PHOTOCOPY
PRESERVATION

PROFILE OF THE UNINSURED: MYTH VS. REALITY

As health reform reaches a critical stage in Congress, fashioning the right solution requires having a clear understanding of the characteristics of the uninsured. Contrary to popular myth, the uninsured are not all poor, elderly, or otherwise vulnerable. In fact, over half of the uninsured live in families where at least one spouse is a *full-year, full-time* worker. Approximately 84 percent come from families whose head works at least part of the year. In addition, while even short exposures without insurance put people at significant financial and health risk, being uninsured is predominately a long-term problem. Finally, those who do purchase insurance, and taxpayers as a group, bear much of the burden of the uninsured -- through both "cost shifting" to private insurance premiums and increased spending on public programs.

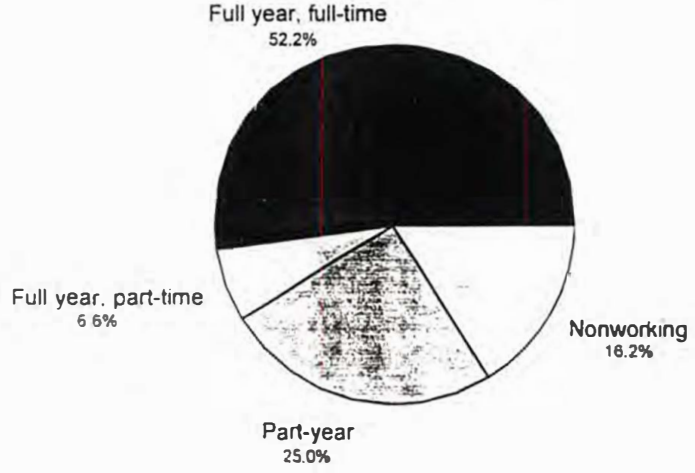
Myth #1: ***The uninsured are unemployed.***

Reality: The uninsured are working Americans.

The vast majority of the uninsured -- 83.8 percent -- belong to working families. Federal programs already cover most of the non-working population. Medicare provides near-universal coverage for those over 65, and Medicaid covers 50 percent of those in poverty and 25 percent of those just above the poverty line.

As a result, large numbers of the uninsured are clustered in working families with moderate incomes, who do not qualify for Medicaid. Insurers in general charge higher rates to the self-employed and small businesses, which makes it difficult for them to obtain affordable coverage.

Job Status of the Uninsured



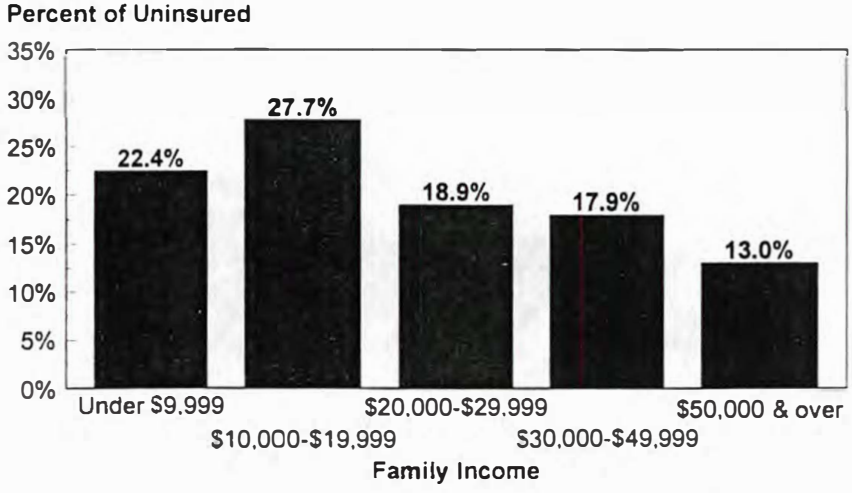
Myth #2: ***The uninsured are poor.***

Reality: **The bulk of the uninsured have moderate incomes; many are middle-income.**

The vast majority of the uninsured -- 72 percent -- have incomes above the federal poverty threshold. While the average uninsured American family has a modest income, it is far from being in poverty.

The bulk of the uninsured are in hard-working families for whom health insurance is unaffordable. Because small businesses and the self-employed have difficulty obtaining affordable insurance, almost one in three of the uninsured is a member of a family making more than $30,000 a year.

Family Income of the Uninsured

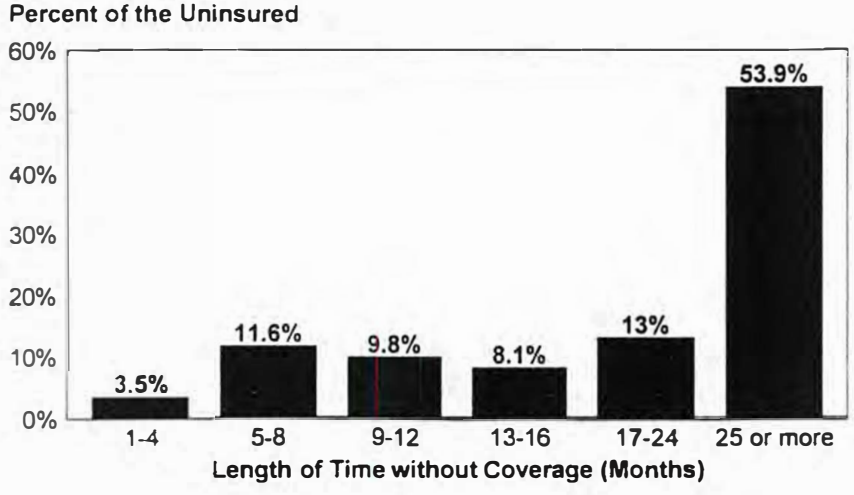


Myth #3: ***For most of the uninsured, being without health insurance is a short-term, rather than a long-term, problem.***

Reality: **54 percent of those uninsured today will be uninsured for more than two years. 75 percent will be uninsured for more than a year.[1]**

Some have suggested that being uninsured is a short-term problem, not a long-term condition. Even short periods of time without insurance do put people at significant financial and health risk. But being without health insurance is not a short-term problem. A recent study from the University of Missouri reports that nearly 75 percent of uninsured Americans are "chronically" uninsured, and will remain uninsured for longer than one year. Less than one in twenty out of those uninsured today will obtain health coverage before they have been uninsured for five months.

Distribution of Uninsured, by Time without Coverage

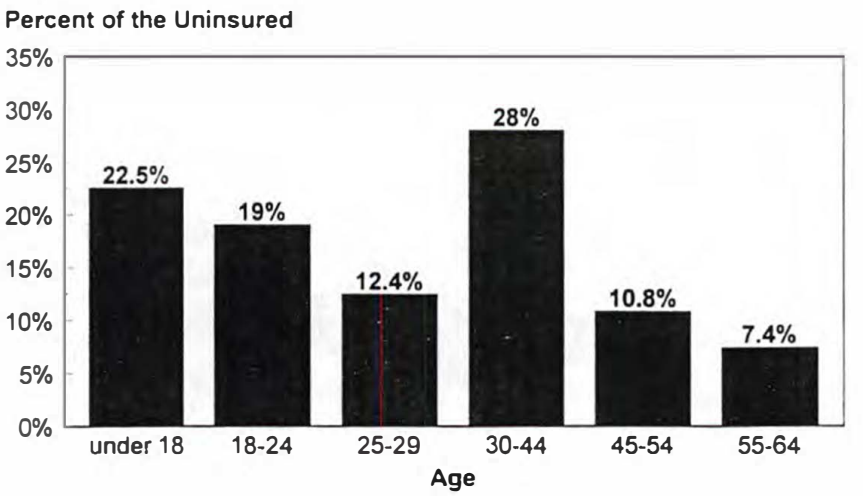


Myth #4: ***The uninsured are mainly young and healthy; they choose not to buy insurance.***

Reality: **Almost one quarter of the uninsured are children. Nearly half of the uninsured are over 30. Less than 30 percent of the uninsured are between 18 and 30 years of age.**

Most of the uninsured are not young, healthy adults, but rather children and persons over 30. Nevertheless, the young are a disproportionate share of the uninsured, because, with modest incomes and poor access to affordable coverage, they cannot pay for insurance.

Age of the Uninsured



Myth #5: ***I have health insurance--the uninsured do not affect me.***

Reality: **-- Americans who lose their jobs may well become uninsured.**
-- Private insurance costs are high because of the uninsured.
-- Taxes are higher because of high Federal health costs.

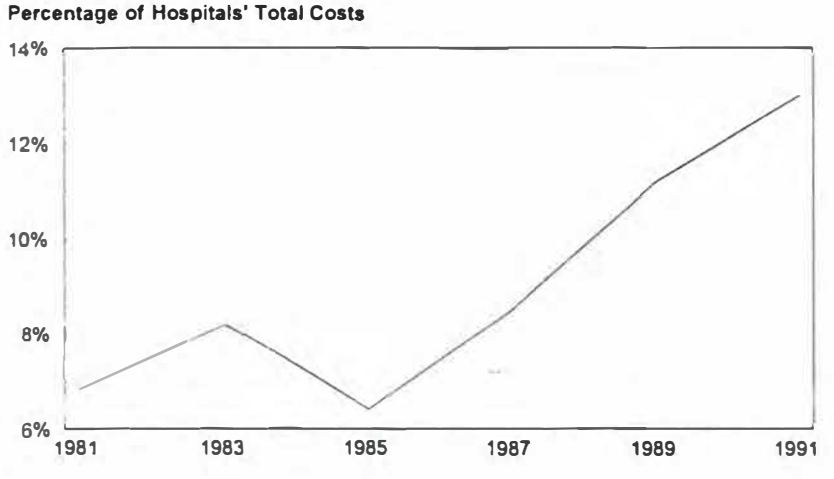
Nine out of ten Americans with private health insurance receive insurance through employers. Those who lose their jobs for an extended period of time may well lose their health insurance.

In addition, the uninsured place a large direct burden on those who do have insurance -- through higher taxes and through higher private insurance premiums. The effects of a large uninsured population go well beyond the individuals without coverage. The uninsured do receive health care -- often in emergency rooms, at very high costs. Hospitals, doctors and other providers raise the fees they charge those who have private insurance in order to cover the bill for the inefficient, high-cost services received by the uninsured.

The lack of private health insurance for some raises taxes for all. Some say the obvious solution is to cut, or "cap," Medicare and Medicaid. But cutting these programs puts pressure on doctors, hospitals and other providers to raise the fees they charge those with private insurance. As government programs pay less, everyone else pays more.

According to the Congressional Budget Office, unreimbursed costs for hospitals alone totaled over $28 billion in 1991. As a result, private payers are charged substantially more by hospitals than the actual cost of their services.

Hospitals' Unreimbursed Costs, 1981-1991



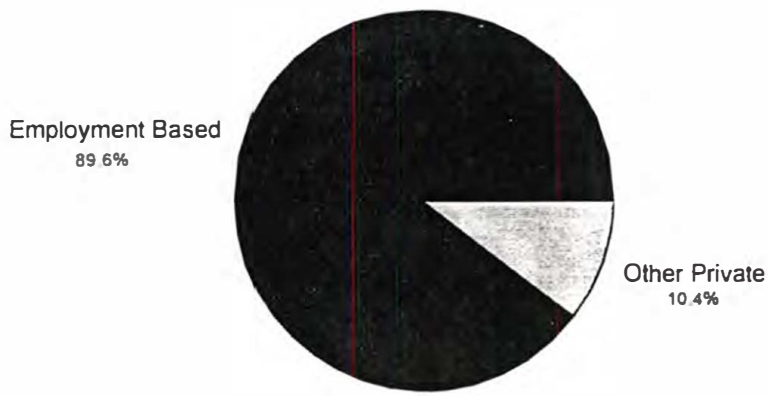
Myth #6: ***An employer mandate is not necessary to fix the health care system, or to decrease the number of uninsured.***

Reality: **The United States has an employment-based health care system. The major cause of increasing numbers of uninsured is employers not providing coverage.**

According to the March 1993 Current Population Survey, nine out of ten of the nonelderly who purchase private insurance obtain it through the workplace.

Recent increases in the number of uninsured can be attributed to a decline in the number of employers who offer coverage. The share of the nonelderly population with employment-based coverage declined from 66.8 percent in 1988 to 62.5 percent in 1992. This fall was partly offset by a rise in the number of nonelderly Americans with publicly-financed health insurance -- from 12.4 percent to 15.1 percent. Even with this boost in publicly-financed coverage, the share of the non-elderly who are uninsured grew from 15.9 percent of the population in 1988 to 17.4 percent in 1992.

Source of Private Health Insurance, 1992



Conclusion

For millions of Americans with health insurance, the fear of losing their health coverage is a constant source of insecurity: over 38 million Americans were uninsured at some point in time in 1992.

Universal coverage is a universal issue. It is not simply about the unemployed, the poor, or the young and healthy. Hard-working Americans are disadvantaged by today's health care system, and have the most to gain by reform that includes universal coverage. Today, the statistics show that the poor and elderly are covered by government programs, while millions of working Americans and their families are uninsured. Universal coverage is essential to strengthen the link between work and security.

It makes sense to build on the employer-based system. Most people today with private insurance obtain it through their employer -- it is a system that works for the vast majority of Americans. With universal coverage, small business will not be disadvantaged compared to large businesses, and those who purchase insurance will no longer pay more than their fair share.

NOTES

Unless otherwise indicated, all numbers come from the March 1993 Census Population Survey. All CPS numbers refer to the non-elderly population (less than 65 years of age).

1. *Whither the Health Care Crises? Misinterpretations of Chronically Uninsured Estimates*, Timothy McBride, University of Missouri-St. Louis, April 1994.

FACT SHEET
ADDITIONAL STATISTICS ON THE UNINSURED

I. OVERALL

- 39 million without coverage in 1994, up from 36.3 million in 1991. [Employee Benefits Research Institute]
- 58 million uncovered for part of the year. [EBRI]
- The current figure of 37 million uninsured is growing 100,000 a month. [WSJ, June 9, 1993]
- 2.25 million Americans lose health insurance each month [Families USA, September 15, 1993]
- 726,000 more Americans in 1991 went without health insurance than in 1990, despite a large expansion of the Medicaid program. [Center for National Health Program Studies, Dec. 16, 1992]

II. WORKERS AND FAMILIES

A. Workers

- 84 percent of the uninsured are full-or part-time workers and their families. [U.S. Census]

B. Children

- There are 9.8 million uninsured children, which is 14.8 percent of all American children [EBRI, Jan. 1994]

C. Middle Class

- 18 million middle-class Americans have no health insurance. [CBO]
- Most uninsured Americans are middle-class working families. 59 percent of the uninsured have incomes between $11,600 and $45,000 per year. [EBRI]
- 44.7 percent of the uninsured make over $20,000. [EBRI, using 1992 figures]
- Nearly one third of the uninsured -- 12.5 million of the 39 million people without coverage -- have incomes between the official poverty level and twice that amount. [NYT 7/8/94]

- In 1992, 48 percent of the uninsured earned between $14,000 and $50,000 a year. [HHS, June 29, 1994]
- Only 16 percent of the uninsured are in families "without an attachment to the workforce." [Kaiser Family Foundation Feb, 1994]
- Two out of five Americans who lose their insurance have incomes of $30,000 or more. [Families USA, April 1994]
- Ron Anderson, president of Parkland Memorial Hospital (a public hospital)- *"The impression the average person has is that we're talking about welfare mothers. But the majority of our patients are working people. Some work several jobs or in small businesses. We have seen a marked increase in the number of persons who never thought they would use a public hospital."* [Wash. Post, 12/15/93]

D. Employees of Small Businesses

- Less than a third of firms with fewer than 25 workers offer health insurance, compared to 95 percent for firms with over 100 employees. [Kaiser Family Foundation, Feb. 10, 1994]
- 25 percent of uninsured are from firms with less than 25 employees. [Kaiser Family Foundation, Feb. 10, 1994]
- 42 percent of the additional 2.2 million uninsured during 1991-1992 were from families employed by firms with less than 25 employees. [EBRI, Jan. 1994]

E. Voluntarily Uninsured

- A small minority -- only 7 percent of the uninsured population -- are uninsured because they choose to be that way. [Kaiser Commonwealth Survey, August, 1993 and JAMA, May 15, 1993]

F. Security

- Without universal coverage, all Americans, even those with good policies today, are at risk of losing their insurance.

SUMMARIES OF SELECTED ARTICLES: COVERAGE

The following articles on universal coverage are attached:

- "Can The United States Reform Its Health Care System" by Henry J. Aaron [Health Affairs,11/1/93]. One page summary and original attached.

- "Universal Coverage: It's Now or Never" [NYT 6/29/94] In this recent op-ed, Princeton economist Uwe Reinhardt articulates many of the macroeconomic reasons for universal coverage and criticizes the Senate Finance incremental approach. Reinhardt argues that without universal coverage, many reform provisions, such as community rating, are doomed to failure. He criticizes the lack of available subsidies in the Senate Finance proposal, the firm-based subsidy structure in most of the bills (including the HSA), and warns that the faulty financing in the Finance proposal will lead to rationing of health care services for low-income people.

- "An Unpleasant Choice if Employers Won't Pay" [NYT 7/6/94] This article by Robert Pear examines the employer mandate and why many health policy experts favor it as a means to universal coverage. Pear also highlights the large number of working class people who comprise the uninsured, but argues that the mandate will be passed along to workers in the form of lower wages. Good quote from William Custer, Director of EBRI: "*Uninsured people at the poor end of the middle class are least likely to pick up coverage as a result of these [incremental] reforms.*"

- "Frayed Nerves of People Without Health Coverage" [NYT 7/11/94] This article contains anecdotes about uninsured individuals and families. It is useful as background for the human interest side of the debate over the uninsured. Good quote from Drew Altman of the Kaiser Foundation: *"All the studies show that the uninsured get less care and end up sicker than people with insurance."*

- "Players and Payers" [NYT 6/12/94] Yale law professor Michael Graetz and Yale economist James Tobin attack the HSA's chief financing mechanism for universal coverage -- the employer mandate -- as administratively awkward and inequitable. The authors contend that the mandate is passed back to employees in the form of lower wages and that it involves enormous administrative difficulties. They argue instead for a tax cap, an individual mandate with a Stark-like version of Medicare -- in this case called "FedMed" -- with a risk adjustment and reinsurance mechanism.

- "Health System Reform: Let's Not Miss Our Chance" [Stuart Altman, Excerpted from Health Affairs, Spring, 1994] "The Clinton plan incorporates three key components that should be strongly supported by all: universal and comprehensive coverage, a mandated employer-based financing system, and a national expenditure limit." Altman expresses three concerns about 0the Health Security Act's efforts to achieve universal coverage:

    1) relies too heavily on savings from Medicare and Medicaid.
    2) health spending growth reduction targets are unrealistic.
    3) regional alliances are too powerful.

