey Shows" (Washington, D.C.: NFIB, 19 July 1989); National Rural Electric Cooperative Association, *The NRECA Survey of Health Coverage in Smaller Firms: Evidence and Policy Implications* (Washington, D.C.: NRECA, June 1988); and "Mandated Health Benefits—Pro/Con Split along Familiar Lines," *Federation of American Health Systems Review* (May/June 1989): 39-42.
3. Colorado Department of Regulatory Agencies, Division of Insurance, *Health Insurance Availability and Affordability in Colorado: A Report on Underwriting and Pricing Practices* (Denver: Division of Insurance, 1990). Estimates calculated from data available from *County Business Patterns* (U.S. Department of Commerce, Bureau of the Census, 1987).
4. D. Stone, "Preventing Chronic Disease: The Dark Side of a Bright Idea," in *Chronic Disease and Disability: Beyond the Acute Medical Model* (Washington, D.C.: National Academy Press, 1990), 83-103.
5. A total of forty-five companies and thirty-seven agents completed interviews, as follows: Tucson: eight companies, ten agents; Tampa: eleven companies, eight agents; Flint, four companies, nine agents; Denver, twelve companies, ten agents; and ten national companies.
6. In spite of mandatory workers' compensation laws in each state, a relatively high probability of work-related accidents or illnesses is a key reason that many industries are considered ineligible. Most insurers we interviewed do not think workers' compensation plans adequately protect them from medical claims arising from work-related illness or injury.
7. C.G. McLaughlin, "The Dilemma of Affordability: Private Health Insurance for Small Businesses," in *American Health Policy: Critical Issues for Reform*, ed. R. Helms (Washington, D.C.: American Enterprise Institute, 1992).
8. J. Hoadley and J.M. Jones, "Regulating Health Insurance in the Small-Group Market: Proposals to Increase Availability and Affordability," *National Health Policy Forum*, Issue Brief no. 581 (Washington, D.C.: The George Washington University, 1991).

WHAT THE ECONOMIC PLAN DOES FOR SMALL BUSINESS

The Administration's economic plan contains several provisions targeted at small business. While some small business interest groups are upset because the plan raises the top corporate rate to 36%, this provision affects only the most affluent small business owners. The following is a list of some of the provisions in the plan:

- **Lower borrowing costs.** Markets have responded to the President's deficit reduction plan. Long-term interest rates are at a 16-year low, and mortgage rates are at a 20-year low. The House version proposed an increase to \$25,000 while the Senate version proposed \$20,500.
- **Increased expensing.** The President proposed more than doubling from \$10,000 the investment that small businesses will be able to expose immediately. This provision is contained in the House but not in the Senate.
- **Special capital gains tax cut for investments in small and medium-sized businesses.** The President has strongly supported a new provision to cut capital gains taxes for new long term investment in businesses.
- **Retroactive extension of the 25% deduction for health insurance premiums of the self-employed.** This provision is permanent in the House version. The Senate extends it for 24 months.
- **Retroactive extensions of the ability of State and local governments to issue tax-exempt bonds for small businesses.** The House level is \$252 and the Senate is \$152.

Job Growth: During the last four years, only one million private sector jobs were created -- just 20,000 a month. In the first five months of the Clinton Administrations, 740,000 private sector jobs have been created --- over 140,000 jobs per month -- seven times the rate of the last Administration. Several independent analyst have projected that growth in the economy under the Clinton plan will create over 8 million jobs in the next four years. Furthermore, studies by the Joint Economic Committee and the National Venture Capital Association show that the President's capital gains cut for small businesses and his expensing provisions will create at least an additional 200,000 jobs in small businesses.

Only 4.2% Of small business owners that file individual returns will pay more while over 90% will receive or be eligible for a tax cut. Some small business owners who are among the top 1% of taxpayers will have to pay more (this is why small business special interests have been so unhappy about the economic plan). But only 4.2% of the business owners who file individual returns -- proprietorships, partnerships or subchapter S corporations -- will be affected by the increase in individual tax rates, because only 4.2 % of these returns show income over \$180,000 a year. Over 90% of small businesses and subchapter owners S corporation owners will either receive or be eligible for a tax cut through increased expensing, a targeted capital gains tax cut or the extension of the 24% health insurance deduction for the self-

employed.

Only the top 1.2% will pay increased income taxes. The Clinton plan raises income taxes only on households who earn over 180,000 a year or individual filers who take in over \$140,000 a year (adjusted gross income). No matter what your occupation, you will only pay more income tax if you have yearly income of \$180,000. And no family that makes less than approximately \$180,000 will pay nay higher income tax.

Only those business owners who make the most will pay more: Those 4.2% of business owners who will pay higher income taxes are quite well-off. the average business owner who will pay more make \$560,000 a year and nearly half (43%) of all income of these taxpayers goes to people who make over \$1 million. Often these business owners are highly paid doctors, lawyers or investment bankers rather than owners of small businesses such as the corner store.

Aggressive assault in the credit crunch: The President has implemented more than 10 regulatory initiatives designed to increase lending to small and medium-sized businesses. These initiatives have cut unnecessary paperwork and regulations, increased bankers' ability to make "character" loans, and created an ombudsman so that regulatory mistakes get corrected. The bottom line is more business loans at lower interest rates.

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, DC 20210

July 11, 1993

MEMORANDUM FOR: THE FIRST LADY

FROM: RICHARD P. HINZ *Richard P. Hinz*
U.S. DEPARTMENT OF LABOR

SUBJECT: Job Losses and National Health Care Reform

There has been considerable speculation recently about job losses that might result from an employer mandate contained in the health care reform proposal. Some estimates have placed the number of jobs that could be lost in the millions.

There is little empirical basis for most of these projections. The few reputable analyses that have been attempted in the context of employer mandates contained in prior proposals have set the number of job losses as low as 60,000 and as high as 1.5 million. The attached paper provides a brief discussion of the major issues relevant to the analysis of employment impacts and contains summaries of the major studies in an appendix.

The existing analyses may not be applicable to the Administration's forthcoming proposal. Their conclusions are extremely sensitive to the specific elements of earlier proposals, particularly the level of benefits mandated, the financing mechanism (premium versus payroll) and most importantly the absence of subsidies for low wage workers.

All jobs impact analyses have some common elements. These are discussed in greater depth in the attached paper. The two key issues are:

Who ultimately pays: Labor market theory expects workers to pay for most of the increased benefits through reduced wages. The extent to which this occurs lowers any employment effects. Shifting of costs from employers to workers increases with time but is constrained for low wage workers. Minimum wage workers cannot have wages reduced. This requires employers to pay the full amount of any additional benefits.

How sensitive to labor costs are employment levels: Economists vary widely on the estimate of the employment loss that will result from labor cost increases. There is agreement that the employment losses from a given level of higher employer costs increases with time. High sensitivity estimates use factors ten times those of the low end. Mainstream estimates are that over the long-run there is a

0.5 percent decline in employment for a one percent increase in employer costs.

The results of any analysis are highly dependent on the assumptions about these key variables. Studies showing large job impacts are generally short term projections that assume employers will pay the full cost of benefits, use high sensitivity to cost employment assumptions and presume no subsidies. The studies showing minimal job losses are long term projections that assume wage adjustment will be made through the normal operation of labor markets and incorporate large subsidies.

Studies such as the recent NFIB sponsored report that purport to indicate "jobs at risk" (some as high as 15 to 20 million) show only workers whose benefit costs may increase and incorporate none of the key analytical processes. These are essentially meaningless.

Administration staff are currently working on a complete employment impact projection that will be based on the specifics of the reform proposal. This cannot be completed until key design issues are resolved, most critically the cost of the benefit package and the subsidies directed to small firms and low wage workers. A complete analysis should be available shortly after the President reaches final decisions on these issues.

A reasonable expectation is that there will be some employment losses concentrated among very low wage workers and in small businesses because they do not currently provide health benefits to these workers. Some of the potential employment losses can be avoided through subsidies directed to the employers of low wage workers. These types of subsidies are extremely difficult to design, complicated to administer and can be very expensive.

Over the long term there should be significant realignment of employment from health insurance and other sectors into direct health care. This effect is separate from the consequences of the employer mandate.

A BRIEF REVIEW OF THE POTENTIAL EMPLOYMENT EFFECTS OF MANDATORY HEALTH BENEFITS

**RICHARD P. HINZ
U.S. DEPARTMENT OF LABOR
JULY 1993**

The imposition of an employment based health benefits mandate will result in a significant increase in the cost employers must pay to provide benefits. This could cause employers not currently providing health benefits, mostly small businesses, to face a major change in their cost of labor. An employer mandate will also substantially alter the amount and pattern of health care consumption. Both the labor cost and health care spending ramifications of mandatory coverage have potential employment consequences.

The direct labor market effects of a mandate may be considered in terms of three closely related categories:

- * A potential loss of jobs due to a higher cost of labor - A reduction in the demand for labor.
- * Changes in the willingness of some groups to enter or remain in the labor market - Labor supply effects.
- * Changes in the number and distribution of jobs within the health care industry.

LABOR DEMAND

Most analyses of employment effects focus on the general employment demand effect of health care reform. The underlying basis of these projections is the concept that mandating benefits that have not previously been provided, or which are above the current level, will increase the cost of labor. When the utilization of labor is price sensitive (a competitive market) an increase in costs will lower the demand for labor and lead to decreasing employment.

Over the past several years a number of analyses have sought to estimate the labor demand effects of an employer mandate. These estimates range from employment losses as low as 60,000 to as high as 1.5 million jobs. Most of the variation in these estimates is the result of differences in the basic characteristics of the mandate proposal such as the generosity of the benefits package and the nature of the financing mechanism (payroll tax or premium). The sensitivity to these basic design parameters tends to obscure much of the comparability of these analyses. Several critical issues are, however, common to the

evaluation of any labor demand analysis.

WHO PAYS FOR THE BENEFITS - THE INCIDENCE OF COSTS.

If the costs of the mandate are paid entirely by the employer and, therefore, represent an increase in the cost of labor the employment effects can be expected to be negative and in proportion to the cost increase. Conversely, if wages or other compensation are lowered to completely offset any increased benefits the total labor cost is unchanged and there should be no employment effects. The degree to which costs are effectively passed on to workers is likely to be dependent on the interplay of factors related to the timing of the mandate, underlying economic conditions and the nature of any particular labor market.

The general equilibrium theory is that market forces limit the compensation of workers to the value of their marginal production. Externally imposed increases in labor costs, therefore, require downward adjustments in compensation. The dynamics of labor markets are such that these changes tend to occur over a period of years due to rigidities in the wage structure imposed by a range of factors including collective bargaining agreements and the often less formal, but equally restrictive, compensation setting practices of employers.

A mandate imposed with short notice or a great deal of uncertainty regarding its cost provides minimal opportunity for compensating wage adjustments. Conversely, a long phase in period greatly increases the likelihood that employers and workers will forgo wage increases or otherwise adjust the value of compensation packages (labor costs) so that the workers bear the full cost of the mandate.

General economic conditions are relevant to this process. A period of high inflation will facilitate wage decreases by permitting employers to achieve real wage declines simply by holding nominal wages constant. Increases in labor productivity may similarly facilitate the shifting of cost burdens. During a transitional period, productivity gains exceeding real wage increases can offset increased benefit costs. This can maintain the marginal product of labor versus cost equilibrium preventing changes in employment levels.

The character of individual labor and product markets also play a role in the incidence of benefit costs. Workers are generally presumed to accept a benefit for wage exchange to the extent they perceive the benefits of the mandate to have value equivalent to the level of wage reductions required to obtain them. Tax considerations and community rating requirements are important to this process. The replacement of taxable wages with tax preferred benefits should be desirable to workers facing tax rates above

zero providing the benefits are perceived to exceed the difference between their nominal cost and the tax rate (the true after tax or wage equivalent cost).

If the costs of health benefits were calculated on an individual basis and were perfectly aligned with each workers expected utilization of services this exchange would be simple. Problems arise with group rates (in particular community rating) and from workers facing low tax rates. Workers with below average utilization (young and healthy) paying a cost averaged across a large population may not accept wage offsets equal to the employers costs because they believe that their benefits are not matched with the cost. This is exacerbated by the fact that these same workers are often those with no taxable income (below \$15,000) and who therefore do not effectively obtain a subsidy in the exchange of taxable wages for non-taxable benefits.

The extent to which these circumstances may lead to a cost incidence on the employer, the consequent employment impact will vary with the nature of the employer and the labor market in which the employer operates. Some industries may be able to pass along the costs of mandated benefits in the form of higher prices, particularly if there is no substitute product and all of their competitors face equivalent increases in labor costs. Employers may also be able to impose wages decreases if workers face few alternatives employment opportunities (where labor markets are highly segmented). Conversely, readily available substitute products and a sellers market for labor will, to a greater extent, impose the cost on the employer.

Constrained labor and product market conditions may apply to the Hawaiian experience with mandated benefits. The unique geographic circumstances place a high cost on substitute products, especially in a service oriented economy. This facilitates absorption of increased benefits costs through higher prices. Limited labor mobility may also enable employers to more readily impose wage constraints on workers. The interaction of these may explain the limited employment effects of Hawaii's health benefits mandate.

The most rigid constraint that will impose the full incidence of a benefit mandate on employers are minimum wage laws. Employers of minimum wage workers who provide no current health benefits will experience an increase in labor costs of the full amount of the benefit mandate as they are legally constrained from negotiating a wage offset. Unless these employers are able to pass along the cost in the price of products their workers are likely to incur the greatest level of employment effects.

Labor economists generally agree that over the long term the compensation equilibrium will be maintained through adjustments in prices or wages following the imposition of a benefits mandate

except where specific constraints (minimum wage laws) are applicable. Most research shows that this has generally occurred except among younger and low wage workers. There is broad agreement that any job losses that occur will be concentrated in this segment of the workforce.

The analyses of employment impacts which conclude that there would be modest effects (less than 100,000 jobs) are those which take a long term perspective and assume that, to the extent legally possible, the incidence will fall on the worker. They conclude that employment effects will be primarily concentrated in minimum wage workers, implicitly believing that the effects on this group can be somewhat mitigated through price increases although there is no specific analysis of individual labor and product markets.

Analyses concluding employment losses in excess of 1 million are generally short term in perspective. These studies assume a highly rigid wage structure resulting in significant labor cost increases. They generally do not take into account potential price increases and assume that the mandate is imposed over a short term and effective immediately, thus precluding wage adjustments during a phase in period. Implicitly, due to the short term perspective, these analyses discount the effects of productivity increases, inflation or the tax preferred nature of health benefits in facilitating compensation tradeoffs that might limit employment impacts.

SENSITIVITY OF EMPLOYMENT TO LABOR COST - DEMAND ELASTICITY

The second major aspect of a labor demand analysis is the sensitivity of employment to the total cost of labor. While it is generally accepted that increased costs lead to a diminished utilization of labor there is little consensus regarding the magnitude of these changes. One of the reasons for this is the absence of any comparable experience from which to draw conclusions.

This is a problem both in regard to isolating the "pure labor cost" effect from other factors that may be affecting a natural experiment and in the applicability of prior experience to health care reform. It is particularly problematic in the context of a health benefits mandate because the potential magnitude of the cost increase that may be imposed is beyond the scope of what has been observed. The employer of a minimum wage worker required to provide family coverage might experience a 40% increase in labor costs. Extrapolating to this level of cost increases from much smaller increases that can be observed introduces a great deal of uncertainty to the estimates.

The sensitivity of employment to cost changes is generally expressed as a "demand elasticity", the ratio of the percent

change in employment to the percent change in labor costs. Estimates of this relationship in recent years have ranged from as low as 1/10th of percent decline in employment for each one per cent increase in costs to as high as nearly a 2% decline in employment. Recent general estimates based on observation of mandatory benefits such as Worker's Compensation cluster around a 1/2 percent decline in employment resulting from a one percent labor cost increase. These relationships vary for individual markets, by wage levels and from the long to the short term. The short term sensitivity is generally accepted to be significantly less than over the long term.

The labor demand sensitivity estimate, in combination with the assumption about the incidence of costs, are the crux of virtually all analyses of the employment impact of health care reform. An assumption that workers bear the full incidence of cost makes the demand elasticity far less important, and of relevance primarily to minimum wage workers. The view that there are significant impediments to cost shifting makes the elasticity of demand for labor paramount.

Analyses that reach the conclusion that there will be very large employment effects place all or most of the cost incidence on employers and posit a high sensitivity of employment to labor costs. These may be criticized as matching a short term cost incidence assumption with a long term labor demand elasticity. Analyses that find minimal impacts generally anticipate a high level of cost shifting and a relatively low level of sensitivity of employment.

A complete analysis would provide estimates over the short and long term and vary the incidence and cost sensitivity parameters appropriately. This would be likely to conclude that the two factors will tend to offset one and other as they vary in opposite directions (cost shifting minimizing the impact while the negative elasticity of demand is accentuated with time). The level of cost shifting can be anticipated to have a proportionately greater effect over time as a full cost shift eliminates a worker from the group potentially affected by labor demand shifts. This interaction should result in a declining employment impact over time.

The lack of this type of dynamic projection is a major deficiency of the analyses to date. In addition to the uncertainty and very generalized assumptions about the key elements of cost incidence and labor demand, most present either a fully phased in system that has reached an equilibrium state or presume an immediate mandate with no opportunity for compensating adjustments in labor markets. The former obscures what is likely to be a complex process played out over several years in a widely varying manner across different industries and labor markets. The latter is simply an unrealistic possibility, the analysis of which sheds

little light on what is likely to occur.

The consideration of these two key determinants of possible disemployment effects highlights the importance of several design aspects of a reform proposal. Any employment effects will be directly proportional to the cost of the mandated benefit package. In combination with a community rating requirement, as discussed above, an expensive mandatory benefit level will impose significant problems in regard to wage shifts for young and low wage workers. The degree to which legal (minimum wage) and other rigidities lead to increased labor costs for this group will be the primary determinant of job losses.

This makes the structure and extent of subsidies for low wage workers a critical aspect of the system design. A design that efficiently targets subsidies to the employers of workers subject to the dual problems of wage rigidities and highly cost sensitive labor demand can potentially mitigate most of the adverse employment impact of a mandate. This is an extremely difficult task due to the complexity of possible subsidy schemes and the lack of prior experience on which to base expected outcomes and because the level and targeting of these subsidies is contingent on an accurate assessment of the dynamics of this segment of the labor market. Subsidies that fully offset employment effects are also likely to be very expensive.

The manner in which dependents and part-time workers are treated under a reform is also important. The extent to which employers are required to pay the full benefit costs of less than full time workers will create potentially significant cost advantages for employers to substitute fewer full time workers for part timers. In general a fixed benefit cost for full time workers and any cost for others will make it more attractive for employers to use existing workers at overtime rates rather than to add to their workforce during cyclical upswings or the early stages of an expansion.

The treatment of dependents under a mandate may also have employment substitution ramifications. Employers facing a differential cost for workers with and without dependents may have cost incentives to substitute single workers for those with families. The potential for this will be dictated by the pricing and coverage requirements for dependents, particularly those who are working.

LABOR SUPPLY

The imposition of a health insurance mandate on employers may also have an impact on the willingness of some workers to enter or remain in the labor market. While a great deal of attention

has been focussed on the consequences of labor demand changes these potential labor supply effects have been afforded little interest.

When the total level of labor costs maintains a long term equilibrium through compensating adjustments in wage levels some workers wages may be expected to fall more than the value of the additional benefits they receive. This is particularly an issue when a community rate for benefits such as health insurance is mandated.

Community rating by definition results in half of the population receiving benefits below the mean. This imposes a potential disincentive for young and healthy workers to incur the average cost in the form of a wage reduction. A family rate structure and subsidies for non workers poses similar problems. The non-worker, through subsidies, may be able to keep coverage at no cost. Likewise a family member who, when not working, is simply an addition to a family policy, faces a similar zero cost of coverage while out of the labor force. This potentially diminishes the incentives for some workers to enter or remain in the labor force.

When the incidence of benefit costs fall on workers and coverage is universal a mandate may function as a "tax" on some labor resulting in a diminution of labor supply. Estimating the sensitivity of labor supply to this "tax" has all of the difficulties attendant to estimating demand elasticities, particularly the lack of a comparable precedent from which to project behavior.

The generally accepted view is that the labor supply behavior of workers who are the sole or primary earners for a family and who have no alternative sources of support is unaffected by marginal changes in the effective tax rate at the level imposed by a health insurance mandate. High wage earners (above the median) are also presumed to be have inelastic labor supply behavior.

This leaves several sub-groups on which the mandate may have some effect. The two of greatest relevance are older workers nearing retirement and individuals currently out of the labor force and receiving medicaid.

Currently many workers eligible for retirement benefits but not yet eligible for medicaid (55 to 64 year olds) may be remaining in the labor force primarily to retain health benefits as part of an employment based group. Their implicit cost of this coverage is usually far below the benefits received and much less than alternatives they would face upon leaving employment. This is especially true of those with pre existing conditions who could not purchase coverage at any price upon leaving employment. Universal coverage, elimination of pre existing condition

exclusions and community rated prices could induce many of these older workers to leave the labor force.

Alternatively, families now receiving medicaid often face loss of coverage upon entering the labor force. This imposes an effective "tax" on their labor that may be as high as 50% by some estimates, creating a powerful disincentive to work. An employer mandate with subsidies directed toward these low wage workers could remove this barrier because these families would continue to maintain coverage at presumably low costs even upon entering the labor force at low wage levels. This could potentially create a significant positive labor supply response.

As with the labor demand analysis considerable uncertainty exists regarding the magnitude of labor supply responses to a mandate. There has been no significant analysis of this issue to date that has attempted to assign a number or project outcomes. Because any supply effects are likely to occur primarily among narrow subgroups of the population that are the focus of some of the major elements that must be considered in the design of a reform proposal, the treatment of these groups (older workers, medicaid recipients, low wage secondary workers) will dictate any labor supply results.

The conventional wisdom, to the extent it exists, is that there are likely to be offsetting supply changes that will leave net labor supply essentially constant but cause a relatively low level of substitution among workers. Low wage older workers remaining in the labor force primarily to retain health benefits and low wage spouses of high wage workers will depart to some extent. Current medicaid recipients, to the degree that they now remain out of the workforce to retain health benefits, will presumably replace them.

HEALTH CARE INDUSTRY EFFECTS

The universal health insurance coverage that will result from a mandate and expanded programs to cover non-workers has potentially very significant consequences for employment. The utilization of health care services can be anticipated to increase commensurately with the increased coverage and spending. A reform which leads to changes in the pattern of health care consumption, away from acute care and toward preventative and long term care, also has ramifications due to the differing level and types of labor required for these services.

A managed competition type of reform with mandated universal coverage will likely have three types of effects on employment within the health care industry. It will substantially reduce employment in the administrative occupations prevalent in the

current structure of the industry, increase employment overall in health care services, and alter the mix of jobs within the industry.

It is reasonably certain that major employment reductions will occur in the insurance industry and in hospital administration. This will be due to the standardization of administrative practices such as claims processing and the reduction of experience rating and medical underwriting in most insurance contracts.

Most analysts project a significant consolidation in the insurance industry as smaller insurers face increased competition for larger groups. Consolidation of small employers in purchasing groups will also reduce employment in the marketing and administration of insurance. The savings in all of these sectors will provide some of the resources to finance universal coverage. The employment losses in these areas will be directly proportional to the savings achieved and are likely to be in the hundreds of thousands.

Increased expenditures on health care (financed partially through these savings) and the reallocation of resources toward health care resulting from the mandate will lead to substantial increases in employment in the health care industry. This employment growth will be enhanced to the extent consumption of services is redirected toward preventive practices and long term care both of which are relatively labor intensive. Large increases in the employment of nurses, nurse practitioners, physicians assistants, all of the occupations related to the operation of long term care facilities can be expected.

As with the general labor market effects these trends will develop over time. It is likely that the job losses in the administration of insurance and health care will come early in the process with the job gains occurring somewhat later as consumption of health care slowly increases. This time variance will also be caused by the lags required to train workers to fill the demand in the health care sector in occupations such as nursing that have often had labor shortages and which require substantial training.

It is not unreasonable to expect, however, that because the reduction in expenditures on administration will be less than the increase in spending on health care, over the long term there will be a net increase in employment in the health care sector. This will be preceded, however, by a period of some employment losses in conjunction with dislocation and retraining of workers before a new, stable, and potentially higher level of employment is reached.

CONCLUSIONS

A definitive analysis of the total employment effects of health care reform has yet to be developed. The results of any analysis are highly sensitive to the specifics of fundamental design issues such as benefit levels and the subsidies afforded low income workers. Projections made in the context of prior proposals are, therefore, generally not applicable to alternative designs.

Previous studies have provided estimates addressing only the effects of an employer mandate on the overall demand for labor. These analyses project a decline in labor demand ranging from 60,000 jobs to up to 1.5 million jobs. These projections incorporate widely varying assumptions about the ability of employers to shift costs and the sensitivity of employment to these costs, factors about which there is no broad consensus among analysts. The high job loss analyses use worst case assumptions and make a short term point in time estimate. The low estimates are long term equilibrium state projections. This fundamental difference further obviates their comparability.

It can be expected that a mandate will have some negative employment consequences as employers (primarily small businesses) react to increased benefits costs. These can be minimized with a transition period that facilitates wage adjustments and effectively targeted subsidies, particularly if the subsidies efficiently reach employers of low and minimum wage workers. These types of subsidies are complicated and potentially very expensive but are the key element of a system design in regard to its employment effects.

A complete picture of employment effects should incorporate an analysis of labor supply shifts and changes in the health care industry. Universal coverage may induce movements both in and out of the labor force that could be offsetting. The health care industry can be expected to increase its share of employment after a period of some dislocation. Some of this increased employment will be a realignment from other industries, however, which decline in size as the health care industry grows.

A reasonable expectation of the employment consequences of health care reform would anticipate some job losses in general and considerable short term dislocation within the health care industry. This would be followed by considerable job growth in the health care industry, as people enter work there instead of other industries. The long term result of the reform would, therefore, be the job losses associated with the increased employer costs of hiring workers and some degree of shifting of employment into the health care industry.

APPENDIX**SUMMARY OF STUDIES AND TESTIMONY OF THE EMPLOYMENT IMPACT OF
MANDATED BENEFITS**

- o Sheils, John. Vice President, Lewin-ICF. Testimony before the United States Senate Committee on Finance, June 9, 1992.

The witness was asked to discuss the potential for lost employment under the Health America Act, a pay-or-play plan under which employers would face the option of providing health insurance or covering workers under a payroll tax contemplated to be about 8 percent of payroll. Most economists agree that any loss of employment resulting from this plan would be concentrated primarily among minimum wage workers. It is believed that most employers of low-wage workers would choose to pay the tax rather than provide insurance.

There is remarkable consensus among economists that the loss of employment due to increases in the minimum wage has historically been small, with most of the impact concentrated among young teens. Lewin-ICF estimates that the loss of employment under the Health America Act would be between 23,000 and 63,000 jobs. This estimate is consistent with independent job loss estimates developed by Dr. Kenneth Thorpe, Dr. Karen Davis, and the Congressional Budget Office.

- o Custer, William S. Director of Research, Employee Benefit Research Institute. Testimony before the United States Senate Committee on Finance, June 9, 1992.

Based on a simulation done by the Employee Benefit Research Institute (EBRI), between 200,000 and 1.2 million workers could become unemployed as a result of a mandate that employers provided health benefits. These estimates assume that wages and other benefits do not change as health benefits are added.

Under a play-or-pay plan, with a 9 percent payroll tax, EBRI estimates that between 130,000 and 965,000 jobs could be lost if wages and other components of total compensation do not adjust.

- o "Run From Coverage: Job Destruction from a Play or Pay Health Care Mandate." Prepared for Richard A. Arney, Joint Economic Committee (1992), April 9, 1992.

This study estimates that according to conservative estimates, a pay or play mandate with a 7% tax will cause over 712,742 workers to lose their jobs in the first year of implementation, with 43% of this job loss falling on workers in businesses with under 20

employees. The four states of California, Texas, New York, and Florida would account for 42% of these job losses. A 9% payroll tax would result in the loss of 807,416 jobs.

This study utilized data on payroll costs from the paper, "Pay or Play Employer Mandates: Effects on Insurance Coverage and Costs," by Sheila Zedlewski, Gregory P. Acs, Laura Wheaton, and Colin Winterbottom, published in the U.S. Department of Labor's Health Benefits and the Workforce. It then took these costs and calculated firm-specific costs and the negative employment effects they generated by assuming a demand elasticity of $-.73$ for those workers currently uninsured and a demand elasticity of $-.40$ for those workers requiring upgraded insurance. These estimates of demand elasticity were considered to be conservative in light of the evidence that the short run demand is very elastic (-0.87 to -1.20) for workers with the characteristics of uninsured workers.

- o The following three studies by CONSAD Research Corporation were each designed to measure the potential impact of an employer mandate on the levels of employment for different groups. Information from each study is partly taken from previous CONSAD studies.

- o "Jobs-At-Risk and Their Demographic Characteristics Associated With Mandated Employer Health Insurance." Prepared by CONSAD Research Corporation for The Partnership on Health Care and Employment, April 1992.

Findings indicate that under a federal pay or play health insurance plan, about 9.1 million jobs would be at-risk (12% of private sector jobs where workers are employed more than 18 hours per week). "At-risk" entails dramatic changes in the employee compensation package through wages, hours, benefits and/or loss of job. It is measured by comparing the additional premium costs to wages. By definition, only workers earning under \$10,000 can be considered to hold an at-risk job. One-third of all employees working more than 18 hours per week who do not receive own-employer coverage would be part of this at-risk group.

Slightly more than half of the jobs-at-risk are held by workers ages 19-34 and 57% are held by women. Three-fourths of the jobs-at-risk are held by white workers, while one-fifth are held by people who have not completed high school. 28% of jobs-at-risk are held by members of families with annual incomes less than \$10,000.

Three-fourths of workers ages 18 and younger hold jobs-at-risk. 18% of women (9% of men), 16% of African-Americans

risk. 18% of women (9% of men), 16% of African-Americans and Hispanics (12% of white workers), and 83% of workers earning less than \$5,000 per year also hold jobs-at-risk.

This analysis excludes workers employed less than 17.5 hours per week and assumes an employer premium share of 75%.

- o "Employment Impacts Associated With Proposed Employer Health Insurance Options." Prepared by CONSAD Research Corporation for the Health Care Financing Corporation, March 1, 1993.

This study estimates the effects of four health care reform proposals on employment- H.R. 5936, S. 1227, the California proposal, and the Jackson Hole Group proposal. The study concludes that H.R. 5936 would have the smallest impact on employment (200,000 to 400,000 jobs-at-risk), the California proposal would have the second smallest impact (7.3 to 9.4 million jobs-at-risk), S. 1227 would have the third smallest impact (12.5 to 15.6 million jobs-at-risk), and the Jackson Hole proposal would have the largest impact (20.1 to 21.8 million jobs-at-risk). By comparison, the study estimates the number of jobs-at-risk to be 16.3 million in a scenario where employers would be required to contribute all employees' health care coverage at the same rate they currently contribute to their insured employees.

The study found that the demographic characteristics of workers who experience the greatest job impact for one health proposal would be most affected by the other proposals.

- o "The Employment Impact of Proposed Health Care Reform on Small Business." Prepared by CONSAD Research Corporation for The NFIB Foundation, May 6, 1993.

This study utilizes the same methods as CONSAD's earlier report for HCFA, only this report also includes the Heritage Foundation proposal.

In establishments with fewer than 500 employees (representing 68.7 million private-sector workers), it was concluded that both the Heritage Foundation proposal and the House proposal would result in a negligible total of jobs at risk, while the California proposal would result in 9.6% of total private sector employment in jobs-at-risk (6.6 million workers), the Senate proposal would result in 16.7% in jobs-at-risk (11.5 million workers), and the Jackson Hole Group proposal would result in 23.6% in jobs-at-risk (16.3 million workers).

- o Mitchell, Olivia. "The Effects of Mandatory Benefits Packages." In Research in Labor Economics. Eds. L. Bassi, D. Crawford and R. Ehrenberg. Greenwich, CT: JAI Press, 1991: 297-320.

In general, the literature suggests that when labor costs rise by 10 percent, overall labor demand will be reduced by 1 to 5 percent. Mandating employers to provide health benefits is likely to alter relative labor costs in addition to overall labor costs; this will likely induce employers to substitute away from low-wage, low-skilled employees toward more highly-skilled labor and capital.

Many researchers have equated the mandating of health benefits to an increase in the minimum wage. Nearly every study done in this area has concluded that raising the minimum wage by 10 percent results in a 0.5 to 3 percent reduction in employment among teenagers, with a much lesser effect among adults.

The literature also suggests that absenteeism would increase as a result of an employer mandate, since the value of the benefit to workers is not affected by a few additional absences. If health coverage were mandated, changing jobs would be made easier, leading to higher recruitment and training costs, which reduces productivity and output. In addition, more people might be induced to enter the labor force, as was seen in a study where an increase in unemployment insurance payments by 20 percent increased the fraction of women working by 1 percent and raised the hours worked by women by 12%.

- o Klerman, Jacob Alex. "Employment Effects of Mandated Health Benefits." In Health Benefits and the Workforce. U.S. Department of Labor, Pension and Welfare Benefits Administration, 1992.

In this study, Klerman compares the first order effects of mandated health benefits to the impact of raising the effective minimum wage. Estimates of the employer cost of mandated coverage range from 10 to 40 percent of the annual wages of full-time workers earning the minimum wage. From this, it was concluded that a ten percent rise in the minimum wage would yield a less than two percent decrease in employment. However, it should be noted that the recent increase in the minimum wage combined with the potential imposition of a mandated benefit will result in increased uncertainty as to the exact magnitude of the employment effects.

In terms of the affected population, workers who would lose their jobs and/or wages will be concentrated among those who currently do not have employer-provided insurance (about 13 percent of all

workers), as well as among those who are currently covered by another family member's employer (about 25% of all workers). These workers are likely to be young and part-time workers of small employers, many of the same workers who are currently uninsured.

- o Karen Davis, Professor of Economics and Chairman, Department of Health Policy and Management, Johns Hopkins University School of Hygiene and Public Health. Testimony before the United States Senate Committee on Labor and Human Resources, 100th Congress, November 4, 1987.

The testimony was regarding S. 1265, the Minimum Health Benefits For All Workers Act of 1987. In her testimony, Ms. Davis cited a study which used the Data Resources Institute econometric model to predict that there would be a loss of about 100,000 to 120,000 jobs from mandating insurance coverage on employers (adding about .1 percentage points to the unemployment rate). Much of the unemployment effect will be concentrated among African American teenagers. It was emphasized that this study may actually overestimate the loss of jobs, since it does not consider the creation of jobs from new health services (which Davis estimates to be about 100,000 new jobs).

The sectors of the economy most likely to be affected by the mandate are retail trade, the service sector, and the construction sector--sectors which have less impact on international competitiveness.

In her testimony, Davis criticized a study done by Gary and Aldona Robbins for the Institute for Research on the Economics of Taxation (IRET), which estimated a loss of one million jobs from the same proposed legislation. Davis claimed that the IRET study overestimated the per worker cost of the S. 1265 benefit package, it assumed that most employers would have to upgrade existing coverage, it failed to account for coordination of benefits to avoid duplicate coverage, and it did not consider the creation of any health services employment.

- o Dr. Edward M. Gramlich, Acting Director Congressional Budget Office. Testimony before the United States Senate Committee on Labor and Human Resources, 100th Congress, November 4, 1987.

While the testimony does not focus on unemployment resulting from mandated benefits as much as it does on cost estimates, some unemployment estimates are provided. Gramlich believes that Karen Davis is likely to be close to reality in her estimate of a

loss of 100,000 jobs from an employer mandate of a minimum health insurance package.

Gramlich also cited the Minimum Wage Study Commission, which concluded from the existing literature that a ten percent rise in the minimum wage would reduce total employment among teenage workers by one percent to three percent. The overall effect on adults would likely be minimal.

- o Gary Robbins, President of Fiscal Associates, Incorporated. Testimony before the United States Senate Committee on Labor and Human Resources, 100th Congress, November 4, 1987.

Gary Robbins and Aldona Robbins are co-authors of Mandating Health Insurance, a project done for the Institute for Research on the Economics of Taxation (IRET). They estimated that S. 1265 would result in a loss of 1 million jobs (largely as a result of an estimated \$100 billion increase in employer-provided health insurance costs.

In reconciling the differences between their estimates and the estimates of researchers who found less of an impact on employment, Robbins claimed that survey data indicate that many existing employer-provided plans would not meet the minimums specified in S. 1265.

The burden of increased payroll costs would fall more on those in labor intensive sectors of the economy, more on small businesses, and more on low wage workers.

- o Brown, Charles. "Minimum Wage Laws: Are They Overrated?" Journal of Economic Perspectives, Volume 2, Number 3, Summer 1988, pp. 133-145.

The author points out that the literature on the impact of raising the minimum wage on employment is generally in agreement. The more than two dozen time series studies on the estimated impact of a 10 percent increase in the minimum wage on teenage employment find that the reduction in employment amounts to 1 to 3 percent. This translates into an estimated increase in the teenage unemployment rate in a range from 0 to 3 percentage points. The popular belief that these employment effects adversely affect African American teenagers more than white teenagers has only been verified from about half of the studies done.

The author also indicates that the reduction in employment predicted is not necessarily caused by workers being discharged,

since turnover rates in minimum wage jobs are very high. One surprising conclusion is that even under the assumption that the minimum wage had no employment effect, its effect on poverty or the income distribution is not very large. For example, in 1976 when the minimum wage was \$2.30, earnings of workers making less than \$2.80 per hour accounted for only 11 percent of the after-tax, after-transfer income of the poorest fifth of all households. Thus, raising the minimum wage substantially does not raise the income of the poorest households by much at all.

- o Chollet, Deborah. "Public Policy Options To Expand Health Insurance Coverage Among the Nonelderly Population." In Government Mandating of Employee Benefits. Edited by Dallas Salisbury. Washington D.C.: Employee Benefit Research Institute, 1987.

Imposing a mandatory minimum health insurance benefit is presumably equivalent to raising the minimum wage in its effect on employment in low-wage jobs. In reviewing the literature, among teenagers, a 10 percent increase in the minimum wage reduces employment by 1 to 3 percent. This figure, however, might be somewhat misleading because many teenagers who would otherwise look for work, stop looking for jobs and thus are not counted in unemployment statistics. The unemployment effect might actually be greater among adults with similar wages to teenagers, because these adults have a stronger attachment to the labor force.

Workers in retail trade, services, and low-wage manufacturing may be particularly vulnerable to reduced employment. The author believes that the estimates provided are conservative.

- o Anderson, Joseph. "Effects of Mandatory Pensions on Firms, Workers and the Economy." In Government Mandating of Employee Benefits. Edited by Dallas Salisbury. Washington D.C.: Employee Benefit Research Institute, 1987.

The effect of a mandatory universal pension that would provide for a minimum 3 percent defined contribution each year and a participation standard of age 20, one year of service, and 500 hours worked, with 5 year vesting would have cost \$12 billion in 1982. The author estimates that this would have resulted in an increase of .05 of one percentage point in the unemployment rate in the first year. In the short run, 160,000 jobs would have been lost, while in the long run, 60,000 jobs would have been lost. One half of jobs lost would be lost by workers in firms of fewer than 25 employees and another 21 percent would be lost by workers in firms of 25 to 99 employees.

The data for this analysis was produced by the ICF Employee Benefits Cost Allocation Model, 1979-1980, using the quarterly model of the U.S. economy developed by Data Resources, Inc. (DRI).

- o Mitchell, Bridger M. and Charles E. Phelps. "National Health Insurance: Some Costs and Effects of Mandated Employee Coverage," Journal of Political Economy, Vol. 84, No. 3 (1976), pp. 553-571.

This paper estimates that the consequences of mandating employers to provide insurance for their employees and dependents would cause a short-run increase in the unemployment rate of 0.3 percentage points for a low-coverage plan and an increase of 1.4 percentage points for a high cost plan. Most likely, employers would accomplish the change in the employment pattern by reducing the rate of new hiring and postponing the replacement of employees who quit. Essentially there would be no long term effects on employment, except for workers at or near the minimum wage.

The sectors with relatively large unemployment effects are agriculture, construction, wholesale and retail trade, and services. If payroll taxes were used instead of an employer mandate, similar but less pronounced employment effects would result. In addition, the authors predict that for a high coverage plan, the average increase in mandated premiums would be 2.9 percent of wages, which would be recouped in 4 to 5 months of no nominal wage increases if inflation and productivity increase at a combined 8 percent annual rate.

The data for this paper are 1975 projections of data from the 1970 Health Care Survey.

HEALTH CARE COSTS AND THE ECONOMY

Out-of-control health care costs affect not only the financial well being of individuals and employers coping with them directly. They also hurt the economy at large. When health spending rises relentlessly faster than overall economic growth...

It defers money from other consumption spending, chiefly by dampening the growth of cash wages. The bulk of health care spending is charged to employers' total labor costs in the form of Medicare taxes and company-paid health insurance. Since the growth of total labor costs is limited by competition and other market forces, the more health care takes of that limited growth, the less is left to pass onto workers as raises.

FACTS: The Bureau of Labor Statistics reports that from June 1980 to June 1992, the average weekly wages of production and non-supervisory workers, adjusted for inflation, fell from \$235 to \$218. Rising employer health care costs were a central reason.

* Reduced consumption spending economywide means a lower overall standard of living. Kenneth Thorpe, a health economist at the University of North Carolina, projects that the growth of health spending (from 12% of the economy in 1990 to 32% in 2020) will shrink other consumption from 55% of economic activity to 38% -- a drop of nearly a third in the relative living standard.

It defers money from investment, from which future economic growth arises. In the Thorpe study just cited, investment -- from education and infrastructure to savings and business capital formation -- would drop from 15% of the economy in 1990 to 10% in 2020. The Economic and Social Research Institute calculates that through 1997, the annual increase in health care spending will absorb an average 28% of each year's total economic growth.

It balloons the federal deficit and cripples the abilities of government at all levels. Medicaid is the fastest-growing item on nearly every state budget, soaring from an average 9% of state spending in 1980 to 19% in 1990 and to an estimated 26% by 1995, according to the National Governors Association. Medicare, Medicaid and other federal health care spending are a solid roadblock to closing the nearly \$400 billion-a-year budget deficit. Lewin-ICF projects that health care spending will consume 50% of the expected \$783 billion increase (in nominal dollars) in federal revenue from 1993 through 1997. Social Security will consume 26% and interest on the federal debt, 18%. That would leave a mere 6% of the increase for all other spending needs.

SEE ALSO: discussion of health care and employment, in "Other Health Professionals," section on HEALTH PROFESSIONALS.

SOURCES:

1991 Advisory Commission on Social Security.

Chair: Deborah Steelman (202) 637-5889.

Expert Panel Chair: Peter Diamond, economist, Massachusetts Institute of Technology. (617) 253-3363.

Kenneth E. Thorpe, health economist, School of Public Health, University of North Carolina, Chapel Hill. (919) 966-7375. (Thorpe also served on Diamond's Expert Panel for the Steelman Commission.)

HEALTH CARE COSTS AND THE ECONOMY — continued

SOURCES - continued

Uwe Reinhardt, economist, Princeton University. (609) 258-4781.

Janet Kline, section head, Congressional Budget Office. (202) 707-5863.

Walter B. Maher, Director, Federal Relations, Chrysler Corp.
Washington, D.C. (202) 862-5431.

National Governors Association, Washington, D.C. Contacts: Alicia Pelrine, head of human resources policy; Karl Volpe, health care; Rae Bond, press/public affairs.
(202) 624-5898.

The following is excerpted from Economic Implications of Rising Health Care Costs, a Congressional Budget Office study published in October 1992:

4 ECONOMIC IMPLICATIONS OF RISING HEALTH CARE COSTS

October 1992

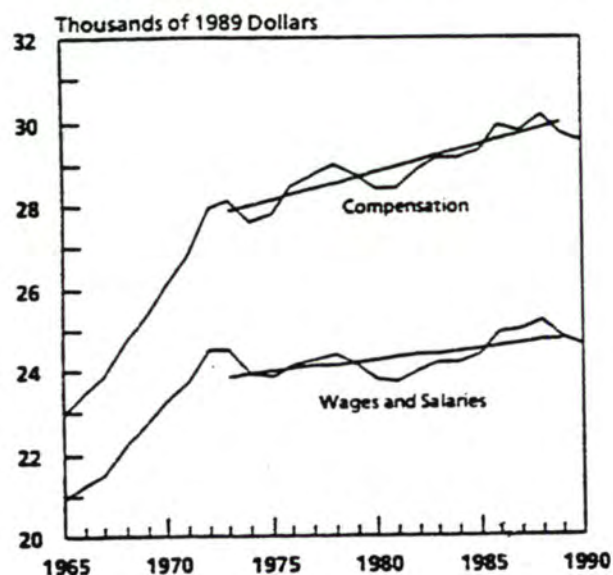
How Rising Costs for Private Health Insurance Affect the Economy

In the United States, most people's health care is financed through employment-based insurance plans. Such plans dominate the market because they are implicitly subsidized by the government: when employers provide health

insurance as a fringe benefit, they can deduct it as an expense, but employees do not have to pay income tax on it. Employer-provided health insurance is also not subject to payroll taxes. In essence, employees whose jobs offer insurance can pay for it using pretax income, which encourages them to buy more insurance than they otherwise would.

As the costs of health care have risen, more people have become concerned that the expense of providing these benefits has impaired the private sector of the economy. For example, some analysts claim that these costs have reduced the ability of U.S. firms to compete in the world marketplace. This study finds that such concerns are overstated.

Figure 3.
Inflation-Adjusted Compensation
and Wages per Full-Time Employee:
Actual Data and 1973-1989 Trends



SOURCE: Congressional Budget Office based on data from the Department of Commerce, Bureau of Economic Analysis.

NOTE: Deflated by the consumer price index for all urban consumers.

Although employers initially pay a significant portion of employer-provided health insurance, in the long run employers shift most of their costs to workers in the form of lower wages or less generous nonmedical benefits. Because workers largely bear these costs, the rising cost for insurance generally has little direct effect on the international competitiveness of U.S. companies (although there could be an indirect effect on competitiveness if higher health costs increase the size of the federal budget deficit, as discussed later). Likewise, business profits are probably not affected much, except for those of firms that have unfunded retiree health benefits.

In the short run, unanticipated increases in health care costs could affect employment, profits, and competitiveness, although the pattern of these effects would vary company by company and is difficult to predict. Unanticipated costs would probably be most significant for firms with long-term labor contracts, but they could also affect companies

that have implicit contracts with their workers to maintain real wages at certain levels. But unanticipated health care costs probably do not have strong and persistent adverse effects on economywide profits and competitiveness.

There are other reasons, however, to be seriously concerned about the rising cost for private health insurance. The sharp rise in health costs, together with slower growth in productivity and total compensation, are the main reasons for the weak growth in workers' real wages and salaries over the past 20 years (see Figure 3). Between 1973 and 1989, two years in which the economy was operating close to full capacity, employers' contributions to health insurance absorbed more than half of workers' real gains in compensation, even though health insurance represented 5 percent or less of total compensation. Thus, the higher costs for health insurance have had a significant impact on household budgets.

Why Do Insured Workers Ultimately Bear These Costs?

To answer this question, one must look at the self-interests of both employers and employees. In a competitive environment, employers seek to keep the total compensation of workers in line with labor productivity. If the real cost of insurance to employers goes up by a dollar (and the additional expenditures on insurance do not affect productivity), employers face strong pressure to cut a dollar from some other form of labor compensation, such as real wages. Employers who fail to make this adjustment would be raising workers' compensation above their productivity, an action that could create unsustainable losses. Such losses could make it difficult for a firm to raise funds for maintaining and modernizing its capital stock and could lead to bankruptcy.

At the same time, health insurance provides a valued service to workers, which means that they would be willing to give up some of their income to obtain it, just as they spend income to buy other goods and services

If insurance were fully valued at the employers' cost, workers would be willing to pay that amount in the form of lower real wages. But even if workers do not fully value health insurance, it seems likely that they would eventually bear most of these costs anyway. Because many workers who have insurance are unlikely to drop out of the labor market or otherwise reduce their hours significantly when real wages decline, employers can shift the costs of health insurance to them with little adverse effect on production and profits.

Although workers probably bear the employers' costs for insurance, they do not pay for the whole cost of insurance; a portion of that cost is subsidized through the tax system. Of course, someone must ultimately pay for the subsidy, but where the burden finally falls is difficult to discern. For example, although the subsidy could be paid for by higher taxes on some people, it could also be borne by others in the form of reduced public services or, alternatively, by future generations in the form of a larger federal debt. Despite these analytical uncertainties, an increase in the subsidy (because of higher costs for insurance) would probably increase the size of the federal budget deficit under current policy because there is no automatic mechanism to offset such revenue losses with either spending cuts or tax increases.

The Effects on the Shape and Structure of the Labor Market

The rising costs for health insurance may have also distorted the shape and structure of the nation's labor markets. That may explain why some employers have moved low-wage workers to part-time status with no insurance or eliminated the lowest-paid positions and hired independent contractors to do their jobs instead. For example, many firms no longer have janitors, gardeners, cafeteria staff, and general-duty workers on their payrolls; instead, those tasks are done by independent contractors. Higher health costs have also

made the availability of employment-based insurance more important in choosing a job. The result has been to reduce the flexibility of the labor market and possibly to hamper its ability to respond to new challenges and opportunities.

How Do the Costs of Government Health Programs Affect Government Budgets and the Economy?

The growth in health care costs imposes substantial pressures on government budgets as well. The federal government's health care entitlement programs—Medicare and Medicaid—are the fastest-growing portions of its budget. Spending on these two programs has grown from about 1 percent of GDP in 1970 to 3.0 percent in 1991. CBO expects that under current policy these programs will eventually rise to 6.1 percent of GDP by the year 2002.

The increasing share of Medicare and Medicaid will make budgeting in the 1990s more difficult. Just the growth in their GDP share between 1991 and 2002 will cost the government an additional \$313 billion in the year 2002. By 2002, these increased costs alone will absorb 17 percent of total federal revenues and amount to 23 percent of all non-health spending (excluding net interest) and almost half of all discretionary spending.² If they are financed through a larger budget deficit, they will raise the interest costs on the federal debt by \$91 billion in 2002.

2. Discretionary spending is divided among three categories: defense, international, and domestic. The domestic programs include education, training, social services, health care and research (excluding Medicare and Medicaid), income security and veterans' affairs, the environment and natural resource management, and transportation.

Effects on State and Local Budgets

Rising health care costs have exerted similar pressures on the budgets of state and local governments. Their spending for health care as a share of GDP has grown consistently over the past decade, and increases in health care costs will continue to challenge state and local governments in the coming years.

States spent about \$100 billion on health care in 1991. CBO projects that such spending could rise to \$244 billion by the year 2000--an average increase of more than 10 percent each year. Most of this increase will result from an escalation in the costs of the Medicaid program, although states also provide funds for public hospitals, clinics, and public health services. In fact, just the growth in Medicaid's GDP share between 1991 and 2000 will add almost \$70 billion to the budget woes of state governments.

Because almost all states have balanced budget agreements, they will have to finance increases in health spending by raising revenues or cutting public services. Illustrative calculations suggest that the increase in Medicaid's GDP share could absorb 12 percent of state revenues (less grants-in-aid) and amount to 18 percent of nonhealth state spending (also less grants-in-aid) by the year 2002. Thus, rising Medicaid costs are likely to crowd out other state priorities, such as rebuilding infra-

structure, funding grants to local governments for education, or providing tax relief.

Effects on the Federal Budget Deficit

Increases in health costs will lead to larger federal budget deficits if policymakers do not enact legislation to finance these expenditures (either through cuts in other types of federal spending or increases in federal taxes). CBO projects that under current policy the federal deficit, after declining in the first half of the 1990s, will swell to more than \$500 billion by the year 2002, largely as a result of increased spending for Medicare and Medicaid.

Federal borrowing of this magnitude will significantly affect the economy because it will cut into private saving that would otherwise have been used for investment here or abroad. CBO's calculations suggest that if federal spending on Medicare and Medicaid could be held to its 1991 share of GDP, output (real GDP) would be about 2.2 percent higher than the CBO baseline by the year 2002. Incomes (as measured by real gross national product) could rise even more--by about 2.4 percent--because servicing costs on debt to foreigners would be reduced. Of course, there is nothing unique about holding the line on health care costs. Many fiscal policies that reduce the deficit by the same amount would have roughly comparable effects, although the precise economic impact would depend on which policy was selected.

In addition, a reduction in federal borrowing would improve the competitiveness of U.S. industry. Lower levels of borrowing would permit a decline in the real value of the dollar compared with that of other currencies, which in turn would allow the prices of U.S. tradable products to fall in relation to those produced overseas. The same process operated in reverse in the 1980s: as federal deficits rose in the early 1980s, the real value of the dollar climbed about 20 percent higher than its level in the late 1970s. In turn, the trade balance--

and the competitiveness of U.S. industry--deteriorated.

Conclusions

Should policymakers be concerned about the rapid growth in health care costs? There are many reasons to answer yes. First, health care markets are not truly competitive and therefore do not work very well. Because health care spending does not have to meet the usual market tests, health resources are not allocated efficiently. Too much money seems to be spent on procedures that have little value. At the same time, many people believe that too few resources are devoted to preventive care, such as immunizations. Such allocations may not reflect individual or social preferences, and many U.S. consumers do not believe that they are receiving their money's worth in health care.

Second, rising health care costs have significantly reduced many people's access to medical care. An increasing number of people do not receive health insurance from their employers. Moreover, the costs of individual health policies have become prohibitively expensive for many. Without access to health insurance, studies have shown that these people receive reduced levels of medical care. Rising health care costs seem to be creating a dual system of medical treatment in the United States. Although most people enjoy access to the best and latest care in the world, an increasing number of people are shut out.

Third, rising costs place significant burdens on workers. Rising health care costs have absorbed much of the growth of employees' real compensation over the past 20 years. Together with the slow growth of productivity, the rising costs for health insurance explain why workers' cash wages have hardly grown over the past two decades. The squeeze has meant that workers have less to spend on everything else. This situation has undoubtedly frustrated wage earners who have trou-

ie making ends meet. These frustrations probably add to tensions between labor and management as well.

Fourth, rising health care costs have most likely distorted the nation's labor market and made it less flexible. Because the costs of insurance are now so high, the availability of health insurance is becoming a more important factor in choosing a job. Moreover, rising costs may explain why large companies are eliminating positions for low-wage workers, such as janitors, and hiring independent contractors instead.

Fifth, rising health costs have also put substantial pressures on government budgets. Health programs are gobbling up a large portion of government resources and are threatening to crowd out other priorities, too. On the federal level, health spending is the only category of the budget, with the exception of net interest, that is rising as a share of GDP. At the state level, increases in Medicaid costs will make it more difficult for states to fund other programs or provide tax relief.

The opportunity cost of rising health care spending--what the nation gives up in order to

pay for it--reflects all these costs. Resources are diverted to health care and, as a result, both workers and governments have less to spend on other priorities. At the same time, the distortions in the labor market, and especially the reduction in national saving that is likely to occur as a result of the pressures on the federal budget, will reduce investment and substantially cut future incomes--in CBO's projection, by almost 2.5 percent in 2002 and even more thereafter.

Whether these opportunity costs, together with costs associated with the growing problem of the uninsured, exceed the benefits likely from an increase in health care spending, is a complex question that lies beyond the scope of this study. Without a doubt, the growth of costs has gone hand in hand with enormous improvements in the ability of doctors to diagnose, treat, and even prevent previously intractable conditions. But there is no mechanism--either a market or a government regulatory plan--in the current health care delivery system that ensures that costs will be kept in line with benefits. Instead, many factors, detailed in this study, encourage higher health care spending, and little stands in their way.

Sparing the knife

Clinton's health care plan won't rip into America's weak job growth

Barbara Sterling used to care for pregnant mothers with acute asthma and high blood pressure. But today, the 37-year-old registered nurse pushes paper instead of pampering patients at the University of Illinois Hospital and Clinics in Chicago. Several months ago, as part of an effort to trim \$17 million from its budget, the hospital announced the elimination of 176 registered nursing positions, including Sterling's in the OB-GYN clinic. Sterling was fortunate enough to find work in the pre-admissions testing department, but many other hospital workers in Chicago may not be as lucky. Just down the street, Rush Presbyterian-St. Luke's Medical Center has announced that it will cut 450 to 800 positions this year. Says Mary Sheehan, director of nursing at the University of Illinois Hospital and Clinics, "There is not a hospital in this metropolitan area that is not looking at some way to contain costs."

Displaced nurses like Barbara Sterling are becoming increasingly common in urban areas across the country today as hospitals pare their budgets in order to attract business from cost-conscious managed-care organizations. And President Clinton's anticipated health care reforms, which are expected to revolve around purchasing alliances that will shop for the highest-quality, lowest-cost care, will only accelerate this streamlining. Registered nurses, who represent one of the largest labor groups in health services—2.2 million out of approximately 9 million workers—are feeling the pinch first. Beyond health services, the 260,000 U.S. pharmaceutical workers are also vulnerable because drug companies are cutting prices and trimming fat in order to sell products to



OPERATION HEALTH CARE REFORM

Many workers worry about Clinton's plan. But experts predict that job creation in the health services and drug industries should continue—at a slightly slower pace.

managed-care organizations. The pharmaceutical industry has announced the elimination of 10,000 positions over the past two years. In addition, many entrepreneurs worry that Clinton's health reforms could cause job losses at small businesses, where anticipated federal payroll premiums, flat premiums for each employee or a combination of the two will raise costs for companies that don't offer health insurance.

But despite the rampant fears of

small businessmen and the recent money-saving moves at hospitals and pharmaceutical companies, most analysts believe that the downward cost pressures from Clinton's health care reforms will be mild. As a result, say experts, both the health services and drug industries should experience slower—but not negative—job growth. And a recent study indicates that small businesses will see only minor job losses. Says David Brailer, a professor of health care systems at the

their current health care costs. But the Clinton administration insists that the payroll tax or flat premium will replace — not add to — the health care costs that more than 60 percent of small- and medium-sized businesses currently pay. And if the administration chooses a payroll premium — which would tax all employers at the same rate — small businesses would likely benefit. The reason: Employee salaries average \$17,500 for companies with fewer than 26 workers compared with \$30,100 for businesses with more than 1,000 workers. In essence, this means that large companies would subsidize small ones. Moreover, the White House promises that its health care plan will phase in any payroll taxes over time and that the plan will include a subsidy or tax incentive to alleviate the shock of new expenses for small businesses.

Boosting productivity. If he makes good on his promise to offer health insurance to everyone regardless of medical condition, Clinton's reform plan could also help make U.S. companies more productive by allowing workers to leave jobs they have outgrown without fear of losing their insurance. Such a plan would help John Sullivan, a 42-year-old Indianapolis lawyer. Sullivan has a 5-year-old daughter with acute asthma who receives special treatments four times a day and has been hospitalized three times at a cost of \$10,000 per stay. Because her pre-existing condition makes her a significant liability for an insurance company, if Sullivan were to change jobs he could have trouble obtaining insurance from a new employer. "If I wanted to change jobs," says Sullivan, "I would be taking a \$10,000 risk."

According to KPMG Peat Marwick, 63 percent of businesses with conventional insurance plans include pre-existing condition clauses that require employees to wait before the plan provides coverage. But a study by the Employee Benefits Research Institute in Washington, D.C., found that only 12 percent of those surveyed ever turned down a job because it did not offer medical benefits. Says Mark Pauly, a health economist at the University of Pennsylvania, "This is a serious problem affecting only a small segment of the labor force."

It's clear that Clinton's health care plan will result in some economic pain. But most economists and health care analysts agree that the rapid growth rate in U.S. medical costs, which is pushing up America's budget deficit and holding back many companies, is far more devastating to long-term growth than health care reform will ever be.

BY SARA COLLINS

BUSINESS

The cement makers' long, sweet ride

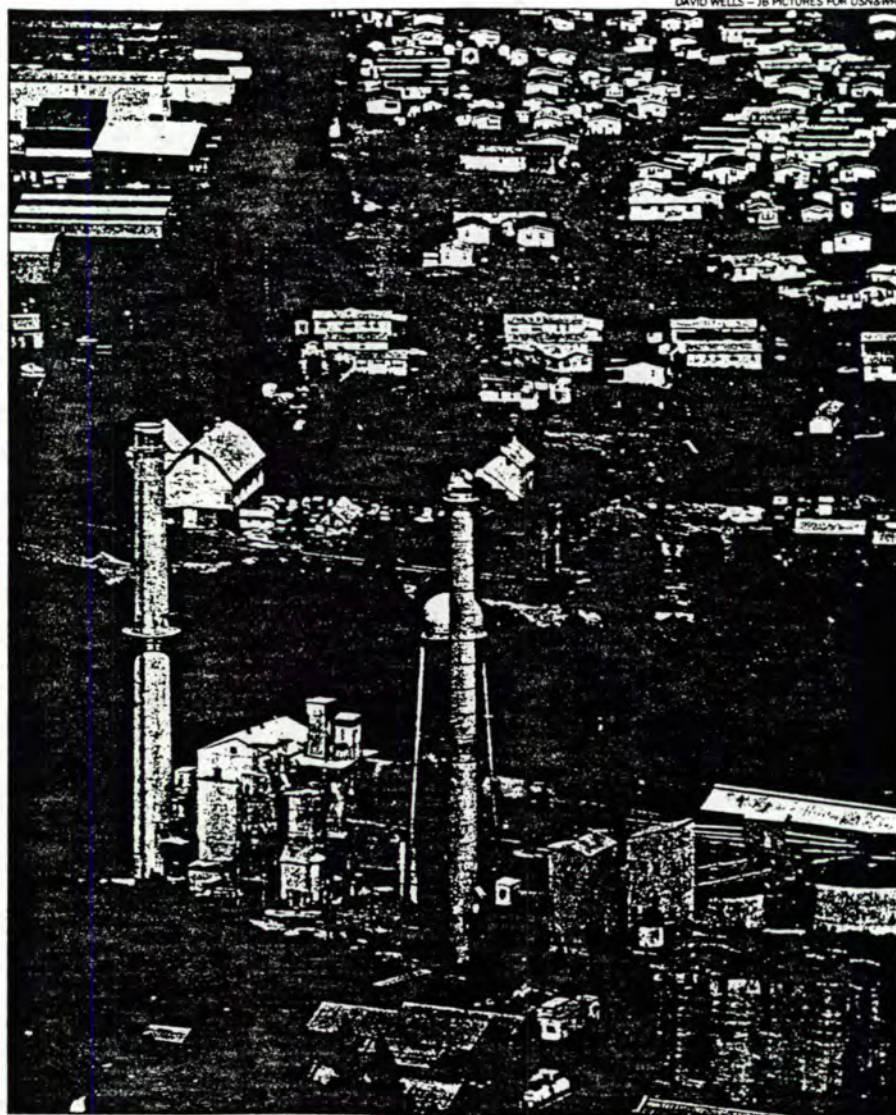
And Washington's new environmental war

On flat farmland outside the town of Paulding, Ohio, sits an agglomeration of storage tanks, conveyors and long, rotating kilns that burn 60,000 tons of hazardous waste a year. Yet ask anyone who lives nearby about Ohio's major burners of toxic substances and the Lafarge Corp.'s Paulding cement plant

**U.S. NEWS
INVESTIGATIVE
REPORT**

isn't likely to come to mind. What does is the new Waste Technologies Industries incinerator located clear across the state, in East Liverpool.