"A Dangerous Year" [NYT 10/28/93] Harvard doctor Rashi Fein argues against delays in the time table for universal coverage because it could take time to realize savings from reform necessary to finance reform in the absence of a broad-based tax. This article is useful background for two reasons: it makes the argument that universal coverage is necessary to eliminate cost shifting in the current system and it counters the Cooper-type argument that we should expand coverage only as savings from competition materialize.

- "Universal Care: Not From Clinton" [NYT 6/12/94] This article by Harvard doctors Steffie Woolhandler and David Himmelstein is useful to get a sense of criticism from proponents of a single payer system. The two doctors contend that managed competition will not produce savings necessary to finance reform. The authors maintain that the Health Security Act would enrich the largest HMOs and open the door to gaming by providers and patients. In addition to criticizing the administrative costs and bureaucracy of the Clinton plan, the authors maintain that the

HMOs that would thrive under reform would threaten quality of care.

- "The Logic of Comprehensive Coverage" [Excerpted from "A New Framework" in The Logic of Health Care Reform, by Paul Starr 1993] This excerpt from Princeton sociologist Paul Starr's book discusses the principles behind universal coverage. It is helpful background material to understand how universal coverage eliminates the problems inherent in a non-universal system, including: cost shifting, adverse selection (only high risk people buying insurance), high administrative costs, and avoiding purchasing insurance until a serious illness develops. Note: Starr is for the employer mandate but argues against employers *providing* health benefits to their employees because he believes it limits consumer choice, discriminates against the unemployed and imposes large administrative costs on employees.

Note on Secretary Bentsen's Statements on Universal Coverage
A nexis search spanning the last ten months revealed statements by Secretary Bentsen on the following three issues related to universal coverage:

- *Lower Threshold for Firms that Want to Self-Insure* The address to the National Association of Manufacturers immediately after the State of the Union address (1/27/94) promising to lower threshold for businesses who want to self-insure.

- *The Need for Cost Containment* The Secretary's prepared remarks before NAM focused on the need to contain costs, contain entitlements, and increase preventive care. Transcript of remarks attached.

- *Slower Phase-In* The Secretary was quoted in the Post in May saying that "*you'll probably see some of these things phased in more than the administration proposed -- both the mandates and the benefits package...there will certainly be a carve out for small businesses...The measure will aim for universal coverage...but...such coverage will 'never be 100 percent.'*" [5/10/94]

Can the United States Reform Its Health Care System?
by Henry Aaron

SUMMARY

In this paper, Henry Aaron examines the prospects for health care reform from more of a political and practical perspective than an economic one. His basic point is that the scope of the administration's proposals are unprecedented in U.S. history and beyond the capacity of our political system to deliver in their entirety. Nevertheless, Aaron looks favorably on many aspects of the President's plan, and he believes a less extensive compromise has the potential to be enacted to "serve as the seed from which real reform can grow."

The author begins with an overview of structural obstacles to fundamental reform, including the political difficulties of changing a multi-billion dollar industry and the shifting of resources that comes with such change. Aaron focuses on the President's proposals in recognition of these underlying forces, and he comments on some of the other major plans. While he labels the President's initiative as "unavoidably complex," he says the Chafee plan "contains no coherent road map to universal coverage and relies upon the rosy claims for cost containment of the more euphoric proponents of managed competition."

Finally, Aaron analyzes five fundamental "questions" that will drive the health care reform debate.

1) Universal Coverage

Support for this goal has grown. The debate will focus on timing and method, which together strongly influence cost.

2) Employer Mandate

A compromise "limited mandate" would allow opponents to claim victory in practice and proponents to win in principle.

3) Spending Limits

The magnitude of savings the President is calling for will take more than four years to achieve. While spending limits are preferable, they will not win majority support.

4) Role of Alliances

Some form of "health alliances" will be approved, although the role and powers of the alliances will not be as extensive as proposed by the President.

5) How much can be implemented over the remainder of this decade

The scope and timing of what can be done ultimately depends on political leadership and will.

Can the United States Reform Its Health Care System?

by
Henry J. Aaron[1]

All too often participants in the debate on health care reform present "best" new systems, rather than "best" reforms of the system that exists. Rather than worrying about how to move from where we now are to where they would like us to be, such advocates pretend that it is possible costlessly to erase current arrangements and start afresh.

Such immaculately conceived visions fail because they do not recognize the enormous investment that the United States (and every other country) has in its current system. Creating wholly new arrangements entails wholesale changes in methods of paying for care, the relationships between patients and health care providers, and perhaps the organization of the delivery of care itself. In a country such as the United States, fundamental change in the health care financing system forces renegotiation of billions -- quite literally billions -- of significant contractual and personal relationships. The wrench of change is compounded if, as under the plan advanced by president Clinton, a large cut in the use or price of medical services is the keystone to financing the new system. Such savings require massive income shifts, changes in practice patterns, or both.

Short of economic or military catastrophe, democracies seldom break so much china in the name of reform. Even parliamentary systems seldom make revolutionary changes when the population is sharply divided, although narrow pluralities can and sometimes do effect sweeping reforms. Under the U.S. governmental system, in which

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[1]Director of Economic Studies, The Brookings Institution

minority interests can marshall numerous and powerful defenses to block major changes not supported by dominant and well-mobilized majorities, they are inconceivable.

The structure of U.S. health care problems compounds this political difficulty. Americans recognize the need to assure and extend insurance coverage. This step will cost money. But most reformers say they also want to sharply slow the growth of health care spending. If both goals are met, reform must inflict losses on some people, businesses, industries, and regions, as the gainers win resources that would otherwise have flowed elsewhere. Such shifts run afoul of the political law, peculiarly apt in this case, that Charles Schultze articulated, "Never be seen to do direct harm."

As noted, however, health reform must do some harm. To pay for extending benefits, one must either raise taxes, which is always politically difficult, or cut somebody's income, which is politically insupportable under Schultze' law, unless the somebody is shown to be a fool ("we are cutting waste") or a knave ("we are slashing fraud and abuse").

I believe that a recognition of these underlying forces is important for interpreting the various proposals for reforming the U.S. system of paying for health care and for making sense of the forthcoming debate. I shall focus on the proposal President Clinton outlined on October 22nd, but will comment briefly on other major proposals that will play a meaningful part in the debate.

The President's Plan

President Clinton's plan begins with a basically conservative political vision, but deviates substantially from it in execution. The conservative vision sees that most Americans are currently well, if unreliably, insured and that all can be covered securely by building on, rather than replacing, the current system. This vision recognizes that curbs on premium growth linked to limits on approved cost sharing and prohibition of balance-billing can create the budget discipline that is largely missing from the current system.

Unavoidable Complexity

Although advocates of the President's plan would deny it, the vision behind the plan rests on an acceptance of the complexity and cumbersomeness of the current system. It does so, because it forswears neat alternative program designs that would scrap the current system. In fact, the president's strategy ***must*** increase complexity because his plan cannot rely exclusively on any one of the three possible ways to achieve universal coverage, but must use all three – an employer mandate to pay for insurance, an individual mandate to purchase insurance, and government provision of insurance.

- Since most Americans, other than those who depend on public programs, are insured through work, the president would extend that system to workers not currently covered by requiring all employers to pay most of the cost of insurance coverage for their employees and families. However, for companies with fewer than 5,000 employees the plan scraps the current employer practice of sponsoring insurance plans for their employees and creates new "regional alliances" that would approve a limited number of insurance plans among which individuals must choose.

- The range of insured services that all approved plans must cover is at least as generous as the average current benefit package, particularly in coverage of mental health and preventive services.

- Exclusion from personal income tax is retained unchanged for required employer-financed benefits. Exclusion for extra employer-financed benefits, such as payment for the share of premium for which employee's would otherwise be responsible, is retained for ten years.

- To avoid disrupting coverage for the elderly and disabled, the Clinton plan would retain government insurance through medicare. But the option of medicare beneficiaries to elect coverage through regional alliances hints at the eventual replacement of government administered insurance with insurance administration by regional alliances for everyone. Meanwhile, the plan adds a new drug benefit and modest long term care coverage. These extensions simultaneously address real problems of the elderly and secure their political support for reform and boost plan costs.

- By definition, self-employed or not-employed nonelderly Americans cannot be covered through an employer. The only way to assure them coverage, in the absence of direct government payment for health coverage, is through what amounts to an individual mandate.

To make the individual mandate affordable, the plan provides subsidies for households containing full-time workers and retirees with incomes below 150 percent of official poverty thresholds, a limit covering most of this group.[2] To ease the shock of the employer mandate for companies that do not currently pay insurance for their employees, the plan contains explicit government subsidies for some companies with 75 or fewer employees in which average earnings of full-time workers are under $24,000 annually. The cap on employer liability for health insurance costs of 7.9 percent of payroll indirectly subsidizes all companies for which the current cost of services

[2]The plan also provides subsidies to individuals or families with incomes up to 250 percent of official poverty thresholds if the family contains one or more part-time workers, but no full-time worker. The incentives of these varied thresholds are quite odd.

mandated under the president's plan exceeds 7.9 percent of payroll. These subsidies are paid for by the government or by payments made by companies that do not now pay for employee health plans.

The president's plan will also redistribute insurance costs among companies in other ways. Companies whose employees are now covered by the plans of relatives employed by other companies will have to shoulder those costs directly. The shift from experience to community rating for all companies with more than fifty but fewer than 5,000 employees will cause even larger inter-company shifts in costs of health care. Companies with above average current costs receive subsidies paid, at least at first, by increased charges on companies with below average costs.[3] If growth of spending is slowed, most companies would have lower insurance costs after a few years. Reportedly at the last minute, a provision crept into the plan to relieve companies of costs of retiree health benefits for people under age 65. This provision, a massive gift mostly to the shareholders of a few, large, old corporations is likely to be subject to the political equivalent of LIFO accounting -- last in, first out.

Each of these steps is initially costly. Exactly how costly is determined by the comprehensiveness of coverage provided under the plan, the generosity of new benefits for the elderly, and the depth of subsidies. The estimated costs of these benefits is $100

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[3]The consensus among economists is that most health insurance costs, before and after reform, are borne by workers through reduced wages. For a thorough review of these issues, see Alan B. Krueger, "Observations on Employment-Based Government Mandates, With Particular Reference to Health Insurance," duplicated, October 15, 1993. Few people other than economists believe in this off set, and economists acknowledge that the adjustment process may be slow and painful.

billion in 1998, the first year in which the plan would be fully operational and four years after presumed enactment.

Paying the Bill

The next step is to decide how to pay for the added costs of new and extended services. The problem for government payers is quite different from that of private payers. Governments have four options. Two – deficit financing and cutting nonhealth programs – can be disregarded. The deficit is already too high, and elected officials have paid in political blood with program cuts to bring it down; further politically acceptable spending cuts in nonhealth programs are decidedly scarce. The fall-out from the deficit reduction debate seems also to preclude more than token use of the third instrument, tax increases. The added federal costs of the president's health plan are therefore financed largely from cuts in current health programs, notably medicare and medicaid.

The added private costs are met initially by public subsidies and by cost shifting among private payers. The magnitude of inter-company shifts[4] has not been reported, but is likely to be quite large, as the cost differences among plans are now frequently on the order of two or three to one. Moreover, these variations arise primarily from variations in local prices, differences in local practice patterns, and work force characteristics. While the president's plan would perpetuate some of these differences, most would be levelled out by proposed community rating within each regional alliance.

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[4]As noted in the preceding footnote, what appear as inter-company shifts in the short run can be expected over time to become shifts in the composition of worker compensation.

Over the longer run, both private and public payers are projected by the Administration to benefit from a sharp slowdown in the growth of health care spending. Real growth of medicare and medicaid, projected to grow under current policy at an annual rate of 8 percent from 1995 to 2000 would be slashed to 1.4 percent in 2000. The ferocity of the implied cost containment is indicated by comparison with the 1980s, when the number of hospital days per person was slashed 30 percent, when medicare and medicaid payments to providers were slashed, but medicare expenditures rose an average of 7.7 percent annually, medicaid expenditures rose 6.5 percent annually,[5] and all other health care spending rose 5.3 percent annually, all after adjustment for inflation.

Administration

President Clinton's plan would also massively change the administration and politics of health insurance. Employers with fewer than 5,000 employees and all individuals would be prohibited from dealing directly with insurers or at-risk providers such as prepaid group practices. Each state would be required to establish one or more non-overlapping regional health alliances that jointly cover the whole state. These alliances would be required to accept applications from entities wishing to sell health insurance and to approve those plans that meet certain conditions, some of which are outlined in the draft plan. The alliances would be the conduit for subsidies paid to

[5]Part of this increase was attributable to extension of medicaid eligibility. In the latter years, part of the increase occurred as states exploited a loophole in federal legislation that permitted them the increase federal payments by an accounting gimmick.

small businesses and low-income households. The alliances would administer risk-rated payments to health plans.

Serious technical and political issues surround these new entities. How would the alliances prevent cream-skimming by health plans? Are available techniques of risk-rating adequate to squeeze the profit out of cream-skimming? If states tried to gerrymander health alliances, are there objective and legally defensible techniques for identifying when such practices are improper? How would the provision prohibiting alliances that span two or more states from favoring providers located locally over providers located in neighboring alliances be enforced? If political differences arise between the president and Congress, on the one hand, and governors and state legislatures, on the other, regarding administration of the plan, are enforcement techniques politically plausible? No reliable answers exist because these questions have never been put in practice.

For example, suppose that the National Health Board allocates to a given state a share of national health spending well below the level the governor or the state legislature deems appropriate or acceptable. Suppose further that they respond by refusing to enforce such limits on local health plans. Is it plausible that the federal government will take over operation of these alliances as called for in the President Clinton's plan? Would it not be preferable to place the states at financial risk, as is done in Canadian provinces, a measure that the administration is reported to have considered and rejected?

Major Alternative Approaches to Reform

Plans that claim to achieve universal insurance coverage without an employer mandate can choose either of two alternative options -- mandatory individual and family purchase of insurance or tax-financed, government insurance -- or a blend of the two.

The Chafee Plan

The proposal advanced by Senator John Chafee and cosponsored by other senate Republicans relies on a mandate that employers make group insurance available to all employees without regard for preexisting conditions or certain other limitations currently common in the group insurance market. But employers would not be required to pay any of the cost of such insurance. Current tax advantages would be extended to the unemployed, but limited in amount for all individual income-tax payers.

Individuals and families would be required to purchase insurance to achieve universal coverage. Unfortunately, however, low income households cannot afford insurance without subsidy. How the Chafee mandate would deal with this problem is unclear. It would provide some subsidies to low-income households, but limit the subsidies initially to households with incomes below 90 percent of official poverty thresholds. The subsidies would gradually be broadened, extending to families with incomes up to 240 percent of official poverty thresholds by the year 2000. The subsidies would be financed out of savings from shaving 2 percentage points annually from the growth of medicare and medicaid spending.

The Chafee proposal leaves fundamental questions about the subsidy and the mandate for universal coverage unanswered. The subsidy budget is implicit in this cost

control target, but the outline of the proposal does not specify the exact size of the subsidies. Would the individual mandate take effect gradually from the bottom of the income scale as subsidies become available? Would it apply immediately to those who will never be eligible for subsidies? Or would it be introduced in some other pattern? The plan does not say, and the absence of evidence that these issues and others (for example, how would the mandate to have insurance be policed?) have been thought through raises doubts on whether the sponsors are genuinely serious about universal coverage.

Like President Clinton's plan, the Chafee plan would create new regional health alliances, although their powers would pale beside those of the Clinton alliances. The Chafee alliances would be responsible for creating an insurance pool for employers with fewer than 100 employees and individual purchasers, but would not be empowered to approve health plans or to enforce fee schedules. The Chafee plan would institute some features of managed competition, but would contain no other administrative measures to slow the growth of private health care spending. As the materials accompanying release of the plan acknowledge, the Congressional Budget Office is not likely to credit the plan with any savings in health care spending other than for scorable cuts in medicare and medicaid.

Like the president's proposal, the Chafee plan would rely on reductions in growth of medicare and medicaid spending to pay for the federal costs of subsidies to low income households. Unlike the president's plan, however, the Chafee proposal calls for

no additional revenues and contains no controls to discourage providers from shifting additional costs to private payers, as they have done over the last decade.

In contrast to President Clinton's plan, which unambiguously promises universal coverage and a genuine budget constraint in the form of limits on the growth of premiums, the Chafee plan contains no coherent road map to universal coverage and relies upon the rosy claims for cost containment of the more euphoric proponents of managed competition.

Full National Health Insurance

Several plans call for the government to directly provide health insurance to everyone. All contain broad benefit packages, contain some form of budget control or fee regulation on physicians and hospitals, and depend on new taxes along with savings from reduced growth of current programs to pay for the new program.

Long advocated by a solid core of liberal Democrats, this approach credibly promises universal coverage and would create powerful regulatory instruments to control growth of spending. But its even more credible promise to move health care spending from private to public budgets has effectively discouraged support among centrist and conservative members of both parties. Nothing in the current debate has so far suggested that the fate of full national health insurance as the perennial bridesmaid will change soon.

Conservative Options

While all of the preceding options promise universal coverage, proposals for reform advanced by conservative House Democrats led by Representative Jim Cooper and by House Republicans and Senator Gramm make no such claim. These plans would mandate that employers make available group insurance to employees but not pay for it. These plans would prohibit underwriting practices that bar new employees from eligibility and would bar preexisting condition limitations. The Republican proposal would expand tax sheltered savings for medical expenses. The plan advanced by Representative Cooper would establish the framework of managed competition, but not force any employer to pay for insurance. The Cooper plan would pay for coverage for households with incomes below poverty thresholds and partial subsidies for households with incomes up to twice official poverty thresholds. No limits would be placed on the growth of medical expenses except those arising from the incentives created by tax sheltered savings for upper income households to buy high cost-sharing plans.

Defining Questions for the Health Reform Debate

The course of the health care reform debate will be determined by how the Congressional participants respond to five fundamental questions. While members of Congress are clearly responsive to their constituents' views and President Clinton and other members of the administration will try hard to shape these views, I believe that the positions of members of Congress are sufficiently set on the first four so that one can predict the opening and middle-game of the great chess match now beginning. The final

moments of this contest, likely to enliven late summer 1994, hinge on answers to the fifth question and still hold important mysteries.

Question 1 **Do participants embrace the principle that government should assure essentially all Americans health insurance coverage?**

Support for this guarantee has clearly grown. The ranks of supporters have long included most Democrats in both houses and now number many Senate Republicans who have endorsed the Chafee plan. Whether a clear majority in the House endorses this proposition remains unclear, but whatever the count may be on the *principle* of universal coverage, what counts is agreement on timing and method, which together strongly influence cost. The critical but still unresolved question is whether the president can mobilize the growing and well-founded middle class fear of curtailment or loss of health insurance coverage into an irresistible force in support of his approach and timetable.