The newer facility got a lot of attention last December when Vice President-elect Gore threatened to keep it from opening pending a congressional study. But the fact is, more



Waste, not. A Bath, Pa., cement plant built to burn coal now burns wastes, too.

University of Pennsylvania, "Reforming the health care system is not going to have a major impact on employment."

There are several explanations for this surprising finding. Even with Clinton's health reforms, demand for medical care will almost certainly increase. That's because America's aging population will require more from the health care system in coming years. In addition, the increasing emphasis on preventive medicine should boost job creation in outpatient clinics and home health care, where growth in employment has averaged 17 percent per year since 1988. Finally, Clinton's pledge to provide health coverage to 37 million uninsured Americans means there will be more work for the health care industry.

Slowdown. This is good news for the economy. The health services industry created 1.4 million jobs between 1988 and 1992, half the total positions produced in America. Job growth in health services will continue, says Tom Runiewicz of the WEFA Group, a Pennsylvania forecasting firm, but it will ease from the 4 to 5 percent annual rate of the last five years to about 3 to 4 percent. "Instead of going 50 miles per hour," says Runiewicz, "health services employment will be going 30 miles per hour—slower but still going forward." Many analysts believe this slowdown in job creation will be less damaging to the economy than continued increases in health care costs, which grew at a real annual rate of 5.5 percent over the last decade and are contributing to the nation's budget deficit. "The cost of failing to get costs under control," says Joshua Weiner of the Brookings Institution, "will be much larger than any impact [on the economy] through health reforms."

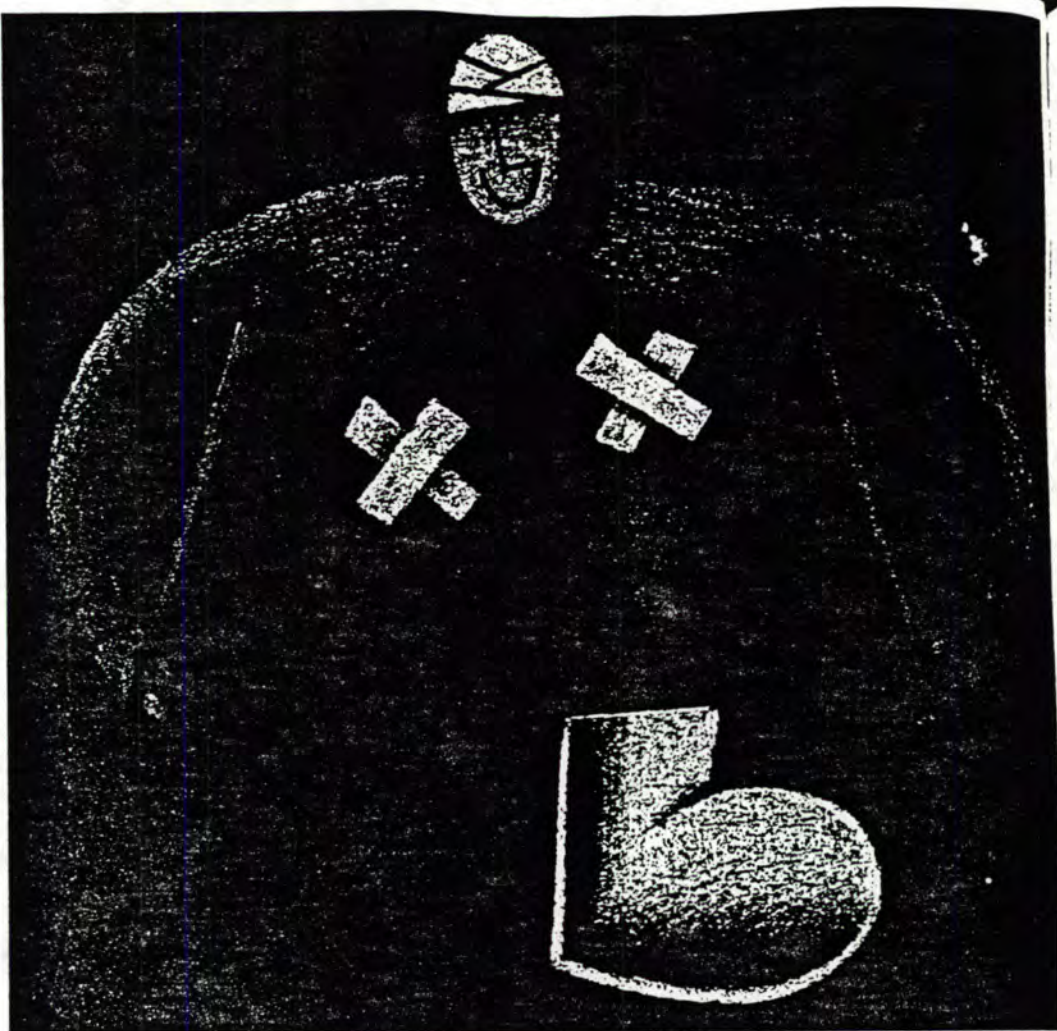
Job growth in the pharmaceutical industry is expected to follow the pattern of health services. Paul Bishop of the WEFA Group points out that the current employment growth rate in the drug industry of 2 to 3 percent is slower than in the boom period of the late 1980s, when job growth averaged more than 5 percent a year. But, says Bishop, the rate today is in line with the industry's 2 percent average annual growth rate of the last decade. And, says Bishop, even health care reform "will not

have a dramatic effect on the number of jobs or growth rates on a long-term average basis." Merck, a New Jersey-based pharmaceutical company that employs 20,607 U.S. workers, is a case in point. The company offered early retirement incentives to 1,600 employees this spring, but it still expects to see slight growth in employment over the next decade.

Experts also believe that small-business layoffs won't be widespread if Clinton's plan for health care reform utilizes payroll premiums. John Sheils of Lewin-VHI, a Virginia health care consulting firm, has told Congress that a payroll premium of 8 percent would result in a loss of 23,000 to 63,000 jobs. But regulation-weary entrepreneurs like Sharon Miller still worry about the bottom-line impact of reform. Miller, who owns three small companies in

Midland, Mich., now offers health benefits to her workers. She believes that buying health insurance through one of Clinton's purchasing alliances would reduce the 10 to 15 percent annual rate of growth in her premiums. Still, if forced to pay a payroll tax or a flat premium for each employee, Miller says she "would probably hire fewer workers."

Miller is hardly an exception. In a recent survey by the Arthur Andersen Enterprise Group and National Small Business United, an association for small businesses, 81 percent of companies with fewer than 500 employees were opposed to a payroll tax. Those companies surveyed that do not currently offer health insurance objected to a sudden increase in their costs; many of the companies that do pay for employee health benefits saw the tax as an additional expense on top of



WALKING TO A NEW JOB

Clinton's plan could boost some companies' productivity by allowing workers with medical problems to move to new jobs without losing their health insurance.

Health Care Reform Prognosis: Pain in the Early Stages
7/6/93, L.A. Times

When President Clinton pledged to reform the health care system, he promised that his efforts would improve U.S. economic competitiveness in the world by slowing the growth in medical costs.

Yet, with the President's proposal still being drafted at the White House, there is evidence that health care reform will bring slower growth, fewer jobs and smaller profit margins long before it pays the economic dividends that Clinton has promised.

In anticipation of health care reform, some companies are already deferring hiring, hospitals and drug companies are laying off workers, managed-care companies are declining to sign up new specialists and the pharmaceutical industry's stock prices are in a tailspin.

Such hardships are to be expected, according to some economists, whenever the government sets out to revamp an industry as vital to the economy as health care.

Mark Zandi, an economic consultant in West Chester, Pa., likened the economic effect of Clinton's health care reform plan to the decline in gasoline prices in the 1980s. While it ultimately proved to be a boon to the economy, it brought considerable short-term hardship, especially in oil-producing states.

"In the long term, health care reform is an unambiguous positive," Zandi said. "But initially, certain elements of the health care industry, and those employers who are going to pay for it, are going to suffer negative consequences."

While the President's plan for reform will not be unveiled at least until September, the plan's general outline is already known: Clinton favors using a combination of free-market forces and price controls to restrict health care spending and provide coverage for all Americans.

In the long term, Clinton's proposal is expected to ease the pressures that have fueled a nearly sevenfold increase in U.S. medical expenditures in the last three decades. By some estimates, it could trim health care spending by more than \$700 million by the year 2000.

If those estimates are correct, reform not only would help dampen inflation and slow the rising federal budget deficit, it would also ease the tremendous impediment that high health care costs have put on U.S. employers as they compete with the Japanese in world markets.

Most economists say they agree with the principal goal behind Clinton's plan. As the President has stated repeatedly: "We will never revive our economy or cope with the deficit until we get health care costs under control."

In the first two years after enactment of health care reform, however, some economists predict that the economic disruption it causes could shave between 0.2% and 0.5% off the nation's annual economic growth rate and deprive the economy of as many as 750,000 new or existing jobs.

Hardest hit would be the Northeast and Midwest, whose economies are more dependent on the health care industry, the economists said. In the South and Southwest, where a higher percentage of employers do not now offer health coverage to their workers, the cost of doing business would increase.

While health care reform is supposed to dampen demand for expensive medical services in the long run, some economists predict that it will increase demand for medical services initially as 35 million currently uninsured people are provided with coverage. Increased demand could, in turn, fuel a surge in inflation in the first few years after reform.

"Initially, it means a giant increase in demand and a lot more money going into the industry. . .," said John Shiels, a health care economist for Lewin-VHI, a consulting firm in Alexandria, Va. "The increase in demand will also create bottlenecks, causing price increases in areas where there are shortages."

Estimates vary widely on how reform will affect overall health care spending in the first few years. According to a summary of economic forecasts published recently by Congress' Office of Technology Assessment, some analysts foresee an initial annual savings of nearly \$22 million under Clinton's reform plan, while other forecasters predict a nearly \$50-million increase.

Audrey Freedman, a well-known labor economist in New York City, cautioned that, even though 35 million more people would be insured under Clinton's plan, demand will not increase as dramatically as those numbers suggest.

Freedman said many uninsured people now receive treatment but often not until they need high-priced emergency care. Thus, while the demand for routine services surely will increase once these people are insured, she predicted, the demand for emergency care is likely to decline.

Yet despite an anticipated increase in demand, many sectors of the health care industry are girding for leaner times because they expect the President's plan to impose a new cost-cutting discipline on them.

"The health care industry has been growing in recent years in anticipation of

rising prices as far as the eye can see," Zandi said. "Now, they know they are going to have to control growth in costs."

Hospital officials say they expect to feel the crunch almost immediately, especially if Congress also follows through on a plan to cut Medicare payments. Hundreds of hospitals are likely to close in the next few years under pressure to eliminate excess capacity, according to the American Hospital Assn., and many of those that remain open will be forced to scale back their operations.

Layoffs already are spreading through the hospital industry. At Rush-St. Luke's Hospital in Chicago, for example, the management recently announced plans to lay off about 800 employees.

Likewise, some economists predict that Clinton's health care plan will cause hundreds of small insurance companies to go belly up. The plan favors the big insurers that already are abandoning high-priced indemnity health insurance in favor of establishing more economical managed-care networks of physicians.

"It will wipe out many small insurance companies and wreak havoc on the free-standing hospitals and the free-standing clinics that are not part of a vertically integrated network of providers," said Uwe E. Reinhardt, a health care economist at Princeton University.

Lewin-VHI has estimated that the system advocated by Clinton could save more than \$11 million a year in insurers' administrative and paperwork costs. But that also means some insurance company employees involved in billing and administration can expect to be out of work.

Like hospitals, manufacturers of pharmaceuticals and medical devices are also beginning to lay off workers as part of cost-cutting moves prompted by Clinton's criticism of their earlier price increases, according to the Pharmaceutical Manufacturers Assn. Drug industry stock prices are down 15% so far this year.

Under the system of managed care that is fast supplanting indemnity health insurance across the nation, primary-care physicians are supposed to act as the "gatekeepers" who control patient access to high-priced specialists. But insurers reported that there is already a critical shortage of primary-care physicians and a surplus of specialists.

A recent survey conducted by Group Health Assn. of America, a trade group, and the U.S. Public Health Service, found that more than half of the nation's health maintenance organizations are finding it increasingly difficult to recruit primary-care physicians.

If the shortage of primary-care physicians continues, as expected, Reinhardt predicts that market forces will quickly boost pay for lower-paid general

practitioners and lower wage scales for high-priced specialists. Soon, he said, physician salaries in excess of \$300,000 a year will be rare.

Well-positioned to benefit from the shortage of general practitioners are nurses and physician assistants, who are widely deemed to be capable of performing many of the less complex procedures usually carried out by doctors. But some economists said many nurses are likely to be laid off by hospitals before their occupation benefits from the changes wrought by health care reform.

Not all of the economic turmoil caused by reform will occur within the health care industry, of course. Because Clinton aims to require all employers to provide health care coverage, proprietors of many struggling enterprises have predicted that they will be forced out of business by health care reform.

The National Federation of Independent Business, which opposes a mandate on employers to provide insurance, recently published a list of as many as 18 million jobs that would be "at risk" if Clinton were to ask all small-business owners to foot the bill for covering their employees.

Many economists say they are skeptical of the federation's projections. Reinhardt predicted that no more than 100,000 small-business jobs would be lost because of a mandate; Shiels said the figure would not exceed 60,000.

Even many big employers that already provide health insurance are nervous, fearing that a proposed new payroll tax to fund health care reform could exceed their current outlays. Only in the auto industry, where health care accounts for about 20% of total payroll costs, are employers confident that they will be paying less under the President's plan.

Many employers are frightened by Shiels' prediction that reform could increase the aggregate costs of health care to U.S. corporations by as much as \$132 million. But until Clinton decides on a financing scheme, these estimates are speculation.

Whatever the increased cost of reform, Shiels predicted, it will result in lower pay for workers. "The only thing that Karl Marx managed to get right," he said, "is that in the end the worker pays all of the bills."

While health care reform certainly will require some sacrifice in all of these areas, experts were quick to note that Americans also will pay dearly if Clinton and the Congress fail to agree on a plan. Unrestrained, health care costs can be expected to continue to erode profits and add to the federal deficit.

As Freedman put it: "Leaving the system alone is a decision too, and an expensive one."

Small Businesses Prepare To Battle Clinton Payroll Tax
Bureau of National Affairs, 6/16/93

Representatives of small businesses are preparing for a major legislative battle with the Clinton administration over financing health care reform with a payroll tax, setting the stage for a contentious partisan debate once the bill is sent to Capitol Hill.

Along with price controls and global budgets for health care spending, the payroll tax financing mechanism is likely to be one of the most controversial components of the administration's health care plan, congressional sources and private sector observers told BNA. While Republicans and conservative Democrats will oppose the plan in the interest of small businesses, the Democratic leadership will pursue passage of the president's reform package, including payroll tax financing, sources predicted.

The White House plan is expected to propose requiring small employers--perhaps those with fewer than 1,000 workers--to pay a "wage-based premium" or payroll tax for the health care coverage of their workers, defined either as a percentage of payroll or a per person amount. While no firm numbers have been set, a 7 percent payroll tax has been mentioned by White House officials, along with a matching contribution of 2 percent by individual employees, sources said. States may be allowed to set the payment amount according to the demographic characteristics and budget requirements of their state.

To ease the burden on small businesses not providing insurance currently, the administration is promising to use government subsidies to phase in the requirement over a period of between three and six years, sources told BNA.

NFIB A Leading Opponent

One of the most vocal opponents of any employer mandate is the 600,000-member National Federation of Independent Business, which plans to lobby heavily against the requirement once the bill reaches Congress. In a pre-emptive strike against the White House plan, the group recently released a study warning that a mandate on small businesses to provide health insurance could cost 900,000 jobs and place the wages or benefits of 18.3 million workers at risk of being cut.

The 65,000 member National Small Business United, although somewhat more moderate in tone, also is likely to campaign against the payroll tax plan, according to spokeswoman Marsha Bradford.

"What we're hearing from our members is that a 7 percent payroll tax would cost them about \$ 50,000, which they can't afford," Bradford told BNA. "Politically, there will be a battle on this one."

The U.S. Chamber of Commerce, with 95 percent of its 215,000 members having fewer than 100 employees, also would lobby against a payroll tax financing scheme, lobbyist Kristin Bass told BNA. While open to the concept of a mandate on employers to offer health insurance if there were subsidies for low-wage workers, the Chamber opposes the payroll tax as a vehicle because many of its members operate on very slim profit margins, Bass told BNA. According to one study, the payroll tax rate could reach as high as 18 percent in some areas if states were allowed to set their own rates, she noted.

Also gearing up to oppose the payroll tax is the Healthcare Equity Action League (HEAL), a 600-member coalition of employers and health care industry groups founded to oppose government mandates and promote incremental reforms. Many of HEAL's larger members are in the food and lodging industry, which generally employ lower-wage workers without health insurance benefits.

The payroll tax is "totally inconsistent" with HEAL's mission statement and "would only increase the burden on small businesses who are struggling to provide insurance now," Joan Simmons, a member of HEAL's board of directors, told BNA.

Not all small business representatives are unequivocally opposed to a payroll tax, however. The Small Business Legislative Council, an coalition of approximately 100 trade and professional associations, may be receptive to the concept if the plan also firmly controls health care costs, analyst John Satagaj told BNA. At least two-thirds of small employers currently provide health insurance, and most would benefit financially if their health care costs were held to 7 percent of payroll, he said.

"We have a bias against mandates, but we're not going to rule anything out until we see how it all fits together [in the plan]," he added.

GOP Opposition Expected

On Capitol Hill, the payroll tax will face stern opposition from Republicans and also some conservative Democrats, and may also be obstructed by Sen. Chairman Daniel Patrick Moynihan (D-NY), sources predicted.

"Republicans are not enthused about a payroll tax" because of its effect on small businesses, Julie James, a minority staff member of the Senate Finance Committee, recently told the ERISA Industry Committee. "There is a real concern among Republicans that you can't impose an employer mandate without wreaking havoc on the economy."

Another Senate GOP aide told BNA that even moderate Republicans "will reject the proposal out of hand" because of the perceived burden on small business. The Clinton proposal would "suck money out of everyone's employment base . . .

[and] give it to little IRSs" that run the health system, the aide said. "It's not going to fly."

Some conservative Democrats are expected to join Republicans in attempting to quash the payroll tax proposal. Rep. Jim Cooper (D-Tenn), the chief sponsor of managed competition legislation introduced last year (HR 5936), recently called the employer mandate "a clumsy and inefficient way" to ensure universal access. "In a jobless [economic] recovery, you need to make sure you don't punish job creation," he said.

Perhaps an even more formidable obstacle will be Moynihan, chairman of the Senate Finance Committee, which has primary jurisdiction over financing health reform. Aides to Moynihan told BNA that historically the senator has had concerns about using a payroll tax for various purposes, but emphasized he has not yet taken a definite position on the Clinton health plan one way or the other. "He has made some statements about job loss, but he is not in the school of anti-mandates," one aide said.

Nevertheless, Moynihan declined to co-sponsor the Senate Democratic leadership's "play-or-pay" health reform bill introduced in the last session of Congress (S 1227), which would have required employers to provide health insurance for their employees or incur a payroll tax set by the secretary of health and human services.

Those who did support play-or-pay still hold key positions in the Senate, however, and can be expected to be leading advocates of Clinton's payroll tax plan. Chief sponsors of that legislation included Senate Majority Leader George Mitchell (D-Maine), Senate Labor and Human Resources Committee Chairman Edward Kennedy (D-Mass), and Sen. John D. Rockefeller (D-WVa). Payroll tax financing is also likely to be supported by House Ways and Means Committee Chairman Dan Rostenkowski (D-Ill), also a previous supporter of play-or-pay legislation.

Sources agreed it is too early to predict whether a payroll tax will pass Congress, noting that its fate is closely linked to the popularity of the overall health care reform plan. "It really depends on how the public feels about [the plan] and how much support Clinton can gain," one source said. "It remains to be seen how the politics play out--we haven't seen anything yet."

Small Businesses Prepare To Battle Clinton Payroll Tax
Bureau of National Affairs, 6/16/93

Representatives of small businesses are preparing for a major legislative battle with the Clinton administration over financing health care reform with a payroll tax, setting the stage for a contentious partisan debate once the bill is sent to Capitol Hill.

Along with price controls and global budgets for health care spending, the payroll tax financing mechanism is likely to be one of the most controversial components of the administration's health care plan, congressional sources and private sector observers told BNA. While Republicans and conservative Democrats will oppose the plan in the interest of small businesses, the Democratic leadership will pursue passage of the president's reform package, including payroll tax financing, sources predicted.

The White House plan is expected to propose requiring small employers--perhaps those with fewer than 1,000 workers--to pay a "wage-based premium" or payroll tax for the health care coverage of their workers, defined either as a percentage of payroll or a per person amount. While no firm numbers have been set, a 7 percent payroll tax has been mentioned by White House officials, along with a matching contribution of 2 percent by individual employees, sources said. States may be allowed to set the payment amount according to the demographic characteristics and budget requirements of their state.

To ease the burden on small businesses not providing insurance currently, the administration is promising to use government subsidies to phase in the requirement over a period of between three and six years, sources told BNA.

NFIB A Leading Opponent

One of the most vocal opponents of any employer mandate is the 600,000-member National Federation of Independent Business, which plans to lobby heavily against the requirement once the bill reaches Congress. In a pre-emptive strike against the White House plan, the group recently released a study warning that a mandate on small businesses to provide health insurance could cost 900,000 jobs and place the wages or benefits of 18.3 million workers at risk of being cut.

The 65,000 member National Small Business United, although somewhat more moderate in tone, also is likely to campaign against the payroll tax plan, according to spokeswoman Marsha Bradford.

"What we're hearing from our members is that a 7 percent payroll tax would cost them about \$ 50,000, which they can't afford," Bradford told BNA. "Politically, there will be a battle on this one."

The U.S. Chamber of Commerce, with 95 percent of its 215,000 members having fewer than 100 employees, also would lobby against a payroll tax financing scheme, lobbyist Kristin Bass told BNA. While open to the concept of a mandate on employers to offer health insurance if there were subsidies for low-wage workers, the Chamber opposes the payroll tax as a vehicle because many of its members operate on very slim profit margins, Bass told BNA. According to one study, the payroll tax rate could reach as high as 18 percent in some areas if states were allowed to set their own rates, she noted.

Also gearing up to oppose the payroll tax is the Healthcare Equity Action League (HEAL), a 600-member coalition of employers and health care industry groups founded to oppose government mandates and promote incremental reforms. Many of HEAL's larger members are in the food and lodging industry, which generally employ lower-wage workers without health insurance benefits.

The payroll tax is "totally inconsistent" with HEAL's mission statement and "would only increase the burden on small businesses who are struggling to provide insurance now," Joan Simmons, a member of HEAL's board of directors, told BNA.

Not all small business representatives are unequivocally opposed to a payroll tax, however. The Small Business Legislative Council, an coalition of approximately 100 trade and professional associations, may be receptive to the concept if the plan also firmly controls health care costs, analyst John Satagaj told BNA. At least two-thirds of small employers currently provide health insurance, and most would benefit financially if their health care costs were held to 7 percent of payroll, he said.

"We have a bias against mandates, but we're not going to rule anything out until we see how it all fits together [in the plan]," he added.

GOP Opposition Expected

On Capitol Hill, the payroll tax will face stern opposition from Republicans and also some conservative Democrats, and may also be obstructed by Sen. Chairman Daniel Patrick Moynihan (D-NY), sources predicted.

"Republicans are not enthused about a payroll tax" because of its effect on small businesses, Julie James, a minority staff member of the Senate Finance Committee, recently told the ERISA Industry Committee. "There is a real concern among Republicans that you can't impose an employer mandate without wreaking havoc on the economy."

Another Senate GOP aide told BNA that even moderate Republicans "will reject the proposal out of hand" because of the perceived burden on small business. The Clinton proposal would "suck money out of everyone's employment base . . .

[and] give it to little IRSs" that run the health system, the aide said. "It's not going to fly."

Some conservative Democrats are expected to join Republicans in attempting to quash the payroll tax proposal. Rep. Jim Cooper (D-Tenn), the chief sponsor of managed competition legislation introduced last year (HR 5936), recently called the employer mandate "a clumsy and inefficient way" to ensure universal access. "In a jobless [economic] recovery, you need to make sure you don't punish job creation," he said.

Perhaps an even more formidable obstacle will be Moynihan, chairman of the Senate Finance Committee, which has primary jurisdiction over financing health reform. Aides to Moynihan told BNA that historically the senator has had concerns about using a payroll tax for various purposes, but emphasized he has not yet taken a definite position on the Clinton health plan one way or the other. "He has made some statements about job loss, but he is not in the school of anti-mandates," one aide said.

Nevertheless, Moynihan declined to co-sponsor the Senate Democratic leadership's "play-or-pay" health reform bill introduced in the last session of Congress (S 1227), which would have required employers to provide health insurance for their employees or incur a payroll tax set by the secretary of health and human services.

Those who did support play-or-pay still hold key positions in the Senate, however, and can be expected to be leading advocates of Clinton's payroll tax plan. Chief sponsors of that legislation included Senate Majority Leader George Mitchell (D-Maine), Senate Labor and Human Resources Committee Chairman Edward Kennedy (D-Mass), and Sen. John D. Rockefeller (D-WVa). Payroll tax financing is also likely to be supported by House Ways and Means Committee Chairman Dan Rostenkowski (D-Ill), also a previous supporter of play-or-pay legislation.

Sources agreed it is too early to predict whether a payroll tax will pass Congress, noting that its fate is closely linked to the popularity of the overall health care reform plan. "It really depends on how the public feels about [the plan] and how much support Clinton can gain," one source said. "It remains to be seen how the politics play out--we haven't seen anything yet."

Rockefeller Says Clinton Plan May Include Small Business Assistance

The Bureau of National Affairs, 7/5/93

The Clinton administration's health care reform plan may include a provision to assist small businesses in paying for their employees' coverage, Sen. John D. Rockefeller IV (D-W Va) told the National Federation of Independent Business June 28. Assistance from the federal government would be intended as a "bridge" to help small businesses and may be coupled with a 100 percent deduction of premiums for the self-employed and a total reform of the insurance industry, said Rockefeller, who participated in a panel discussion with Sen. John Chafee (R-R I). These factors would help make health care affordable for all businesses, Rockefeller said. "Why mandate someone to pay something they can't afford to pay?" he asked, prompting a rare burst of applause from the NFIB members at the organization's annual meeting.

The 600,000-member NFIB and other business groups remain steadfastly opposed to the idea of mandating employers to provide coverage for workers, said to be a component of the Clinton plan.

"The American people don't like government," but that does not mean the federal government cannot step in to ensure health care is made affordable for all, Rockefeller said. "If there is a way in which we can cause those who don't provide health insurance to be able to afford it, that is not an unreasonable thing to do," he added.

Rockefeller warned NFIB that to reject the Clinton proposal would mean that the U.S. health care system will remain unchanged.

"The status quo is what you do not want," he told the group. "What benefits would be covered? A little bit less than last year. Insurers will continue to charge you whatever they want. Cost controls will be every person for himself," he said. Large employers and the government will have the clout to negotiate the best deals with providers, which will set rates for small businesses to make up for the discounts with larger purchasers, he added.

"Every insurer will design its own [claims] forms -- thousands of them . . . Small businesses will continue to pay up to 40 percent more than big businesses just to cover the administrative expenses and overhead," Rockefeller said.

Rockefeller urged the group to weigh the Clinton proposal on its merits. "Put the costs and sacrifices in perspective from what we stand to gain from it," he said, predicting that there will be a national "sigh of relief" when the plan is introduced and "we can begin to explore and analyze it for what it is."

Senate Republicans' Approach

The Senate Republicans' health care proposal will ensure that small businesses have the ability to join forces with other small businesses to bargain effectively with providers and insurers for health care coverage, Chafee said.

Declining to give specifics about the proposal, Chafee said the plan also will include insurance reforms to provide security that insurers "should not pull the rug out from under" small companies if they employ workers with pre-existing conditions or workers who subsequently become ill.

The plan includes no employer mandates, Chafee emphasized. "We don't believe any program should mandate whether or not you should contribute to your employees' health insurance," he said. "That should be arranged by you and your employees." Rep. Mike Andrews (D-Texas) is developing a health reform proposal that strikes a middle ground between the Clinton plan and the Senate Republicans' approach, said Deborah Steelman, moderator of the panel. Andrews was scheduled to appear with Rockefeller and Chafee but was called away for a House vote.

According to Steelman, Andrews' proposal is a version of a managed competition plan. It would require all employers with fewer than 1,000 workers that offer health coverage to use a health insurance purchasing cooperative to offer coverage for employees, she said. However, employers would not be required to pay for or contribute to the cost of coverage under the plan, said Steelman, an attorney who chaired the the Advisory Council on Social Security. Competition would be based on price and quality. The proposal contains no price controls, no global budgets, and no employer mandate, Steelman said.



National Federation of
Independent Business

STATEMENT OF
CHARLES P. HALL, JR., PHD
PROFESSOR AND CHAIR
TEMPLE UNIVERSITY

Before: House Ways and Means Subcommittee on Health

Subject: Health Care Costs and Lack of Access

Date: Thursday, May 2, 1991

I appreciate the invitation to speak at this public hearing on health insurance options.

My purpose here today is to report on the major findings of a health insurance survey conducted by the National Federation of Independent Business Foundation and authored by myself and Dr. John Kuder. The survey consisted of a randomly drawn sample of small business owner members of NFIB in the Spring of 1989. Over 5,300 completed usable surveys were received for a response rate of 29%. We believe that these responses are reasonably representative of small business owners throughout the United States by industry, type and location -- except for those with 4 or fewer employees which are slightly under-represented. In addition, as a group the respondents represent firms that are a bit older and more mature than the universe of small businesses.

The results of the survey support the conclusion that small business owners, like most other Americans, share major concerns about the rapidly escalating costs of health care and health insurance. In addition, the responses reflect the confusion and frustration that result from not being able to identify an easy solution to the problem.

Background

Suite 700
600 Maryland Ave. S.W.
Washington, DC 20024
(202) 554-9000
FAX (202) 554-0496

Small businesses have always been a dynamic force in the American economy. They remain so today. Millions of Americans own and operate small businesses. Over 19 million report income or loss from business activity. Self-employment (including small closely held corporations) is the principal occupation for over 9 million Americans and their employees.

Small business has earned a reputation over the past two decades as the nation's "job generator." New firms and



those with fewer than 20 employees have been responsible for a disproportionate share of the net new employment generated over the last 20 years. The U.S. Small Business Administration estimated that firms with fewer than 100 employees created 64% of the 10.5 million net new jobs that were created between 1980 and 1986. Small business now employs over half of the private sector workforce.

As will be presented later, the majority of small businesses with fewer than 100 employees do provide health insurance coverage for their employees. Therefore, size alone is an insufficient reason for not sponsoring employee health coverage. This testimony is designed to provide the Committee with insight as to why some small businesses offer health insurance and why others do not.

Key Findings of the NFIB Foundation Survey

A discussion with any American about his/her health and the health of others is very likely to evoke strong feelings and value statements. Because health care services and health insurance are seen as factors influencing an individual's health and the burden of illness, discussions of these markets are also likely to be affected by strong value judgements. Owners of small businesses are no different. Because they are business owners, they also have strong feelings about the economic viability of their enterprises. In an effort to identify and measure some of these attitudes, the survey incorporated a number of questions about small business owners' attitudes toward general health-related issues and the markets for health care services and health insurance. On many of these issues small business owners disagree among themselves, disagreement that is not easily explained by economic factors. However, on important issues like the right to health care, the cost of health insurance and health services, and the responsibility of businesses to provide health insurance coverage for their employees, there is consensus. Key findings include:

- * 69% of the small business owners agree or strongly agree that every American has a right to basic health care.
- * 63.5% agree or strongly agree that all Americans should receive a minimum level of health care regardless of their ability to pay.

Small business owners across the nation are a diverse group with varied opinions about many issues. They are, however, virtually unanimous in their serious concern about the cost of both health care and health insurance.

- * 92.4% agree that the cost of health insurance is a serious business problem. Note that only 30% of the respondents feel that the cost of employee health insurance can be passed on to customers in the form of higher prices, and 72.7% feel that health insurance costs would raise payroll costs to the point where it would be difficult to compete.
- * 90.3% believe that health care is becoming prohibitively expensive.

These results leave no doubt about how important the cost of health services is to operators of small businesses across the nation. This is consistent with a 1986 study in which small business owners identified "cost of health insurance" as their single most important problem (out of 75 listed problems). Further,

- * 86% feel that individuals themselves have the first responsibility to see that they have health insurance coverage, while only 24.8% believe that employers have a responsibility to provide employee health insurance.

Nevertheless, over half (53.3%) feel that health insurance should be one of the first employee benefits that employers provide, when they are able to do so, and 64.1% said that they would like to provide better (or some) health insurance for their workers. This, perhaps, stems from the fact that 64.3% felt that businesses cannot attract first-rate employees without providing health insurance.

- * Yet, 73.5% of the respondents felt that their employees would prefer a straight wage increase to an increase in health insurance benefits, and 75.9% would be more inclined to handle an increase in compensation through a wage increase.

The economic ability and/or incentive for employers to provide health insurance benefits depends upon the market conditions for their product or service, the labor market conditions from which they obtain their employees, and the firm's particular cost structure. There were significant differences in coverage by industry group, with wholesale and manufacturing firms most likely to provide insurance, while agriculture, retail and service firms were at the other end of the spectrum. Sponsorship of health insurance went up in direct proportion to the percentage of employees that were perceived as heads of households; conversely, coverage declined as the proportion of part-time employees increased.

- * 37.6% of the respondents already provide health

insurance benefits for all their employees, while another 25.5% provide benefits for some employees. Just over a third (33.8%) provide no benefits.

- * Not surprisingly, coverage was directly related to the size of the firm (if over 50 employees, 63.4% had coverage for all employees; if less than 5 employees, only 21.2% provided insurance), firm location (nearly 49% of urban firms had coverage, while less than 28% of rural firms did), and the age of the firm (the longer in business, the more likely to have coverage). There was little variation by region of the country.
- * Health insurance coverage also reflected a straight line relationship with both gross sales/receipts and the owners' salary or draw. No surprise here. The access to coverage is determined mainly by the cost of insurance.

It comes as no surprise that over 62% of the small business owners surveyed disagreed or strongly disagreed that "the cost of employee health insurance can be passed on to customers in the form of higher prices." That some disparity exists no doubt reflects the wide range of businesses represented in the survey. Nevertheless, most small business owners clearly did not see a price hike as a variable alternative. Indeed, over four times as many respondents (18.5%) strongly disagreed with the statement that prices could be raised as compared with those that strongly agreed.

We have already seen that small businessmen and women strongly support the idea that all Americans are entitled to some basic level of health care services. They also expressed a majority opinion that the individual should be primarily responsible for his/her own health insurance. However, relatively few believed government should directly pay for health benefits.

Given their limited support for government involvement in paying for health services, it came as no surprise that a substantial number of small business owners felt that "government interferes in health care too much." Respondents were not asked to identify where or how this interference takes place. It is reasonable to infer that Medicare and Medicaid, as the two largest government health care programs, must be major factors.

- * Like most Americans, small business owners reflected some confusion and frustration in dealing with the crisis. Though less than 42% felt that government should pick up the cost of health insurance even for the unemployed, over 60%

felt that government must play a more direct role in health care to bring costs under control. At the same time, less than 13% would support a tax increase to support health care assistance to the poor.

More likely, this apparent contradiction reflects the ambivalence that most Americans feel when confronting the complex issues relating to health care. The traditional American reluctance to support "big government" seems to run head-on into a growing frustration with a system that all too many see as being out of control. In grasping for solutions, they may not always think clearly, consistently or logically.

- * Lest it be thought that small business owners are insensitive to the health insurance needs of their workers, it should be noted that when those who had a plan were asked why they instituted them, by far the most common answer was that the employees needed it (59.4%). On the other hand, the most common reason for not having a plan - again by a wide margin - was that premiums are too high (65.3%). This is a classic clash between values and economic reality.

For a number of years, policy makers have openly expressed disappointment regarding the ability of regulatory policy to successfully control the cost of health care. As an alternative, many have supported efforts to rely more heavily on policies designed to increase competition among health insurers and health care providers. Small business owners, most of whom are in very competitive markets, are in a good position to tell us about the degree of competition they witness in the health insurance and health services markets.

- * Nearly 50% of small business owners disagreed with the statement that "insurers compete hard to sell me employee health insurance." Less than 7% felt strongly that there was strenuous competition for their health insurance business. Insurers would probably agree. Few actively compete in the small group health insurance market. However, health insurer competition was not necessarily more strenuous for the business of employers with a larger number of employees and which already offered a health insurance plan than it was for the very small.

The majority of respondents agreed with the statement that there is no real competition among providers of health care services. This small business perception of the health care marketplace is not likely to be shared by health care

providers, most of whom feel that they currently face intense competition for market share.

Survey participants were also asked about responsibility for employee health insurance coverage. It is apparent that the majority of respondents felt the primary responsibility for seeing that the employee has health insurance coverage lay with the individual employee and not the employer. Fewer than 6% of respondents disagreed or strongly disagreed with the statement that individuals have first responsibility to see that they have coverage. The majority of small business owners did not believe it was their responsibility to provide employee health insurance, and the smaller the employee group the less likely the owner was to feel this responsibility. In fact, the consequences of mandated benefits would be very negative.

- * 67.1% disagreed with the idea of requiring employers to provide health insurance benefits. Taken in conjunction with the stated desire of over 64% to provide better benefits, this suggests that many small business owners simply do not feel they have the capacity to do so. Even at rather modest levels of costs (e.g., \$50, \$100, or \$150 per employee per month), it was clear that such mandates could have a severe impact. At the middle range (\$100), less than half (46.3%) felt that they could purchase the mandated insurance and make adjustments elsewhere, while staying in business. Over 23% indicated that they would let all of their employees go and try to continue operating. Another 21.5% simply responded that they would get out of business. Even allowing for some overstatement of their probable reactions, these results suggest that there could be a significant impact on employment from such a mandate.

- * Less than 20% of the small business owners who responded to the survey reported personal earnings of \$50,000 per year or more. This suggests that many of them could earn more working for someone else than by maintaining their own business and supporting their families through that business. While most of them are probably willing to pay some price for independence, we cannot ignore the fact that the added burden of mandated insurance coverage could well drive many of them out of business.

- * Finally, when those who currently do not provide coverage were asked what would prompt them to voluntarily provide health insurance to their full

time employees, the two most frequently mentioned reasons, by a wide margin, were increased and/or more stable profits, and a reduction of 50% in insurance costs. It is safe to say that the latter is not going to happen. There is also emerging an equally serious problem -- the problem of rising health care and insurance costs pricing small business out of the marketplace. The 90% who deemed health insurance as becoming "prohibitively expensive" represent a completely different and difficult problem.

Conclusion

Not unlike other Americans, owners of small businesses seem to be faced with a serious dilemma regarding their values about the provision of health services, the high cost of these services, and who has the responsibility for paying the bill for health care. The vast majority of small business owners feel every American has the right to basic health care and most agree with the statement that Americans should receive a minimum level of health care regardless of their ability to pay. They do not, however, support mandated benefits.

Respondents view the cost of health care and health insurance as a very important and vexing problem. Many business owners believe that because of the high cost of health insurance premiums, their firm's marginal profitability position, and their belief that they could not pass on the cost to customers, providing any (or better) health insurance benefits to their employees would not be a wise financial decision. Further, approximately one-fifth of owners who do not sponsor a plan believe they do not qualify for group health insurance policies, and many owners believe their employees would prefer wage increases to increased insurance benefits.

Furthermore, many are of the opinion that because their employees' families are often covered by the policies of other family members, much of the premium expense would be wasted. Despite the many reasons to not sponsor health insurance, the majority do offer a plan to at least some employees, and another majority indicated they would like to provide better or some health insurance for employees. It all boils down to an issue of cost.

Clearly, the problem of the uninsured is a serious one. There is evidence that most small business owners share concern about the problem with the rest of society, and like the larger body politic, they are unsure of the solution.

Thank you for the opportunity to present these findings.

Gubernator's Copy

GOVERNOR LAWTON CHILES
National Federation of Independent Business
June 28, 1993

It's an honor to accept this plaque on behalf of all of the people in Florida who worked hard to make our health care reform plan a reality.

Even more than the award, however, I appreciate the leadership, and support from Bill Herrle and the folks at NFIB-Florida. You were a great help in passing a law that will work for all of us.

Bill, I look forward to working with you again later this year when we take on workers' compensation reform. We came close during the last session. Next time, we're going to make it.

These two issues are by far the biggest threats to our economy and to our status as a world leader.

- My state has confronted the health care crisis head on and today, I want to offer my view from the "front lines." We've examined the problem -- and we've developed a Florida solution. But, we still face a national challenge that all of us must help to solve.

- Health care costs are draining the budgets of American households, robbing state and local treasuries, contributing to the uncontrolled growth of the national deficit, and are placing a growing burden on our small businesses.
- But, those rising costs haven't translated into expanded access or greater coverage. Instead, just the opposite is true. More and more Americans are now unable to afford insurance for themselves and their families.
- One in four Americans has a member of their family who's without health insurance.
- People on pensions aren't safe either -- some are being cancelled.
- Our workers' compensation system was designed as a safety net for people injured on the job. You know firsthand how that net has grown into a tangled mass of litigation and paperwork. More resources are spent on the process than on the people who need help.
- The skyrocketing cost of workers' comp has limited the ability of our small businesses to expand, offer higher wages and take advantage of new opportunities.

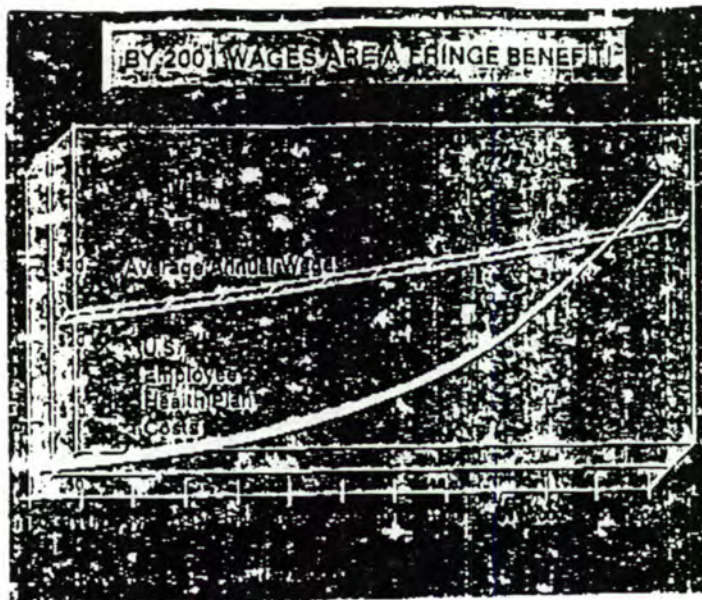
- In Florida, ten percent of the cost of a new home goes to cover workers' compensation costs. Nationally, Ford now spends more money for health care than steel.

((((((KILL LIGHTS -- TURN ON SLIDE PROJECTOR))))))

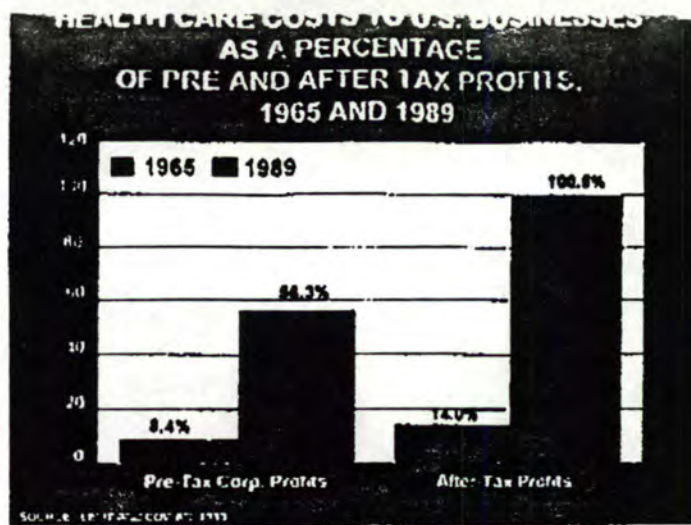


- This is the cover of the January issue of "Florida Trend", a statewide business magazine. That's me on the left. On the right is Jon Shebel, the president of our state's oldest and largest business group, Associated Industries of Florida.
- The year before, we had gone head-to-head over a tax increase I needed to fund the growing needs of a growing state:
 - * Nearly 1,000 people a day move to Florida
 - * 80,000 new school children
 - * 30,000 new community college and university students
 - * Florida was number one in violent crime
 - * We had overcrowded prisons

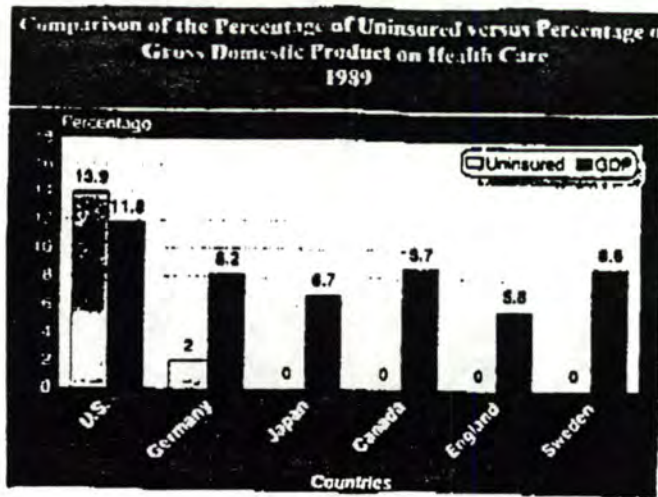
- After absorbing increases in health care costs, we had no other revenues left over. Mr. Shebel told me about how skyrocketing health care costs were eating up members' gross profits.
- We realized we had a common problem and decided to work together to solve it. The result was the passage of two major health care reform acts, the most recent of which takes effect in three days.



- That top red line shows the projected increase in average wages. The bottom yellow line shows the projected increase in health care costs for the average employee. Around the year 2000, health care coverage could be the primary form of compensation and salaries will be a fringe benefit of employment.
- It's the same with workers' comp premiums. They've more than tripled since 1980. Small businesses are bearing the brunt of both our workers' comp and health care problems. You represent the fastest-growing segment of our economy.
- You already pay 25 - 30 percent more in premiums than larger businesses. Will you be able to afford coverage that's growing even more expensive?



- In 1965, health costs ate up just 8.4% of pre-tax profits. By 1989, they ate up over half.
- After tax profits: In 1965, health costs took 14%. Twenty four years later, over 100% of your after-tax profits.
- You and I agree that small businesses shouldn't pay more than its fair share to finance national health care reform. Everyone should share the responsibility for paying for it.
- But you are already paying more than your share. As a result, you should also expect to see a greater share of the savings realized from health care reform.
- Some of you now provide health care coverage to your employees. Some of you have been forced to drop insurance as the prices have soared. And, some of you have never been able to provide it.
- Whatever your situation, none of you are on a level playing field with our international competition.



Let's look at how we stack up against the rest of the world in terms of what we pay versus what we get.

- Nearly 14 percent of all Americans are uninsured, yet we spend nearly 12 percent of our gross domestic product on health care. In Germany, only two percent of the population is not covered, and they spend just a little over eight percent of their G.D.P. on health care.
- Look at Japan, Canada, England and Sweden. They have everybody covered and nowhere do they spend more than nine percent of their G.D.P. to do it.
- Those nations have made a critical investment in their human resources -- and their industries are reaping the benefits.
- I believe that our government also has a legitimate responsibility to give our businesses - especially the small businesses that are the heart of our economy -- a better chance to compete in today's world market.

- Make no mistake, uninsured Americans do get care. But, they get it in the emergency room at four or five times the cost of a doctor's office visit.
- We all pay for it. The costs are shifted on to the people who do have insurance.
- I once believed that we couldn't have full access without cost controls. Now I realize that the reverse is true: We will never be able to control costs until we have full access.
- Ironically, I am told by many small business owners that the reason they can not afford health care is that workers' comp premiums are too high. And, we know that health care costs are driving up workers' comp prices.
- That means if we want workers' comp reform, our first step must be to fix the health care system.

FLORIDA REFORM:
WHAT IT DID

- ◆ Market-based with business participation
- ◆ Uses information rather than regulation to discipline the market
- ◆ Volume purchasing
- ◆ Broad-based assumption of risk

- In the first hour of Saturday, April third, the Legislature passed Florida's landmark health care reforms. I remember that day well -- it was my 63rd birthday. It was the nicest birthday present I've had in a long time.
- We went with a market-based approach that involves business. There are no employer mandates.
- We're going to let the market forces work the way they do in your business.
- Instead of regulations, we're counting on information to hold the providers accountable.
- We're going to pool the buying power of the self-employed, small business and government. That way, you can get the same or better deal that large businesses get.
- And we're getting back to the original concept of insurance -- spreading out the risk over a large group of people.

CHPA Regions



Best of all, the emphasis is on local control, because that's where health care is produced and consumed and that's where the decisions should be made.

- We've divided our state up into eleven regional Community Health Purchasing Alliances. These alliances will pool their local money and bargain for the best health care at the best price.
- CHIPPAs will be private, non-profit bodies controlled by business.
- Of the 17-member boards that run them, two-thirds of the members will be from business, and the majority of those will be from small business.

I am confident now that we are on our way to a better, more efficient health care system for all our residents.

((((((KILL PROJECTOR -- TURN ON LIGHTS))))))

We accomplished this goal by engaging the very people and groups we'd have to rely on to build the new system.

- In November of 1992, we held a summit that brought together representatives from business, government, the health care and insurance industries, and many other areas.
- But all of us agreed that our biggest challenge -- and our overriding concern -- was to provide full access.
- Our next challenge is to bring together many of those same players to help us overhaul the workers' comp system.
- We need organizations like NFIB to come to the table at the beginning of our discussions -- so that we can count on their help when the issue reaches Congress and their individual state Legislatures.
- I'm pleased that we are developing Florida solutions to national problems. But, let me emphasize that we still need the federal government as a full partner in these efforts as well.

One of your members, Daniel Richardson, from Rochester, New York, is having the kind of problems many of you are facing.

Daniel is the administrator of a nursing home owned by his family. It employs 150 people.

Providing health care coverage for those employees is getting increasingly more difficult because the costs are rising 12 to 15 percent a year.

Daniel wants to keep providing health insurance to his employees but he is going to need help to do it.

11A

- We need a comprehensive federal plan that guarantees everyone the right to health care. Otherwise, the cost-shifting will continue, and we will be right back where we started.
- With a federal plan, we can establish some real controls on workers' comp rates too.
- I'm very encouraged that we now have a President who appreciates the magnitude of the challenge we face and is open-minded about how to get the job done.
- For the first time ever, we ~~know~~ now have real leadership from the White House on the issue of health care reform. I am confident that the President as well as the First Lady are committed to giving states flexibility to develop and implement their own strategies.
- From talking with many of your members, I know your feelings about the proposals for a national health care plan. And, I know that tomorrow, you will travel to the Capitol and express those feelings to your elected representatives.
- Let me share some perspective from my 18 years on the Hill. There's no shortage of people who will point out problems with new ideas. There are entire industries in this town that exist for that reason.

But, as NFIB-Florida demonstrated, you can play a powerful role not just in the debate - but also in the development of the policy.

- Realize that your political clout and influence can be put to greater use than simply opposing a bill you don't like.
- I challenge you to offer your expertise and your leadership to help build a plan you can support. Add your voices to those who are seeking a solution. Be there when the discussions begin -- and stay there until the last gavel strikes.
- That's what NFIB-Florida did on the health care issue. That's what I will ask them to do again for workers' comp. And, that's what I ask you to do now.
- If there is any lesson to be learned from our Florida solution it is that success is based on a spirit of cooperation and good-faith negotiation.

I hope that will be the focus of your efforts as we face up to our national challenge.

Thank you.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

September 16, 1993

PRESS BRIEFING
BY
ERSKINE BOWLES, ADMINISTRATOR,
SMALL BUSINESS ADMINISTRATION
AND
KEN THORPE, DEPUTY ASSISTANT SECRETARY,
HEALTH AND HUMAN SERVICES

The Briefing Room

3:55 P.M. EDT

MR. ANDERSON: This will be an on the record briefing featuring Erskine Bowles, Administrator of the Small Business Administration. The topic is health care reform and small business. Mr Bowles will be joined by Ken Thorpe, who is a Deputy Assistant Secretary at the Department of Health and Human Services. And Mr. Bowles will have a short opening statement. After that we will end sound and camera.

Q Excuse me, why?

MR. ANDERSON: Why?

Q Mr. Bowles was on the record this morning, why isn't he on the record this afternoon?

MR. ANDERSON: I don't know.

Q Dee Dee said it would be on the record.

MR. ANDERSON: The briefing is on the record.

Q Your just fighting for broadcast interest now and we appreciate it.

Q Well, in that case it's a -- (Laughter.)

MR. ANDERSON: Fair enough. I do apologize for the many delays. As you might imagine this is a scheduling meltdown of historic proportions -- this coming into this week before the President's speech. The problem principally is one of principles and them being torn apart in different directions. Mr. Bowles has just come from a meeting with the members of the Black Caucus. And we do apologize for the delay but we are ready. Erskine Bowles.

ADMINISTRATOR BOWLES: Good afternoon. I think we've had a -- at least for the small business community, an exciting and good day with the President. We had a chance this morning, as you know, for a number of people who had written the President to come visit with him and to read their letters and talk about their concerns about health care.

We also had an opportunity to go to a small business here in the District, and we had small businesses from throughout the country come and visit with the President and talk to him about their concerns and their thoughts about health care and the solution to our health care problems.

MORE

I think over and over again we heard small businesses talk about the absolutely skyrocketing increases of health care costs that they are experiencing -- health care costs that are growing by 20 to 50 percent a year. And we also heard these same small businesses talk about the abuses of a current health care system that are focused upon them. And I'm talking about things like exclusions for pre-existing conditions, things that I've experienced with a diabetic child.

Each one of these small businesses talked over and over again about how they had tried to control the cost of health care, how they had tried to do such things as to hold the cost of health care down by switching programs, by going to managed care, by trying self-insurance, by reducing benefits, by passing a bigger cost along to their employees, and how nothing had really helped. That the cost of health care continued to rise and rise rapidly and eat into their profits.

And the President had a chance to listen to them and talk about his plan. And he had a chance to talk to them about the plan he would present and how that plan would offer to them real insurance, rock solid comprehensive insurance, and insurance that they could afford.

He talked about the caps and subsidies that would hold down the cost of health care, and he talked about the mechanisms that would keep the cost of health care from increasing at too rapid a rate.

And he also had a chance to talk to them about something they brought up, which was workers' comp, and how workers' comp was the only item on most of these small businesses' income statement that was increasing at a more rapid rate than health care, and how we would hold that down.

And the last thing we talked about was offering 100 percent deduction for the self-employed instead of 25 percent that they have now to put them on a level playing field.

I think we had a good day. We had a large group of small businesses there representing lots of different markets, and I think we all had a chance to learn something. I know the President felt he benefitted from it greatly. Thank you, I'll take your questions.

Q Mr. Bowles, some of the small business owners there with more than 50 employees said that under the President's plan, their costs would go up -- double or triple what they are now. Some of them said they are now paying, in the case of Daryl Routzahn, only 2.9 percent of payroll. One other business owner said he talked to President Clinton after the formal session and he indicated some interest in looking into, or changing that 50 employee cut-off so that businesses -- small and mid-size businesses with more than 50 employees -- might also get some government subsidy. Is that under consideration now? Has that changed? Will businesses with 50 or more employees get a government subsidy?

ADMINISTRATOR BOWLES: Clearly, I can't say whether or not that will change. What -- I do think it's a mischaracterization to say a number of the small businesses would experience increased costs. I think a few of them will. But clearly, the vast majority would experience not only lower costs, but the availability to have real insurance coverage -- comprehensive, rock solid coverage.

Let me give you an example, okay? One of the people that was there today, Marilyn Hart of Design Plastics in Fort Worth, Texas -- today Ms. Hart, who has 65 employees so she doesn't fall

under the less than 50 cap -- she pays \$166,000 a year for coverage. That's for 100 percent of her employees. Okay, that's 15.4 percent of payroll. Under the plan, she would only have to pay about \$85,000, which is a savings of almost 50 percent. And the coverage she would be able to offer her employees would be better.

Now, if she chooses to cover not only the employer portion, but the employee portion too, she would still save 25 percent. So she's going to be far better off, and her employees are going to be far better off. And she's going to save money, and that will enable her to go out and hire more people.

Q If I could follow on Gene's question. When the President said that this was one of the things that he was most concerned about -- this 50 employee cut-off -- what was he talking about? What is he prepared to do to relieve that burden?

ADMINISTRATOR BOWLES: Well, as you well know, this President is focused on small business. And he has spent -- I can't tell you the countless hours -- making sure that we put together a health care plan that would help small business, that would be good for small business, that would hold down the costs for small businesses.

Now the cap is at 50 today, and it is probably one of the things that the President would like us to take a look at. But we are going -- you know, today for companies with less than 50 employees, clearly the vast majority of them -- if you call them up and ask them, just ask them -- you know, how are you going to be under this new plan? -- they'll tell you that we're going to have better coverage at a lower rate.

Q Do your surveys specifically quantify how many people who have employed between 50 and 100 would be affected adversely by this?

ADMINISTRATOR BOWLES: I don't know. I can tell you that I did read Ms. Staddler's article the other day, and she quoted five small businesses, and four out of those five would have reduced costs.

Q But you've done extensive surveys. You don't have any numbers that can tell us? When you say a vast majority would get lower cost, you don't know how many would get --

ADMINISTRATOR BOWLES: I just can't give you an exact percentage, I just don't know. I'm sorry.

Q The other side that NFIB and other people are saying is that not only might people have some increased cost, say in the 50 to 100 employee range, but some there will be substantial job loss. I know you all are starting to look at the question of what the job loss will be like. What types of small businesses are likely to not only have increased cost, but suffer job loss? What conditions --

ADMINISTRATOR BOWLES: Again, I think the vast majority of all small businesses will have lower costs. And therefore, with lower costs, they will clearly, clearly be able to go out and hire more employees.

Q But you know a lot about small business. What's the profile of --

ADMINISTRATOR BOWLES: I spent my entire career in small business -- (Laughter.)

Q Right. So what's the profile of a small business person who would be imperiled not with only increased costs, but maybe having to cut jobs or shut down.

ADMINISTRATOR BOWLES: Let me give you some statistics, okay, so you can live with this. National Small Business United came out today -- or just last week -- and they said the average small business that doesn't supply health care to their employees has an average payroll of about \$7,400. Well, you know what it's going to cost that small business that doesn't provide health care to provide health care to its employees? Less than a dollar a day.

They also said for the average small business that provides health care coverage to their employees, the average payroll is about \$15,600. It's going to cost that small business less than two dollars a day. And I dare say, that's going to be a significant savings for that small business, and they are going to be able to take those dollars and go out and hire new people and buy -- and -- go out and make new capital expenditures that will create jobs.

Q Could you answer the question please?

Q The President said today -- he conceded today, I believe for the first time, that there would be some gross job loss. That overall, if the current system stays in place, there will be more job loss. And that if your system passes, he says, there will be reduced job loss. But he did concede that there would be some job loss --

ADMINISTRATOR BOWLES: Every single company, you know, won't win. That's impossible, okay? But the vast majority will. And that's what I'm trying to drive home to you.

Q Do you think it's important for people to know which types of businesses the conditions that will exist, where they will have job loss?

ADMINISTRATOR BOWLES: I think what I have just told you is I believe that the vast majority of all small businesses will be able to offer their employees comprehensive, rock-solid, real insurance. Not some insurance that's going to be jerked away two years from now. Or not some insurance where the rate is going to skyrocket a year from now. Or not some kind of insurance where you're subjected to pre-existing conditions exclusions. But real insurance, and insurance at a lower rate.

I think what we have asked small businesses to do is to call a 1-800 number to the SBA, give us your numbers, okay, and we'll tell you exactly whether you are going to have increased costs or decreased costs. And we believe that the vast majority will find out the costs will go down.

Q Have you given out an 800 number?

ADMINISTRATOR BOWLES: No, but we will.

Q Mr. Bowles, what I want to follow up on is you're saying the vast majority will have lower costs. As you well know, the vast majority of small businesses, when you get to businesses that have five or fewer employees or very few employees, that is the vast majority. But when you get to this segment that has more employees, you are getting to more substantial businesses that are more the engine of the economy -- the small businesses that are really contributing more to the economy and --

ADMINISTRATOR BOWLES: -- the way their health care costs are increasing, the health care is going to end up being the

salary and your cash wages are going to be in the fringe benefits the way it's growing.

Q Indeed. But given that, you said that this group is something the President wants you to look into. Is that something that's going to be done now? Will --

ADMINISTRATOR BOWLES: Oh, we continually -- continue to take the input. The very purpose of having meetings like today is to listen to the small business community, to listen to others that will be affected by the plan, to go and take that information and come back and evaluate it and see how we can improve a plan. I mean, we always are looking for ways to improve a plan, and we'll do that up until the day it goes forward.

Q What are your projections on the job loss in the insurance industry?

ADMINISTRATOR BOWLES: I don't --

Q -- regardless of size?

ADMINISTRATOR BOWLES: I'm sorry. I don't know any numbers on those.

Q How about the projection of overall job loss in small businesses? I'm not disputing your point that the vast majority may end up saving money --

ADMINISTRATOR BOWLES: I believe that you will see job gains in the small business community. I think the example that I just gave you of Marilyn Hart is a perfect example of the kind of person who is going to have -- be able to go out and hire more people, not less. She's going to save money. She can use that money to hire additional people. She can use that money to go out and make capital expenditures to become more productive. I think she'll be able to have job gain, not job loss.

Q Do you have figures on gross jobs lost and gross jobs gained?

ADMINISTRATOR BOWLES: I'm sorry, I don't.

Q Do you have figures on -- you don't have -- there's been no study on this?

ADMINISTRATOR BOWLES: Yes, sir?

Q What arguments would you make to the NFIB and other groups for employer mandate? If you were sitting down with them now, what --

ADMINISTRATOR BOWLES: What I'm saying is today small business has the worst of all worlds. It can't be any worse. We have every abuse in the system today. The cost shifting that goes on is all shifted right onto the backs of small business. We have a skyrocketing cost increase. You know, those people who can afford to buy insurance -- you know, the costs are going out of the roof. Some people, because the costs are so bad or insurance is just not worth it anymore, you know, can't buy it.