Question 2 **Should universal coverage be achieved by requiring employers to sponsor, *and pay most of the cost for,* insurance for their employees?**

On the answer to this question hinges the fate of President Clinton's approach to health care reform. In the Senate, nearly all Republicans and a few Democrats, constituting (at least) a filibuster-sustaining minority oppose such a mandate. Nearly all House Republicans and a solid bloc of conservative House Democrats, who together form a majority, also now oppose a mandate as extensive as that proposed by the president.

The outcome of the health care reform debate may well hinge on whether the president and his administration can persuade enough opponents to a full blown mandate to accept a limited mandate that would initially force relatively few businesses to change their practices. Opponents of a sweeping mandate would claim that they had won in practice, while proponents would claim they had won in principle.

Question 3 Should the United States impose an effective budget constraint on growth of health care spending?

If this question refers to a nationally legislated limit on the annual growth of health insurance spending, whether translated into caps on health insurance premiums or imposed through fee controls and hospital budget caps, the line-up in both the House and Senate closely resembles that on forcing employers to pay for health insurance for their workers.

The important difference, as far as President Clinton's proposal is concerned, is that no obvious compromise exists. The administration could easily accept less stringent limits on premium growth than it proposes. But opponents cannot agree to *any* such limit without capitulating, *in flagrante delicto*, on the fundamental principle of disagreement with the president's approach to cost control. Furthermore, many opponents to a legislated cap on spending hold fast to the faith (I believe to an illusion) that their method of controlling costs is not only "lighter but tastes better." They believe that various measures to promote price sensitivity among insurance purchasers and to standardize the health insurance product will suffice to produce a sustained slow-down

in the growth of health care spending, while the president's approach will fail through bureaucratic elephantiasis.

President Clinton will no doubt continue to try to persuade the public that national spending goals can be met, at least through the year 2000, by eliminating medical waste, fraud, and abuse. In so doing, I believe he will be making a serious blunder. First, trying to wring so much out of health care spending as quickly as he proposes is not practicable. Cuts of the magnitude he projects -- one sixth of baseline acute care spending by 2000 -- would require radical changes in medical behavior of providers or large cuts in their incomes. But while many providers acknowledge instances of waste, I think most believe they are now doing the right thing most of the time. And large cuts in provider incomes are likely to provoke guerilla warfare by the groups whose complicity in, if not actual support for, reform is essential for its success.

Those who note that citizens are more satisfied with their health care financing systems in countries that spend far less than the United States does should acknowledge that large savings will *eventually* be possible. But they can still insist that such savings will take much more than the four years the president allows their achievement.

Second, large sustained reductions in the growth of health care spending must eventually force the denial of some beneficial care to some people. Despite the palpable truth of this assertion, it is more effective in emptying a room of elected officials than shouting "fire." The efforts of elected officials to avoid it is understandable, as the choices that rationing will impose are ethically and politically distressing. But health care reformers who insist on claim that enormous savings can be quickly achieved

complicate the task of politicians bent on fuzzing this truth. The president's claims of fast and large savings, which come too quickly for cuts in waste, fraud, and abuse credibly to generate, defeat the political desire to banish the ogre of rationing.

For all of these reasons, I believe that President Clinton's proposed national health budget and limits on premium increases will fail to win majority support. The limited chances for acceptance of the principle of a national health budget were doomed by the high cost of the plan developed by his advisors. The atmosphere created by the 1993 budget debate made politically unthinkable the advocacy of increased taxes on anything but the voluntary inhalation of poison. This situation is highly regrettable, in my view, as President Clinton's repeated insistence on national spending limits are essential for the sustained control of growth of spending is correct. Spending limits are also necessary to create the incentives for efficient resource allocation and even to enable managed competition to achieve its full potential.[*]

President Clinton's health proposal also embraces price regulation of physicians and hospitals that continue to deliver services for fee. But it is not clear how this mandatory extension to the private sector of current practice under medicare and medicaid could win approval outside the general framework of the president's plan.

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[*]Henry J. Aaron, *Serious and Unstable Condition: Financing America's Health Care*, Brookings, 1991; Henry J. Aaron and William B. Schwartz, "Managed Competition: Little Cost Containment without Budget Limits, *Health Affairs*, vol 12 (supplement 1993), pp. 204-215; Henry J. Aaron, "Budget Limits *and* Managed Competition, *Health Affairs*, vol. 12 (Fall 1993), pp. 132-136.

Question 4 What role, if any, should mandatory associations of insurance buyers play in mediating the purchase of insurance by private businesses and individuals?

Something called "health alliances" is likely to win congressional approval, given their inclusion in both the president's plan and that of Senate Republicans. But the role and powers of the alliances remains in doubt. At a minimum, they would assemble small purchasers into large groups for the purchase of insurance. The larger question is whether they will be vested with regulatory powers to approve health plans, to regulate fees, to pay subsidies to business (if an employer mandate survives), and to pay subsidies to households.

For reasons set forth above and elaborated below, I think Congress is not likely to approve powers for health alliances as extensive as proposed by President Clinton. The incentives are large for health alliances in states politically in the control of a party different from that in control in Washington (even assuming one party *is* in control) to pursue policies that are intolerable to Congress or the president. The regulatory demands on the National Health Board or other federal agencies to police the health alliances are enormous and probably unmanageable.

Despite these difficulties, however, the infinite variations in the design and possible powers of health alliances make this the most negotiable element of the reform debate. A broad consensus has developed on the failures of the small group market. Health alliances are a natural vehicle for effectuating any limitations on permitted practices. The case for insisting that health plans all quote prices for a standard plan to help purchasers compare prices is also powerful. This requirement is an element of the

president's and Senator Chafee's plan. It could easily be accepted by all participants in the debate other than those who never met a government function they didn't dislike. Alliances could become the agency for administering medicaid and for offering coverage to any medicare beneficiaries who wished to switch from HCFA.

Any compromise is likely to invest health alliances with powers well short of those proposed in the Clinton plan. A process of gradual evolution would then commence, as Congress added, subtracted, and modified alliance powers. The eventual character of the alliances would be influenced by their initial design, but it would be determined largely by future decisions. The creation of health alliances would be a watershed event, bringing into existence entities that in the future could become enforcers of managed competition, managers of an employer mandate, or the administrators of government sponsored health insurance.

Question 5 **How much change in health insurance arrangements can be implemented over the remainder of this decade?**

No hard analysis can answer this question. How much can be done and how fast it can be done depend on political leadership and will. In fact, U.S. history contains no example of legislation that remotely resembles the President's proposal for reforming health insurance in the depth and pervasiveness of institutional change. It has become commonplace to compare reform of health care financing to enactment of the Social Security Act in 1935. This analogy is faulty, but instructive. On a scale of complexity starting at zero, if the Social Security Act rates a 10, President Clinton's health reform plan rates 200.

The Social Security Act was passed during a time of great economic distress, an era of chaos in the American capitalist system that more closely resembles the current conditions of Russia or the near collapse of Britain after World War II than the slowly emerging and comparatively minor chronic difficulties the United States is now experiencing. Nevertheless, the largest element of that landmark legislation, old age insurance, was financed by taxes that did not start until 1937, nearly two years after enactment, to pay for benefits that did not start until 1940, more than four years after enactment. Survivors insurance was enacted only in 1939. These programs began with a delay and grew slowly. More fundamentally, they replaced essentially nothing and required virtually no one to rewrite existing contracts or change then existing pension arrangements.

In contrast, the president's health care reform would transform the financing and organization of the delivery of roughly 11 percent of gross domestic product. It would bring into existence a wholly new type of agency, the regional alliances, with sweeping regulatory powers and would do so in the space of less than two years. Quite apart from the huge administrative task this represents, the successful operation of these alliances hinges on the successful execution of difficult technical tasks, such as risk rating, that have never been carried out in practice before and whose feasibility remains in doubt, even among experts sympathetic to an employer mandate.

Under some circumstances, such enormous change is possible. The mobilization for World War II involved direct control of most of the U.S. domestic economy and the creation of countless agencies with new and untried powers. The exigencies of war

elicited enough cooperation and tolerance for mistakes to make that episode the most glorious triumph of government policy in U.S. history.

The practical question facing Congress involves how much change to ask the American people to embrace during a peacetime of relative prosperity and how fast to ask them to accept it. In making this decision, Congress and the administration that will have to administer the new legislation will not be able to draw on the good will, patriotic fervor, and sense of shared sacrifice that united the nation after Pearl Harbor. They will not even be able to count on the toleration of experimentation born of economic desperation that smoothed the way for the untried and often unsuccessful innovations of the New Deal. They will confront a public suspicious of government and elected officials, that is mostly satisfied with the access to health care it now enjoys but is worried about losing it, and that is bombarded by information and disinformation provided by groups with enormous economic stakes and not all of whom hold truth in high regard. Against this background, I believe that the plan advanced by President Clinton asks more of the political system than it can or will deliver.

The mystery that will not be settled until late next year is whether the administration can keep alive in the public the recognition that reform is imperative and that its plan contains many good ideas that should survive in any compromise plan. Can those committed to reform prove sufficiently flexible to start down a road to reform the end of which cannot be seen and that will not be reached within the political lives of most of those asked to begin the journey?

Universal Coverage. It's Now or Never.

By Uwe E. Reinhardt

PRINCETON, N.J.

Alone among the industrialized world, the typical American family must worry that medical bills could bankrupt it some day, or that a stricken parent, son or daughter could go without needed care. That nightmare haunts not only the millions of Americans who are uninsured, it should worry anyone whose insurance coverage comes with a job that may be lost.

When he was elected President, Bill Clinton vowed to end this insecurity through "universal coverage." His reform proposal would require all employers to provide employees and their dependents with comprehensive coverage and to pay 80 percent of the premium. Americans who were unemployed or self-employed and not covered by Medicare or Medicaid would be required to buy private insurance, with the help of Federal subsidies where needed.

There can be no question that Mr. Clinton remains passionately committed to reaching the goal of universal coverage before the year 2000. Alas, he must work with a Congress that remains deeply divided not only over how best to achieve it but over the goal itself.

At the moment, there are numerous proposals before Congress, none of them coming close to offering universal coverage. One of the plans that is at least keeping the process moving, however, is the compromise bill being worked out in the Senate Finance Committee. Made public yesterday by the chairman, Daniel Patrick Moynihan, the bill would rely on a combination of incentives, new regulations and so-called "triggers," which would require employers to insure their workers if more than a certain percentage of the population remained uninsured by some future date. Whether even this version will prevail is very much in doubt.

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Fundamental to this compromise strategy is a reform of the private insurance market. All insurers would be required to sell policies to all comers in order to preclude the game of "cherry picking" by which private carriers have traditionally sought to avoid customers with health problems.

For this to work, the carriers' premiums would have to be averaged over a large pool of policyholders in a defined geographical area, so that an individual's premium would be insulated from his or her health status. These "community-rated" policies could not exclude people with existing illnesses. The new regulations, it is hoped, would make insurance coverage more accessible to the chronically ill and a more effective safety net for employees who lose their jobs.

The legislators who worked long hours to forge this compromise may have had the best of intentions. They may believe that this is all the health reform the American voter will accept, and they may be right. Their strategy, however, would leave many Americans behind. Unless insurance coverage is made compulsory, as President Clinton had proposed, many young and healthy Americans might choose to go without insurance, then throw themselves on the mercy of community-rated insurance when they grow older or get sick. This would leave insurers with a relatively sicker group and thus drive up the community-rated premiums.

Unless Congress stands ready to spend $60 billion to $100 billion a year in premium subsidies for unemployed or low-income working families, community-rated insurance may be no easier to afford than a Mercedes-Benz — which, in principle, is "accessible" to all Americans now.

> Congress seesaws while 20 million Americans will remain uninsured.

At the moment, the financing for adequate subsidies is nowhere in sight. Many members of Congress seem to believe that the rapid growth of health maintenance organizations and other managed-care plans, with their strict cost-control systems, will make health insurance more affordable. But there is no assurance that managed care will significantly cut health spending. And if it does, lowered spending will deprive doctors and hospitals of the financial cushion with which they have long been able to underwrite the care they give to people without insurance.

Thus, unless it includes some assurance of adequate financing, the compromise strategy could impose very harsh rationing on the millions of low-income Americans it is likely to leave uninsured. Not only the uninsured will bear the expense of that rationing, it will spill over onto the rest of us. Prolonged neglect of proper health care for millions of Americans could unleash a major public health hazard, in the form of communicable diseases.

In short, one need not be a card-carrying socialist to support the principle of universal coverage for very pragmatic reasons, which is probably why so many Americans do support it and why so many of our overseas competitors instituted it decades ago. Americans might be surprised to learn that both Japan and Germany finance their universal insurance systems through the employer, with premiums that vary with the employee's income, usually in the form of a flat percentage of the gross payroll, shared equally between employer and employee.

These countries do not tie the size of that premium or of public subsidies to the size of the firm, to avoid tempting employers to, for example, hire part-time workers or pay more overtime rather than hire another employee who will put them over the limit. Unfortunately, most of the reform proposals now before Congress do make an issue of the firm's size.

In the end, the seesaw in Congress over health reform could leave us without any bill at all this year, or with one that allows so many key provisions to be delayed that it recalls Scarlett O'Hara's famous remark, "tomorrow is another day." Even this would probably be better than nothing. But these proposals are likely to leave 20 million Americans uninsured by the end of the decade, most of them in the lower middle-income groups. By then the cost of ordinary spells of illness will quickly break the bank of such families, and even that of many solidly middle-class people.

HEALTH CARE SECOND OPINIONS
An occasional series.

If American voters are content to couple their otherwise excellent health care system with this unseemly game of Russian roulette in health insurance, then let them be mindful that the game may hit their own households one day, when they are sick and for some reason uninsured.

Let them then be "individually responsible" for their plight, as many affluent Americans would no doubt like them to be, and as they themselves had planned to be, when they were employed and well insured, not just young and healthy.

On the other hand, if American voters truly crave secure and affordable health insurance, as survey after survey suggests, then now is the time to communicate that to Congress, loudly and unmistakably. Opportunities for significant health reform arise only every couple of decades. If we miss the train this time, the next one may be far behind.

An Unpleasant Choice if Employers Won't Pay for Health Care

By ROBERT PEAR
Special to The New York Times

WASHINGTON, July 7 — President Clinton's goal of health insurance for all Americans is often described as a moral imperative or a political objective, but it is also a pocketbook issue.

In one sense, there is no mystery about how to reduce the number of uninsured: it just takes money. The question is who should pay.

In trying to achieve universal health insurance coverage, Mr. Clinton and Congress will confront an unpleasant choice in the next few weeks. If employers do not pay most of the cost, as Mr. Clinton has proposed, then the Government and consumers must pay more.

Many people describe Mr. Clinton's proposal for an "employer mandate" as an alternative to taxes. Still, the public would ultimately pay. Economists say that employers would pass on the costs to their workers by reducing the amount of money available for wages or future pay raises.

Guarantees, but Not for All

Members of Congress are skittish about requiring everyone to obtain insurance, and many flatly oppose Mr. Clinton's proposal to make employers pay most of the cost. Many lawmakers now suggest that the Government should initially try to guarantee coverage for some fraction of the population, perhaps 95 percent, as the Senate Finance Committee has proposed.

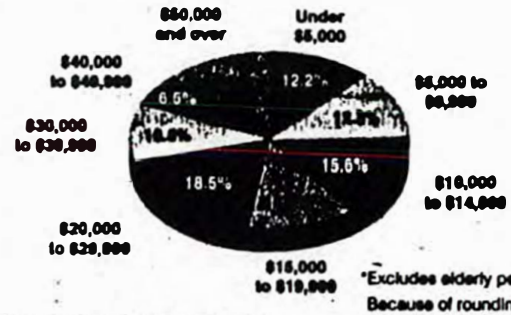
What difference does it make whether 95 percent or 100 percent of the people have insurance? And who is most likely to remain uninsured? Those questions are at the heart of the current debate over how to redesign the nation's health care system.

Currently, the Government estimates that 39 million Americans, accounting for 15 percent of the population, have no health insurance. But such numbers imply far more precision than is possible with any measuring tools now available. People's insurance status is continually changing as they change jobs, marry and divorce, move from one state to another and go on and off the rolls of programs like Medicaid and Medicare.

DEMOGRAPHICS

The Uninsured, by Income

The percentage of uninsured Americans in each family income category, 1992 figures.*



*Excludes elderly people.

Because of rounding, figures do not add to 100 percent.

Source: Employee Benefit Research Institute

The New York Times

Virtually all the major health care proposals now in Congress would make health insurance more available, prohibit insurers from denying coverage to people with a history of illness or disability and prevent insurers from charging extremely high premiums to people with high medical risks.

But such changes, by themselves, would not solve the problem, and experts warn that half measures could have unintended adverse effects. Alice F. Rosenblatt, an actuary at Coopers & Lybrand, the accounting firm, said that "a small proportion of the uninsured, probably less than 5 percent, have been denied coverage because of pre-existing conditions like cancer and cardiovascular problems."

Moreover, unless there is some mechanism for enrolling all people in health plans, millions of Americans are likely to remain uninsured because they do not want to be bothered, see no need for coverage or cannot afford their share of the cost.

"Many people may rationally choose not to purchase health insurance coverage, either because they have low income or because they believe they have a low risk of needing health care services," said William S. Custer, research director of the Employee Benefit Research Institute, a nonpartisan organization whose members include businesses and labor unions.

The Young May Go Without

If there is no requirement for people to have insurance, many who are young and healthy will probably go without it because they see no immediate need, given the cost. If significant numbers of healthy people go without insurance, the average risk of [illegible]ders rises, and their pre[illegible]se as a result.

[illegible]6 million people 18 to 29 [illegible].ave no health insurance. They account for 30 percent of the uninsured. It is desirable to have these people in the insurance pool because their medical costs are generally lower than those of older people, actuaries say.

Under most of the proposals in Congress, poor people would pay little or nothing for health insurance. The Government would pay the premiums for people with incomes below the official poverty level, now $14,764 for a family of four. Lawmakers assume that affluent people can buy private health insurance, costing $4,000 to $6,000 a year for a family, if they do not receive coverage through employers.

So, health policy experts say, if employers are not required to provide insurance to their employees, the people most likely to be uninsured are people in the middle-income range, particularly those who work for small companies.

"All the major proposals would give full coverage to people below the poverty line," said Mr. Custer of the Employee Benefit Research Institute. "That's the first group that would pick up coverage. Uninsured people at the poor end of the middle class are least likely to pick up coverage as a result of these reforms."

Eleven million people without insurance, or 28 percent of the uninsured, have incomes below the poverty level. They could get coverage at little or no charge under most of the proposals pending in Congress.

If the Government provided coverage similar to what the average employer now offers, it would cost $2,000 a year for each uninsured person. For every million people who received fully subsidized coverage, the Government would have to pay at least $2 billion a year.

Nearly one-third of the uninsured — 12.5 million of the 39 million people without coverage — have incomes between the official poverty level and twice that amount. Under the major proposals, these people would get some financial assistance from the Government to help them buy insurance.