So what I'm saying is this plan addresses the need. You know, NFIB has come out with some statistics that I saw themselves the other day. They did a survey back in -- let me see if I can find it -- that some -- Professor Charles Hall -- Temple did. And in that survey they said -- they found out that 92.4 percent of small business owners agree that the cost of health insurance is a serious business problem. Sixty-nine percent of small business owners agree

or strongly agree that every American has a right to basic health insurance. Sixty-four percent of all Americans should -- small businesses agree that all Americans should receive a minimum level of health care, regardless of their ability to pay. And probably the most important one is over 60 percent of small businesses in this NFIB survey felt that the government must play a more direct role in health care to bring the cost under control.

So what I would say -- we are doing exactly that. We are attacking the problems that are compounding on the backs of small businesses. We're going to reduce the cost. We're going to put mechanisms in to control the increase in cost. And we're going to provide rock-solid, comprehensive, real insurance. And I think if you call the members of the NFIB -- individual companies and ask them what it costs today and what it costs under the plan, you'll find that the vast majority will have better coverage at lower cost.

Q But the reality of the lobbying fight that you're facing on the Hill gives NFIB a lot of weight.

ADMINISTRATOR BOWLES: I'm just trying to get by the rhetoric and get to the facts.

Q I understand that --

ADMINISTRATOR BOWLES: And the facts are the plan will be really good for small business.

Q -- but I'm talking about political reality on Capitol Hill. A lot of people whose jobs depend on support from organizations like the NFIB will obviously be listening to their complaints about the plan. How are you prepared to counter that?

ADMINISTRATOR BOWLES: I'm not worried about politics. I'm here --

Q You're not?

ADMINISTRATOR BOWLES: -- as a business person. Okay? I spent my entire career in the business sector and the private sector, so I'm here to tell you the truth. And the truth is that I believe that the vast majority of all small businesses will be better off. That's why we're asking small businesses to call us -- tell us what it costs today and what your coverage is today, and we'll tell you what it'll cost tomorrow and what the coverage is tomorrow. And I think you will find out if you go and ask the businesses -- get by the rhetoric, okay? Look at the facts, and the facts will tell you that the vast majority of all small businesses will be better off.

Q The NFIB apparently made a case, though, with the administration to treat independent contractors the way they are currently treated under tax law. And I'd like to know the rationale behind why the administration decided to change the treatment on up to 10 million business owners?

ADMINISTRATOR BOWLES: I certainly wouldn't give any trade organization credit for that position. I think that's a position that we have and I think it's the right position.

Q But it wasn't a week ago. A week ago you were treating independent contractors as employees.

ADMINISTRATOR BOWLES: I think clearly, as we go through this process, we are looking at a plan that is still -- you know, the President hasn't even delivered the plan yet. I know you may have a bootleg copy of it. But this is a plan that's still being developed. That is a portion of a plan. It is one of the things we looked at, it's one of the things that's been in the discussion for a long

period of time. And a position has been taken, and that position is the one you just said.

Q Why did you change your position, is what I'm asking.

ADMINISTRATOR BOWLES: I don't know if the position was changed, to tell you the truth.

Q Is was in the original ---

ADMINISTRATOR BOWLES: I could say that we've gone through lots of different times of looking at it.

Q You said you expected some net job gains out of this program in the small business sector. I mean, what do you base it on and how many do you expect?

ADMINISTRATOR BOWLES: Well, all I can do is base it on the ones that I have talked to -- okay? -- in the surveys that I have done myself. And I can tell you that we have called literally hundreds of small businesses, and we have found that the vast majority of those small businesses will have lower costs and be able to offer better coverage.

Q That's not the question I asked you. The question I asked you -- the question I asked -- Mr. Bowles, the question I asked was how many net job gains you expect from this and on what you based that job gain expectation? Do you have some, Gene?

MR. SPERLING: You know, we've just -- so far there has not been a study that has accurately portrayed our plan. The studies that the NFIB has assume no subsidies. They have no clue as our plan did not look at the lower administrative costs. So there has not -- there has not been a serious study in that regard.

The main point that Erskine is trying to say is if the overall majority of businesses you have are going to see their administrative costs go down, are going to see their -- those who are providing, see their health care costs go down, that is going to lower both their security in hiring more people, and it's going to lower their cost of hiring. And the chances -- for those small businesses, the net gain -- that their job gains will lead to a net job gain is very strong.

But, Gene, you asked about the 50 to 100, but you just asked as if the whole universe of those businesses don't provide health insurance. Those who do provide health insurance are clear winners. Those who provide full coverage are going to see their costs go down -- are going to see their costs go down dramatically. And even if there are some small businesses who see some of their costs go up, I say -- want to suggest there is very little evidence to suggest that that would in any way lead to a job effect. That people might -- that may be their theory, but the studies that have looked at the minimum wage lately have shown there have been far greater minimum wage increases, that there was no employment effect at all. And I think that's been reported by some of your papers. Those were talking about even when New Jersey increased from \$4.25 to \$5.05, which was an eight -- a substantial increase in cost that did not have any job effect at all.

So the overwhelming thing to keep in mind is most businesses and most small businesses provide health insurance, their costs will go down. Their administrative costs will go down. Their security in hiring more people will go down. So any logic that would lead you to say that some people have higher costs and that will have a job effect, that same logic should mean that there will be job -- there will be job gain. I don't know if there is a conclusive study

at this moment on what the effect is. But I will say that anything that's being put out there that's suggesting there is job loss is bogus. And that is pretty generous.

Q I think we're wondering, Gene, where the President got his information that would lead him to acknowledge that there might be a job loss involved here.

MR. SPERLING: The President said -- he said that's he's not going to tell you that everybody is going to be -- that every single person is going to immediately feel an immediate financial benefit in every single way. But that does not mean that there is not going to be a job gain -- I mean, this is part of an overall economic plan that is designed to bring the deficit down, to bring low interest rates down, to give people security that they can hire workers without having to fear an explosion in health care, or that if one of their workers were to get sick, their health care costs were to go out of control -- this is part of an overall plan that I don't think we have any question is going to be good for the economy and good for job growth.

But overwhelmingly -- and I mean, Erskine's heard this. We've heard this all through the campaign. The fear, the insecurity over health care costs is -- clearly has a deterrent affect on people -- on employers. And I don't know if there is a conclusive study. We have not even put out the final facts of our study. But I do suggest that one should look very, very skeptically to anything that one has heard on the negative side, and that the overwhelming -- that if you provide insurance, your costs are going down and that that will have a positive wage or employment affect. Either your current workers will likely receive a higher wage, or you will have more capacity to hire future workers.

THE PRESS: Thank you.

END

4:20 P.M. EDT

Clinton Aides Predict Health-Care Plan Will Result in Net Job Gain in Long Term

By RICK WARTZMAN

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — White House officials predict President Clinton's health-care plan would generate more jobs than it would cost over the long term. But they concede that the impact on the job market during the first few years is less clear.

The employment issue is sure to be one of the most politically explosive aspects of the coming health-care debate.

Some studies already have asserted that the president's proposal, which would mandate that all employers contribute to their workers' medical coverage, would cost millions of jobs in the long run.

But administration officials argue that those models don't take into account a variety of offsetting factors, including government subsidies that would be offered to small businesses.

"It's hard to know what the effects would be in the short run, although they're likely to be small," said Laura Tyson, chairwoman of the president's Council of Economic Advisers, in an interview. "But the beneficial effects of the plan would strengthen over time."

The idea is that by reining in the growth of health-care costs, companies should have more money to spend in other areas, including hiring. Ms. Tyson said the Clinton plan would probably result in a net job gain within five or six years of being put into place, but she declined to provide a specific estimate.

Not everyone agrees with the administration's assessment. Princeton University labor economist Alan Krueger figures the plan would mean 200,000 to 400,000 fewer jobs in 10 years than would otherwise be the case.

Still, Mr. Krueger, whom the administration credits with having one of the most sophisticated economic models in this area, noted that would be only a small job loss in the context of a labor market with 120 million workers. "This is going to be a big issue for opponents of the plan," he said, "but it's largely a red herring."

Pinning down the likely impact of the Clinton plan on the job market is a difficult, if not impossible, task. The president's proposal would do so many things simultaneously — extend comprehensive health benefits to every citizen, call on every employer to help provide insurance coverage for their workers, and cap the growth of both private and public-sector medical costs — that no economic model exists that factors in all of the variables.

"Some of this is unknowable," Ms. Tyson said. "The models are very imperfect."

There are other complications as well. For instance, administration economists are still struggling to understand the eventual impact of the proposal on early retirees. The White House has said the government would pick up the bulk of the health costs for early retirees, leading some in the administration to fear that companies would be encouraged to shed many of their older workers.

Early retirees, aged 55 to 65, are too young to be covered by Medicare, the federal health-care insurance program for the elderly and disabled, and have become a particular burden for the nation's Big Three auto makers as well as companies in other mature industries. But it remains unclear whether companies that take advantage of the early-retiree provision would be assessed a special surcharge potentially lessening the fallout from the

measure.

In addition, the administration is trying to determine what would happen to the ranks of the self-employed, who would enjoy enhanced tax benefits under the health plan. And White House officials are wondering whether as many as a quarter of the nation's welfare recipients could be prompted to enter the job market if health coverage were guaranteed.

Of course, no part of the labor market would be as roiled by the Clinton proposal as would the health-care sector. But while some occupations, such as insurance agents, are likely to suffer under the plan, home-based health-care providers and others could prosper.

In an appearance yesterday on CBS-TV's "Face the Nation," senior White House adviser Ira Magaziner said that when it comes to jobs, "there's likely to be some gain in the short term, and then on net balance, we think there will be some gain in the long term as well." In an interview later, Mr. Magaziner clarified his remarks and said he was talking about short-term gains in the health-care sector alone. He said he agreed with Ms. Tyson that the net effect on the overall job market is more uncertain during the first few years.

During the talk show, Mr. Magaziner was challenged on several points by the heads of the American Medical Association, Health Insurance Association of America and National Federation of Independent Business.

James Todd, executive vice president of the AMA, said he worries about the administration's emphasis on cost containment. "We're beginning to wonder if they're putting dollars first, putting the patient second," he said. NFIB President Jack Faris said his 610,000 members, who are owners of small firms, "tell us they have great fear that this will put them out of business" because of the employer mandate.

In response, Mr. Magaziner said the proposal shouldn't lead to a rationing of medical services, as Dr. Todd suggested, because there is so much waste in the current system to be squeezed out first.

Clinton to Call for a Ban On Plutonium Production

By a WALL STREET JOURNAL Staff Reporter

NEW YORK — In his first speech to the United Nations General Assembly, President Clinton is expected to call for a world-wide ban on the production of plutonium and enriched uranium, as part of an effort to contain the spread of weapons of mass destruction.

Mr. Clinton believes that the spread of such weapons represents the primary danger to the world in the post-Cold War period. According to a senior administration official, the need to stop the proliferation of weapons of mass destruction, including nuclear, chemical and biological arms, will be one of the major themes of Mr. Clinton's speech this morning.

In addition, the president will call on other nations to stop testing nuclear weapons, as part of his overall support for a comprehensive ban on such tests. He will push for a strengthening on the ban of export of missile technology. Though he isn't expected to give details, Mr. Clinton's proposals reflect the fact that the administration's interagency review of proliferation issues is completed, officials said.

Clinton Backs Away From Plan to Weaken Welfare Work Rules

WASHINGTON (AP) — The Clinton administration is backing away from a plan to weaken work requirements for thousands of married parents on welfare.

The Department of Health and Human Services withdrew its plan Friday, three days after outlining the shift in policy in a memo to state welfare agencies.

HHS had wanted to allow welfare recipients from two-parent families to spend as little as eight hours a week on the job, instead of the 16 hours Congress required when it passed the law in 1988.

Sen. Alfonse M. D'Amato (R., N.Y.), accused the administration of weakening the work requirements at the same time President Clinton has promised to overhaul the welfare system and force recipients to take a job after two years on the rolls.

The work requirements are to take effect Friday and require states to find jobs or job training for as many as 120,000 unemployed parents on welfare. The administration had tried to postpone the effective date for two years, but Congress refused.

"Now that they can't delay any longer, the administration is now trying to water down these work requirements," Mr. D'Amato said Thursday after learning about the administration's memo, but before it was withdrawn Friday. "It's clear that this administration is evading welfare reform."

The administration, as well as state welfare agencies and advocates for the poor, had argued that the changes would have given states flexibility to design work programs to help participants find permanent jobs.

But on Friday, a senior official at HHS said the plan had been scrapped. HHS decided to conduct a further review after receiving questions from lawmakers and state welfare agencies, said the official, who spoke on condition of anonymity.

States and advocates for the poor have complained that the new rules will force them to shift money away from training and education programs for single mothers on welfare into creating community service jobs for laid-off fathers.

Clinton Revisits N.Y. Public Seen as Uninformed Diner to Sell Health About Tap Water Problems Plan Study: Contamination May Kill 900 Each Year

By Ruth Marcus
Washington Post Staff Writer

NEW YORK, Sept. 26—President Clinton today returned to a Queens diner he visited during the primary—this time on a new campaign to sell his health care plan to the American people.

Sitting on a stool at the counter of the Future Diner in Flushing Meadows, Clinton met with people who had written to the White House about their health insurance problems and worries.

Each offered a dramatic personal example of the problems Clinton has diagnosed with the existing health care system: soaring premiums, insurance companies that refuse to cover "pre-existing conditions," companies that balk at paying for recommended treatment and people forced into poverty by medical bills.

"I just don't believe that we have to go on for another year or five years or 10 years being the only nation in the world that can't figure out how to give health care to everybody," Clinton said. He said the White House has received 700,000 letters on the issue and continues to get about 10,000 each week.

Her voice breaking, Marcia Blaize Callender described her family's ordeal after they learned her 18-month-old son Matthew had a terminal illness. When her husband lost his job, Callender said, her insurance company refused to cover Matthew because his illness already had been diagnosed.

The couple gave up their apartment, Callender quit work to care for her son, and her husband took a job with lower pay in order to qualify for medical benefits for Matthew, who died last December. "It is not Matthew's illness or the illnesses of other children that affects the quality of life," she said. "It is a health care system that withholds support from these same children."

Noting that Americans change jobs on average eight times during their working years, Clinton said it is "unconscionable" that people lose their insurance if they switch jobs or become unemployed.

"No family should have their grief compounded and their economic misery reinforced by this kind of problem," he said.

Linda Haftel described her fear of losing her health insurance since being told last year that she has multiple sclerosis—a diagnosis she has hidden from her insurance company. "All that I've worked to build seems in jeopardy from what will be the rising costs of a lifelong illness," she said.

Clinton said his system would protect people like Haftel. "This is the only country in the world where you can lose your insurance because you really need insurance," he said.

Mary Jayne Van Wyck, who received a liver transplant, has prescription bills of \$800 monthly and said that despite her college degree and MBA, she cannot work because she would lose her disability and Medicare coverage if she took

a job. "So I'm stuck at a poverty level with no insurance and keep my fingers crossed," said Van Wyck. After the event, when Clinton had left, Van Wyck appeared to suffer a seizure and was taken from the diner in an ambulance.

Other people described the burden of paying for health insurance. Mark Fish said he and his wife, who earn \$40,000 annually, pay \$8,000 a year for coverage for themselves and their young son—an amount Clinton said would be cut roughly in half under his plan.

Ewen Gillies said that after "a working lifetime of paying for the very best hospital and major medical insurance on the market," he had to come up with \$100,000 for a bone marrow transplant and chemotherapy for his wife because the hospital demanded the money in advance and his insurer refused to pay more than \$60,000 for the treatments.

By Gary Lee
Washington Post Staff Writer

Millions of Americans may be unaware they are drinking and showering in contaminated tap water, and federal and state officials are to blame for leaving the public largely uninformed, according to an environmental watchdog group.

Citing data from the Centers for Disease Control and Prevention, the Natural Resources Defense Council's two-year investigation of the nation's drinking water said as many as 900,000 people get sick each year from waterborne diseases and that 900 may die annually from water contamination.

In one highly publicized case in Milwaukee last March, an estimated 370,000 people fell ill and at least 47 died after drinking contaminated water from the city's supply.

Situations like Milwaukee are occurring all over the country on a smaller scale, but we don't hear about them because a lot of people don't report illnesses," said Erik Olson, who wrote the NRDC report for release today. "And a lot of other areas are at risk unless something is done soon."

The NRDC found that lax enforcement of the nation's safe drinking water laws by federal and state authorities is a major part of the problem. The Environmental Protection Agency logged 300,000 state and federal violations in 1991 and 1992, according to Olson, but only 1 percent resulted in penalties.

And her problem is official silence when water safety violations are discovered. Only in 11 percent of drinking water law violations is the public informed in a timely fashion by federal or state officials, the study said, referring to 1992 General Accounting Office data.

One reason state officials appear reluctant to penalize water facilities, Olson said, is that they seem to feel that water departments are performing a public service and should be treated leniently.

EPA spokesman Chuck Fox acknowledged that there are some problems with drinking water contamination and said the NRDC re-

port is "constructive" in helping bring the issues to light. "Some of the findings in the study seem to be consistent with our own findings," Fox said.

He added that state enforcement of water quality violations is a "key problem" and said the EPA is actively looking for ways to strengthen its ability to pressure states to more stringently enforce the Safe Drinking Water Act.

Last month, EPA Administrator Carol M. Browner recommended to Congress a package of proposals aimed at improving the quality of drinking water nationwide. The proposals focus on ways to make enforcement of water quality laws less cumbersome. The Clinton administration also has requested \$3.7 billion in increased funding for enforcement of drinking water quality laws.

Fox stressed that there is not a major problem with water quality. "The U.S. has one of the safest drinking water systems in the world," he said. "We're just talking about finding ways to make it better."

Olson also said that in general water systems across the country are complying with the environmental rules. "There is no need for public panic," he added.

The number of violations of drinking water regulations differs significantly from region to region. In the District, there were only two violations registered in 1991 and 1992, according to the study, compared to 1,990 violations in Virginia and 332 violations in Maryland during the same period.

The most common contaminants in drinking water are microorganisms such as bacteria and pathogens, Olson said. But drinking water also accounts for about 20 percent of the total lead exposure—mostly from pipes and solder—for an average person.

The report recommends several steps for alleviating problems with tap water, including the establishment of a revolving fund for local water systems to upgrade their equipment and better enforcement of rules that require public notification of drinking water problems.

Job Losses in Health Plan Are Denied

By STEVEN GREENHOUSE
Special to The New York Times

WASHINGTON, Sept. 27 — Recognizing that in this day and age the econometric study is mightier than the sword, the Clinton Administration has begun fighting back against reports concluding that its health care plan will cause huge job losses.

One study, largely financed by companies that do not provide health insurance for their employees, asserts that requiring employers to pay for health coverage would wipe out 3.1 million jobs. Another study, sponsored by the National Federation of Independent Business, a small-business lobbying group, estimates that such costs would put 12.7 million jobs at risk and cause one million layoffs.

Labor Secretary Robert B. Reich said in an interview that the studies were "incorrect," adding, "They're based on questionable assumptions and they didn't factor in our subsidies for small business."

Gene Sperling, an assistant to the President for economic policy, called the studies "bogus" and "inaccurate."

Research Called Sloppy

And in a letter to the study estimating 3.1 million lost jobs, Laura D'Andrea Tyson, chairwoman of the Council of Economic Advisers, sounded like the economics professor she used to be as she chided the authors for what she viewed as sloppy research. She said, for example, that the study ignored how the plan would hold down health costs for companies large and small, enabling them to expand.

These officials also said the studies overlooked how President Clinton's plan might create hundreds of thousands of new jobs in certain areas by, for example, expanding home-based health care.

"There are some things in the plan we think will increase employment," Ms. Tyson said in an interview. "There

are some factors that will reduce employment, and there are things that would change the composition of employment. When we weigh all these things, we believe the net effect on the total of jobs will be small."

'Dr. Kevorkian Prescription'

Republicans have seized on the studies as Exhibit No. 1 to oppose that part of Mr. Clinton's plan to require all businesses to pay part of the cost of insurance for their employees.

"We're likely to lose 3.1 million jobs because of this plan," said Representative Dick Armey of Texas, chairman of the House Republican Conference.

Clinton officials say the plan will hold down costs for businesses.

"The plan is really a Dr. Kevorkian prescription for the jobs of American working men and women."

As so often happens when Government proposes a new burden on employers, business lobbyists are howling — not that the mandate will eat into their profits (that wins little sympathy), but that it will force them to lay off their workers.

Small-business opponents of the plan requiring employers to buy health coverage make a straightforward economics argument: it would increase the cost of labor. And when labor becomes more expensive, employers are not able to afford as much of it. The result: layoffs and fewer new hirings, especially among low-wage workers.

"From what I'm hearing from businesses, my anecdotal instincts tell me that the estimate of three million job

losses is a low number," said Richard Berman, executive director of the Employment Policies Institute, a business-backed research organization that sponsored the study estimating 3.1 million jobs would be lost. "There are over 700,000 restaurants in the U.S.; if each restaurant cuts back one job on average, that gives you almost 25 percent of the total."

Small-Business Subsidies

The Administration's biggest complaint with the studies is that they ignore the subsidies to help small businesses afford insurance premiums. When two professors from Baruch College, June and Dave O'Neill, did the study for the Employment Policies Institute, they estimated that small, low-wage companies like restaurants and retailers that do not now offer insurance would have to spend more than \$4,000 per worker in health care premiums for many low-wage workers, equal to more than 30 percent of their wages.

Administration officials note that the President's plan would place a ceiling on what businesses pay. Under the plan, many small businesses with low-wage workers would receive Federal subsidies, so they would pay no more than 3.5 percent of their payrolls.

"For a worker earning the minimum wage of \$4.25 an hour, our cap would cost just 15 cents an hour more," Secretary Reich said. "That shouldn't cause much in the way of layoffs."

Ms. O'Neill and Wilbur Steger, an author of the study estimating a loss of one million jobs, conceded that the figures they used differed from those in the plan announced by the President. But they said they made the best estimates they could with the information available.

The two economists contended that the Clinton plan would cause far greater job losses among small businesses than the Administration predicts. They said the Administration would have problems finding money to pay for the tens of billions of dollars in subsidies planned for small businesses.

In early versions of the Clinton plan, before the subsidies were added, Administration officials estimated that the requirement that employers buy health coverage might cause small businesses to lay off 200,000 to 700,000 workers. But with the subsidies, one official estimated it would cost about 150,000 jobs at small businesses that do not now provide health insurance.

"That represents one month's worth of job creation," one Administration economist said. "Isn't that worth it when what we gain in return is health security for all Americans and an end to spiraling health care costs?"

SMALL BUSINESSES MAY GAIN A BREAK

Mrs. Clinton Says Health Plan Would Limit Premiums on Employee Insurance

By STEVEN GREENHOUSE

Special to The New York Times

WASHINGTON, July 28 — Seeking to ease the fears of small businesses, Hillary Rodham Clinton said today that they might be allowed to pay significantly lower health care premiums under the Administration's health care proposals than large companies would.

At a closed meeting with members of the House Small Business Committee, Mrs. Clinton suggested that the Administration was thinking of limiting what many small businesses would have to pay for health care to less than 3.5 percent of their payrolls.

Members of the committee applauded this suggestion because it could mean that the small businesses would pay far less than the 7 percent to 9 percent of payroll that had earlier been discussed. Some Administration officials say large businesses will pay 7 to 9 percent.

The Administration plans to require all businesses to pay for their employees' health insurance. The most likely mechanism is a payroll premium; for companies that already provide insurance, this would replace the money they now pay in premiums for private policies.

Break for Low-Wage Companies

As quoted in a summary of the meeting furnished by one member of Congress, Mrs. Clinton said: "As it now stands, the small businesses who currently provide health insurance benefits are subsidizing those who do not. This cannot be allowed to continue. Those employers and employees who are not contributing are getting a free ride, and the rest of us pay through increased insurance premiums and taxes. Everyone must contribute."

In her remarks, Mrs. Clinton, chairwoman of the President's task force on health care reform, sought to placate many owners of small businesses who are not now paying health care premiums and worry that the Administration's plan, by requiring payment for insurance, could force them out of business.

White House officials said in interviews afterward that the Administration was leaning toward giving the most generous treatment to low-wage, low-profit businesses with fewer than 50 employees. These businesses are considered most vulnerable to the cost of the new requirements. But the officials said they had not yet decided how to define which companies were low wage and low profit.

"This is important, no question about it," said Representative John J. LaFalce, a Buffalo-area Democrat who is chairman of the Small Business Committee. "If you are going to include all employers, you need some kind of break to ease the plight of these types of businesses."

One Adversary Isn't Mollified

Mrs. Clinton also said the Administration would allow an appeal process for small businesses that insist they are unable to pay the premiums.

Officials from small-business organizations said Mrs. Clinton's remarks seemed intended to reduce the resistance of small business not only to the President's forthcoming health care reforms but also to the President's \$500 billion deficit-reduction plan.

But Mrs. Clinton's comments did little to ease the concern of the Administration's main small business adversary, the National Federation of Independent Business, which has more than 600,000 members.

"We don't believe the Government should be telling any business owner how much he or she should contribute," said Leslie Aubin, the federation's health care analyst. "If you're paying nothing now, and you have to pay in 3 to 4 percent of payroll, that will seem like an awful lot."

One White House official said that even at the original 7 percent to 9 percent level, the plan should also reduce the percentage of payroll that many large businesses pay for health care.

Break for the Self-Employed

In another move that reassured small business, Mrs. Clinton said that under the Administration's plan the self-employed would be able to deduct 100 percent of their health care premiums.

Administration officials assert that their health care plan will not call for new taxes but rather premiums that will replace the health care premiums that employers and employees now pay. No final decisions have been made on the size of the premiums, officials said, adding that the package will probably be made public in September.

One official working for the health care task force said the Administration was leaning toward a fixed per-employee premium, like those now used by most insurance firms. Such a premium of, say, \$2,500 per employee, would replace a premium that is now based on a percentage of an employee's income.

Under Mrs. Clinton's suggestion, if there was a 4 percent cap on health care premiums for a small business in which the average worker was paid \$15,000, it would have to pay \$600 per employee.

Representative Jan Meyers of Kansas, the senior Republican on the House Small Business Committee, gave a mixed review to Mrs. Clinton's outline of the plan. "I generally do not like employer mandates, and there is an employer mandate in this plan," she said. "For those who aren't offering insurance, it may be very difficult for those small businesses who are barely making it."

But she said that for those small businesses now offering health insurance, the Administration's plan would probably slow, and perhaps stop, the rapid spiral of health care premiums.

National Federation of Independent Business Press Conference

Date: September 23, 1993
Location: Hyatt Regency Capitol Hill
Sponsored by: NFIB
Your Name/Phone: Beth Rattner (202) 488-5009

Summary: President and C.E.O. of the NFIB, Jack Faris, led the press conference off by saying the NFIB agreed with probably 90% of the President's speech and that his six strategic points were "excellent." Their press release for today, however, read, "SMALL BUSINESS OWNERS REAFFIRM 'SOLID OPPOSITION' TO HEALTH INSURANCE MANDATE."

Faris then released the results of their recent Gallup poll, which stated that 85% of small business were in opposition to mandated health insurance. The poll was a random telephone sampling of 1000 of their members, having reached 870 in the Monday through Wednesday time frame. Their key point was the 60% said they "strongly opposed" requiring employers to contribute 80% of the premiums for the purchase of health coverage for full-time employees. John Motley chimed in at one point reiterating that NFIB represents its members and that its members are "dead set against employer mandates."

Faris and Motley both made the comment "subsidies are temporary, mandates are forever." Faris said the NFIB reflected its members' wishes, and that once the President's plan was submitted to Congress, the NFIB would give its members a "menu" of options to choose from, including Chaffee's bill, Cooper's, etc., and would then release an endorsement accordingly.

Faris was alerted to Governor Celeste's presence as soon as he arrived. As soon as the conference was over, all reporters gathered around Celeste who then gave a solid 5 minutes on how the President's plan will implement many of the NFIB's goals. Jack Faris then joined Celeste and fiercely questioned him on employer mandates. Celeste pointed out that 80% of Americans have said this is the "most fair" method for achieving broad-based care.

Media Coverage: 5-6 cameras, including CNN, the Washington Times, BNA News (see Kiki Moore for others).

Attachments: NFIB press releases, selected Gallup results.



NFIB SMALL BUSINESS NEWS

600 Maryland Avenue, Southwest, Suite 700 • Washington, DC 20024 • 202-554-9000 • Fax 202-554-0490

The Guardian of Small Business for Fifty Years

FOR IMMEDIATE RELEASE:
September 23, 1993

FFI, CONTACT: Terry Hill or Angela Jones
(202) 554-9000

SMALL BUSINESS OWNERS REAFFIRM "SOLID OPPOSITION" TO HEALTH INSURANCE MANDATE

WASHINGTON, D.C.--The Administration's elaborate campaign touting the virtues of its health reform plan has won few, if any, converts among the small-business community.

Preliminary results of a Gallup poll, released today by the National Federation of Independent Business, show 85% of the small-business owners surveyed still oppose proposals that would require employers to pay 80% of the cost of health insurance premiums for all full-time workers. The Administration's plan to force business owners to pay a pro-rated share of premiums for part-time employees met similarly monolithic opposition (84%) from survey respondents.

"The Administration has been trying to sell small-business owners on the alleged benefits of accepting an employer mandate," said Jack Faris, president of the 600,000-member NFIB. "The survey shows that, even when sugar-coated with promises of a government subsidy, small-business still isn't swallowing this bitter pill."

Faris said his group commissioned the Gallup study to determine if the Administration's effort to court support for his plan had changed small-business owners' previously documented opposition to a health insurance mandate. "We don't underestimate the President's eloquence or his ability to sway opinion on this or any other issue," Faris said. "But the survey confirms that small-business remains steadfastly opposed to this part of the Administration's plan."

While enthusiastically supporting many elements of the Administration's health reform plan, NFIB has adamantly opposed efforts to require all businesses to pay for employee health coverage. The small-business group has maintained that such a mandate would create severe economic problems, including the loss of as many as 1.5 million private sector jobs.

-more-

-2-

The Gallup survey supported NFIB's contention that small-business payrolls have little elasticity to accommodate higher costs associated with employee benefits. When asked how they would adjust to just a 3.5 percent increase in payroll, over a third (35%) said their first move would be to hike prices, passing the cost on to consumers. One in seven (14%) said their initial response would be to lay off at least some workers or leave current vacancies unfilled. A quarter of the respondents hoped to avoid immediate layoffs by cutting or freezing worker pay (11%), reducing the hours of some employees (9%), or paring back other employee benefits.

Most respondents indicated more than one action would be needed to offset a 3.5% increase in payroll costs. Survey results indicate that both consumers and employees would pay a heavy price if business owners implemented "phase two" of their effort to deal with higher payroll costs:

- o nearly half of the businesses (48%) will be forced to raise prices,
- o nearly a third (31%) would have to let workers go or leave jobs unfilled,
- o 28% would have to freeze or cut worker pay (the same percentage that would cut their own earnings from the business), and a quarter would reduce hours for at least some of their workers
- o 15% would trim employee benefits.

Conducted this week, the survey polled 870 small-business owners throughout the country. The vast majority (78%) said the single biggest problem with America's health care system is its cost. Only nine percent of the respondents identified lack of universal insurance coverage as the system's worst problem, and only two percent agreed that the quality of health care is the pre-eminent difficulty.

Virtually all respondents (97%) agreed that health insurance costs are a serious problem for small business. Indeed, seven of every 10 (69%) characterized health insurance prices as a "very serious" problem.

#

Health-Plan Subsidy for Small Business Holds Surprises

✓ Analysis of Four Hypothetical Firms Shows Payments Could Vary a Lot

By BRENT BOWERS

Staff Reporter of THE WALL STREET JOURNAL

Many small businesses with low-paid workers look forward to a federal subsidy under President Clinton's health-care plan. But what is their piece of the pie?

Figuring that out is no piece of cake. The administration says annual health-insurance contributions of companies with 50 or fewer workers would be capped from a low of 3.5% of payroll where wages average less than \$12,000 a year to a high of 7.9% where they average more than \$24,000. However, the administration is vague about defining payroll and the exact methods for calculating an employer's projected payments.

So, The Wall Street Journal asked three health-care analysts to compute the Clinton plan's expected subsidies for four hypothetical small companies. Their conclusion: Small-business owners should expect surprises. The size of a subsidy could vary tremendously — more than most entrepreneurs realize — and would depend on numerous factors such as a company's structure. Thus, in the four case studies, the average subsidy per worker ranged from \$159 to \$1,706 a year.

All three analysts emphasized, however, that computations at this early stage of the health-care debate depend a lot on guesswork. The analysts are: Jane Jensen, a principal and health-care actuary at William M. Mercer Inc. in Denver; John O'Donnell, director of health-care policy and legislation at Buck Consultants in Secaucus, N.J.; and Thomas Kuhlman, vice president in the Chicago office of benefits consultants Towers Perrin.

Here are the four scenarios — based on the Clinton proposal that employers would be responsible for 80% of yearly premiums

and workers for 20%, with the annual cost of insurance coverage projected to average \$1,800 for individuals and \$4,200 for families nationally.

A restaurant: The owners, a husband and wife, pay themselves \$20,000 each a year. The dining establishment employs 10 full-timers; three need individual coverage and the rest require family coverage. These workers each earn an average of \$13,500 a year. Ten part-time workers — evenly split between individual and family coverage needs — put in an average of 15 hours a week and make an average of \$5,500 a year.

Analysis: The employer's 80% share of individual insurance is \$1,440 for its full-time workers and half of that, or \$720, for part-time workers. The Clinton plan projects that the restaurant's annual contribution for family insurance would be \$2,240, representing 80% of the weighted average premium adjusted for the number of two-worker families in a proposed regional health alliance. For half-time workers, family coverage would cost the restaurant half of that, or \$1,120.

Using these figures, the company's share of annual premiums for all employees — including the owners — would be \$33,680. But its total payroll of \$230,000, divided by 17 workers — including the owners and counting each part-timer as half of an employee — yields an average wage of \$13,529. That means the company's contribution would be capped at 3.8% of payroll, or \$8,740. The government would pick up the difference, or \$24,940 a year.

Point to ponder: "There are glaring omissions" in the Clinton proposal for calculating employment levels, says Mer-

cer's Ms. Jensen. Take a company with one full-time worker earning \$15,000 and one half-timer earning \$5,000. "Do you figure average wage by dividing \$20,000 by 1.5 to get \$13,333, or do you assume the half-timer is 'equivalent' to a full-timer earning \$10,000 and thus divide \$25,000 by 2.0 to get \$12,500?" she asks. "The proposal doesn't say. There are thousands of those kinds of [unanswered] questions."

A vitamin-pllI maker: Organized as a usual C corporation, it is owned by four partners. Each gets \$110,000 in salary and bonuses, \$50,000 in dividends and \$50,000 in tax-deferred profit-sharing and pension benefits. The 50 full-time employees — 20 with individual coverage and 30 with family coverage — earn an average of \$15,600.

Analysis: The combined annual payroll of the 50 workers' wages and the four owners' salaries and bonuses comes to \$1,220,000, or an average of \$22,593. With an average wage below \$24,000, the manufacturer meets one requirement for a lower cap on payroll contributions. But the concern wouldn't receive the lower cap because its work force exceeds 50 people, including the owners. So, it would pay the maximum 7.9% of payroll, or \$96,380 a year. Its annual payment for 20 individual health-insurance policies and 34 family policies would come to \$104,960. The government subsidy? A scant \$8,580 a year.

A consulting company: The company, set up as a sole proprietorship, is owned by a woman who takes its entire annual pretax profit of \$13,000. As the sole employee, she must also pay the individual's portion of health insurance.

Analysis: The owner would be ineligible for a subsidy on her individual annual contribution of \$360 because she makes

more than 150% of poverty-level income for someone living alone. As the employer, however, her yearly contribution would be capped at 3.8% of \$13,000, or \$494. Uncle Sam would fork out a \$946 subsidy.

Point to ponder: The Clinton plan allows the owner to deduct the entire \$854 from her personal income taxes.

A textile producer: Organized as a so-called Subchapter S corporation, its owner takes no salary. But he gets \$170,000 a year in corporate pretax profit, which flows to him as undistributed taxable income. Sixteen full-time workers earn an average \$10,500 a year. Four get individual coverage and the rest get family coverage.

Analysis: The picture here is murky. Indeed, two sets of assumptions produce startlingly divergent results. If you count the owner as a member of the work force but exclude his income, the manufacturer's average wage is \$9,882 and the employer's share of the health-insurance bill would be 3.5% of \$168,000, or \$5,880. Since the premium for the 17 employees would be \$34,880, the federal subsidy would be \$29,000 a year.

But if you include the owner's income as "wages," the employer's contribution toward the premium is 5.5% of \$338,000, or \$18,590. That would produce a smaller government subsidy of \$16,290.

Point to ponder: Under current federal law, Mr. Kuhlman of Towers Perrin notes, owners of Subchapter S corporations "aren't considered employees for purposes of participating in benefit plans." Will Mr. Clinton ignore such owners' income in figuring their companies' payroll? "That's an issue the administration needs to sort out," he says.

Plea Last Month for Armor in Somalia Was Ignored in U.S., Army Aides Say

By THOMAS E. RICKS
And DAVID ROGERS

Staff Reporters of THE WALL STREET JOURNAL
WASHINGTON — U.S. casualties in Somalia this week might have been far lighter if a request made last month by the U.S. commander there for additional armored protection had been acted on by Defense Secretary Les Aspin, Army officials said.

In early September, Army Maj. Gen. Thomas Montgomery, the deputy com-

A Shift in Attention

The twin crises in Somalia and Russia have shifted the White House's attention away from the struggle to enact much of its domestic agenda. Article on page Axx. And while the crisis in Russia is turning out the right way for President Clinton, the other is going badly, tragically wrong. Capital Journal, page A18.

mander of the United Nations military force in Somalia and commander of the U.S. contingent there, told his superiors in the U.S. that he needed a battalion of armored troops — that is, about 600 to 800 soldiers, with about 55 tanks or armored personnel carriers — to protect the light infantry already there. The request, in somewhat reduced form, was relayed by Marine Gen. Joseph Hoar, head of the U.S. Central Command, which oversees Somalia, and forwarded to the Joint Chiefs of Staff.

The disclosures could aggravate Congress's already sour mood over the Somalia situation. The Senate Appropriations Committee Chairman Robert Byrd has vowed to press for a vote this week on a cutoff of funds for the mission. The Clinton administration is anxious for more time, and the president is scheduled to meet today with top national security advisers and military leaders in the expectation of announcing a policy decision soon.

While Gen. Montgomery's request for armored troops was never formally rejected, it wasn't acted on either, despite extensive discussions down the chain of command. Frustrated by the inaction, senior Army officers at least once informally prodded the staff of the Joint Chiefs for action, an Army officer said. Mr. Aspin declined at the time to send the armored troops after receiving conflicting advice from Gen. Colin Powell and other members of the Joint Chiefs, a Pentagon official said.

Others familiar with the situation said there was little sense of urgency at the Pentagon when the request arrived. And the need for the armored vehicles wasn't as clear last month as it is now, partly because the forces of Somali warlord Mohamed Aidid hadn't yet begun to show how adept they could be at shooting down U.S. helicopters. In addition, they said, commanders on the ground always ask for more resources than they really need.

However, in the wake of Sunday's fighting, which more than doubled the number of U.S. combat deaths in Somalia, the Pentagon acted quickly to fulfill Gen. Montgomery's request. Mr. Aspin ordered the deployment of four heavy tanks and 14 Bradley Fighting Vehicles and other equipment making up about one-third of what the general asked for last month.

Mr. Aspin's failure to act on Gen. Montgomery's request is already provoking members of Congress, irate over the seven-hour delay that occurred Sunday before a group of U.S. troops were rescued in downtown Mogadishu. The bulk of the nearly 100 casualties that the U.S. forces suffered in the Somali capital occurred during those seven hours before U.N. forces were able to rescue a group of 90 U.S. Army Rangers pinned down under heavy fire without armored protection. The U.S. was forced to rely on Pakistani

and Malaysian armored vehicles to rescue the Rangers because it had no tanks of its own. About 70 of the 90 Rangers were killed or wounded in the firefight.

The nervousness in Congress was evident yesterday afternoon during a crowded closed-door Capitol briefing with scores of lawmakers and high administration officials. Defense Secretary Aspin and Secretary of State Warren Christopher intended to consult with Congress on the Somalia policy, but the format and lack of specific answers only angered members and reinforced the perception that the mission's goals remain unclear.

The pressure now is for the White House to narrow the American mission in order to expedite withdrawal. Another alternative, calling for a larger buildup, is favored by some prominent lawmakers who fear the U.S. would otherwise be seen as deserting the U.N. But this would require a consensus and resolve that didn't show itself yesterday.

"Either have a buildup or get out as soon as possible," declared Rep. John Murtha (D., Pa.), chairman of the House Appropriations defense subcommittee. Senate Majority Leader George Mitchell said: "I'd be amazed if the the Senate voted for an immediate withdrawal as long as we have hostages over there."

Among Republican conservatives, there was open hostility. And while Senate GOP Leader Robert Dole argued to give Mr. Clinton until Oct. 15 to spell out his goals, rank-and-file members were clearly frustrated.

"Not a chance," said Rep. Harry Johnston (D., Fla.), who heads the House Foreign Affairs Africa subcommittee, when asked if a majority in the House would vote to sustain funding for the Somalia mission.

Job Losses in Health Plan Are Denied

By STEVEN GREENHOUSE

Special to The New York Times

WASHINGTON, Sept. 27 — Recognizing that in this day and age the econometric study is mightier than the sword, the Clinton Administration has begun fighting back against reports concluding that its health care plan will cause huge job losses.

One study, largely financed by companies that do not provide health insurance for their employees, asserts that requiring employers to pay for health coverage would wipe out 3.1 million jobs. Another study, sponsored by the National Federation of Independent Business, a small-business lobbying group, estimates that such costs would put 12.7 million jobs at risk and cause one million layoffs.

Labor Secretary Robert B. Reich said in an interview that the studies were "incorrect," adding, "They're based on questionable assumptions and they didn't factor in our subsidies for small business."

Gene Sperling, an assistant to the President for economic policy, called the studies "bogus" and "inaccurate."

Research Called Sloppy

And in a letter to the study estimating 3.1 million lost jobs, Laura D'Andrea Tyson, chairwoman of the Council of Economic Advisers, sounded like the economics professor she used to be as she chided the authors for what she viewed as sloppy research. She said, for example, that the study ignored how the plan would hold down health costs for companies large and small, enabling them to expand.

These officials also said the studies overlooked how President Clinton's plan might create hundreds of thousands of new jobs in certain areas by, for example, expanding home-based health care.

"There are some things in the plan we think will increase employment," Ms. Tyson said in an interview. "There

are some factors that will reduce employment, and there are things that would change the composition of employment. When we weigh all these things, we believe the net effect on the total of jobs will be small."

'Dr. Kevorkian Prescription'

Republicans have seized on the studies as Exhibit No. 1 to oppose that part of Mr. Clinton's plan to require all businesses to pay part of the cost of insurance for their employees.

"We're likely to lose 3.1 million jobs because of this plan," said Representative Dick Armey of Texas, chairman of the House Republican Conference.

Clinton officials say the plan will hold down costs for businesses.

"The plan is really a Dr. Kevorkian prescription for the jobs of American working men and women."

As so often happens when Government proposes a new burden on employers, business lobbyists are howling — not that the mandate will eat into their profits (that wins little sympathy), but that it will force them to lay off their workers.

Small-business opponents of the plan requiring employers to buy health coverage make a straightforward economics argument: it would increase the cost of labor. And when labor becomes more expensive, employers are not able to afford as much of it. The result: layoffs and fewer new hirings, especially among low-wage workers.

"From what I'm hearing from businesses, my anecdotal instincts tell me that the estimate of three million job

losses is a low number," said Richard Berman, executive director of the Employment Policies Institute, a business-backed research organization that sponsored the study estimating 3.1 million jobs would be lost. "There are over 700,000 restaurants in the U.S.; if each restaurant cuts back one job on average, that gives you almost 25 percent of the total."

Small-Business Subsidies

The Administration's biggest complaint with the studies is that they ignore the subsidies to help small businesses afford insurance premiums. When two professors from Baruch College, June and Dave O'Neill, did the study for the Employment Policies Institute, they estimated that small, low-wage companies like restaurants and retailers that do not now offer insurance would have to spend more than \$4,000 per worker in health care premiums for many low-wage workers, equal to more than 30 percent of their wages.

Administration officials note that the President's plan would place a ceiling on what businesses pay. Under the plan, many small businesses with low-wage workers would receive Federal subsidies, so they would pay no more than 3.5 percent of their payrolls.

"For a worker earning the minimum wage of \$4.25 an hour, our cap would cost just 15 cents an hour more," Secretary Reich said. "That shouldn't cause much in the way of layoffs."

Ms. O'Neill and Wilbur Steger, an author of the study estimating a loss of one million jobs, conceded that the figures they used differed from those in the plan announced by the President. But they said they made the best estimates they could with the information available.

The two economists contended that the Clinton plan would cause far greater job losses among small businesses than the Administration predicts. They said the Administration would have problems finding money to pay for the tens of billions of dollars in subsidies planned for small businesses.

In early versions of the Clinton plan, before the subsidies were added, Administration officials estimated that the requirement that employers buy health coverage might cause small businesses to lay off 200,000 to 700,000 workers. But with the subsidies, one official estimated it would cost about 150,000 jobs at small businesses that do not now provide health insurance.

"That represents one month's worth of job creation," one Administration economist said. "Isn't that worth it when what we gain in return is health security for all Americans and an end to spiraling health care costs?"

And Now, Anxiety as Terrible as the Floods

By ISABEL WILKERSON

Special to The New York Times

ST. LOUIS, Sept. 24 — On a balmy Sunday after church, Elizabeth Crane stood in a parking lot trying to recall her address. It had been a month since the river took the house she lived in for 44 years, the little town of Hardin, Mo., where she settled as a war bride, the antique table linens from her mother in Germany and even the cemetery where she buried her husband.

"Let me see," she said, looking to the pavement for clues. She thought hard, then opened her purse and began mining for anything with her house number on it, growing more frustrated with each wrong envelope she found.

"Here it is," she said, finally, retrieving a scrap of paper. "Front Street. 402 Front Street."

The river that had broken her heart took a piece of her memory, too.

Post-Traumatic Stress

It has been nearly three months since the great rivers first rose up against towns and farms in the Midwest. In some places the rivers are rising again, and now — after weeks of levee-shoring heroism followed by the tearful taking of inventory and determined attempts to clean up — the signs of post-traumatic stress disorder, the kind that haunts some combat veterans and survivors of plane crashes, have set in among many of the region's ordinarily stoic river people.

If Hurricane Andrew, with its single, violent touchdown in 1992, was like a heart attack to South Florida, the Midwest floods of 1993 have been like a cancer, gradual and insidious and frighteningly enduring. People who have lost everything and lived like orphans in motel rooms and relatives' basements do not know when or if they will be able to rebuild, or even if their towns will exist.

Many barely had the chance to

Continued From Page A1

assess the damage and clear the debris before the fall rains started, bringing a new wave of flooding and prolonging the summer's nightmare.

"I can't believe this is happening again," said Marty Bohamonde, a spokesman for the Federal Emergency Management Agency, driving past cornfields and roadsides flooded anew by the Mississippi River. "A week ago the river was in its banks. Now it's back again. It just never ends."

What little time the flood victims had to clean up before winter set in could be lost if the rains continue. And as they resign themselves to government trailers or cramped apartments, flood refugees grieve for the homes and lives they fear will never be the same.

"We're not over it yet," said Dorothy LeFever, a retired housekeeper whose town, Alexandria, Mo., was wiped out by the flood. "It gets you inside. I shake all over. My stomach ain't right. My nerves are bad. I get a choking feeling when I eat. Sometimes I walk and I walk. Then I go get my Bible. That's only thing that comforts me."

As the crisis wears on, flood victims are exhibiting a range of reactions, from anger to depression to denial — from the auto mechanic who, after losing everything, could not remember what he did for a living to the 4-year-old boy who still cannot talk about the cat he lost in the flood.

For Tracy Kehoe, a flood victim living in a temporary apartment outside St. Charles, Mo., with her husband and two young daughters, the only way she has been able to make it is to pretend the flood never happened.

"Then the kids will ask if we're ever going home, and I have to face reality," Mrs. Kehoe said, adding that she then goes into the bathroom and turns on the faucet "so the kids can't hear me cry."

Anxiety and depression have set in at a time when people here most need their minds clear to negotiate the bureaucracy set up to help them, to get on with the cleanup and to make the hard choices confronting them — where to rebuild their homes, where to find work and schools.

Natural Grieving

Psychologists say these responses — Mrs. Crane's memory lapse or Mrs. LeFever's loss of appetite, for instance — are normal reactions to painful and extraordinary circumstances and are part of natural grieving. They are results of crisis overload, specialists say.

"The reality of the flood is something nobody can change," said Dr. John F. Snyder, a clinical psychologist at Southern Illinois University in Carbondale. "It lasted longer than anybody projected. The stress factor went on and on. It's the kind of stress that is debilitating, that wears people down. It's like there is a zero sum ability to cope."

For people already beaten down by the rivers, the current rains are further insult, making life messier and even more depressing. The rains delay the cleanup and draw out the grieving. But in towns already at rock bottom, there is little left for the new floodwaters to destroy.

While the rest of the country turns its attention to President Clinton's health care plan or the debate over the North American Free Trade Agreement, things are as bad as they ever were for many people here.

Disrupted Family Life

For the last two months Michael Cantrell, a financial officer who lives in Quincy, Ill., but works across the Mississippi in Hannibal, Mo., has been forced to leave his wife and infant daughter to live with co-workers during the week. The bridge connecting Quincy and Hannibal has been closed since July, at one point making a 20-minute commute seven hours long.

Sometimes when he returns home on weekends his 7-month-old daughter, Lindsey, does not know who he is. "The first time I stayed two straight weeks, and when I got home she didn't recognize me and wouldn't hardly look at me," Mr. Cantrell said. "I kind of feel like a divorced father who has weekend visiting privileges."

He has missed milestones like her first tooth and first attempt at crawling. His wife, Linda, has been taking videos, but her husband is not in many of them.

Mr. Cantrell may be separated from his family for some time. Before the fall rains began, the bridge was not expected to reopen before late October. Now it may not be open until next spring. "The frustrating thing is not knowing when it's going to end," he said. "We're going into our ninth week doing this, and there is no end in sight."

'Lot of Disillusionment'

The crisis has begun to drain the deep well of pioneer spirit evidenced in the early stages of the flood.

"The initial response was, 'Let's get in there, we're a team, we're going to beat this thing,'" said Dr. Morris Paulson, a clinical psychologist at the University of California at Los Angeles who worked as a Red Cross volunteer in flooded parts of Illinois much of the summer. "Now there is a lot of disillusionment. I don't think the wounds have healed. People are in a heightened state of unsureness."

Those who appear to have the hardest time coping are the elderly whose lives and memories were washed away, and the residents whose lives were on the edge even before the floods struck.

One 70-year-old Missouri man lost his wife to cancer in May and his life's possessions to the floods in July. He turned to a counselor, Doug Hatfield, for help. Mr. Hatfield recalled, "I was sitting with him this week and he said, 'Why should I live?'"

"I have no answer to that," the counselor said.

A burly blue-collar worker broke down at a Red Cross center, and his troubles cascaded out: He had lost his home and his job and was unable to tell his wife how bad things were because she had epilepsy and he feared she would not be able to bear it. The two of them were holed up in a motel room with their three young children, and he did not know how much more he could take. A social worker, Linda Berkowitz, guided him to a back room to talk.

"His eyes were filled with tears by the time we sat down," Ms. Berkowitz said. "I told him, 'Just go ahead and cry,' and he did. He just cried and cried and cried. He cried for about 15 minutes. He kept saying, 'I don't even know who you are, and here I am crying like a baby.' And I kept saying, 'You are not the first.'"

The Loss of a Home

What makes it especially hard for some people is that there is not the same social validation for those grieving the loss of a home as there is for those grieving the loss of a loved one, some counselors say. The home may be the repository of life possessions and memories and the symbol of security and connectedness to the larger world, but those who lose one are expected to pull themselves together.

"American society has trouble accepting permanent scars and permanent misfortune," said Aphrodite Matsakis, a staff psychologist and specialist in post-traumatic stress disorder at the Veterans Affairs Medical Center in Silver Spring, Md. "It goes against the grain because we feel we are masters of our fate, so therefore people who have gone through these losses are encouraged to get over them quickly."

That is not likely to happen in the flooded and still soggy sections of the Midwest, where it may be more than a year before people can return to their homes and farmers to their land.

"It's going to be a long, long, long recovery period," said Virginia Mogaard, associate professor of human development and family studies at Iowa State University in Ames. "We are looking at not weeks and months, but a year or more."

As painful as the flood victims' experiences are, specialists note that feelings cannot kill. But not all flood survivors believe this.

Vic Wilson, an 85-year-old Missouri man in the devastated town of Alexandria, had diabetes, a heart attack, a light stroke and heart bypass surgery. When the floods hit he was forced from his home like the rest of the town and fell into a deep depression. "He kept saying, 'Take me home, take me home,'" said Mrs. LeFever, a neighbor. "I just cried, 'We can't take you home!'"

Mr. Wilson died three weeks ago Tuesday. While his death certificate may say heart failure, neighbors like Mrs. LeFever are convinced he died of a broken heart.

== POLITICS & POLICY ==

*1 CLINTON: STRAYS FROM SPEECH TO DEFEND PLAN

"President Clinton told the nation's governors [8/17] that there would be 'no free ride' under his health care reform plan and said all Americans -- employers and individuals alike -- would have to pay something for coverage." Clinton: "I think every American should know that health care is not something paid for by the tooth fairy. I don't pretend to have all the answers, but I'm absolutely sure this is the problem that America cannot let go, that we cannot walk away from" (R.A. Zaldivar, PHILA. INQUIRER, 8/17). CHICAGO TRIBUNE reports that "more than once" he "pushed the idea of shared sacrifice in helping to provide coverage" for the uninsured (Steve Daley, 8/17).

AD LIBBING: ARKANSAS DEMOCRAT-GAZETTE reports that NFIB's John Motley made an appearance at the NGA prior to Clinton's speech in which he said reform would be like "tying small businesses to a sled and pushing them down a mountain, hoping they'll remain upright." Clinton, "tossing out his prepared remarks, spent much of the speech ... arguing otherwise, saying the reform effort would promote jobs rather than cut them" (Noel Oman, 8/17). Clinton listened to Motley's comments backstage where First Lady Hillary Clinton "challenged Motley's televised image, saying again and again that he was wrong" (Judy Keen/Judi Hasson, USA TODAY, 8/17). L.A. TIMES: "Clinton and Motley succeeded in highlighting what clearly will be a major point of contention in the coming debate: whether health care reform will hurt business or help it, stimulating job-creation or stifling it. ... The president's decision to rebut Motley also was a clear demonstration of the administration's new-found resolve not to let critics define the issue" (Edwin Chen, 8/17). Clinton: "If you just imposed a mandate and did nothing else, would it cost jobs? Yes, it would. ... That is not what we propose" (Oman, 8/17). Clinton said that reform would cut companies' costs, allowing them to invest those savings "in creating new jobs" (Hasson/Keen 8/17).

BEST OF FOUR: Clinton said an employer mandate is the best of the four available alternatives. TRIBUNE: "For the first time in a public forum, Clinton rejected the idea of a single-payer, Canadian-style program favored by many Democrats" (Daley, 8/17). Clinton said a single-payer plan would "require us to replace over \$500[B] in private insurance premiums with nearly that much in new taxes. I don't think that's a practical option." Clinton said requiring all individuals to purchase insurance would encourage employers to discontinue the health plans they currently offer. And continuing with the current system, would mean the gov't and employers would continue to pay for the insured. Clinton: "That leaves the fourth alternative, which is to build on the system we now have" (Paul Richter/Edwin Chen, L.A. TIMES, 8/17).

EMPLOYER MANDATE: Clinton "insists" that employers provide coverage for workers (Oman, 8/17). But Clinton "made it plain that his effort would seek first to reduce health care costs by revamping the insurance system and reducing government red tape.

Health Plan's Break for Small Business Remains Blurry

Lack of Data Adds to Skepticism About Financing of Clinton Proposal

By BRENT BOWERS

Staff Reporter of THE WALL STREET JOURNAL

Small-business owners panting to figure out the subsidy they could get under President Clinton's health-care plan might need to put their calculators back in the drawer for a while.

Some unanswered questions about the plan's proposed subsidies for small businesses are making it harder to say who can get the break, and how much the program will cost.

The shortage of hard data is adding to skepticism about how the health-care overhaul will be financed. "The Clinton numbers have changed from week to week and in some cases are based on unrealistic assumptions," says Rep. Jan Meyers of Kansas, the ranking Republican member of the House Committee on Small Business. "Probably a lot of the figures we have won't be worth much, not by design, but because people don't have a full grasp of the numbers."

Under the Clinton proposal, contributions of businesses with 50 or fewer employees would be capped from a low of just 3.5% of payroll if wages average less than \$12,000 a year to a maximum of 7.9% if wages average more than \$24,000.

Thus, many small companies would pay only a few hundred dollars a year for health coverage that is projected to cost an average of \$1,800 for individuals and \$4,200 for families. (The plan calls for employers to pay 80% of health-care premiums and for workers to pay 20%.) The government would pick up the rest of the tab from an enormous "subsidy pool" of \$419 billion spread out over six years for both businesses and low-income individuals.

But small-business specialists say it

isn't clear yet how a key figure, payroll, will be defined. Indeed, administration officials acknowledge that they haven't yet worked out a formula for calculating a company's average wage.

A Big Omission

That is a big omission. For example, a work sheet prepared by the administration contains a "scenario" in which a small business has 10 employees who earn an average \$12,000. "Business pays no more than \$420 per employee, or 3.5% of average worker pay," the work sheet says.

But Thomas Kuhlman, vice president in the Chicago office of employment-benefits consulting firm Towers Perrin, notes that the owner's pay will have to enter the calculation, although not always in the same way.

"They don't define what payroll is," he says. He says his firm is assuming the health-care plan will follow the same rules as tax law, meaning that owners of regular corporations will have to include all their compensation in computing average wages, but that owners of so-called Subchapter S corporations won't, because they aren't considered employees. (Such corporations are legally organized as corporations, but taxed as partnerships.)

"In the absence of detail, which certainly is missing, that's our best guess," Mr. Kuhlman says. Thus, he says, a business owner who makes \$60,000 and pays four workers a total of \$37,000 would have an average worker pay of \$9,250 at an S corporation and qualify for the most generous subsidies, while the same owner would have average pay of \$19,400 at a regular corporation, and qualify for much less relief. (This hypothetical example assumes that the S-corporation owner pays

himself no straight salary at all. Moreover, offsetting the difference to some extent would be a requirement for the S-corporation owner to pay the full cost of his own coverage as a self-employed person, Mr. Kuhlman says.)

Sam Starr, a tax partner in the Washington office of Coopers & Lybrand, anticipates that any salaries that S-corporation owners pay themselves would probably be included in computing average wages, but company earnings that flow through to them as undistributed taxable income might not.

An official who is advising the Clinton administration on the small-business aspect of the plan acknowledges that "S corporations are an issue. We're having discussions."

As businesses attempt to lower their average worker pay, the adviser asks, will there be a "stampede" to S corporations? "That's one of the issues."

Question of Stock Options

The adviser, who requests anonymity, adds: "We haven't defined payroll. We're having a number of discussions" about what should be included. Some question marks: Do stock options, stock dividends or capital gains count? "We do need to refine our plan," he says.

Another unanswered question is what small-business's share of the \$419 billion subsidy pot would be. While this hasn't been spelled out, "it's a huge chunk," says White House health-reform spokesman Kevin Anderson.

Even so, the nation's biggest small-business lobbying organization, the National Federation of Independent Business, opposes the Clinton proposal. One

reason, says Leslie Aubin, the federation's health-care-policy analyst, is that small businesses don't trust the administration's figures. "The numbers don't add up," she says. "How do you find out how many businesses qualify for subsidies? If we don't get the right numbers, we won't be able to achieve health-care reform."

No Figures

Indeed, the administration hasn't yet worked out exactly how many concerns qualify, much less how many workers they have. And officials at the federal Bureau of Labor Statistics, the Small Business Administration and the Census Bureau all say that they have no figures breaking down average wages at companies with fewer than 50 workers. Private consulting firms also say they lack such data.

"That's a number we're still working on," says Mr. Anderson, the White House spokesman. "The models come up with dollars that you need in macro terms before they come up with a head count."

Some specialists say they are confident the administration has done its homework and is basing its calculation of \$419 billion in gross subsidies on hard data or reliable extrapolations. (The administration emphasizes that after subtracting expenditures that would be shifted out of Medicaid and Medicare programs, the net budgetary cost of the subsidy program would be a little over \$160 billion.)

Mr. Kuhlman of Towers Perrin says he is eager to see the final numbers. "It's really going to be an interesting economic game," he says.

Clinton Health-Plan Interim Controls On Insurers Draw Fire From Industry

By GREG STEINMETZ

Staff Reporter of THE WALL STREET JOURNAL

Interim controls on the insurance industry under the Clinton administration health plan could hasten the exodus of small insurers from the health-insurance business but big insurers would feel little impact, according to industry officials.

Nevertheless, the officials charge the rules cast the entire industry as the

Small-Business Uncertainty

Unanswered questions about the Clinton health plan's proposed subsidies for small businesses are making it harder to determine which businesses can get the break, and how much the program will cost. Enterprise, page B2.

"bogeyman" in the health-care debate by accusing them of abuses they argue have largely been eliminated by state legislation.

The Clinton plan calls for rules "to reduce the potential for disruption in the health-insurance industry during the transition" to the Clinton system.

Ban on Dropping Customers

Among the proposed rules are requirements that insurers not drop sick customers during the transition and that they stop isolating specific individuals and groups for hefty rate increases. The draft of the Clinton plan also calls for the creation of a pool, subsidized by the insurance industry, to cover people whom insurance companies turn down.

The prospect of interim controls isn't new. Clinton administration officials disclosed last spring that such a step was likely because they feared some insurers would try to dump people from their rolls before a new health system was up and running. Indeed, the short-term insurance industry regulations are discussed in a 239-page draft of the Clinton health proposal that has been floating around Washington for weeks.

But the issue has gotten renewed attention in recent days after senior White House adviser Ira Magaziner spoke to reporters about it.

Insurance officials say the administration appears to be promoting the transition rules because they provide a platform to blast the industry. That, in turn, would make it easier to pass health-reform measures the industry finds objectionable, they say.

"I think it's peculiar that they bring this out as an issue," said Chip Kahn, executive vice president of the Health Insurance Association of America. "I think there's an organized campaign to make it look like insurers are against reform."

Rules Against Abuses

By prohibiting insurers from selectively jacking up rates and dropping sick people, the proposed rules make it seem as if such practices are widespread, Mr. Kahn said. But, he said, most states have already passed rules against those abuses. Besides, most people are covered by self-insured plans and government plans, such

as Medicare, where such abuses have never been a problem, industry officials argue.