Whether such subsidies would be adequate depends on many questions: the amount of the assistance, the cost of the insurance and [illegible] portion, if any, paid by employers.

Mr. Custer sounds a cautionary note. "It is extremely unlikely that simply lowering the costs of insurance will achieve universal coverage," he said.

Clinton Administration officials say that universal coverage is not only good health policy but also good politics. Health care is a pocketbook issue, they say, because people can be impoverished by medical bills.

"People who work should not be left behind when we reform the health care system," said Gregory E. Lawler, a lawyer coordinating the health care campaign at the White House. "They should have guaranteed private insurance."

More than half of the uninsured are working adults. Eighty-four percent of the uninsured live in families headed by workers. But in recent years, there has been a decline in coverage provided by companies with fewer than 25 employees. Such companies say they are often unable to obtain affordable health insurance for their workers because insurers charge them higher premiums, reflecting the risks and the administrative costs associated with small groups.

Concern for Children

Congress has for years shown special concern for the medical needs of children, and that impulse is clear in many proposals to overhaul the health care system. The Finance Committee, for example, accepted a proposal by Senator Donald W. Riegle Jr., Democrat of Michigan, to provide extra subsidies to help pay insurance premiums for children in families with incomes up to 2.4 times the poverty level.

Nearly 10 million children under 18 years old have no health insurance coverage, and most of them could obtain it under the bills now pending in Congress.

About one-third of the uninsured children are in poor families. Another third live in families [illegible] incomes between the poverty [illegible]vice that amount. The r[illegible]ive family incomes exce[illegible] the poverty level.

THE NEW YORK TIMES, MONDAY, JULY

Frayed Nerves of People Without Health Coverage

By ERIK ECKHOLM A1

At the age of 52, unemployed after an international career as a manager, Bob Hughes is astonished to find himself without health insurance and wishes Washington would do something about it.

"I don't want a dole from the Government," said Mr. Hughes, who lives with his wife next to a golf course near Houston and cannot afford the $568 monthly premiums they were quoted this year. "Just a little help, a little protection until I get re-employed."

The Uninsured: Who Are They?

A special report.

Mark Elias, a 36-year-old self-employed woodworker in New Orleans, has plenty of business, but he and his wife think they would rather spend their money on private schools for their three children than on health insurance. Mr. Elias, who makes custom doors and windows to the sonorous voice of Rush Limbaugh, would rather live with risk than see the Government meddle with health care.

Lauren Bright, a 26-year-old actress, survives in New York City by waiting on tables. "I'm honestly thinking of giving up acting in search of a career with benefits," she said. "It's a sad thing."

In San Francisco, Trinidad Estrada, a 29-year-old mother of three who stands in a restaurant all day making burritos, wonders how she will come up with $1,000 for foot surgery; she resents the free coverage the state gives to people she regards as loafers.

These are some of the 39 million uninsured people, more than one in seven Americans, at the center of an epic political battle as Congress decides how far the country will go toward universal coverage. Their plight has been called a crisis and a non-crisis, their numbers called understated and overblown.

Whatever the politics, evidence

Continued on Page A12, Column 3

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points unequivocally to serious hardships for tens of millions of Americans. But this problem cannot be swept away, it is clear, without costly Government subsidies or painful mandates on employers and possibly both — a predicament that goes a long way toward explaining the pitched combat that will resume this week in Congress.

"All the studies are finding the same numbers," said Drew E. Altman, president of the Henry J. Kaiser Family Foundation in Menlo Park, Calif. "The argument over the size and shape and seriousness of the problem is really a smoke screen for the more legitimate debate over how to solve it."

Profile of the Uninsured

The burdens fall largely on working families with low-to-moderate incomes. In half of uninsured households, a person works full-time and in another third of households a person works part time or part of the year, according to Federal data analyzed by the Employee Benefit Research Institute.

Many uninsured people work for small businesses offering no benefits, or in low-wage or contract jobs. A vast majority be-

millions uncovered who live in stifling need.

Minority members with lower-than-average incomes are disproportionately uninsured. While 14 percent of white Americans under 65 were uncovered in 1992, 23 percent of blacks under 65 and 35 percent of Hispanic Americans under 65 were.

Disparities among the states are also striking. In much of the South and the West, where jobs without benefits are more common and Medicaid is often less generous, more than one in five people under 65 are uninsured. In many Northern and Midwestern states it is closer to 1 in 10.

People who are excluded by insurers because of pre-existing medical conditions — a history of cancer or a chronic disease — have provided heart-rending stories in the health care debate. Banning such exclusions is a goal of many bills in Congress. Yet, these account for only a small fraction of the uninsured, perhaps one million of them, studies suggest.

The commonly quoted figure of 39 million or so uninsured is a snapshot of the population at any point and includes a changing mix of people. Over the course of a year, 58 million people are uncovered at least temporarily, research shows, but many regain coverage when a family member finds a new job

'Going Without Care

But a closer reading of the statistics shows that despite the turnover, the long-term uninsured remain numerous. A new analysis by Timothy D. McBride, an economist at the University of Missouri, finds that three-fourths of those who are uninsured on a given day, or about 29 million people, remain uncovered for one year or more and more than half of them, or 21 million people, for at least two years.

Beyond anxiety, being uninsured takes a medical toll. Most people find ways to get care when it is vital, either paying out of pocket or finding charity care. But they tend to seek help less often and late.

"All the studies show that the uninsured get less care and end up sicker than people with insurance," Mr. Altman of the Kaiser Foundation said. "Insurance per se makes a huge difference."

Many younger, healthy people voluntarily forgo the expense of insurance. In a survey last year of 2,000 adults, conducted by Louis Harris and Associates for the Commonwealth Fund and the Kaiser Foundation, 7 percent of those who lacked insurance said they did not want it, though the reasons were not specified.

Owners of restaurants and other small businesses who have offered to help pay for premiums note that some employees choose to be uncovered rather than pay their share. But it is not clear whether this is more a reflection of lack of interest or the financial strains on many workers.

Between Jobs

Medical Insurance Or Their House

The home of Bob and Susie Hughes, in Conroe, Tex., north of Houston, is filled with mementos of a career abroad: dolls from Shanghai, an incense burner from Indonesia, a painting from Vietnam. Mr. Hughes admits he never thought much about health costs during his years as an executive and sales manager with several companies. That changed after Mr. Hughes left his last job in early 1992 as Southeast Asian sales manager for a petroleum equipment supplier, just as the company was going under.

With no new job in sight, the couple bought a private insurance policy. "They kept raising the premiums and the deductibility to the point where we couldn't afford it," he said of the premiums that jumped this year to $568 a month with a $2,500 deductible. "Faced with the choice of a house or medical insurance, I chose my house," he said. Their coverage ended two months ago.

"I've never taken unemployment from the state or the Federal Government," he said. "I've gone though my savings and I've had to take money from my 401(k). All I want is a little parachute."

Mr. Hughes said his main focus was on

in San Francisco. Trinidad Estrada, a 29-year-old mother of three who stands in a restaurant all day making burritos, wonders how she will come up with $1,000 for foot surgery; she resents the free coverage the state gives to people she regards as loafers.

These are some of the 39 million uninsured people, more than one in seven Americans, at the center of an epic political battle as Congress decides how far the country will go toward universal coverage. Their plight has been called a crisis and a non-crisis, their numbers called understated and overblown.

Whatever the politics, evidence

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Continued From Page A1

points unequivocally to serious hardships for tens of millions of Americans. But this problem cannot be swept away, it is clear, without costly Government subsidies or painful mandates on employers and possibly both — a predicament that goes a long way toward explaining the pitched combat that will resume this week in Congress.

"All the studies are finding the same numbers," said Drew E. Altman, president of the Henry J. Kaiser Family Foundation in Menlo Park, Calif. "The argument over the size and shape and seriousness of the problem is really a smoke screen for the more legitimate debate over how to solve it."

Profile of the Uninsured

The burdens fall largely on working families with low-to-moderate incomes. In half of uninsured households, a person works full-time and in another third of households a person works part time or part of the year, according to Federal data analyzed by the Employee Benefit Research Institute.

Many uninsured people work for small businesses offering no benefits, or in low-wage or contract jobs. A vast majority believe they simply cannot afford to pay hundreds of dollars a month in insurance premiums.

The uninsured do not include the group that would otherwise be most vulnerable, the elderly. Since the creation of Medicare in the looser fiscal climate of the 1960's, everyone 65 and over has basic coverage that is largely paid for by the public.

The uninsured also do not include many of the poorest Americans, who are often covered by Medicaid, the Federal-state program. Yet, fewer than half of Americans who live below the official poverty line — an annual income of around $15,000 for a family of four this year — are on Medicaid, leaving millions uncovered who live in stifling need.

Minority members with lower-than-average incomes are disproportionately uninsured. While 14 percent of white Americans under 65 were uncovered in 1992, 23 percent of blacks under 65 and 35 percent of Hispanic Americans under 65 were.

Disparities among the states are also striking. In much of the South and the West, where jobs without benefits are more common and Medicaid is often less generous, more than one in five people under 65 are uninsured. In many Northern and Midwestern states it is closer to 1 in 10.

People who are excluded by insurers because of pre-existing medical conditions — a history of cancer or a chronic disease — have provided heart-rending stories in the health care debate. Banning such exclusions is a goal of many bills in Congress. Yet, these account for only a small fraction of the uninsured, perhaps one million of them, studies suggest.

The commonly quoted figure of 39 million or so uninsured is a snapshot of the population at any point and includes a changing mix of people. Over the course of a year, 58 million people are uncovered at least temporarily, research shows, but many regain coverage when a family member finds a new job with benefits, just as Mr. Hughes in Texas hopes to do.

This turnover has been seized on by both sides in the health care debate. Seeking broad support from the middle class, the White House stresses how widely shared the insecurity is, noting that one in every four currently insured Americans will spend vulnerable months at some point over the next two years. Opponents, asserting that relatively small numbers are chronically uncovered, say the whole problem has been exaggerated.

...ers and end up sicker than peop... with insurance," Mr. Altman of the Kaiser Foundation said. "Insurance per se makes a huge difference."

Many younger, healthy people voluntarily forgo the expense of insurance. In a survey last year of 2,000 adults, conducted by Louis Harris and Associates for the Commonwealth Fund and the Kaiser Foundation, 7 percent of those who lacked insurance said they did not want it, though the reasons were not specified.

Owners of restaurants and other small businesses who have offered to help pay for premiums note that some employees choose to be uncovered rather than pay their share. But it is not clear whether this is more a reflection of lack of interest or the financial strains on many workers.

Between Jobs

Medical Insurance Or Their House

The home of Bob and Susie Hughes, in Conroe, Tex., north of Houston, is filled with mementos of a career abroad: dolls from Shanghai, an incense burner from Indonesia, a painting from Vietnam. Mr. Hughes admits he never thought much about health costs during his years as an executive and sales manager with several companies. That changed after Mr. Hughes left his last job in early 1992 as Southeast Asian sales manager for a petroleum equipment supplier, just as the company was going under.

With no new job in sight, the couple bought a private insurance policy. "They kept raising the premiums and the deductibility to the point where we couldn't afford it," he said of the premiums that jumped this year to $568 a month with a $2,500 deductible. "Faced with the choice of a house or medical insurance, I chose my house," he said. Their coverage ended two months ago.

"I've never taken unemployment from the state or the Federal Government," he said. "I've gone though my savings and I've had to take money from my 401(k). All I want is a little parachute."

Mr. Hughes said his main focus was on finding a job, not on politics, and he is active in Forty Plus, a group that helps experienced professional people find work. Asked about the Washington debate, he chuckled heartily. "I'd like to get the same kind of coverage Bob Dole gets for the same premium," he said, referring to the Republican Senator who has called universal coverage too expensive.

"I think if the Federal Government has their employees on a master plan, they ought to offer it to everybody in career transition," Mr. Hughes said.

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Out of Reach

No Funds for Care Or for Insurance

Enrique and Trinidad Estrada of San Francisco, parents of children aged 9, 7 and 4, are struggling toward the middle class. Mr. Estrada, who is 31 and has lived in this country nearly all his life, works all night delivering tortillas, his wife, who came from Mexico to marry him at age 19, works all day making burritos in a restaurant. Neither receives health benefits.

For years they lived with Mr. Estrada's parents, saving to buy their small blue house in the Mission District. To meet the $1,800 monthly payments they rent out the bottom floor for $700, cramming themselves into the top floor, where they have one bedroom and a fold-out sofa on which all three children sleep. Between house payments and baby sitters, Mrs. Estrada said, buying health insurance would be unthinkable.

Mrs. Estrada has not paid much attention to the battles in Washington over health care, but she wonders about the fairness of things. Because of their jobs and home ownership, she said, her family did not qualify for Medi-Cal, the California version of Medicaid. "The people who are working — why shouldn't we have it?" she asked. "I see people who are as young as I am begging on the streets, and they get everything from the Government."

Still, the Estradas do not seem to dwell on the issue of health care. Mr. Estrada has never been to a doctor. Mrs. Estrada received free care under a public program when she was pregnant, but has not seen a gynecologist in the four years since she gave birth, she said with no sense of alarm.

The children get low-cost checkups at a publicly financed clinic. "They look so healthy," Mrs. Estrada said, "and I don't worry about it."

But a painful condition in her right foot has caused her concern and highlighted the family's vulnerability. She had one operation at a cost of $300, which she paid in monthly installments. But the operation did not cure her, and doctors say she needs another procedure, which will cost $1,000. "It's going to be very difficult for us to find the money," she said.

Out of Luck

Aspiring Actor Gets Pneumonia

Milo Pacheco is a 26-year-old aspiring actor who has lived in New York City since 1991, working as a waiter or bartender to pay the bills. Like many of his friends in the arts and the restaurant world, he was last covered during college, when he stayed on his parents' policy, but now he has no money to spare for insurance.

Until March he was lucky, paying for doctors as he needed them. Then disaster struck, a severe pneumonia and infected fluid around the lungs. He had a chest tube inserted and spent 18 days in the hospital, racking up bills of more than $25,000.

Mr. Pacheco said he now owed several thousand dollars for doctor bills and a CAT scan, which he will slowly pay off. A thoracic surgeon near his parents' home in southern New Jersey, where he sought treatment, was a guardian angel, accepting a surfboard in lieu of a hefty fee. The hospital is chalking off his $20,000 bill to charity care and will recoup much of that from the state and the bills of the well-insured.

Mr. Pacheco's experience has only added to the fears of his girlfriend, Lauren Bright, who is also 26 and waits tables between acting jobs. "When you're paying rent and trying to save a little money, you just hope that you don't get sick," she said.

She has avoided going to the doctor but is grateful that gynecological care, at least, is available on a sliding scale through Planned Parenthood. But now, largely because of the threat of health costs, she said, she is rethinking her choice of careers.

Mr. Pacheco and Ms. Bright both scoffed at the suggestion, made by some economists, that many young adults were not worried about living uninsured. Among people working in restaurants, who seldom receive benefits, for example, "health care is a regular topic of discussion these days," Mr. Pacheco said. "It's always a concern."

He added that he believed that employers ought to contribute at least a share of the cost of worker coverage, as President Clinton proposed.

Ms. Bright said she would welcome government health subsidies; if a plan with complete coverage were made available in the range of $100 a month, she would take it. But existing cut-rate plans, she said, are not worth it because of their limited benefits.

"I have friends who are Australian and Canadian, and I so envy the fact that they have national health care," she said. "They end up waiting to go home to see a doctor."

BY THE NUMBERS

The Uninsured: A National Snapshot

The percentage of people under 65 in each state who were uninsured in 1992

Nev.	26.6%
Okla.	25.8
La.	25.7
Tex.	25.7
D.C.	25.5
Fla.	24.2
Ark.	23.5
Miss.	22.7
N.M.	22.5
Ga.	22.4
Calif.	22.2
S.C.	20.8
Ala.	20.1
Alaska	19.3
Idaho	19.0
W.Va.	18.5
S.D.	18.5
Ariz.	18.5
U.S.	**17.4**
Va.	17.4
Ky.	17.1
Mo.	16.6
N.C.	16.4
N.Y.	16.1
Tenn.	16.0%
Ore.	15.5
Ill.	15.3
N.J.	15.3
N.H.	14.8
Colo.	14.6
Md.	14.0
Wyo.	13.8
Del.	13.4
Me.	13.1
Ohio	13.0%
Utah	13.0
Kan.	12.6
Ind.	12.6
Wash.	12.4
Mass.	12.4
Mont.	12.3
Mich.	11.9
Iowa	11.7
Neb.	11.3
R.I.	[illegible]
Vt.	[illegible]
Penn.	10.[illegible]
N.D.	10.5
Wisc.	10.5
Minn.	10.0
Conn.	9.5
Hawaii	8.1

Source: Employee Benefit Research Institute

Against Principles

Business Owner Hates Regulation

A talk with Mark Elias, the woodworker, suggests why the President's proposals for universal coverage have not drawn an irresistible groundswell of support. Running his own business in Slidell, La., a gritty town east of New Orleans, and making an annual income of about $40,000, he feels he cannot afford to buy insurance for his own family, including his wife, a 13-year-old and 11-year-old twins, let alone his three employees. But his sense of independence extends to his attitude about government regulation of health care.

The family has been uninsured for two years, since Mrs. Elias left a job with an insurance agency. They looked into buying a policy but especially in light of their desire to send their children to private school, they believed they could not afford rates of $300 a month, with a $2,500 deductible.

"Fortunately, we haven't had any kind of doctor bills," said Mr. Elias, who admits to some worry. He guesses that someone in the family goes to a doctor about once a year, but he cannot remember the last time anybody went.

"I'm not one to run to the doctor for every ache and pain," he said. "Maybe if I was older I'd be more concerned."

At its income, the Elias family would not qualify for subsidies under the main health care plans being debated in Washington, although proposed changes in insurance rules might reduce the price of available policies. Mr. Elias is dubious in any case.

"Even if it was a good deal, I'd rather not have the government give me something," he said. "I'd rather not have my taxes go to [illegible]

Interestingly, while health care costs had risen dramatically since the passage of Medicare and Medicaid in 1965, Nixon's Comprehensive Health Insurance Plan (CHIP) included very limited cost containment. Growth in health care costs was not then the compelling issue it was to become in the 1990s.

Further action on this or any other national health insurance proposal was halted by a series of unanticipated events, including the resignations of both President Nixon and Rep. Wilbur Mills (D-AR), then chairman of the powerful House Ways and Means Committee. Not until late in President Jimmy Carter's term did the reform debate resurface, and even then congressional activity was limited, with no results. Almost a decade later, in the late 1980s, the huge growth in the cost of health care, the realization that millions of Americans lacked health insurance, and a growing fear by millions more that their health insurance coverage would not be available when they needed it made health care reform a major national issue again.

Who are the uninsured? The profile of the uninsured, as traditionally low-income working families, undoubtedly influenced the Clinton administration's decision to expand the employer-based system as the solution for universal coverage. Linkage to employment makes it easier to track and administer national health care coverage. It also keeps much of the funding for the health care system off the government's "books."