Nevertheless, some small insurers do rely on their ability to raise rates and drop customers. By forcing insurers to keep every customer without being able to charge that customer more for coverage, the administration is saying to insurers "stay in the business and get burned," said Thomas Pyle, an executive with Metropolitan Life Insurance Co.

The Clinton health plan already puts the squeeze on small insurers by encouraging health maintenance organizations over traditional fee-for-service medicine. Small insurers don't have the money to set up HMOs, potentially driving many of them out of the health-insurance business. The transition rules would only hasten their departure, industry officials say.

Consumer advocates, however, say the transition rules are a must, in part because the state reforms are riddled with loopholes. "The protections are needed as an interim step," said Gail Shearer of Consumers Union. "The president is trying to curb some of the most insidious abuses." They also say the creation of a pool to pick up people not covered by insurers is essential, and goes well beyond anything the states have.

Existing-Home Sales Eased in August, But Continue to Outpace 1992 Levels

By BILL RICHARDS

Staff Reporter of THE WALL STREET JOURNAL

Growth in existing-home sales leveled off in August, but continued to strongly outpace last year's sales, with first-time buyers leading the push to take advantage of low interest rates.

Sales of existing single-family homes fell to 3.81 million units in August, according to the National Association of Realtors. That's down about 1.3% from July on a seasonally adjusted, annualized basis. Annualized figures reflect what would be the yearly sales if they continued at the August pace.

August existing-home sales were up 14.1% from August 1992, marking the second-strongest, year-to-year increase after July. The national median resale price for single-family homes rose by 4% to \$109,200 from \$105,000 a year ago.

Frederick Flick, the association's vice president for research, said that while August's sales growth wasn't as strong as July's, the latest figures reflect continuing market strength. Mr. Flick said he expects existing-home sales to remain strong for the rest of 1993, averaging around 3.6 million units monthly, up 4.4% from 1992.

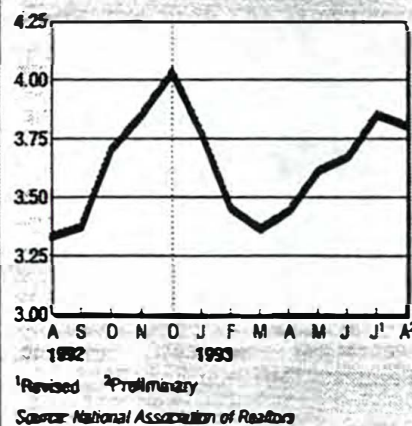
The strongest regional showing in August came from the Northeast, where existing-home sales climbed nearly 9% over July. Resales in the Midwest, which had been strong in July, dropped by 9% last month, in part, said Mr. Flick, because of the bad weather and heavy flooding there.

California continued to feel the impact of defense and computer-industry cuts, lagging behind the rest of the nation in August, with resales down 2.9% from July, according to separate figures released yesterday by the California Association of Realtors. The state's resale pace was about 10% ahead of the year-earlier pace, the group said.

Driving the strong national resale market have been mortgage rates, which con-

Existing-Home Sales

Sales of existing single-family homes, in millions



for 30-year fixed-rate mortgages hit 7.11% in August, falling to 6.95% at the end of last week. Those low rates continued to push home-loan applications, one of the leading resale indicators, to more than 70% above normal, as tallied by the Mortgage Bankers Association of America.

David Seiders, chief economist for the National Association of Home Builders, said that while the national resale figures were interest-driven in August, the low rates also underscore the economy's basic weakness. "Interest rates continue to trend down," he said, "because the economy is weak, job growth is weak and consumer confidence is weak."

Mr. Seiders said buyers for new and existing single-family homes are coming from the rental market. "At current interest rates, a lot of people are discovering it's cheaper to buy than rent," he said. As a result, multifamily-housing starts are at "abysmal lows," Mr. Seiders said.

THE WALL STREET JOURNAL TUESDAY, SEPTEMBER 28, 1993

ing statutes similar to those used to convict members of the Mafia and drug rings. In a conspiracy case, prosecutors can present to a single jury a full picture of everything the conspirators allegedly did or planned, including evidence that might not be relevant to a specific crime. Jeh Johnson, a former federal prosecutor, notes that "if the government can prove a defendant was aware of the conspiracy and did something to become involved in it, he becomes as liable as the rest."

Under those rules, the government need not prove that Abdel Rahman directly ordered his followers to blow up any targets. It may be enough to show, as the indictment charges, that he "provided instruction regarding whether particular acts of terrorism were permissible or forbidden [under Islamic law, presumably], served as a mediator of disputes among members of the organization, and undertook to protect the organization from infiltration by law-enforcement authorities."

The racketeering statutes also offer the government a second crack at trying Nosair for the murder of Kahane without running afoul of the constitutional prohibition against double jeopardy. Many people, including the judge in the case, were outraged when a state jury convicted Nosair of gun possession but acquitted him of the murder itself. It is a well-established principle that the same act can be prosecuted twice if it violates the laws of different "sovereignities." And though murder as such is not a federal crime, killing someone to further a racketeering conspiracy, as Nosair is accused of doing, is.

Some legal experts think U.S. Attorney White may have drawn the conspiracy too broadly. If she cannot prove all that is alleged, they think, she may wind up with fewer convictions than she might have won in a series of narrowly defined cases. As to Abdel Rahman, the feds may have figured they had nothing to lose. They had no narrow case against him, and if he is acquitted of the larger charges, they can resume deportation proceedings and "kick his butt out of the country," as an official puts it.

But where could he be sent? Egypt has put in only a quarter-hearted request for extradition; Mubarak would vastly prefer to have Abdel Rahman in a U.S. prison than on trial in Egypt, fluttering terrorists' hearts. The sheik's lawyers have talked about having him go voluntarily to Afghanistan, but no one wants to see him free in that hotbed of Islamic fundamentalism. Mohammad Mehdi, head of an Arab-American organization, predicts that "the sheik is going to be our guest in America for many years." Fine by Washington, as long as his guesthouse has bars on the windows.

—Reported by Richard Behar/*New York*, Dean Fischer/*Cairo* and Elaine Shannon/*Washington*

HEALTH CARE

PROGNOSIS: FEWE



Clinton may not know it yet, but his advisers predict job losses from health-care reform

By DICK THOMPSON WASHINGTON

WHILE BILL CLINTON RELAXED ON Martha's Vineyard last week, staff members were sweating and fretting back in Washington, studying computer models for answers to one of the most explosive questions facing his health-care-reform proposal. That question—the subject of a showdown meeting scheduled with the President this week—is, How many jobs will be lost during the long transition to reform?

Clinton has publicly stated that health-

care reform will "boost job creation," a claim that unnerves many of his advisers. What they know—and what some of them fear Clinton has not been told—is that the Administration's own preliminary computer-aided studies of the "employment effects" of health reform predict "significant" job losses.

TIME has learned that according to one computer run, the plan would slow net employment growth by as many as 1 million jobs over the next five years. Other Administration forecasts—based on computer simulations of the U.S. economy by various government departments and the Urban Institute, a Washington think tank on contract to the White House—have produced lower estimates of job losses, sources said. But they do not support Clinton's claims of job gains.

Sources caution that these forecasts re-

18

JOBS



THE FIRST LADY ON VACATION: Exerting a "chilling effect" on reform sessions.

sulted from a draft of the health-reform plan that is still being refined, and was tested on an econometric model that included "faulty assumptions" about the ways in which employers, workers and health-care providers are likely to respond to health-care reform. Still, these estimates—and others by independent economists who predict job losses in the 200,000-to-600,000 range—galvanized Clinton's health-reform advisers last week into a crash program to refine both their computer models and the health-care plan in order to minimize their forecast of unemployment. Says a worried official: "The jobs issue is probably the most sensitive one we face in health-care reform."

Privately, several of the President's advisers contend that the current runaway

spending on public and private health care is a growing burden on the economy, which, like a surgical patient who must feel worse before he can get better, might need to endure modestly higher unemployment for several years as the price of reform. Trouble is, Clinton has not prepared the public for any sacrifice. He and his top health-care strategist, Ira Magaziner, have been selling health-care reform as a four-course free lunch. Everyone will be covered. It won't require new taxes. It will immediately boost job creation. And it will immediately reduce the federal deficit. "Several of us," says a political adviser to Clinton, "are worried that we're creating expectations for health care that can't be met."

No business will be required to pay more than 7.6% of its total payroll for health insurance. For big companies, such as automakers, which now pay about 19%, the potential savings would provide an incentive to hire new workers. But for small firms that now provide no health insurance, the requirement will add to the cost of labor. Some of these firms will cover the cost by cutting profits, raising prices, withholding raises or extending overtime hours. But many firms will not have these options. Most vulnerable are enterprises like restaurants and farms, which employ many of the nation's 4.8 million minimum-wage workers and often operate with slim profit margins. For them, cutting jobs may be the only option. The National Federation of Independent Business has estimated that 1.6 million jobs will be lost over five years. A new study, financed by restaurant owners, forecasts losses of 3.1 million.

The White House rejects these figures as flawed because they don't sufficiently account for jobs created in firms that save money through lower insurance costs and because they are based on false assumptions about the tightly guarded reform plan. The next computer runs, to be conducted on the Urban Institute's microsimulator (called TRIM, for Transfer Income Simulator), will include various "transition subsidies" designed to minimize job losses for small businesses and low-income employees. His advisers plan to present Clinton with four options this week for easing the transition, but one official said they were having trouble designing subsidies that were not "a nightmare to administer."

Hillary Clinton, who heads the health-care-reform effort, is committed to a rapid phase-in, by January 1996, for universal coverage and a generous basic-benefits

package—though few others believe this schedule is realistic. She has waved off warnings of job losses as the propaganda of greedy business interests. Her strong views and assiduous hunting of suspected leakers have exerted what one official describes as a "chilling effect" in sessions she attends. Nevertheless, at a recent meeting, her colleagues report that Laura Tyson, chair of the President's Council of Economic Advisers, cautioned that once the plan is released, respected outside economists will run it through standard econometric models, which will probably show job losses. "and some of those numbers might be big."

Clinton health-care planners have tried to address the concerns raised by small business, which enjoys great influence in Congress. They emphasize that under the proposal, the smallest businesses will pay as little as 3.5% of their payroll for insurance, rather than the 7.6% top rate, with taxpayers subsidizing the rest. And the smallest businesses will be allowed a slower phase-in of the new expense. Insists Magaziner: "We think we can do this without having a negative employment effect."

Magaziner, backed by Hillary Clinton, has so far insulated the President from internal assessments that might challenge his rosy scenario. But that, officials say, will change in the meeting scheduled this week.

Many small-business owners who want to provide health coverage for their workers will back reform because the current situation inflicts large and growing burdens on them. Audrey Rinker, owner of a graphics shop in New Port Richey, Florida, has been denied coverage by three insurance companies because her workers have pre-existing illnesses. Says Rinker: "We need

something done right now." Even when they can get insurance, small companies pay some of the highest rates. Barbara Silver Miller, co-owner of a vending-machine firm in Phoenix, Arizona, has seen premiums for her employees rise 20% to 30% a year.

To reform this festering mess, some Clinton officials argue privately, the transitional loss of a few hundred thousand jobs is not a high price to pay. Certainly not in an economy that employs 120 million workers and creates 2 million jobs a year. Yet for the individuals involved, a single job lost on a Nebraska farm isn't really "a net wash" when a new job—requiring relocation and training—is created in a Detroit auto plant.

—With reporting by Dan Goodgame/Washington



IRA MAGAZINER: No such thing as a free lunch?

19

Health Care Quandary: Will Coverage Cut Jobs?

By SYLVIA NASAR
Special to The New York Times

WASHINGTON, Aug. 26 — The Clinton aides finishing up his health plan are wrestling with a devilish quandary: how to keep the creation of universal coverage from costing low-wage workers a pay cut or even their jobs.

At first glance, it would seem that these workers would be the plan's biggest winners. Domestic, farm workers, sales clerks and others with modest earnings account for most of today's 16.3 million uninsured workers.

A policy paid by employers that is as good as that offered by Fortune 500 companies would be the equivalent of a raise of several thousand dollars, seemingly just what is needed for workers who, as a group, have seen their pay and benefits shrink for nearly two decades.

But labor economists in the Administration and academia are acutely aware that unless the requirement for employers is balanced by potentially large Government subsidies, it is those low-wage workers, not businesses, who are likely to wind up footing the bill as employers seek to compensate for increased costs.

Lost Jobs or Wage Cuts

"You'd expect to see fewer low-wage jobs because it would be more expensive to hire less-skilled workers," said Barbara Wolfe, a labor economist at the University of Wisconsin. "There's reason to be very concerned and very cautious."

Daniel Hamermesh, a labor economist at the University of Texas in Austin, said: "Either there are going to be job cuts or wage cuts or, more likely, a combination of both. It's got to be one or the other."

Ira C. Magaziner, the President's top health care adviser, recently called worries about job losses "crazy." But economists involved in the planning process have been raising the issue all along.

Administration officials are aware of the problem, although they are under strict orders not to discuss estimates of potential job losses. "We're studying the issue intensively so that our plan has the largest possible job creation impact," said Gene Sperling, deputy assistant to the President for economic policy.

Estimates Vary Widely

Potential job losses depend, among many other things, on the cost of coverage and how much of the direct cost of employing low-wage workers would increase. Administration officials say potential job losses for low-wage workers, in the absence of a subsidy, is likely to be 200,000 to 700,000.

Some academics outside the Administration, maintaining that universal coverage is likely to cost more than the Administration now realizes, believe the potential lost jobs could be two or three times that large, ranging up to 3 million.

Many Republicans view Government requirements like the minimum wage and family leave as hurting small businesses, and they are likely to pounce on this issue when the health care plan is made public.

Labor economists believe that when the Government requires employers to provide a benefit, most of its cost is eventually shifted to workers, through cuts in their cash wages or other benefits. But since it is difficult to squeeze the pay of workers who earn close to the minimum wage, employers have often cut jobs, substituting machines for people and, more often, more skilled workers for less skilled ones.

"Many workers will be totally unaffected, but it will have a serious effect on low-wage workers," said June O'Neill, a labor economist at Baruch College who says job losses are potentially very large.

The overwhelming majority of the uninsured are low-wage workers in a handful of industries like restaurant

service, retail sales, construction and farming. Because they are not scattered throughout the economy, their employers face potentially large increases — in the double digits — in payroll costs.

"Somebody who keeps their job and has health insurance may be better off," said Robert Topel, a labor economist at the University of Chicago. "But you have to think about the millions who no longer have jobs."

Some Administration officials say they are confident that job gains in high-wage companies will offset losses, if any, at the bottom of the job ladder. Thus, the Administration's plan could reinforce a host of trends that have been bearing down on the least-skilled, least-educated Americans for the last two decades and add to the schism between the fortunes of low-wage and high-wage workers.

To limit the impact on low-wage workers, health care planners have suggested that the requirement be phased in over five to seven years and that the amount small businesses would have to pay be limited to 3.5 percent of payrolls, about half what larger companies pay. They have also recommended that employees' contributions be capped based on their income and that the Government provide subsidies.

Subsidies to business would grow or shrink with the actual number of jobs lost, but they are very difficult to design and could wind up stimulating accounting games if not outright deceptions by businesses. That could swell the Federal budget deficit, a very

Change could cost those who earn the least.

risky step given the public focus on it, not to mention the Administration's own push to cut its growth. The official line is that the subsidies will be small and can be financed by "administrative savings" or, at most, a tax on smokers, but most economists are highly skeptical.

Heavy Burdens Seen

In a study released recently by the Employment Policies Institute, a research organization backed by business, Professor O'Neill and her husband, Dave M. O'Neill at Baruch College, both highly regarded labor economists, concluded that the problem was potentially far bigger than the Administration has been saying.

The O'Neill study assumed that the average cost of a policy for a single worker would be \$2,400 and the average cost of a family policy would be \$5,900, about the average cost of covering workers today, and that employers would not be able to cut pay below \$8.50 an hour. From this they calculated that, while overall labor costs in the entire economy might rise just 2.5 percent, certain industries, restaurants, for example, would face potential increases in their labor costs of 16 percent.

Economists involved in the health care planning process, on the other hand, assume that the plan will cost roughly \$2,000 per worker, far less than the average businesses pay now, and that businesses will be able to cut more from low-wage workers' pay and wind up cutting fewer jobs.

Other labor economists consider the O'Neills' estimates credible.

"I think her estimates could be fairly conservative," said Finis Welch, a labor economist at Texas A&M University.

THE NEW YORK TIMES, MONDAY, AUGUST 30, 1993

Religious Leaders Hold —A 2d World Parliament

By PETER STEINFELS
Special to The New York Times

CHICAGO, Aug. 29 — With two hours of invocations and blessings that should have roused the heavens — or possibly created stupor there — religious leaders from every corner of the globe and virtually every imaginable faith opened a once-in-a-century Parliament of the World's Religions this weekend.

On Saturday, Buddhist monks, Hindu swamis and Muslim imams, along with Sikhs, Zoroastrians, Bahais, Theosophists and goddess worshipers, joined more familiar religious figures like Joseph Cardinal Bernardin, Roman Catholic Archbishop of Chicago, to begin eight days of prayer, meditation and dialogue with 6,000 participants at the Palmer House Hilton Hotel.

Among the world's ills that the international Who's Who of religious leaders in attendance hope to heal are some, including violence, caused by religion itself. The leaders are also asking whether their religions can unite to deal with issues like AIDS and violence against children.

The meeting is the centennial of the 1893 World's Parliament of Religions, held as part of the Columbian Exposition here. That first gathering, held on the site of what is now the Art Institute of Chicago, was a landmark in American religious history.

Swami as Star of 1893

Besides signaling a place for Catholicism and Judaism in the American religious mainstream, the 1893 Parliament introduced Eastern religions like Hinduism, Buddhism and Bahai to a wide public, aiding their growth on these shores.

Thousands of fascinated Midwesterners observed a crimson-robed James Cardinal Gibbons, Roman Catholic Archbishop of Baltimore, offer an opening prayer amid Eastern Orthodox prelates in unfamiliar black robes, a Shinto high priest in flowing white, a turbaned Hindu in saffron, and Confucian and Buddhist leaders in Chinese and Japanese dress.

It was a scene somewhat like this weekend's but startling to a public that like the great majority of the 400 official delegates, was overwhelmingly Christian. The star of the 1893 assembly was Swami Vivekananda, a 30-year-old spokesman for Hinduism.

"Do not care for dogmas, or sects, or churches, or temples," he preached. "They count for little compared with the essence of existence in each man which is spirituality." It was a message that struck chords in an America where schoolchildren encountered similar thoughts in the writings of Ralph Waldo Emerson and Thomas Jefferson.

Gloomy Prospects

Swami Vivekananda denounced the sectarianism that "has filled the earth with violence, drenched it often and often with human blood," and he called for "the death knell to all fanaticism."

This week, too, appeals for an end of religious warfare are present and have become a virtual litany, while major sessions are also devoted to environmental issues and political and economic injustices.

Today, participants heard a report arguing that the "old dream had failed" and that the earth could not sustain unlimited economic growth. The report was delivered by Dr. Gerald O. Barney, a physicist who directed a similarly gloomy "Global 2000 Report" for President Jimmy Carter in 1980.

"We are now a species without a vision," Dr. Barney said, appealing to the religious leaders to grapple with the scientific and economic realities and "dream a new dream" for the planet.

'A Global Ethic'

The Parliament will close next Saturday when the Dalai Lama speaks in Grant Park and a group of religious leaders meeting here issue a "Declaration of a Global Ethic." The Rev. Hans Kung, a Swiss Catholic theologian and frequent object of Vatican censure, oversaw the drafting of the 5,000-word document.

The Vatican itself is represented here by Archbishop Francesco Gioia of the Pontifical Council for Interreligious Dialogue.

Other participants in the Parliament include Russell M. Nelson, one of the Council of Twelve Apostles of the Church of Jesus Christ of Latter-day Saints; Thich Nhat Hanh, a Vietnamese Buddhist monk, and Imam Mustafa Ceric, a leader of Muslims in Bosnia and Herzegovina.

Two prominent black American Muslims, the Imam Warith Deen Mohammed, a Sunni, and Louis Farrakhan of the separatist Nation of Islam will make presentations.

So will major Jewish leaders, including Sir Sigmund Sternberg of England and Rabbi Emil Fackenheim of Israel.

The National Council of Churches

will be represented by its president, the Rev. Syngman Rhee, and its executive director, the Rev. Joan B. Campbell. Homi Dhalla, world leader of Zoroastrians, has come from India, and Abdullah Omar Nasseef, secretary general of the World Muslim League, from Saudi Arabia.

Feminist spiritual movements centered on goddess worship will be represented by writers like Riane Eisler and Charlene Spretnak, among others.

Mother Teresa canceled her scheduled appearance because she is recovering from malaria.

But even within the religious world, there is disagreement about the Parliament's merits. The Southern Baptist Convention, for instance, is among groups that declined to send a representative. Many evangelical and fundamentalist Christians believe that such gatherings are at best a distraction from spreading the Gospel and at worst a confusing compromise of their belief that Christianity is the only way to salvation. Conservative and fundamentalist believers in many other religions hold similar positions.

'Same Desire for Peace'

"We have the same desire for peace and reconciliation as 100 years ago," said Dr. Daniel Gomez-Ibanez, the executive director of the group that organized this year's Parliament. "But then there was a mood of optimism in the United States. Today there is a mood of anxiety all around the world."

Besides the change in mood, a comparison of the two Parliaments reveal other telling changes in the United States. The handful of people representing Hinduism and Buddhism in

1893 or the sole Muslim — an American convert — would today find at least tens of thousands of fellow believers in the Chicago area alone.

There are more than a dozen Hindu places of worship around the city and suburbs, 28 Buddhist organizations and scores of mosques.

Leadership in organizing the current Parliament was taken five years by local Hindus, Buddhists, Bahais and Zoroastrians as well as some sympathetic Christians. For several years it continued on a shoestring budget, almost collapsing entirely in 1991.

Eventually more than 125 religious groups joined in the group that organized the Parliament, which is financed by grants from foundations and donors and registration fees. The overflow number of registrants will have a choice of more than 700 lectures, panel discussions, workshops and exhibits of religious art, music and dance.

THE NEW YORK TIMES, MONDAY, AUGUST 30, 1993

Clinton Takes Back 50% of Early Gains For Some Firms Under Health-Care Plan

By RICK WARTZMAN
And HILARY STOUT

Staff Reporters of THE WALL STREET JOURNAL

WASHINGTON — The Clinton administration has decided to take back half the early financial gains realized by companies that take advantage of a Clinton proposal in which the government would pay most of the medical costs for early retirees.

The decision on early retirees came as President Clinton's health-care team all but completed the financing provisions of his health-care overhaul plan, shrinking its deficit-reduction figure to about \$70 billion through the year 2000 from an earlier estimate of \$91 billion.

Under the early retirees' provision, the government would pay 80% of the average

Calpers Serves Notice

Calpers, the giant pension fund, said it expects health-care providers to agree to a 5% rollback in premiums for 900,000 families. Separately, small-business employees hope the Clinton health-care plan wipes out fraud involving a multiple-employer welfare arrangement. Articles on pages B5 and B2.

cost of a federally guaranteed package of health benefits. This population, age 55 to 65, is too young to be covered by the federal Medicare program, and has become a major burden for the nation's auto makers in particular.

But in order to replenish the Medicare and Social Security trust funds, companies that reap a windfall from the government's assumption of early retiree medical costs would have to pay back an assessment to Uncle Sam. Each company's assessment would be equal to half the gain it realizes over the first three years from the retiree provision, according to Clinton officials. After the three-year period, these companies would enjoy the full gain.

Despite the smaller deficit-reduction estimate and the nailing down of certain policies, officials said most of the final cost and savings estimates in the health plan will be little changed from those found in a widely circulated Sept. 7 draft of President Clinton's proposal.

Most notably, the administration is sticking by its earlier estimates for Medicare and Medicaid savings, which have been attacked by lawmakers in both parties as too ambitious. The total estimated savings from capping expenditures in the two giant government health programs will be within a couple of billion dollars of the earlier \$238 billion, five-year projection, Clinton officials said.

The latest set of calculations are subject to one more round of computer runs and then approval by Mr. Clinton during the next several days.

Officials said they've also decided that large corporations that elect to stay outside the regional insurance-purchasing pools established by the Clinton plan would pay an annual surcharge of 1% of payroll. This special assessment, which is designed to bring in about \$4 billion to \$5 billion a year, would be used to help fund academic medical centers and other parts of the "health-care infrastructure."

Additionally, the health-care team will recommend to the president that the tax on cigarettes be raised by between 75 cents and \$1 a pack, officials indicated; the current federal levy is 24 cents a pack. The exact amount, one of the most politically sensitive details in the proposal, was still being closely guarded last night. Officials said they also will propose taxing all other tobacco products, including cigars and chewing tobacco.

The near-final numbers were discussed at a meeting yesterday afternoon between senior White House adviser Ira Magaziner, Deputy Treasury Secretary Roger Altman, White House Budget Director Leon Panetta and his deputy, Alice Rivlin, and several administration economists. The new figures reflect fresh analysis from the Treasury and the Office of Management and Budget. The administration aims to have a detailed legislative proposal up to Capitol Hill by late next week or early the following week.

For all the "scrubbing" of the numbers by Treasury and OMB officials, the main

elements of the Clinton plan remain the same as they've been for months. The proposal includes no broad-based tax increases, but rather generates most of its financing from a new mandate that all employers pay for part of their workers' health coverage.

Nonetheless, significant changes were made in a few areas. One relates to the subsidies that would be provided to small businesses and low-income individuals to help them afford a federally guaranteed package of health benefits. Because the administration is now using new, higher inflation projections and has decided to build in an extra cushion in case more people qualify for the subsidies than expected, the cost of this measure has increased to about \$90 billion when fully in effect in 1997 from \$80 billion.

Officials said they also intended to alter the provision capping the required health contributions of small, low-wage companies. The draft would have based the caps for those with fewer than 50 employees solely on the average wage of the employees in the business. According to Clinton aides, the updated plan would make the caps, which still range from 3.5% to 7.9% of payroll, sensitive to the size of the company's work force as well. One official said that this change, which is sure to be contested by some small businesses, wouldn't affect the overall cost of the subsidies.

Because the administration now doesn't anticipate passage of the health plan until late next year, Clinton officials said they've stretched out the deadline slightly for states to come into the new system. The draft had put it at Jan. 1, 1997. Officials said it would probably be shifted to later in that year. The belated passage of the plan would also delay the imposition of the increased tobacco taxes, one factor in the lower deficit-reduction figure.

Clinton Administration Accuses Bonn Of Blocking Its Efforts to Isolate Iran

By ROBERT S. GREENBERGER
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — Germany has emerged as Iran's champion in the West, and is infuriating the Clinton administration by obstructing U.S. efforts to isolate the regime in Tehran.

In recent months, negotiations have begun on restructuring Tehran's short-term debt to German financial institutions, which would relieve immense pressure on the government. Germany also has blocked or objected to initiatives to restrict Western trade with Iran until it halts terrorist activities and its huge arms buildup. A Germany company also may be involved in talks to help Iran complete work on a massive nuclear reactor.

German diplomats insist that their government has a different approach toward Iran—instead of isolating the regime, they say, it is more productive to engage Iran constructively to try to persuade it to alter its behavior. But U.S. officials insist that Germany's actions have gone far beyond that.

Although U.S.-German relations are basically sound, Secretary of State Warren Christopher recently delivered a "stern" message during a meeting with Germany's foreign minister to complain about actions toward Iran. Mr. Christopher told his German counterpart that the U.S. was particularly disturbed by several high-level Iranian visits to Bonn, and that at a time when Iran was trying to undermine the Middle East peace process, it was important to put pressure on Tehran, not reward it.

Shared Intelligence

After the meeting, U.S. officials shared with German officials U.S. intelligence that documented examples of Iranian support for terrorist activities.

The U.S. has urged its allies to forgo commercial interests and join in pressuring Iran. Following a meeting with allies in Luxembourg in June, Mr. Christopher said: "Iran's economy is in trouble. Iran will be vulnerable to concerted pressure from the West."

Earlier this year, Germany and France, concerned about Iran's mounting foreign debt, heeded the U.S. message and curbed their credits to Tehran. By March,

German financial institutions had stopped honoring letters of credit from five major Iranian banks.

But now, after a series of high-level visits from Tehran, negotiations are under way to reschedule about \$5 billion in short-term Iranian debt, including about \$1 billion that is due this year. In addition, according to a senior U.S. official, Germany is trying to persuade France and Italy to do the same.

"Short-term debt is exactly where Iran is vulnerable," the official says. "If they can't repay their short-term debt, corporations won't do business with them." The official complains that Germany is undermining U.S. policy and even working with Iran to thwart it.

Bonn also is strengthening other, more ominous ties. This month, Iran's minister of intelligence and security, Ali Fallahian-Khuzestani, visited Germany. On his schedule was a meeting with his German counterpart, as well as a private meeting with officials at Siemens AG, which once had a contract to build the Bushehr nuclear reactor for the shah of Iran. The overthrow of the shah and the Iran-Iraq war put the project on hold, even though much of it had already been paid for by Tehran. As a result of U.S. pressure, Siemens said after the Iran-Iraq war that it wouldn't complete the project.

Now, however, it may be coming out of the deep freeze. Iranian officials and the German company are believed to be discussing a plan under which work on the reactor would be completed by a subsidiary of the Czech group Skoda. However, Siemens holds a stake in the Czech subsidiary, according to intelligence sources. But a German official said Bonn had decided not to cooperate in the Bushehr project and therefore it was "extremely unlikely" that Siemens was involved.

Economic Benefits

Some U.S. officials say Bonn is encouraging, or at least not blocking, such activities because they provide export earnings to a German economy that has been hard-pressed by the costs of unification with the former East Germany. Historically, Germany also has had a special relationship with Iran. While the U.S. and Britain held sway over most of the Middle East, Germany believed that Tehran was its sphere of influence.

U.S. officials complain that Germany has become Iran's primary supporter in international meetings. For example, at the Group of Seven meeting of major industrial nations in Tokyo in July and at a meeting last month of U.S. and European Community foreign ministers, Germany blunted U.S. efforts to increase the pressure on Tehran. One U.S. official said a statement issued after the September meeting would have been stronger had it not been for German objections. "What's behind this is a different view of how one should deal with Iran," says a German official.

The U.S. believes that Iran remains actively involved in terrorism. U.S. intelligence analysts believe that the recent shooting of William Nygaard, the Norwegian publisher of Salman Rushdie's "The Satanic Verses," represents a double message from Tehran. It was the third attack on a foreigner associated with the book, whose author is under a death threat from Iran for what it says blasphemes Islam. And, analysts believe, the shooting was meant to express Iran's displeasure over Norway's prominent role in promoting Mideast peace.

Costs begin to overtake efforts to provide benefits



One in a series of profiles of Tampa Bay families and businesses and how health care reform will affect them

■ Eddie Mills has prided himself on providing his employees with health and pension coverage. But he's having to cut back, and worried about the Clinton plan.

By KIM MORRIS
Times Staff Writer

ST. PETERSBURG — Eddie Mills is a small-business owner who thinks providing health coverage to his workers is the right thing to do.

For 23 years, he's been offering his workers health insurance, in addition to a pension plan — both benefits hard to find in many businesses of his size. He runs three

Mills-Anderson Opticians Inc. shops in Pinellas County.

Recently, however, Mills stopped covering one of his workers who was able to get coverage through his wife's company. The worker, who was considered a high risk because of previous surgery, cost Mills \$313 a month to insure, the highest of all his workers. Another employee may be able to switch to his wife's policy, saving Mills' company still more money.

It bothers Mills to eliminate a benefit he has prided himself on providing. It also bothers him to shift the burden of coverage to another employer, albeit a much larger one.