Not surprisingly, there is considerable evidence that the uninsured receive less health care than the insured receive.[1] When the uninsured do receive care, they often use the expensive emergency departments of tertiary care hospitals. In addition, delayed treatment adds significantly to the cost of health care today.[2] Thus, even though the uninsured make up 16 percent of our population, it is estimated that their coverage would add only about 5 percent to total health care spending.[3]

Serious as the problems of the uninsured are, this is not the issue driving the current political debate. What is different than in the past is the heightened insecurity of the middle class regarding continuation of their own health insurance plans. The underlying problems are a partial breakdown in the private health insurance market, particularly for small firms and individuals, and the uncontrolled growth in health care costs.

Growing health care costs. The U.S. health care crisis has been exacerbated by health care costs that continue to escalate at twice the rate of general inflation. The United States also spends much more than other industrialized nations for the health care of its citizens. Nevertheless, these other countries—among them Canada, Japan, Germany, and the United Kingdom—provide universal access to a broad range of health services.

The substantially higher expenditures in the United States are related to several factors—in particular, our lack of a national system that limits total

have it?" she asked. "I see people who are as young as I am begging on the streets, and they get everything from the Government."

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Va.	17.4	Colo.	14.6	Mass.	12.4	Minn.	10.0
Ky.	17.1	Md.	14.0	Mont.	12.3	Conn.	9.6
Mo.	16.6	Wyo.	13.8	Mich.	11.9	Hawaii	8.1
N.C.	16.4	Del.	13.4	Iowa	11.7		
N.Y.	16.1	Me.	13.1	Neb.	11.3		

Source: Employee Benefit Research Institute

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"Even if it was a good deal, I'd rather not have the government give me something," he said. "I'd rather not have my taxes go for social programs."

But he also knows that if medical catastrophe strikes, he could get help. "I'd probably have to go to the clinic," he said, referring to a nearby public medical center. "We'd work something out. They couldn't leave us out on the street, at least that's the way I understand it."

Players And Payers

By Michael Graetz and James Tobin

Dusan Petricic

NEW HAVEN

The President and First Lady have achieved remarkable consensus on a truly revolutionary principle: All Americans must be entitled to adequate medical services without regard to ability to pay or risk of ill health. Now it's up to Congress to embody that principle in law, a historic opportunity comparable to the enactments of Social Security in 1935 and Medicare in 1965.

Unfortunately, excessive solicitude for existing institutions and interests, and the difficulties of reconciling them with the Clintons' fundamental principles, have made their proposal a bureaucratic and legalistic morass.

The biggest flaw in the dministration proposal is the requirement that employers pay the prem. ims — a mandate whose awkwardness and unfairness stand out starkly in a system dedicated to universal coverage.

Employer-based medical insurance is a historical accident — one that no one would choose now if given a clean slate. During World War II, trade unions and employers circumvented Federal wage ceilings by offering medical fringe benefits. Their popularity and generosity boomed after the war, as Congress sheltered them without limit from income and Social Security taxes.

The fact that employers write the checks for medical care does not mean that they bear t.. full costs. They can generally shift some costs to workers in reduced take-home pay and some to customers in higher prices. The sure losers are taxpayers who have to make up the revenue lost to the tax-shelter.

Much of the Administration's 1,300-page proposal is devoted to expedients intended to mitigate the difficulties and anomalies of employer mandates. It's a hopeless task. Some families have no employed members. Some have two or more. Many employees work part time. Some have more than one job. Americans frequently change jobs, employers, work locations, places — even states — of residence.

Under an employer mandate, responsibilities for paying a family's premiums would frequently be divided among several sources — various employers, governments and the family itself — in proportions varying month to month. Keeping track of these liabilities would surely involve extensive paperwork and administrative hassle, contrary to Mrs. Clinton's claim that an employer mandate eliminates the need to track individuals.

Nor would the new system be equitable. Equity demands that public subsidies, direct or via employers, be a larger share of premiums and of income the poorer the family. Equity also requires that families' subsidies be the same if their incomes are the same.

But in the Clinton plan, subsidies depend more on the size of employers' payrolls than on families' ability to pay. The system is also full of bad incentives — for example, not to hire workers with dependents.

It's individuals who get sick and need medical services. It's individuals and families whose ability to pay is the natural criterion of equity. It's individuals who must be guaranteed coverage. So it's individuals who must be required to have insurance. Let employers help pay the premiums if they wish, but count those payments as taxable income. Treat the self-employed exactly the same as employees.

> The misbegotten employer mandate.

Let people choose where they will buy insurance. One option should be a version of Medicare or a selection of the health plans made available to Federal employees. Let's call this option Fedmed.

Fedmed would offer the basic universal medical insurance package at premiums that in total would cover the costs. Let private health plans offer the same package, provided they do not pick and choose members or charge higher premiums for risky cases. As in the Clinton plan, it would probably be necessary to collect money from plans that happen to have low-risk clienteles and distribute them to plans with high-risk members.

With these provisions, Fedmed would be protected against becoming the last-resort insurer of bad risks. As in Medicare itself (which would continue as at present) people could choose their own physicians and other providers.

Fedmed would have low administrative costs and would wield enough clout to limit payments to providers. It would also let people change employment status, residence or family situation without losing coverage. But it need not be a monopoly.

Federal subsidies to individuals would take the form of refundable tax credits, "vouchers" or a credit card payable to Fedmed or other insurers. For low-income families the subsidies would cover the whole premium of the basic package; most other families would receive vouchers at least as valuable to them as the current tax exemption for employer-provided insurance.

A family of four in the 28 percent tax bracket with a $4,300 insurance package would receive vouchers of $1,204 — 28 percent of the premium. No family would face an out-of-pocket cost of more than 10 percent of income for the basic package.

This plan would not require new broad-based taxes or new burdens on employers. One source of financing would be redirecting the Clintons' proposed subsidies to employers and low-income people, about $100 billion in 1999. Eliminating the tax shelter for employer-paid premiums would contribute $125 billion, and our plan would replace Medicaid acute care for those under 65 (about $75 billion more).

Robert Reischauer of the C.B.O destroyed a semantic attraction of employer mandates when he testified recently that federally required purchases of insurance should be included in the budget. Their popularity is waning among businesses and in Congress, where support appears to be growing for the plans of Representative Jim Cooper and Senator John Chafee; unfortunately, these plans do not assure universal coverage in this century.

Our proposal is not a radical reconstruction. It builds on the best of existing institutions. A victory for it would be a victory for the basic principles that the Clintons have so eloquently set forth.

Michael Graetz, professor of law at Yale, was Assistant to the Secretary of the Treasury from 1990 to 1992. James Tobin, emeritus professor of economics at Yale, won the Nobel Prize in Economic Science in 1981.

Economic Analysis

Health System Reform: Let's Not Miss Our Chance

by Stuart Altman

Abstract: Support for reform is at its highest level, but criticism of President Bill Clinton's plan is widespread. Nevertheless, the core components of the Clinton plan should be supported. These include (1) building on existing employer-based health insurance with a mandate that employers offer coverage to all workers and pay a substantial portion of the premium; (2) requiring that coverage be universal and benefits comprehensive; and (3) controlling total health care spending via a national expenditure limit. This paper does, however, suggest three changes to strengthen the plan: developing a broader base than Medicare and Medicaid to pay for reform; setting the national health care spending limit at a higher level (gross domestic product plus 1 percent); and strengthening the powers of the regional health alliances.

As early as 1920, while many other European countries were establishing national health programs, the United States began to assess ways to finance health care and improve its delivery system. In 1930 President Franklin D. Roosevelt decided not to include a national health plan with his Social Security program. This lost opportunity resulted in periodic tinkering with the U.S. health care system, such as the Hill-Burton Hospital Construction Act in 1946, until the passage of Medicare and Medicaid in the mid-1960s. In some cyclical fashion, the United States has revisited health care reform every ten to fifteen years since 1935. This effort has been challenged by one or more of the dominant three issues: the lack of adequate financial coverage, rapidly rising health care costs, or questions about the appropriateness and the quality of care.

The debate in the mid-1960s centered on advancing access for the elderly and disabled. With the leadership of a strong president, the country passed the first significant federal health legislation, which created the Medicare and Medicaid programs. During the 1970s the growing problem of the uninsured among the nation's working population forced an examination of the private insurance market. President Richard M. Nixon proposed his version of a national health insurance system, which built on the existing private employer-based system and mandated that all employers must offer and help pay for a comprehensive range of health benefits.

Stuart Altman is Sol C. Chaikin Professor of National Health Policy at the Heller School, Brandeis University, in Waltham, Massachusetts.

health care spending, such as exists in these other countries. These countries also have enacted government policies and regulations that control the number of medical specialists and actively promote the use of primary care providers as the basis of their health care delivery systems. In addition, European health systems use global budgeting, which places controls on the development and diffusion of high-cost new technologies and restricts the growth of hospital budgets and physician fees. These European global budgeting systems, which rely on sector-specific budgets—that is, a separate hospital budget and a separate budget for outpatient and physician services—differ from the budgeting system proposed in the Clinton plan. The Clinton plan instead would use controls on the rate of growth in spending, leaving to each health care plan the decision on how to allocate its funds.

Business response. Variation among payers for health care services allows providers to obtain additional revenue from some payers to offset losses from other payers, or to shift costs. This cost shifting to well-insured private patients translates into health insurance companies paying 30 percent more than the actual costs of the care received.[4] As a result, many health care providers have not had to directly confront the financial pressures imposed by governmental payment and coverage restrictions.

Increasingly, businesses that are faced with high and rising health insurance premiums and that lack the same bargaining power as government are being forced to reduce the health care benefit package provided through insurance, limit coverage for nonworker family members, or shift a larger portion of the insurance bill onto workers. Thus, while it might appear that employers are paying more of the bill, it is actually workers themselves who are paying more. Of course, most economists believe that it is workers who pay for the coverage even when it is "paid" by the employer. Psychologically, however, workers resent the high costs more when they pay directly for insurance.

Medicare spending. Legislated in 1983, the Medicare hospital prospective payment system (PPS), and more recently, the Medicare fee schedule for physicians (resource-based relative value scale, or RBRVS), have reduced the rate of growth in spending by the federal government.[5] By the end of the 1980s the rate of Medicare spending growth was below that of growth in national health spending. Preliminary data from the Health Care Financing Administration (HCFA) on Medicare outlays for physician services show an increase of only 5.6 percent for the first ten months of 1993, compared with 9.5 percent for the same period in 1992.[6] The private rate of growth was significantly higher.

Because PPS affects only the payment rate for Medicare, hospitals have managed to increase their costs beyond the Medicare limits and to maintain profit margins by charging more to other payers. Hospitals also have sought

to recoup lost revenues by providing services that pay higher Medicare rates, such as open-heart surgery, and by providing services not controlled by PPS payments, such as expanded outpatient services.[7]

The ability of the Medicare program to control its payments to hospitals while total hospital expenses continued to rise at pre-PPS levels strongly suggests that, to be truly effective, cost controls must be comprehensive and must apply to all payers of the service, public and private. Should the Clinton plan be enacted as proposed, it will be complicated but necessary that the same level of control be developed with the two separate spending control systems, one for Medicare and one for private health plans.

Analysis Of The Clinton Plan

Given the complexity of designing any comprehensive national health insurance plan, including offering a realistic financing system, one can easily find aspects of the plan to criticize. I, too, have several concerns. But in basic design the Clinton plan does address the major problems of our health care system. By building on rather than destroying our current financing system, it minimizes the disruptions that would be caused if we went to a completely governmental, tax-based system. Most importantly, the Clinton plan incorporates three key components that should be strongly supported by all: universal and comprehensive coverage, a mandated employer-based financing system, and a national expenditure limit.

Universal and comprehensive coverage. First and foremost, the Clinton plan provides universal coverage with health care benefits that are broad-based and comprehensive. Some have criticized the benefits as being too comprehensive (and therefore too expensive). Such criticisms come from a mind-set that is focused on designing a benefit package for low-income populations that is paid for by someone else and that leaves the general population either to receive different benefits or to supplement the core benefits. This is the wrong way to think about a true national health insurance plan. Using the political process to decide what level of benefits the average American wants and is willing to pay for (either through a community-rated premium or from taxes) may not be perfect, but it does bring into play all of the forces for expanding and contracting the benefits offered. The president or Congress cannot, as some contend, simply add benefits without balancing value with cost, since they must develop the means to pay for the added coverage or face the added political pressure from those who would be required to pay for it.

The debate surrounding the benefits included in the plan will go on throughout the reform process, and some changes no doubt will occur. Such changes, however, will be marginal and will not affect the ultimate likeli-

hood of passage of the plan. What is critical to the Clinton plan and to whether this country does create a universal health insurance system is the requirement that all employers offer the agreed-upon benefits to all workers and pay a substantial proportion of the premiums.

The employer mandate. The Clinton plan requires that employers pay 80 percent of the average premium for mandated benefits offered by health plans in their region. Interestingly, this is the same percentage required under President Nixon's CHIP. There is nothing magical or crucial in the percentage selected, other than that it should be a substantial proportion of the total premium. Perhaps this proportion will be one of the compromise items during the legislative process.

Much of the criticism of the Clinton plan comes from representatives of small businesses and some economists who believe that the employer mandate would destroy hundreds of thousands or even millions of jobs.[8] In response to these dire predictions, several alternative proposals have been introduced, which, while still relying on an employer-based insurance system, drop the requirement that employers pay a major proportion of the premium. I believe that these predictions seriously distort what would happen to the employment market under the Clinton plan. Recent testimony by the chair of the Council of Economic Advisors and economists of the RAND Corporation supports this conclusion.[9] Further, it should be clearly understood that the alternative plans are neither universal nor comprehensive.

While these alternative plans would provide subsidies to help low-income uninsured populations purchase coverage, and most of the plans attempt to reform the health insurance market for small businesses and individuals, all of these proposals would still leave millions of Americans without coverage. To me, the employer mandate is critical to any proposal that seeks to provide universal coverage and still retain an employment-based insurance system.

Ironically, the uninsured are disproportionately represented in just those small businesses the alternative proposals would free from the mandate. The uninsurance rate is almost 34 percent in firms with fewer than twenty-five employees and 26 percent in firms with twenty-five to ninety-nine employees.[10] This uninsurance rate would be much larger were it not for the fact that for many of these workers, other family members receive insurance from their employers. Thus, the health care expenses of workers whose firms do not provide coverage are added to the insurance costs of the employers that do provide coverage.

Given the market assumption that requiring firms that do not offer health insurance to do so leads to a loss in jobs, it also should hold that reducing employment costs to firms that now insure their workers will

increase employment in those firms. In addition, one must consider the employment effects on firms that now pay for the cost of care used by the uninsured. The Prospective Payment Assessment Commission (ProPAC) estimated that for 1991 the uninsured generated unreimbursed expenses of $10.8 billion for hospital inpatient care alone.[11] To this amount must be added billions of dollars for unreimbursed expenses incurred for outpatient care, particularly emergency room services, as well as for physician services and other types of health care. These expenses are added to the bills of those who are privately insured. If everyone were insured, this hidden tax would be eliminated, thereby further reducing the cost for those firms that now provide insurance—perhaps adding jobs as well.

There is no model at this time that reflects all of the expected gains and losses that would result from the Clinton plan, or any other plan. But, given the likelihood that the increase in total health care spending from the reform plan will be small—or as under the Clinton plan, negative—once the cost containment features are factored in, I postulate a positive net employment effect for the nonhealth sector and a negative impact on health care employment. In total, the net employment results are likely to be small in either direction or could completely offset each other.

Mindful of the criticisms by those opposed to an employer mandate, the Clinton plan includes a series of subsidies for firms most likely to be affected. Not only would firms with fewer than seventy-five employees and an average annual payroll of less than $24,000 per worker have a limit on the percentage of payroll required for health insurance (between 3.5 percent and 7.9 percent), but all firms whose employees receive health insurance coverage through a regional alliance would have the percentage of payroll for such coverage limited to 7.9 percent. This includes firms with more than 5,000 employees who choose to use the regional alliance. Employees who work for firms using the regional alliance also can receive a subsidy to assist them in paying their share of the coverage if their family income is below 150 percent of the federal poverty level. Such employees are entitled to this subsidy even if they work for a firm whose average payroll is in excess of the subsidy limit, regardless of the firm's profitability. Such a provision is certainly justified on equity grounds for such low-income employees relative to others with comparable income, but this subsidy is in effect a hidden wage increase paid for by the government. It may be that the designers of the Clinton plan overreacted to critics of the employer mandate and provided too many subsidies to private companies and their workers. This concern is heightened when the subsidy for early retirees is added.

National health expenditure limits. There has been much criticism about the size, scope, and power of the regional alliances, particularly about

their control over health plan premiums. Many of the alternative reform proposals, while requiring regional purchasing associations to help small firms and individuals to buy insurance economically, stop well short of giving these regional entities any influence over the health care system, including how much is spent. This, I believe, is a mistake.

To control future growth in health care spending, this country has three choices: (1) rely completely on market forces, (2) use tight price controls and supply constraints, or (3) limit the total flow of funds going for health services and leave allocation of these funds to market forces.

The administration is correct in relying on indirect spending controls rather than direct price controls. Price controls can be effective for limited time periods when excessive spending results from price increases that have been bid up by rapid and artificial increases in demand or drastic reductions in supply as, for example, in wartime or during panic buying. Today's increase in medical spending, however, has resulted from an uncontrolled flow of funds into the health care system, leading to excess capacity for many types of expensive services. Having health plans responsible for their own allocation decisions within externally generated budgets is likely to be the best way of both reducing total spending and increasing the efficiency of the health care system. Other countries that use sector-specific budgets have been successful in reducing total spending but have less-efficient health care systems. These sector-specific budgets impede the transfer of services across sectors as, for example, from inpatient to outpatient care.

Without an external spending limit, competition among managed health care plans alone cannot generate sufficient savings to bring total health care spending down to levels that are in line with the growth in the nation's income or inflation rates. Experience with managed care plans indicates that savings of at most 10 to 20 percent can occur. For the most part, these are one-time savings with yearly increases similar to those in traditional fee-for-service systems.[12] The president's plan, however, would require reductions in the annual growth in private spending of closer to 50 percent. Such savings cannot be generated without an external budget constraint. Without such savings, this country faces the real prospect that its spending for health care will still reach 20 percent of gross domestic product (GDP), despite expanded market competition to slow the growth rate. As we approach this rate of spending, serious dislocations in other sectors of the economy surely will occur.

Concerns About The Clinton Plan

Among my concerns about the Clinton plan are the following: (1) It relies too heavily on savings from Medicare and Medicaid to fund the new

Medicare benefits and broader health reform; (2) it may bring total health spending down to almost no real per capita growth; and (3) it limits the responsibilities of the regional alliances over the shape and size of the delivery system. Let me state at the outset that I believe it is appropriate to look to expected savings to help pay for reform. My problems are with focusing primarily on savings from Medicare and Medicaid, the expected magnitude of these savings, and the ceiling level for private spending.

Do not rely on savings from only Medicare and Medicaid. The major beneficiaries of health care reform, in addition to newly insured persons, would be currently well insured Americans, including those associated with our largest and most profitable corporations. Well-insured companies and their employees now pay extra premiums in three ways: They pay for employees' noninsured family members; they pay for the health care costs incurred by the uninsured; and they pay when government forces providers to accept payments that are lower than the cost of the medical care used by government beneficiaries. Covering all Americans and including Medicaid recipients in private health care plans would help to reduce these add-on costs. In addition, if the Clinton plan is successful in reducing the rate of growth of all health care spending, those who are currently well insured by private plans will see additional savings.

We should not, therefore, rely exclusively on the savings from government programs, particularly programs that already have in place much stronger financial control systems than is the case in the private sector. Instead, we should ask all who are now well insured to invest some of the savings they will realize under total health care reform. Some will call this a tax increase (and I know there is political reluctance to raise taxes), but this is not a normal tax increase. It is a form of shared savings or an investment. Such shared savings could come in various forms: an earmarked add-on in all provider rates, a set-aside or add-on fee to private health plan premiums, or some form of a broad-based health tax. Most surveys suggest that Americans would be willing to pay a small amount to see health care reform become a reality.

You may ask, Why not accept the political reality that it is much easier to get through Congress a payment system that relies only on savings from government programs? The answer is that we are not likely to see the savings that are required from only these two programs without opposition from providers of these services and their patients. Opposition to cuts in the growth rate in Medicare spending for hospital care and outpatient services will not be eliminated because these savings will be used in part to finance the new Medicare prescription drug and community long-term care benefit programs. Some of these savings will be used to fund broader health reform. Concerns also will be raised about the negative impact of these cuts on the

quality and availability of services whose payments have been reduced. Some of these concerns may be real, for several reasons.

First, Medicare payments for inpatient care and for physician services already have been cut back significantly below provider costs and private payment rates. Even before the reductions legislated in the Omnibus Budget Reconciliation Act (OBRA) of 1993, Medicare hospital payments were estimated to equal only 88 percent of provider costs. For physician services, Medicare payments are now on average 30 percent below private rates, and for several services they are 50 percent or more below private rates. Volume growth in these large spending items also has slowed and has even declined in the case of hospital care. Further spending cuts in these two programs may therefore require reductions in Medicare services.

Second, Medicare thus far has been able to reduce growth in payment rates to providers without seeing a backlash from providers or a cutback in services to beneficiaries. This is due to the ability of most providers to find other patients whom they can charge higher rates. Under the Clinton plan such extra revenue generation or cost shifting would become very difficult, as tight limits would be placed on private spending rates. With no place to add extra revenues, hospitals and doctors would be forced to make major cuts in costs. Given that the cuts will be real and are likely to require significant and noticeable reductions in services to beneficiaries and in health care workers' incomes, providers and their patients are likely to mount extensive lobbying campaigns on state legislatures and Congress to provide new funds for Medicare.

Third, the major growth areas in spending under the two government programs in recent years have been in outpatient testing and procedures, home health care, and other noninstitutional care. There are no provisions in the Clinton plan to significantly change Medicare's utilization controls. Even if the plan wanted to, there are no good programs for controlling services in these areas without questions about restricting needed care. The one mechanism that does exist is to cut provider payment rates. To make the kind of cuts needed, however, would require sizable reductions in the payment rates for these services.[13]

Finally, the payment rates for most Medicaid programs are lower than for Medicare and much lower than private rates. Therefore, health plans covering Medicaid individuals under the reform plan would have to produce sizable utilization reductions. If they did not, substantial amounts of cross-subsidization would be needed in regions with extensive Medicaid populations. These subsidies would be more extensive because each state's payment rate would be capped at 95 percent of its current level.

Set lowest spending control levels at rate of GDP growth. The Clinton plan expects that within two years of enactment, the growth rate

in total private health care spending will fall 2.5 percentage points below the baseline (a reduction in the expected growth in spending of 30 percent). Within four years spending growth would be required to fall still further to only the overall per capita growth in the Consumer Price Index (CPI) (in essence, no real growth in spending). Hence, the expected rate of growth of private spending would be expected to fall by more than 30 percent between 1995 and 2000. Thereafter, the plan leaves control of the level of spending to Congress or, if by default, to the National Health Board. The board would be required to set the ceiling at the rate of per capita growth in GDP. For Medicare the long-term growth rate is expected to fall by somewhat less than private spending, or about 30 percent, from a baseline of 11.1 percent to 7.8 percent. This is before the additional spending for the two new high-demand and high-growth services of outpatient prescription drugs and community-based long-term care are added. Therefore, it is not that the cuts in growth in Medicare spending are too large relative to expected reductions in private spending, but that combined reductions in the rate of growth of total spending may be too large.

I support aggressive controls on health spending. However, the reductions suggested by the Clinton plan seem unrealistically tough. To succeed, they would shift the United States from being among the fastest-growing health-spending countries to one of the slowest. The average real growth in health expenditures per capita in Organization for Economic Cooperation and Development (OEDC) countries during 1986–1991 was 3.4 percent.[14] The U.S. rate was 5.3 percent. The Clinton plan would bring the per capita U.S. growth rate down to slightly above 2 percent by the year 2000. Thereafter, it will be up to Congress to decide the tightness of the limits.

If spending growth is not brought down to these tight limits, then several components of the plan would begin to add significantly to the cost of reform, or Congress will be forced to reduce subsidies for low-income persons or low-wage firms or to scale back the new Medicare benefits. By relying so heavily on Medicare savings to finance health reform and to keep Medicare payments in line with private payments, the private premium growth limits must be kept very tight. Thus, these limits should not be thought of as benign targets or a "backup" system; rather, they are critical to the success of the Clinton plan. This could spell trouble in the years after passage if these tight spending caps are not met. I suggest instead that the spending growth rate and subsidy rates be revised to reflect a higher ceiling for health care spending, such as real per capita GDP plus 1 percent. Such a growth rate is more in line with the controls used by other major industrial countries. These reductions still would generate substantial savings from the baseline growth rate.

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Summary

A true nation

and Congress should build upon the fact that most Americans will benefit from health care reform and should help pay for it. This would not be in the classic form of a tax increase, but rather a reduction in the savings rate. If we do not move in this direction, we face the real possibility that those who oppose comprehensive reform will use the tightness of the premium limits as a justification to sabotage the entire package. Or, if the Clinton reform plan does pass, financing problems will occur very quickly as we find that the spending limitations are unattainable.

Strengthen, not weaken, the regional alliance. If we are serious about making the national health care budgeting system work, then it is likely that the regional alliances will need more authority to affect the size and shape of the health care system. As envisioned under the Clinton plan, the powers of a regional alliance are limited to only indirect controls over the administrative and financial aspects of the health plans in its region, not the health care delivery system itself. While over time tough price negotiating between plans and providers could "wring" some redundancies and inefficiencies from the system, this is likely to be a very long and cumbersome process. Furthermore, there is no evidence that market forces alone will ever achieve the level of constraints necessary.

The Clinton plan requires substantial savings very quickly. Regional authorities should have the power to assist in reducing the excess capacities of high-cost services in the region and even to force the system to cut back to the point that some waiting for nonemergency care might occur. This is how other countries have kept their spending rates below U.S. rates.

We also should not eliminate most of the business community as allies in controlling costs. There is little to be gained in administrative savings by requiring employers with more than 500 workers to join a regional alliance. To assist the regions in controlling spending, therefore, I recommend that firms of 500 workers or above be required to operate their own corporate alliance. Their premiums would be affected by how well they control their expenditures. But they would not be allowed to violate the reform rules concerning no coverage restrictions based on health status, and all workers would have to be covered with the firm paying 80 percent of the premium. This would keep these powerful community interests involved in controlling the health care costs of their region. If we do not strengthen the cost containment powers in the community, we cannot then expect the health care system to bring spending down close to GDP growth. Easy savings from administrative inefficiencies or "fat" in the system will not do it.

Summary

A true national health insurance system has been long in coming to the

United States. If we let this opportunity for reform pass without making some significant changes, the problems will be much more serious a decade from now. I therefore applaud the Clinton administration for pushing this issue to the top of our domestic agenda and strongly support the basic approach it has taken to solve our health system's interrelated problems. The changes I have recommended, while important, are small in comparison to the many areas with which there is agreement. I also believe that these changes can be added without doing serious harm to the plan's overall structure. What is most important is that we enact a reform plan that will solve the pressing problems of our current health care system.

The author thanks Carmella Bocchino for her valuable assistance in writing the paper by providing technical material as well as critical analytical insights. The final judgments of this paper are, however, the author's.

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A Dangerous Year

10/28/93

By Rashi Fein

BOSTON

Americans have waited a very long time for a national health insurance program. So what difference does it make that between President Clinton's address to Congress on health care reform in September and his presentation of the plan yesterday, the timetable for completing the phase-in has slipped

Delayed universal coverage could sink the plan.

from 1997 to 1998? After all, it is nearly half a century since President Harry S. Truman called for universal health insurance.

Does one year matter? You bet it does. It makes a real difference not only to Americans without insurance but also in containing the costs of health care. President Clinton knows that, and surely did not want to delay full coverage. But he evidently chose to do so because he has decided to finance the program out of savings in the cost of health care delivery rather than out of taxes. Realizing such savings will take extra time.

The President's Health Security Plan is complex. Unwilling to break the link between insurance and employment and to substitute broad-based taxes for today's premiums, he was forced to achieve universal coverage by requiring that employers provide insurance.

Still, he needs dollars to pay for extending benefits to employees whose employers can't bear the full costs and to individuals who need financial help.

These dollars would come largely from reductions in unnecessary paperwork in medical offices, from reductions in the cost of care and from savings in Medicare and Medicaid, rather than from broad-based taxes.

To achieve such gains and savings, the program combines reform in financing with reform in health care delivery — even though both concerns operate in very different time frames. The attempt to cram evolutionary changes into a revolutionary timetable promotes further complexity.

Obviously, everyone should support the search for efficiency. It's more desirable to cut waste than to raise taxes. But the savings that come from reforming the system will come only over a long period of time.

The tree must be planted today, but will not provide shade tomorrow, perhaps not even by 1998.

HEALTH CARE SECOND OPINIONS

An occasional series.

As a result, there will surely be new pressure to lengthen the phase-in timetable beyond 1998.

Opponents will argue that although universality is meritorious, America cannot afford it: "Some year, perhaps, but not so soon. Let's save the dollars first, then phase in universal enrollment."

But it would be disastrous to hold universal enrollment hostage to cost containment. That would break faith with the millions of uninsured and underinsured who need help immediately, and the millions more who would benefit from knowing they would never lose their insurance.

Another reason to reject delay is that the program can easily collapse. Opponents could make the apparently reasonable (but fallacious) argument that it would be rational and judicious not to enact universal coverage until the gains in efficiency materialized. They would be wrong.

The fundamental reason to reject delay is that we cannot have real savings and real cost containment without universal enrollment. Such enrollment is not a welcome bonus delivered with cost containment dollars; it is what makes cost containment possible. Only with universality can we eliminate the practice of making patients with insurance pay the medical costs of those without it.

There are numerous ways to finance health care subsidies without increasing the deficit. If we need more money to erect the structure of benefits, let's raise it with broad-based taxes wholly earmarked for the Health Security Plan.

A surcharge of 5 percent on individual and corporate income taxes would raise more than $40 billion in 1998. Proposals for a value-added tax, rejected at an earlier stage, can be re-examined.

Universal health insurance is worth paying for. If, over time, we reduce the increases in medical costs and expenditures, so much the better. We can use the dollars for deficit reduction.

Over the last month, the timetable has slipped one year. If the misguided critics of the Health Security Plan seek to postpone rather than to improve it, they will argue for still another year's delay, and another. In the end, Harry Truman — and Bill Clinton — will have gone unheeded.

Rashi Fein is professor of medical economics at Harvard Medical School.

Universal Care? Not From Clinton

By Steffie Woolhandler and David U. Himmelstein

CAMBRIDGE, Mass.

President Clinton's evanescent promise of health security merely distracts from outcomes his plan would guarantee: more bureaucracy, less consumer choice and a health system owned by a few insurance giants. As Congress sorts out the options, it needs to scrap the Clinton plan in favor of the single-payer approach that works so well in Canada, where virtually all medical providers are paid by the Government.

Advocates for managed competition, which forms the basis of the Clinton plan, attribute soaring costs to overinsurance that leads to too much care, too much choice and too little medical competition. But Americans already pay the world's highest out-of-pocket costs yet have fewer doctor visits, hospital days and even transplants than Canadians, who spend less and have greater choice.

No evidence links competition with lower costs. Big employers and state Medicaid programs already use the hard bargaining and restrictions on choice that Mr. Clinton envisions, but their health spending has soared. Premiums for health maintenance organizations have risen as fast as traditional Blue Cross premiums.

Massachusetts has the nation's highest percentage of people in H.M.O.'s — and the highest per capita health costs. Nor does experience here bode well for the Clintons' employer mandates: as costs soared, the state's requirement that employers cover their workers was postponed, then abandoned. Six years after passage of Gov. Michael Dukakis's "universal health insurance" law, there are more uninsured, not fewer.

Insurers and H.M.O.'s have found more profit in gaming the system than in cutting costs. Ten percent of the population consumes 72 percent of health care, so the surest way to undercut competitors is to avoid the sick or drive them away with unsatisfactory care. Mr. Clinton's plan would augment these scams with new games. His health alliances would pay higher premiums for sick patients; clever insurance executives could recommend batteries of unproven screening tests for all enrollees, dubiously labeling millions with premium-inflating diagnoses like "borderline diabetes" or "early Alzheimer's." Regulators can't stop such abuses; they failed to prevent even the gross fraud of Empire Blue Cross or flagrant neglect of patients by I.M.C., the largest Medicare H.M.O. The complexity of the Clinton plan would open more loopholes than its arcane regulatory structure could ever plug.

Steffie Woolhandler and David U. Himmelstein, professors at Harvard Medical School, helped found Physicians for a National Health Program.

What the Clinton plan would do is enrich the biggest insurers and wipe out small insurers and individual medical practices. The Clintons loudly denounce the small insurers' trade association. But the biggest insurers, like Aetna and Prudential, helped finance the Jackson Hole Group, which honed the managed competition plan.

Only such giants have the capital to assemble the sprawling provider networks demanded by big employers and regional health alliances, and the clout to extract discounts from hospitals and doctors by threatening to withdraw a large chunk of business. Costs would be shifted to smaller plans, driving their premiums up and subscribers away; the big plans could also wipe out smaller competitors through price wars.

Once they'd muscled out competitors, the big insurers would enjoy a quasi-monopoly. (Already, 10 insurers control 70 percent of the H.M.O.'s.) Oligopolies don't compete.

The mirage of competition among hospitals is already evaporating. Boston's two biggest hospitals have merged; mergers have made many smaller cities one-hospital towns. Half of Americans live in areas too sparsely populated to support competition.

While a single-payer system could save $100 billion a year on administrative overhead, the Clinton plan would boost administrative costs. It would pump an extra $300 billion through private insurers, whose current overhead is 14 percent. It would privatize Medicaid (current overhead, 4 percent) and, in some states, Medicare (current overhead, 2 percent). Private insurers would administer coverage for those who are now uninsured (current overhead, 0 percent). The $30 billion hike in insurers' overhead would dwarf any savings from the Clintons' streamlined billing form.

> More bureaucracy, less choice, bigger insurance giants.

Moreover, Mr. Clinton would add a new layer of bureaucracy — the

of spending goes for administration; in the U.S., it's 24.8 percent. The growth of managed care would increase the bureaucracy; the Mayo Clinic employs 70 people just to phone cost reviewers for managed-care plans.

The President's rosy image of universal coverage under clones of today's best H.M.O.'s is hardly germane; they haven't slowed cost growth. Managed competition means harsher limits imposed by profit-driven insurers. Mediocre doctors who prescribe low-cost care will be H.M.O. favorites; superb but less frugal clinicians will be unemployable. Already some H.M.O.'s forbid their doctors to speak publicly about quality problems.

Low-income patients stuck in bottom-tier H.M.O.'s would fare worst, but others are also at risk. To cut costs, Boston's Bay State H.M.O., a middle-class plan, abruptly fired hundreds of psychiatrists. Patients were to call an 800 number, describe their problems and be assigned a new therapist. Press 1 if you're schizophrenic!

The President would force working Americans to pay dearly for care. Employer-paid premiums are, in effect, deductions from employees' wages. By mandating a fixed contribution per employee, the plan would impose identical deductions on a C.E.O. making $1 million a year and on his $20,000-a-year secretary. (By contrast, with a 5 percent payroll tax, the boss would pay $50,000, and the secretary $1,000; paying for health care through the income tax would be even more progressive.) So a disproportionate burden would be borne by the working poor (and the sick, through co-payments and deductibles) — a hidden tax that Congress would surely reject if it were made explicit. Mr. Clinton is trying not so much to avoid taxes as to avoid fair taxes.

If the President's plan does pass, its inevitable collapse will make single-payer reform harder. Because managed competition would foster ownership of health care by big insurers, dislodging them would require buying back the hospitals and practices they'd bought with our mandated premiums and tax dollars. The small-scale care most Americans prefer — the familiar receptionist answering the phone, the doctor able to schedule an extra-long visit without a manager's permission — would be long gone, along with any vestige of medicine as a calling, not just a job. Their resurrection would be more difficult than repurchasing

THE NEW YORK TIMES, SUNDAY, JUNE 12, 1994

From: The Logic of Health Care Reform

liance with a premium up to the average. Others previously covered by Medicaid, such as the "medically needy" who have exhausted their assets paying for medical care, will have been covered under an alliance plan to begin with.

Medicare would remain a separate program, although at age sixty-five retirees could opt to remain in the alliances and pay the difference between the amount Medicare would pay to the plan and its premium for the elderly. The Clinton plan would expand Medicare to include the same coverage of prescription drugs available to the under–sixty-five population.

The Health Security Act also includes support for home- and community-based long-term care for the disabled of all ages, and it calls for new tax incentives and tighter standards for private long-term care insurance. While veterans would retain existing rights to health services run by the Department of Veterans Affairs, the VA would begin transforming its facilities into integrated health plans that could enroll veterans for comprehensive coverage through the alliances. The Department of Defense health care system would also move in the same direction. Coverage of all federal employees would shift to the health alliances; thus members of Congress would get their coverage through the same alliances and health plans as average citizens.

The transition to a reformed system would take place in stages. The Clinton plan phases in universal coverage, state by state, between 1996 and 1998, and defers some elements of the benefits package, notably broader mental health and adult dental coverage, until 2001. Regional caps on premium increases would not go into effect until 1996. The proposed support for home-based long-term care would be introduced gradually between 1996 and 2000.