"We're in critical times because of the economy and competition," he said.

That's how it works under the current

health care system in the United States. Small companies frequently don't provide insurance for their workers and large companies frequently end up covering small-business employees whose spouses work at the larger company. More than half of the estimated 37-million uninsured Americans are small-businesses employees and their dependents.

Providing access to every American is the ambitious goal of the Clinton administration. A committee headed by Hillary Rodham Clinton has spent months trying to hammer out a comprehensive health plan that would achieve that goal.

Although the plan has not been completed, it is fairly certain that the business

Please see **INSURANCE** 6E

Insurance from 1E

community is going to bear a good deal of the responsibility for insuring America's citizens — either through a flat premium, payroll taxes or a combination of both.

Because they think they pick up the tab for small employers who don't provide insurance, many large businesses back Clinton's efforts.

But many small-business owners dread the result, still perhaps months away.

Even Mills, who already picks up the tab for covering most of his workers, is fearful, despite reassurances from proponents of the plan that he will come out ahead.

Mills picks up the full cost of insuring five of the six employees who work at his three stores. It runs him about \$150 to \$160 a

month per employee, he said.

This year, Mills himself qualified for Medicare. He had been without coverage for two years because of a pre-existing condition that made it impossible to find insurance.

Health insurance costs are equivalent to about 18 percent of his payroll, and Mills says he pays between 36 and 38 cents on every payroll dollar to cover benefits. While that includes the pension plan he provides his workers, it doesn't include workers' compensation.

When the continually rising premiums on workers' comp pushed his payroll taxes to 51 cents for each salary dollar, Mills bailed out of the system. He made a number of his workers officers, which reduced the number of employees to below the minimum required for workers' comp coverage.

Mills has been following closely the machinations of Clinton's health-reform com-

mittee.

He knows of — and likes — the proposal that would combine the medical components of workers' compensation and automobile insurance into a single comprehensive health program. If Clinton opts for a tax to finance the plan, the figures most often mentioned are around 7 percent for employers and 2 percent for workers.

But Mills doesn't believe a 7 percent payroll tax is sufficient to pay for all the things the administration wants and he feels sure the mandated tax will only get higher — for both workers and business owners.

"They're proposing to cover the 37-million people not covered," Mills said. "If that is their intention, then 7 percent will not be adequate. It will take more."

Mills predicts taxes could go as high as 15 to 20 percent in five years. He's seen the costs of other government programs spiral

out of control.

But Kevin Andlerson, an analyst with the non-partisan Alliance for Health Reform in Washington, D.C., says that won't happen. Tying spending on health benefits to a payroll tax, in fact, should assure cost controls because it will take an act of Congress to raise taxes.

"Increases (in taxes) are now up to legislators, who, if you really look at the facts, are far more reluctant to raise taxes than the private sector is to raise premiums," he said.

Mills fears that if the plan freezes health care costs, it could hurt his eyewear business. "My expenses will go up but I won't be able to raise prices," he said. "In the end, I honestly don't think I'll come out ahead," Mills said. "If it's beneficial to me financially, it will only be so this first year."

But he would be happy to be proven wrong.

VIA SATELLITE

THE NATION'S NEWSPAPER

SPORTS
FINAL



H. Darr Beiser, USA TODAY
KEN GRIFFEY JR.: Hits
441-ft. grand slam, 4C

TORONTO HOLDS LEAD IN AL EAST

TIPS BALTIMORE AS YANKEES
HIT DETROIT, BOSTON LOSES;
PHILLIES WHACK ST. LOUIS
► BASEBALL, 1,3,4,6C; NL STATS, 7C

TESTOSTERONE MAKES ALL-SPORTS TALK RADIO WORK

FORMAT DRAWS LISTENERS
TO CASH-STARVED AM, 1C

USA TODAY

NO. 1 IN THE USA . . . FIRST IN DAILY

WEDNESDAY, JULY 28, 1993

NEWSLINE

A QUICK READ ON THE NEWS

WALL STREET: Dow Jones industrial average slips
2.24 points to 3565.46; NASDAQ composite index falls to 701;
30-year Treasury bond yield rises to 6.68%. 1,3B.

Marco's second stop: Tulsa, Okla.

Where should our reporter's
next stop be, Cheyenne, Wyo.,
Colorado Springs, Colo., or
Santa Fe, N.M.?

Call and vote. Details, 1D



By Nick Galifianakis, USA TODAY

RELEASED: Pennsylvania Gov. Robert Casey leaves
Pittsburgh hospital, recuperating from heart, liver trans-
plant; critics question his candor about health history. 9A.

ILLEGAL IMMIGRATION: President asks Con-
gress for \$172.5 million and more help, including 600 more
Border Patrol agents, to combat illegal immigration. 4A.

IBM CUTS: Computer giant, led by new CEO Louis
Gerstner, left, will cut 35,000 jobs
by end of next year; slashes quar-
terly dividend, reports \$8 billion
quarterly loss. 1,2B.



AP

CANCER RISK: Workers in
smoky bars, restaurants can face
50% greater risk of lung cancer
than others. 1D.

PHONE CALL: Dialing 900-
number phone service starting
Nov. 1 will give caller warning of
call's cost and chance to hang up.

Boston star Lewis

By Jack Carey
USA TODAY

Boston Celtics captain Reggie Lewis, 27,
who passed out during an NBA playoff
game in April, died Tuesday night after
collapsing while shooting baskets.

"It's a time of incredible grief," said Celt-
ics executive Dave Gavitt late Tuesday.

After Lewis' April collapse, team doctor
Arnold Scheller said he had a life-threaten-
ing heart ailment like the one that killed
college basketball star Hank Gathers in

1990, and probably would not p
"You can die from this," Sche
told Lewis, a 1987 first-round di

But Lewis, against team wish
second opinion and was told
nerve condition that could be c

Lewis arrived at Brandeis Un
about 4 p.m. ET Tuesday and w
baskets, said Brandeis' Jack Mo

Witnesses said Lewis fell to
about 5 p.m., was limp and
stopped breathing and had no p
Lewis "wasn't doing anything"

Workers may

DENNY FORGIV

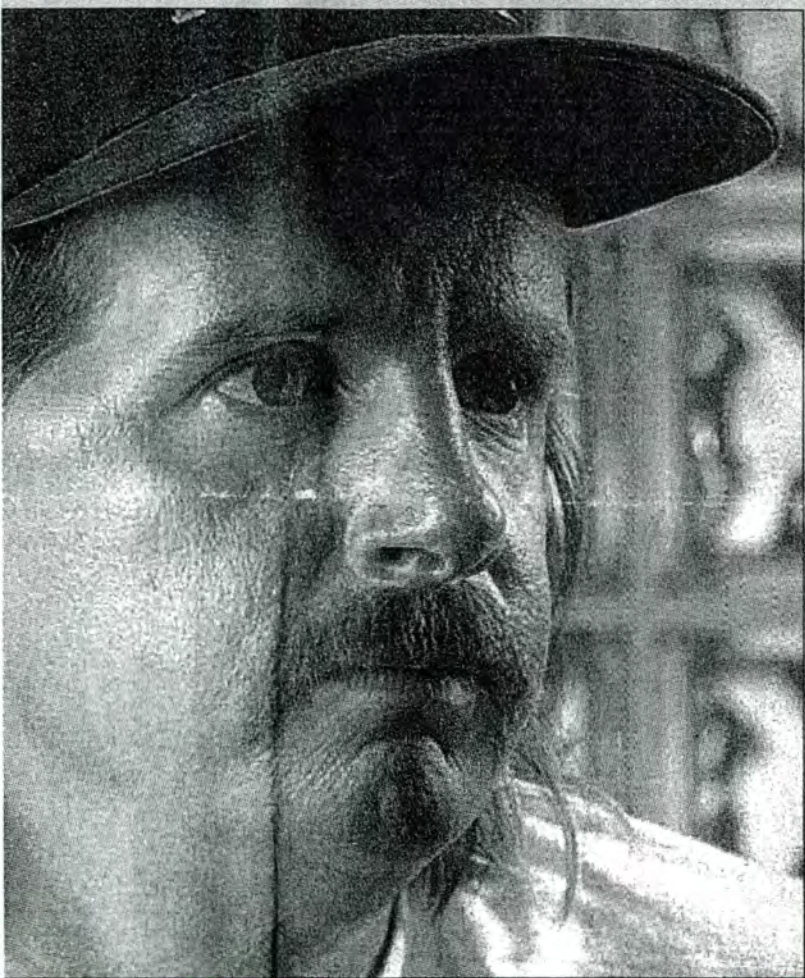
Beaten trucker, on eve of trial: 'Give them



Workers may pay 20% of care

GINY FORGIVING

icker, on eve of trial: 'Give them a chance'



Reginald Denny photo by Rob Brown, USA TODAY

ng,
st
est

ie flooded
upbeat as
1 and Con-
r victims.
use over-
3 billion in
)-27 vote
stalling by
ied to off-
cuts.
President
k for \$11



ATTACK: Video image of Reginald Denny during attack.

COVER STORY

Victim is at

Health plan premiums would vary by region

By Judi Hasson
USA TODAY

Employees would pay 20% of their medical insurance premium under a health-care reform financing plan favored by White House advisers.

President Clinton still has to agree before unveiling health-care reform in mid-September.

It has been delayed while he pushes his deficit-cutting package through Congress.

How to pay for reform has been the biggest holdup. Other elements have already been decided. Included: coverage for abortion and more mental-health care than most have.

How financing would work:

► Employers and workers would pay insurance premiums, but the amount would vary depending on regional costs. Employer share: 80%.

► All employers would be required to provide insurance — even those who hire only a domestic worker like a nanny. But those not paying for insurance now would be phased in.

Small businesses would get a subsidy, but the requirement is still a stumbling block.

"We've got enough mandates on employers," says Senate Minority Leader Robert Dole of Kansas.

"They can call it a premium if they want to," says Leslie Aubin, National Federation of Independent Business. "It's still a tax on payroll, and it will result in fewer people getting hired."

Clinton's advisers expect to save \$60 billion by streamlining the health-care system.

That money would go into a national fund to cover the uninsured and subsidize premiums paid by low-income workers and small businesses.

Before the plan is out, a White House rapid response team — modeled on the Clinton campaign's "war room" — will be answering critics.

Political adviser Paul Begala says security will be the key to the sales pitch.

"Is this going to make my life better? Will I be able to look at my kids when I put them to bed and know that if something happened that we could pay for the health care, that even if I get old or sick, I won't get dumped?"

Vets cheer study on defoliant

By Linda Kanamine
and Carol J. Castaneda
USA TODAY

Vietnam veterans groups Tuesday applauded a new study that links more diseases to wartime exposure to the defoliant Agent Orange.

The Clinton administration quickly pledged to extend disability benefits.

"Relief will be available for people long overdue for it, as well as for their widows and orphans," says Bill Crandell of Vietnam Veterans of America.

The National Academy of Sciences study is the most comprehensive look yet at whether herbicides used to defoliate Vietnam's jungles caused diseases in U.S. troops.

It found sufficient evidence linking Agent Orange to:

- 3 types of cancer.
- 2 skin disorders.

And, pending further study, it left the door open for coverage of other serious diseases.

Vets already are compensated for two of the cancers — soft tissue sarcoma and non-Hodgkin's lymphoma — and the skin disorder, chloracne.

Now they'll be eligible for benefits for Hodgkin's disease, a type of cancer, and a metabolic disorder called porphyria cutanea tarda.

Of 40,097 Agent Orange claims, 1,600 veterans say they have Hodgkin's disease from Agent Orange exposure; an unknown number say they have the metabolic disorder.

Retired Navy admiral Elmo Zumwalt Jr. was one of the commanders who ordered the spraying of Agent Orange.

Son Elmo III was exposed and died of lymphoma in 1988.

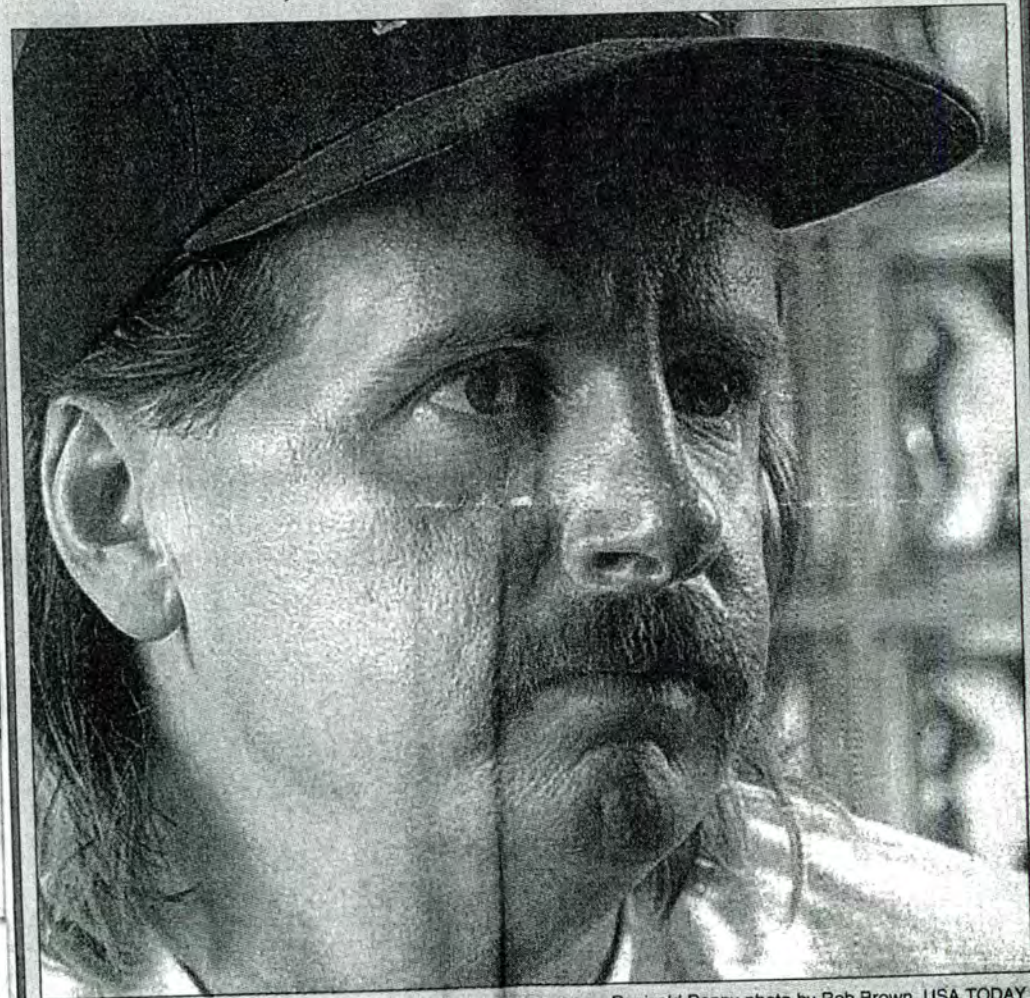
"This is the first report that has not been manipulated by the government, therefore, it does represent progress," says Zumwalt, who has led the fight for Agent Orange benefits.

PHOTOCOPY
PRESERVATION

Workers may pay 20% of ca

DENNY FORGIVING

Beaten trucker, on eve of trial: 'Give them a chance'



Reginald Denny photo by Rob Brown, USA TODAY

Aid funding, dry forecast lift Midwest

By Sandra Sanchez and Leslie Phillips
USA TODAY

The forecast for the flooded Midwest is cautiously upbeat as dry weather moves in and Congress antes up aid for victims.

Tuesday, the House overwhelmingly passed \$3 billion in flood aid. The 400-27 vote came after days of stalling by conservatives who tried to offset funds with budget cuts.

Before the vote, President Clinton said he'll ask for \$1.1



ATTACK: Video image of Reginald Denny during attack.

COVER STORY PHOTOCOPY PRESERVATION

Victim is at

Health plan premi would vary by regi

By Judi Hasson
USA TODAY

Employees would pay 20% of their medical insurance premium under a health-care reform financing plan favored by White House advisers.

President Clinton still has to agree before unveiling health-care reform in mid-September.

It has been delayed while he pushes his deficit-cutting package through Congress.

How to pay for reform has been the biggest holdup. Other elements have already been decided. Included: coverage for abortion and more mental-health care than most have.

How financing would work: ▶ Employers and workers would pay insurance premiums, but the amount would vary depending on regional costs. Employer share: 80%.

▶ All employers would be required to provide insurance — even those who hire only a domestic worker like a nanny. But those not paying for insurance now would be phased in.

Small businesses would get a subsidy, but the requirement is still a stumbling block.

"We've got enough mandates on employers," says Senate Minority Leader Robert Dole of Kansas.

"They can call it a premium if they want to," says Leslie Aubin, National Federation of Independent Business. "It's still a tax on payroll, and it will result in fewer people getting hired."

Clinton's advisers expect to save \$60 billion by streamlining the health-care system.

That money would go into a national fund to cover the uninsured and subsidize premiums paid by low-income workers and small businesses.

Before the plan is out, a White House rapid response team — modeled on the Clinton campaign's "war room" — will be answering critics.

Political adviser Paul Begala says security will be the key to the sales pitch.

"Is this going to make my life better? Will I be able to look at my kids when I put them to bed and know that if something happened that we could pay for the health care, that even if I get old or sick, I won't get dumped?"

Vets study defoli

By Linda Kana and Carol J. Ca
USA TODAY

Vietnam veterans Tuesday approved a study that links wartime exposure to Agent Orange to health problems.

The Clinton administration quickly pledged ability benefits.

"Relief will come for people long overlooked as well as for their families," says a Vietnam Veterans of America spokesman.

The National Academy of Sciences study is a comprehensive look at herbicides used in Vietnam's jungles and their effects in U.S. veterans.

It found a link between Agent Orange and skin diseases.

▶ 3 types of skin diseases

▶ 2 skin diseases

And, pending the results of the study, it left the door open for other studies.

Vets already have won two other types of soft tissue sarcoma and Hodgkin's lymphoma and the skin disorder.

Now they'll get benefits for a type of cancer called biliary dysplasia and cutaneous tinea.

Of 40,097 claims, 1,600 have Hodgkin's disease.

Agent Orange is a known neurotoxin and the metabolic disorder.

Retired Navy Admiral Zumwalt Jr. was spraying Agent Orange.

Son Elmo and died of leukemia.

"This is the first time the government has not been sued for Agent Orange."

has not been the government does represent Zumwalt, who for Agent Orange.

Health-care reform costs a

Stark shoots from the lip on proposals

By Judy Keen
USA TODAY

With his graying hair and authoritative air, Rep. Fortney "Pete" Stark is the very picture of the dignified lawmaker.

A liberal, 11-term Democrat from northern California's Bay Area, he easily could be an unexceptional House veteran.

Except for that mouth.

The irrepressible Stark, who with little provocation spouts caustic quips, has lately aimed at President Clinton's health-care reforms — dubbing them "fairy dust" in one of his more printable references.

Stark chairs a Ways and Means health subcommittee that could be an early test of the administration's overdue reform plan. His fealty to party and president will be doubted if he doesn't support it. So far, he's resisting mightily.

The mouth has gotten him in trouble before: In 1990, he had to apologize after he called Louis Sullivan, President Bush's only black Cabinet officer, a "disgrace to his race."

Stark wants a Canadian-style health plan — just one big system financed by the federal government — and he's not going to get it from this White House.

So he calls Ira Magaziner, the top White House health-reform guru, a "nut" and a slang word for a rear portion of the human anatomy.

He muses about whether it's politically correct to call the president and other Arkansans "crackers" — a derogatory term for some Southern whites.

Of Clinton and his staff, Stark observes: "They think they're pretty smart, and they don't think there's anybody else smart in town. ... They're freezing us out."

Magaziner, acknowledging Stark's "leadership on health care," says the two agree on the need for reform. "We disagree on other points ... but hope we can come to agreement."

Stark doesn't think Clinton under-



By H. Darr Beiser, USA TODAY

STARK ASSESSMENT: Californian doesn't mince words on the health-care plan: "Someplace that's supposed to exist that does not exist."

“
(Clinton and his staff) think they're pretty smart, and they don't think there's anybody else smart in town. ... They're freezing us out.
”

— Rep. Fortney 'Pete' Stark

make it clear to the White House that he thinks there are some serious errors in their proposals," says McDermott, who also backs a Canadian-style system.

Some of Stark's ire is borne of the

cost controls and regulations that permit states to enact Canadian-style systems. "And then I'll be with them in a New York minute."

The rogue role comes naturally to Stark. Before going to Congress in 1973, he was a "rich white banker." One reason for his bank's success, he says: the neon peace sign he plopped on its headquarters building just across the bay from San Francisco.

He's a solid liberal, supporting gun control and legalization of some drugs, and has won most elections handily.

A workaholic who spends his rare time off playing tennis and traveling, Stark says his 85-year-old mother is his top health adviser.

He says he's trying to be more polite in his dealings with the nation's

Small firm concerns at the biggest

By Judi Hasson
USA TODAY

White House health advisers are settling on a solution that will be familiar to most people.

Employers and employees share the cost of health insurance.

The difference: Under the plan now on President Clinton's desk, all employers — even those with one worker — would be required to provide insurance.

The objective is to fulfill Clinton's campaign promise: provide a comprehensive, affordable package of benefits for all Americans, including those now uninsured; provide a safety net so you can never lose your insurance even if you lose your job; and not penalize those who already have good benefits.

The financing proposal appears to carry more weight than past proposals because top White House health advisers are behind it.

It replaces a much-criticized payroll tax. Some argued higher-income workers would be penalized by the tax, a percentage of pay, rise with pay levels.

The plan envisions the number of uninsured — now 37 million — will shrink dramatically as all workers get health insurance.

And the unemployed would be covered by a national fund using \$9 billion in Medicaid and \$9 billion in Medicare because workers covered by those programs would get insurance through the workplace.

\$21 billion because hospitals would no longer have to shoulder the cost of most uninsured patients.

The rest coming as tax revenue through efficiencies in the system. By that theory, as companies slow and companies have more taxable income. Clearly, they can deduct their insur-

WASHINGTON

Health care reform costs a shared burden

Small firms' concerns are the biggest

By Judi Hasson
USA TODAY

White House health advisers, casting about for a way to finance health reform, are settling on a solution that will be familiar to most people.

Employers and employees would share the cost of health insurance.

The difference: Under the proposal now on President Clinton's desk, all employers — even those with just one worker — would be required to provide insurance.

The objective is to fulfill Clinton's campaign promise: provide a comprehensive, affordable package of benefits for all Americans, including those now uninsured; provide security so you can never lose your insurance even if you lose your job or get sick; and not penalize those who already have good benefits.

The financing proposal apparently carries more weight than past trial balloons because top White House health advisers are behind it.

It replaces a much-criticized payroll tax. Some argued higher-income workers would be penalized because the tax, a percentage of pay, would rise with pay levels.

The plan envisions the number of uninsured — now 37 million and growing — will shrink dramatically as all workers get health insurance.

And the unemployed would be covered by a national fund using \$60 billion the White House projects will be saved by revamping the system:

- \$9 billion in Medicaid and \$11 billion in Medicare because some workers covered by those federal programs would get insurance through the workplace.

- \$21 billion because hospitals no longer would have to shoulder the cost of most uninsured patients.

- The rest coming as tax revenues grow through efficiencies in the new system. By that theory, as cost increases slow and companies save money on health insurance, they'll have more taxable income. Currently, they can deduct their insurance costs no matter how much it is.

The plan: What's in, what's out

President Clinton is reviewing a health-care reform proposal that contains these elements.

WHAT'S IN

- Everyone would have a basic package of benefits, provided through local consumer pools.

- All employers would pay 80% of insurance premiums; an employee would pay 20%.

For part-time workers, employers would pay a pro-rated share. A national fund would make up the difference and pay full premiums for the unemployed.

Small businesses and low-income workers would get subsidies, too.

Big companies — 5,000 or more workers — could opt out of local pools and run their own plans, following national rules.

- Prescription drugs would be covered with 20% co-payment by

patient; no deductible.

- Children's dental-care covered; adult dental care phased in.

- More mental-health coverage than most people have now.

- Abortion coverage.

- Long-term care phased in.

- A national budget limiting health spending.

WHAT'S OUT

- Coverage for illegal immigrants. They could get free emergency hospital care if indigent.

UNDECIDED

- Price controls on doctors, hospitals, laboratories, etc.

- Whether to tax benefits that exceed a basic package or to tax companies that provide benefits beyond a basic package. Companies now can deduct all health insurance costs.

By H. Darr Beiser, USA TODAY
The words on the health-care reform do not exist.

roles and regulations that it takes to enact Canadian-style health care. 'And then I'll be with them for a minute.'

que role comes naturally to Clinton before going to Congress in 1994 as a "rich white banker." Clinton, for his bank's success, he has been peace sign he plopped headquarters building just a few blocks from San Francisco. Clinton is a solid liberal, supporting gun control and legalization of some drugs. Clinton has won most elections

aholic who spends his rare free time playing tennis and traveling. Clinton's 85-year-old mother is a health adviser.

Clinton is he's trying to be more political in his dealings with the nation's health officials, but he warns,



By H. Darr Beiser, USA TODAY
DOLE: 'Employers have limits, too, on how much they can absorb.'

their region of a guaranteed health package; employees would pay 20%.

Until the White House details the benefits package, it's hard to say whether average Americans would pay more or less than they do now.

Employees could choose among three systems — a health maintenance organization, a list of doctors organized in a network, or old-fashioned fee-for-service medicine.

Patients would still have out-of-

include an annual deductible of \$200 for individuals and \$400 for families, and a 20% co-payment for services.

Consumers could choose individual coverage, a family plan or one for an adult and one child. Two-earner couples would not be penalized.

When Clinton unveils his plan, requiring all employers to participate could be a stumbling block.

Says Leslie Aubin of the National Federation of Independent Business, "We are worried about forcing small, marginal, struggling new businesses to bear new costs."

Says Senate Minority Leader Robert Dole, R-Kan., "Employers have limits, too, on how much they can absorb without losing jobs or shutting down their business."

The White House, preoccupied with getting the president's economic package passed by Congress, has yet to brief Congress or other groups on the key element of financing the nearly finished health plan.

But an intensive lobbying effort will begin once Congress recesses in August. Clinton is expected to begin discussing the plan publicly in August and unveil details in September.

Administration officials hope coverage for all can be in force by 1996 — when Clinton faces re-election.

The irrepressible Stark, who with little provocation spouts caustic quips, has lately aimed at President Clinton's health-care reforms — dubbing them “fairy dust” in one of his more printable references.

Stark chairs a Ways and Means health subcommittee that could be an early test of the administration's overdue reform plan. His fealty to party and president will be doubted if he doesn't support it. So far, he's resisting mightily.

The mouth has gotten him in trouble before: In 1990, he had to apologize after he called Louis Sullivan, President Bush's only black Cabinet officer, a “disgrace to his race.”

Stark wants a Canadian-style health plan — just one big system financed by the federal government — and he's not going to get it from this White House.

So he calls Ira Magaziner, the top White House health-reform guru, a “nut” and a slang word for a rear portion of the human anatomy.

He muses about whether it's politically correct to call the president and other Arkansans “crackers” — a derogatory term for some Southern whites.

Of Clinton and his staff, Stark observes: “They think they're pretty smart, and they don't think there's anybody else smart in town. ... They're freezing us out.”

Magaziner, acknowledging Stark's “leadership on health care,” says the two agree on the need for reform. “We disagree on other points ... but hope we can come to agreement.”

Stark doesn't think Clinton understands health care or Congress. He wants the president to skip writing a bill and instead send Congress broad outlines to shape into legislation.

“He should let us try,” Stark says. “He's treating us like children.”

At the White House, Stark's name-calling is dismissed as resentment because he's not getting his way.

Still, he displays a photo of himself and Hillary Rodham Clinton in his Capitol Hill office. “To chairman Pete Stark with thanks for your help and best wishes!” it reads.

And he spares the first lady from much of his verbal venom. “She's bright,” he says. “She's light years ahead of Ira Magaziner. But politically, her idea is to say something comforting to every group. She never delivers any bad news.”

Stark says there's lots of bad news in the evolving Clinton plan.

Its untried concept of universal coverage organized by consumer pools that will negotiate for lowest-cost care, he says, is like the fountain of youth: “Someplace that's supposed to exist that does not exist.”

To make his point, Monday he introduced a bill that would force members of Congress to enroll their families in the cheapest health plan in their districts.

Behind Stark's barbs lie a warning and a desire to help, says Rep. Jim McDermott, D-Wash. “He's trying to



By H. Darr Beiser, USA TODAY

STARK ASSESSMENT: Californian doesn't mince words on the health-care plan: “Someplace that's supposed to exist that does not exist.”

“
(Clinton and his staff) think they're pretty smart, and they don't think there's anybody else smart in town. ... They're freezing us out.”

”
— Rep. Fortney ‘Pete’ Stark

make it clear to the White House that he thinks there are some serious errors in their proposals,” says McDermott, who also backs a Canadian-style system.

Some of Stark's ire is borne of the arrogance that comes with knowing an issue inside and out. His subcommittee basically runs the nation's Medicare system, and he's been thinking and breathing health care for decades. He wants to be a player.

“They keep telling us we don't have anywhere else to go. Bull—. We don't have anywhere else to go: We can write our own bill.”

Some White House aides hope reform legislation can be routed around Stark's subcommittee. The administration treats him gingerly — it hasn't shut him out of meetings, and aides say they're sure he'll eventually be on their side.

“He commands hundreds of pages of fine print of law and regulation that determine the flow of over \$200 billion a year in Medicare and Medicaid spending,” says Alain Enthoven, the economist who conceived the Clinton health-care philosophy.

“Hospitals and health-care organizations can find their revenues raised or lowered by the favor or disfavor of Mr. Stark. Imagine his power if all of America's health-care finances were controlled by his subcommittee.”

But Stark's mutiny has limits. One day, he knows, Clinton will appeal to him as a loyal Democrat to endorse the administration's approach.

When that happens, Stark says, “I will.” But first, he'll try to win firm

cost controls and regulations that permit states to enact Canadian-style systems. “And then I'll be with them in a New York minute.”

The rogue role comes naturally to Stark. Before going to Congress in 1973, he was a “rich white banker.” One reason for his bank's success, he says: the neon peace sign he plopped on its headquarters building just across the bay from San Francisco.

He's a solid liberal, supporting gun control and legalization of some drugs, and has won most elections handily.

A workaholic who spends his rare time off playing tennis and traveling, Stark says his 85-year-old mother is his top health adviser.

He says he's trying to be more polite in his dealings with the nation's top elected officials, but he warns, “Deference isn't acquiescence. I can't change the way I am.”

one worker — would be required to provide insurance.

The objective is to fulfill a campaign promise: provide comprehensive, affordable paid benefits for all Americans, including those now uninsured; provide so you can never lose your job even if you lose your job; and not penalize those who already have good benefits.

The financing proposal applies more weight than pay balloons because top White health advisers are behind it.

It replaces a much-criticized roll tax. Some argued higher workers would be penalized the tax, a percentage of pay rise with pay levels.

The plan envisions the uninsured — now 37 million growing — will shrink dramatically as all workers get health insurance.

And the unemployed would be covered by a national fund of \$1 billion the White House project be saved by revamping the :

► \$9 billion in Medicaid billion in Medicare because workers covered by those programs would get insurance through the workplace.

► \$21 billion because hospitals would have to shoulder cost of most uninsured patients.

► The rest coming as tax reductions grow through efficiencies in the system. By that theory, as creates slow and companies money on health insurance have more taxable income. ly, they can deduct their insurance costs no matter how much it

Under the proposal, employers would pay 80% of the average



**PHOTOCOPY
PRESERVATION**