While establishing a federal framework for financing, coverage, benefits, and consumer protections, the Health Security plan gives the states authority to set up the regional alliances and to adopt a variety of different approaches to controlling costs and improving the delivery of care. At the federal level, a presidentially appointed National Health Board would interpret rules about coverage and benefits, allocate limits on premium growth among the alliances, and establish a system for monitoring how well plans, providers, and the system as a whole are performing. The states would not only establish the alliances but also retain authority to regulate insurance, certify plans, and license health professionals.

The Health Security plan would affect nearly every aspect of the health care system. Without trying to cover every feature, I want to explore the core elements in more detail in order to help explain how they fit together—and why they work.

The Logic of Comprehensive Coverage

Although hardly anyone opposes universal coverage or comprehensive benefits in principle, many have doubts whether they are workable or affordable in practice. But much as other industrialized countries provide comprehensive coverage for all their citizens, so can the United States—if we use reform to insist on mutual responsibility for payment and clear accountability for the costs.

The Health Security plan requires universal participation in the interest not only of fairness but also of lower cost to the community at large. Lack of coverage doesn't prevent money from being spent on medical care; most of the sick and injured still receive treatment, albeit less adequate care often at a later and more costly stage of illness. If insurance is voluntary, some who are healthy

gamble on their good fortune and then throw themselves on the compassion of others in the hour of their need. A decent society will not leave them to suffer, but a prudent nation will have asked them beforehand to share in the cost. Most of us willingly pay for fire protection even though our house may never burn. Similarly, we must pay for health coverage to support the health care in our communities that may someday save our lives.

Universal participation makes coverage more affordable for three distinct reasons. First, it reduces the number of free riders who force others to pay more in taxes and medical bills for the uncompensated care that they (or their employees) receive. So while universal coverage provides protection to the uninsured, it also protects the rest of the community from hidden cost shifts.

Second, universal coverage reduces the problem of adverse selection that afflicts a voluntary system. If coverage is voluntary, the individuals and small groups that purchase it will include disproportionate numbers of people with high expected costs, and the resulting higher premiums will then deter many other lower-risk people who otherwise might have bought insurance.

Third, a universal system has lower administrative costs. It obviates the need of hospitals for elaborate admitting and eligibility verification procedures to protect against unpaid bills, and it cuts the administrative cost of insurance itself by eliminating functions performed in a voluntary system, such as screening out the sick.

Universal participation also makes it feasible to remove some of the most egregious limitations on coverage in the current system. Under a voluntary system, some people will wait until they get sick to buy insurance; that is one reason why insurers restrict coverage of preexisting conditions. A universal system can fairly

Covered Benefits

- Hospital services, including bed and board, routine care, therapeutics, laboratory and diagnostic and radiology services and professional services
- Emergency services
- Services of health professionals delivered in professional offices, clinics, and other sites
- Clinical preventive services
- Mental health and substance-abuse services: inpatient mental health treatment, up to thirty days per episode and sixty days per year; psychotherapy up to thirty visits per year
- Family planning services
- Pregnancy-related services
- Hospice care during the last six months of life
- Home health care, including skilled nursing care, physical, occupational, and speech therapy, prescribed social services and home-infusion therapy after an acute illness to prevent institutional care
- Extended care services, including inpatient care in a skilled nursing home or rehabilitation center following an acute illness for up to 100 days each year
- Ambulance services
- Outpatient laboratory and diagnostic services
- Outpatient prescription drugs and biologicals, including insulin
- Outpatient rehabilitation services including physical therapy and speech pathology to restore function or minimize limitations as a result of illness or injury

- Durable medical equipment, prosthetic and orthotic devices
- Routine ear and eye examinations every two years
- Eyeglasses for children under age eighteen
- Dental care for children under age eighteen

Additional Benefits in the year 2001

- Preventive dental care for adults
- Orthodontia if necessary to prevent reconstructive surgery for children
- Expanded coverage for mental health and substance abuse treatment

prohibit such limitations because no one can put off paying for insurance until the moment they need it.

Comprehensiveness of health coverage, like universality, reflects an interest in efficiency as well as equity. Benefits packages vary in their scope of coverage and extent of cost-sharing. The scope of benefits covered in the guaranteed package in the Clinton Health Security plan corresponds to the list in good corporate health plans today (see chart, above). The benefits package, however, is especially comprehensive on the "front end" (primary and preventive care) and on the "back end" (there are no lifetime or annual limits on hospital or physician coverage).

Broad benefits in these areas reflect two central objectives of reform: preventive care and security. The plan encourages a shift toward preventive care by guaranteeing coverage of a basic list of clinical preventive services of proven efficacy, such as immunizations and specific

screening tests, without any copayment. And it eliminates the annual and lifetime limitations on hospital and physician coverage as well as other exclusions buried in the "fine print" of insurance contracts that expose many families to catastrophic costs and financial ruin.

Restricting both the "front" and "back" ends of health coverage often produces counterproductive results and savings that prove to be illusory. Limits on primary and preventive care lead to avoidable illness, costly delays in treatment, and greater use of emergency rooms. And when coverage runs out, many people facing catastrophic health costs end up at public hospitals or with unpaid bills, and the taxpayers or privately insured pay for their care anyway.

While its coverage is broad in scope, the Health Security plan does not eliminate all patient cost-sharing. Rather, it provides for three types of cost-sharing that correspond to the principal modes of coverage in the market today. For *fee-for-service coverage*, the cost-sharing would be in the middle range of private plans. There would be deductibles of $200 per individual and $400 per family, with 20 percent coinsurance for physician and hospital care, up to a maximum out-of-pocket cost of $1,500 per individual and $3,000 per family. Prescription drugs would carry a separate $250 deductible and 20 percent cost-sharing, up to a maximum out-of-pocket expense of $1,000.

For *HMO coverage* (the low cost-sharing option), there would be no deductibles, nor would there be any coinsurance on hospital care. The Health Security plan does, however, call for a $10 copayment per physician visit, which is higher than many HMOs charge today. The HMO copayment for drugs would be $5 per prescription.

The third type of plan, a *combined* structure, offers

the low HMO cost-sharing when patients use providers within the network but requires the higher fee-for-service cost-sharing level when patients use providers outside the network. This is the arrangement used by preferred provider networks.

The level of benefits in the Health Security plan is squarely in the mainstream; the plan does not ask Americans to accept a lower standard of coverage or offer them only minimal protection if they lose a job or get divorced.

Several other proposals for reform, however, call for only minimal coverage, restricted to catastrophic costs or a mere "barebones" package. Some conservatives believe that Americans are "overinsured" and want to use tax policy and health reform to encourage high deductibles and copayments as a method of cost containment. That approach, however, will not only fail to guarantee security; it is also unlikely to control costs effectively for the most basic of reasons: Most people won't accept it.

If national reform provides only minimal coverage, the great majority of Americans will obtain supplementary insurance. Nine out of ten Medicare beneficiaries today have supplementary coverage either through a private Medigap policy or Medicaid. These supplementary benefits typically reduce patient cost-sharing and generate higher rates of physician and hospital use *under Medicare*. Thus widespread supplementation raises costs in the basic insurance program, defeating the economic rationale of the coverage limits. A new federal program with high cost-sharing and limited benefits for the under–sixty-five population would just repeat the same mistake. Most Americans would get extra coverage from their employers, and the very poor would retain the broader coverage of Medicaid. With only

low-wage workers facing the benefit limits, there would be little effective discipline on costs. A reformed system is far more likely to control costs by making a single health plan accountable for comprehensive coverage than by dividing coverage between a minimal basic package and widespread supplementation.

This is the broader lesson of integrated health plans. Many coverage restrictions that developed under traditional insurance do not make sense as rules for the emerging health care system. Since traditional insurers have not had contracts with providers, much less control over them, they have been unable to allocate resources among different types of services or achieve savings by managing services more efficiently. To control costs, they have often simply excluded services—such as primary and preventive care, outpatient drugs, and home health services—that can reduce overall costs if managed properly. Integrated health plans do precisely that, substituting ambulatory for inpatient care and managing the full range of services to provide broader coverage more economically.

The new paradigm of integrated health care requires a change in thinking about coverage. Under a more integrated system, arbitrary limits on coverage by type of service or provider often get in the way of cost-effective treatment; coverage without those restrictions yields better treatment at lower cost. Genuine savings in health care come not from trying to shift risks to individuals, but from placing those risks on organizations that can manage them and be held clearly accountable for both costs and quality.

A uniform benefits package among competing plans facilitates that clear accountability. If each plan offers a different package, the myriad complex variations make it difficult for consumers to make clear-cut price com-

parisons. A uniform package enables consumers to compare apples with apples and thereby encourages plans to compete on price. Consumers will also feel more confident about choosing a lower-cost plan if they know there are no hidden exclusions.

Requiring plans to offer a uniform package does not prevent them from offering other benefits in supplementary packages (although those must be fully priced to include utilization effects on the basic plan). The required package sets a common reference point that is essential not only for price competition but also for determining rights and obligations. If a national guarantee of universal coverage is to have any meaning, there needs to be a national standard. All parties involved must know what is included in the coverage that citizens have a right to expect, plans have an obligation to provide, and government has a pledge to guarantee.

Some reform proposals accept the need for a standard benefits package but, rather than spell it out in legislation, assign the responsibility to an administrative board. The political appeal of this approach is obvious. Defining a benefits package is inevitably contentious. However, if the American people are to evaluate any proposal, they must know what the benefits are. Moreover, no one will be able to determine how much coverage will cost without knowing what coverage includes. Some critics have charged that the Clinton program vests too much power in government bureaucracies. The National Health Board set up under the Clinton plan, however, would only interpret the benefits package. Other proposals give an administrative board authority to *determine* the standard package, which would make the board far more powerful. In another area as well—the role and power of the purchasing alliances—conservative alternatives ostensibly

aimed at reducing costs and bureaucracy actually increase them.

The Role of the Health Alliances

No aspect of reform is so poorly understood and so critical to its success as the broad-based purchasing alliances of the Health Security plan. Without the alliances, it will not be possible to shift the choice of health plans from employers to consumers, to restore genuine community rating, and to achieve effective reform of the insurance system.

The Clinton plan calls for two types of purchasing alliances. Regional health alliances would cover all employees of firms with fewer than 5,000 workers, public employees, part-time workers, the unemployed, and other individuals outside the labor force—in all, more than 80 percent of the population under age sixty-five. The regional alliances would thus constitute a pool covering the vast majority of Americans at community rates. Corporations with more than 5,000 employees, as well as some multiemployer plans of similar size established through collective bargaining, would be eligible to establish their own corporate health alliances. Corporate alliances would still have to provide their employees at least the guaranteed benefits package and a choice among the three types of plans, but they would not be eligible for any federal subsidies and would pay an assessment equal to 1 percent of payroll. (The assessment goes for medical education and public health and makes up for the cost advantages that companies enjoy in running a self-contained pool without the unemployed, the retired, and the poor.) Large corporations could opt into the regional alliances on an initially risk-adjusted basis, a provision designed to offset the costs of large companies with many older workers. If they came

LEVEL 1 - 10 OF 13 STORIES

The Washington Post

January 27, 1994, Thursday, Final Edition

SECTION: EDITORIAL; PAGE A26

LENGTH: 303 words

HEADLINE: For the Record

SERIES: Occasional

BODY:

From remarks by Treasury Secretary Lloyd Bentsen in Washington yesterday before a meeting of the National Association of Manufacturers and the Association of Private Pension and Welfare Plans:

It doesn't make any sense to me that our nation accounts for 40 percent of all health care spending around the world, and we have only 5 percent of the people. It doesn't make any sense to me that what we get for that additional spending is a lower proportion of citizens with health care than the other industrial countries. And listen to this one: A typical insurance policy here provides less coverage ... than in any of the other major industrial countries.

... think we agree on universal coverage within an employment-based system. I k we agree on portability regardless of where you work or your health status. We need to reduce job lock and to start agreeing to insure unhealthy people instead of only healthy people.

We agree we need to do more in the way of preventive medicine -- immunizations and the like -- so that doctors don't have to see children coming into an emergency room because the parents couldn't afford an immunization shot. We agree consumers need more information, need to know more about quality and the costs of their care. And we agree that to be effective the plan must achieve real cost containments head-on ...

We've had experience with runaway entitlements. And the president has made it clear that he will not support a plan that could become another runaway entitlement. And that's why you have the circuit breakers; that's why you have the limitations on the subsidies. If someone can convincingly demonstrate the numbers are wrong, we'll modify the plan to make it right. In this town, you don't do anything big anymore if it's not going to reduce that deficit.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: January 27, 1994

UNIVERSAL COVERAGE AND ECONOMIC GROWTH

OVERALL MESSAGE:

As part of the President's long-term economic strategy, health care reform is designed to:

- bring health care costs under control, helping businesses and reducing the deficit
- provide workers with the security they need to move from job to job in a free-trade, change-oriented economy
- increase the overall productivity of the American economy by increasing labor mobility and reducing inefficiencies in the health care system

PRESENTATION:

I. **Health Security and Job Lock:**

- Eliminating job lock is an essential component of a productive, more efficient workforce.
  - In a recent Employee Benefits Research Institute (EBRI) survey, 20% of respondents said they or a family member had based a job decision solely on health benefits.
  - Research by Brigitte Madrian at Harvard has found that mobility rates for married men are depressed by 25 percent because of job lock.

Impediments in the current system:
1) can't take the same insurance with you from job to job
2) you or a family member might have a pre-existing condition
3) next job might not have benefits
4) no guarantee of affordable benefits if in-between jobs
5) no benefits during retraining or continued education

With universal coverage, all these problems are eliminated.

WITHOUT UNIVERSAL COVERAGE:

- Any plan that does not guarantee workers that they will have affordable health insurance if they lose their jobs or change jobs still creates job lock. While some incremental reform plans may address job lock, none solve the problem. Saying that workers who lose their jobs will have the ability to purchase it on their own is not any different from laws already in place in many states today, but it is far from providing guaranteed health security for all workers.

- The Dole plan only allows you to take your insurance with you from job to job, and eliminates pre-existing condition exclusions longer than six months.

    - If the employer at the next job doesn't pay for health benefits, Dole's portability is like saying you can take the company car with you to your next job -- as long as you buy it yourself. It's the same if you lose your job.

    - If you're the head of a family of three making $33,000 a year -- and you get laid off in April, that could mean your family has just $11,000 of income that year. But since $11,000 is right at the poverty line, and the Dole plan only has subsidies up to 90% of poverty, your family might have no help with health benefits for the rest of the year.

II. **Need a system that has incentives that reward work**. Incremental reforms do NOT help the working middle class. Providing subsidies for the poor, with no guarantee that any worker above the poverty level will have coverage, does little to reward work. [Note: this is not "welfare lock", because as long as those on welfare take jobs that leave them below poverty, they likely have fully subsidized insurance.]

It doesn't make sense for people who work to have no health care; it doesn't make sense for people who work to be forced to pay for the health care of people who aren't insured.

- Cooper leaves out 16 million of the 18 million uninsured middle class. Dole leaves out the same 16 million.

- Under the Dole plan, if you're on welfare, you get coverage. But if you take a low-wage job where you make 100% of poverty, you'll have no benefits and no subsidy. (because he only provides subsidies up to 90%)

III. **Inefficiencies** associated with the uncompensated care cost-shift and inefficiencies in the insurance market can lead to a less efficient economy.

IV. **Level playing field.** Without universal coverage, the playing field does not get leveled for businesses that cover their workers.

FACT SHEET

- In a recent Employee Benefits Research Institute (EBRI) survey, 20% of respondents said they or a family member had based a job decision solely on health benefits.

- Research by Brigitte Madrian at Harvard has found that mobility rates for married men are depressed by 25 percent because of job lock.

- One million adults and children are on welfare because it's the only way their families can get health insurance coverage [Moffit and Wolfe]

- Research by Barbara Wolfe at the University of Wisconsin indicates that AFDC caseloads would decline by 18% if recipients were guaranteed private insurance coverage comparable to Medicaid when they moved from welfare to work.

- A family of four with income 25 percent above the poverty level would keep 24 cents of each additional dollar earned under the Clinton proposal, but only 5 cents of each additional dollar under the Cooper proposal. [Center on Budget and Policy Priorities report]

- A study by Jonathan Gruber of MIT showed that approximately 100% of the cost of mandated maternity benefits at the state and federal level was passed back to workers in the form of lower wages.

- Despite an employer mandate passed in 1974, total private non-farm employment in Hawaii has increased by 90 percent, compared to 54 percent in the United States as a whole.

- The CBO's analysis of the Health Security Act predicts that "Overall, businesses' costs for health insurance would be significantly reduced by the proposal. Businesses' insurance premiums for active workers would drop by about $90 billion below our baseline level in the year 2004..."

- In 1971, President Nixon first proposed extending the employer-based health insurance system to all employees. Nixon's proposal was one of shared responsibility between employers and employees -- with the employer paying 75% of the premium and the employee paying 25%.

ATTACHED ARTICLES

1) Excerpt from the definitive study on job lock by Brigitte Madrian at Harvard. This study produced the commonly cited 25% number as the amount which job lock reduces labor mobility.

2) Best newspaper article on job lock -- from the Minneapolis Star-Tribune. Contains several good anecdotes.

3) Page from an EBRI survey on job lock.

4) One-pager with facts on "Medicaid lock."

5) Best newspaper article on Medicaid lock -- from the LA Times. Contains a few good anecdotes.

6) Excerpt from major study on Medicaid lock. Shows that AFDC caseload would be reduced by 18% with universal coverage.

7) Excerpt from Boston Globe article which contains the story of Jim Bryant, who works but has no health insurance. The President has talked about him in a radio address, and he met with him on Tuesday before his NGA speech.

8) Recent Michael Kinsley article from the New Yorker which describes why insurance reform "won't work in practice."

9) New York Times article on a recent Center on Budget and Policy Priorities report that criticizes the subsidy scheme of the non-universal alternatives. Says that "if subsidies are not carefully designed they will discourage people from working and may encourage companies to drop health insurance they now provide to employees."

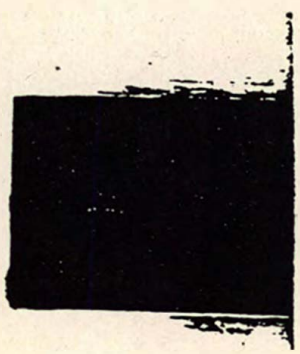
WORKING PAPER SERIES

EMPLOYMENT-BASED HEALTH
INSURANCE AND JOB MOBILITY:
IS THERE EVIDENCE OF JOB-LOCK?

Brigitte C. Madrian

Working Paper No. 4476

NATIONAL BUREAU OF ECONOMIC RESEARCH, INC.



insurance experiment is 60 percent that from the family size experin and expected medical expenses for other health insurance are 80 percent those of family size. Similarly, the effect of job-lock from the family size experiment is 51 percent the effect of using $\hat{\beta}_3$ from the pregnancy experiment, while expected medical costs are 54 percent of those for an expectant family. This suggests that the difference in the mobility rates of the control and the experimental group between those with health insurance and those without health insurance is largely accounted for by differences in expected medical costs faced by these groups.

V. Conclusions

The evidence presented above suggests that there is substantial health insurance-related job-lock. The change in mobility from having other health insurance is 25 percent greater for those with employer-provided health insurance than for those without employer-provided health insurance. In addition, individuals with larger families are less likely to leave their jobs if they have health insurance than if they do not. And finally, while having a wife who is pregnant increases mobility among those with no health insurance, it reduces mobility substantially (30 percent to 40 percent) for those who have employer-provided health insurance. These results are robust to changes in specification and in the sample over which they are estimated.

Estimating the welfare consequences associated with job-lock is a more difficult issue. Although an explicit welfare calculation is beyond the scope of this paper, there are three factors to consider in evaluating the implications of job-lock for economic efficiency. The first is whether there is an important match specific comp

If job turnover results in increased match quality between ers and firms, job-lock will result in a loss of economic efficiency. In contrast, if workers are essentially "replaceable", job-lock will only affect the distribution of output. To the extent that job-lock does lower productivity, a second important consideration is whether these losses are temporary or permanent. While pregnancy is a preexisting condition that comes and goes in a matter of months, some of individuals facing job-lock will be affected by conditions that last for years.

Finally, some might ask whether job-lock is a benefit, rather than a cost, for firms. If firms make job-specific investments in worker human capital, they may want to reduce turnover among their employees. This is a commonly cited reason for employer provision of pensions. The effect of job-lock, however, is separate from the general mobility reducing effect that results from the provision of fringe benefits because it is the workers with high expected medical expenses who will be most likely to stay. Presumably the firm would rather reduce turnover among workers with low expected medical expenses than among those with high expected medical expenses. More importantly, job-lock is not created by the firm but is imposed by the benefit policies of other firms, either because other firms exclude preexisting conditions or, less frequently, because they do not offer health insurance.

June 16, 1993

Insurance concerns affect job choices, many workers say

By Jill Hodges and Darlene DePass
Staff Writers

If Kevin McGannon were to leave his job at Reliance Motion Control in Eden Prairie, he and his wife, Bonnie, would be without health insurance.

He's got a degenerative bone disease and she has epilepsy; chances are any new employer's policy would exclude coverage of those illnesses for at least a year. "I do feel kind of trapped in my job," he said. He had considered changing careers, but now, he's not going anywhere. In the meantime, she has signed up for coverage under her employer's policy, which will cover her epilepsy after a year.

"I'm going to have to hold on to dual policies," she said. "I can't burden my family by not having myself covered."

Insurance continued on page 16A

Staff Photo by Mike Zerby

Kevin and Bonnie McGannon have needed to consider their insurance concerns in job decisions.

Insurance/ In some cases, job lock also can work in reverse

Continued from page 1A

The couple is not alone — increasing numbers of workers report that health care concerns are dictating their job decisions.

A recent Star Tribune/WCCO-TV Minnesota Poll found that 21 percent of the state's adults have remained in a job they wanted to leave primarily to maintain their health insurance. The survey of 1,001 randomly selected Minnesota residents was conducted by phone April 30 to May 9 and has a margin of sampling error of 3.1 percentage points, plus or minus.

According to the Employee Benefits Research Institute (EBRI) in Washington, about 13 percent of job applicants turn down job offers because of health insurance concerns. In most cases, the potential employer did not offer health insurance. In other instances, the company's insurance was worse than the coverage at their current jobs or cost too much.

"Health insurance has become almost a critical element when people are interviewing, looking for a job, particularly for family people [who] have children and dependents," said Andrew Whitman, a professor at the University of Minnesota's Carlson School of Management.

A recent MIT survey showed that the growing phenomenon, known as job lock, reduces turnover by 25 percent. The study, which focused on married men, showed that the average turnover rate would increase 12 to 16 percent if health insurance were not a consideration in switching jobs.

"Men with more than one source of health insurance are much more likely to change jobs," said Brigitte Madrian, the study's author.

Job lock also can work in reverse: Virginia Scott was essentially locked *out* of a job for health insurance reasons. The hotel where she worked as a housekeeper didn't offer insurance and her husband's policy doesn't cover spouses who are employed. Scott, who lives in Benton County near Foley, said her independent insurance policy consumed a good chunk of her paycheck from the hotel, so she quit.

"Basically we're back to a one-wage family," she said. "I'd love to work, but. . . ."

Job lock tightens its grip when a member of the family has a pre-existing medical condition, including anything from pregnancy to cancer. Typically, if the condition is covered at all, the coverage does not kick in for one to two years.

Further, research shows that employers, particularly those in small businesses, have incentive to screen out prospective workers with health problems because they would drive up insurance costs, said Craig Olson, a professor at the Industrial Relations Research Institute at the University of Wisconsin in Madison.

Olson said prescreening will become increasingly difficult under the Americans With Disabilities Act (ADA). The 1990 act prohibits employers from asking job applicants about their health history or requiring them to submit to medical examinations.

Recently, the Equal Employment Opportunity Commission adopted a policy statement on the ADA that prohibits employers from refusing to hire people with disabilities because of concerns about health insurance costs. The policy also requires employers to give equal access to health insurance provided to other employees. However, the policy does not bar clauses that exclude treatment of pre-existing conditions as long as the exclusions do not single out particular disabilities.

So people with pre-existing conditions are left to cobble together coverage any way they can.

Ann, the owner of a small business in Stillwater, provides health insurance for all her employees but cannot get coverage through the company for herself. Her insurance carrier, Blue Cross Blue Shield, won't allow her on the policy because she has diabetes.

Desperate and determined to get medical coverage, Ann, who had a $10,000 eye operation because of her illness, pretends she is still employed by her parents' company, a firm she left several years ago. She's been forced to cling to her parents' policy, which ironically is also Blue Cross Blue Shield. She tried to get other insurance, but no one would take her, she said.

"It makes me real angry because it's not right. I'm real lucky because I had my parents, but what if I didn't? And what do I do when they sell or go out of business?"

She said she can't afford to be without coverage — her medical complications can be severe and medical costs could be exorbitant.

Health insurance concerns not only

keep people from switching jobs, they delay retirement, said Jonathan Gruber, an assistant professor of economics at MIT. When health insurance benefits are extended for a year after retirement, the number of people retiring early increases by 15 percent, he said.

Health insurance first became part of employment packages during World War II, when controls were imposed on wages, Whitman said. After that, unions began focusing on expanding and developing benefits in contract negotiations. By the 1970s, health insurance accounted for about 4 to 5 percent of employers' payroll costs. As the costs continued to grow in the 1980s until they hit about 8 percent of payroll, Whitman said, employers began backing off on benefit promises, requiring co-payments and, in some cases, eliminating health insurance altogether.

According to the U.S. Bureau of Labor Statistics, 69 percent of employees at small companies (100 employees or fewer) and 83 percent of employees at medium and large companies are covered by employer-based health insurance. Employers often compensate for health insurance costs with lower wages, Gruber said. When maternity benefits became standard in the 1970s, he said, nearly 100 percent of the extra cost came out of women's salaries. So far, workers seem willing to accept the tradeoff: An EBRI study in September showed that workers with health insurance would require an average of $4,600 more in annual salary to take a job without the insurance.

"It looks like at least in the past, these benefits have been valued by the workers, and they're willing to take a cut in wages," Gruber said.

Take John Musta: He recently shut down his business and took a job at a furniture restoration company in St. Michael primarily for the health insurance. "The pay is less, but I have that coverage now," he said.

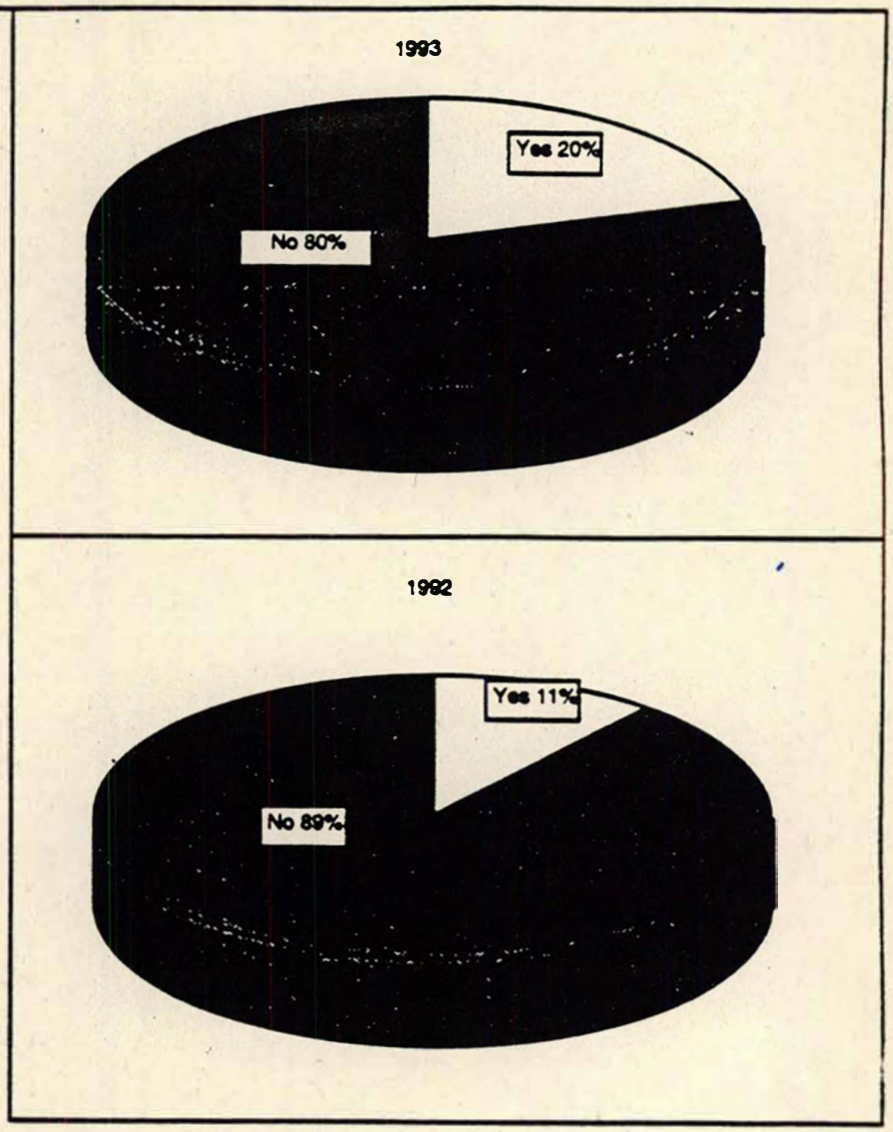
Similarly, Bruce Torgerson, a business manager in the health care industry, said health insurance costs figure prominently in his personal job decisions as well as in his business.

"Five or 10 years ago, the first question I asked was salary," said Torgerson, of Bloomington. "The last five years or so, the first question I ask is benefits, with health care at the top."

Question 9

Have you or a family member ever passed up a job opportunity or stayed in a job you would have preferred to leave soely because of health benefits?

- Twenty percent (20%) of all respondents said they or a family member had based a job decision solely on health benefits.



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JAN 26 1994

PEOPLE STAYING ON WELFARE TO GET HEALTH COVERAGE

At least 1,000,000 adults and children are on welfare because it's the only way their families can get health care coverage. Together, they comprise 7 percent of the 14 million people currently on AFDC.

There have been several recent studies which have examined the effects of the provision of health insurance and welfare participation. Research by Moffitt and Wolfe, Keane and Moffitt, and Ellwood and Adams suggest that the provision of health insurance could reduce welfare caseloads by 10 to 20 percent.

Eligibility for Medicaid has traditionally been linked to actual or potential receipt of cash assistance under the AFDC or SSI programs. Legislation in the last decade has extended coverage to some low-income children and pregnant women who are not on welfare. This fact was not fully reflected in these ıdies. Therefore, the Administration conservatively estimates that there are at ast 1 million people on welfare to get health care coverage.

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FYI FOR WAR ROOM WORDSMITHS —
BE CAREFUL WITH THIS STAT. IT'S 1 MILL PEOPLE TOTAL (ADULTS + CHILDREN COMBINED) NOT 1 MILLION ADULTS, AND THEIR CHILDREN. IT HAS THE POTENTIAL TO SET MOYNIHAN OFF. THANKS,

—— Steve

Medicaid, Welfare Dependency, and Work: Is There a Causal Link?

Robert Moffitt, Ph.D., and Barbara L. Wolfe, Ph.D.

Medicaid exerts a strong "pull" on potential welfare recipients, increasing the probability that a number of single mothers will apply for and stay on welfare in order to be covered by Medicaid. However, the availability of private health insurance coverage exerts a strong positive influence on women's decisions to work and a strong negative effect on welfare participation rates. If private insurance coverage were as comprehensive as Medicaid and readily available at all jobs, its impact on promoting work would be substantially greater than is the impact of Medicaid in promoting the use of welfare.

INTRODUCTION

The Medicaid program is the major source of health insurance coverage for the poor population in the United States. With few exceptions, eligibility for this program is tied to participation in welfare programs. This article provides evidence that the availability of Medicaid plays an important role among the female-headed portion of the potentially eligible population in their choice between work and welfare dependency. Similarly, private insurance plays a significant role. The interesting question for us is what the value, both relative and absolute, of these insurance programs is in determining choices between work and welfare.

For several reasons, the Medicaid program has increased in importance during the past few years. First, the exploding cost of health care in the general population has caused Medicaid expenditures to mushroom. Second, the decline in the real value of cash benefits to the poor, especially in the Aid to Families with Dependent Children (AFDC) program, has increased the relative importance of Medicaid and other such in-kind transfers in the total welfare package. In 1988, 53 percent of all means-tested transfers to the poverty population were in kind, and Medicaid accounted for 70 percent of them. Third, and less recognized, the number of uninsured in the United States has been growing for some time. The number of persons with no insurance coverage now hovers around 31 to 38 million, up from approximately 25 million in the 1970s and 26 to 35 million in the early 1980s. In this deteriorating situation, Medicaid is the primary program financing health services for the low-income population.

We expect that Medicaid plays a role among the potentially eligible population in the choice between welfare dependency and work, which have historically been and continue to be mutually exclusive alternatives for most persons. We have gathered evidence concerning whether the Medicaid program induces poor female-headed families to go onto

Robert Moffitt is with Brown University and Barbara L. Wolfe is with the University of Wisconsin. The views expressed are those of the authors and do not necessarily reflect those of the Health Care Financing Administration, Brown University, the University of Wisconsin, or their sponsors.

Table 4

Simulated Effects of Increases in Medical Benefits on Aid to Families with Dependent Children (AFDC) Recipiency and Employment of Poor Single Mothers

Simulated Changes	Change in: AFDC Participation Rate[1]	AFDC Caseload	Absolute Change in Employment Rate[2]
	Percentage Points	Percent	
Increase in Medicaid of $50 per Month[3]	2.0	5.9	-5.5
Increase in Private Health Insurance of $50 per Month:[4]			
Assuming Current Coverage Levels	-5.3	-15.6	11.7
Assuming Coverage for All Workers	-7.3	-21.5	16.0
Private Insurance for All Workers	-3.5	-10.7	7.6
Increase in Private Health Insurance up to Medicaid Level:[5]			
Assuming Current Coverage Levels	-6.0	-17.61	3.3
Assuming Coverage for All Workers	-8.3	-24.4	18.1

[1]Base is 34 percentage points
[2]Base is 56 percentage points
[3]Represents 34.5 percent increase in Medicaid index
[4]Represents 56.5-percent increase in private health insurance if covered.
[5]Represents 64.2-percent increase in private health insurance if covered.

SOURCE. Based on equation reported in Moffitt and Wolfe, 1992

Push and Pull Are Evident

The major finding is that the positive and negative correlations observed in Table 3 remain, even after controlling for these other forces. However, we also find that many of those forces have a significant effect on welfare participation and employment rates. The availability and generosity of private health insurance, for example, exerts a strong positive effect on employment rates and a strong negative effect on welfare participation rates. Correspondingly, low private health insurance benefits exert a push toward AFDC that complements the pull of high Medicaid benefits.

To obtain some feel for the magnitude of the effects shown by the data, we present in Table 4 predictions of the effects of changes in Medicaid and private health insurance on welfare participation and employment rates. As the first row shows, a simulation of an increase in monthly Medicaid benefits of $50 suggests that such an increase is expected to raise the AFDC participation rate by 2 percentage points (from 34 to 36 percent) among poor single mothers. The AFDC caseload would increase by 6 percent, and the employment rate would drop by more than 5 percentage points. Thus, consistent with the evidence in Table 3, Medicaid benefits appear to pull women onto the AFDC rolls and out of the labor force.

On the other hand, a simulation in which we increase private health insurance by $50 a month suggests effects more than double in size and in the opposite direction. The AFDC participation rate would fall by more than 5 percentage points, the AFDC caseload would decrease by almost 16 percent, and the employment rate would climb by 12 percentage points. Therefore, our evidence indicates that adequate private health insurance has a greater potential for encouraging poor single mothers to work than Medicaid currently has for encouraging them to receive (or to continue to receive) welfare: Private health insurance

has the potential to be a more influential factor in decisions about welfare and work than does Medicaid.

This analysis also provides an answer to the relative importance of Medicaid incentives and private health insurance incentives. A reduction in private health insurance benefits of $50 per month (not shown on the Table) would have effects equal in size but opposite in direction to those shown in the table. Thus, the push of low private health insurance is much more important than the pull of Medicaid in increasing AFDC participation and lowering labor force attachment among low-income female heads.

PRIVATE INSURANCE: THE SUPERIOR WORK INCENTIVE

If private coverage were increased by $50 per month and extended to all poor single mothers who worked, the AFDC participation rate would decline by more than 7 percentage points and the AFDC caseload by more than 21 percent. This policy would also increase employment by 16 percentage points, or by more than 28 percent, among this population.

If, instead, the value of private coverage were increased to the current level of Medicaid (assuming first-dollar coverage and no cap on expenditures, with a few exceptions), then the AFDC participation rate would be reduced by 6 percentage points and the caseload by nearly 18 percent. This policy is also expected to increase participation in the work force by more than 3 percentage points.

If we took a more generous step and both increased the value of private coverage to the level of Medicaid and extended private coverage to all of these female workers, then we predict a decline of more than 8 percentage points in the AFDC participation rate and almost a 25-percent reduction in the AFDC caseload. The labor force participation of these women is expected to increase by more than 18 percentage points, or nearly one-third. On average, this would represent a potential savings (combined AFDC and Medicaid) of more than $4,000 per year per woman who either leaves the AFDC rolls or who is discouraged from joining AFDC, even if she were to continue to receive food stamps. If the average woman who left the rolls (or never joined) worked full-time and stopped receiving food stamp benefits, the savings from the Food Stamp program would be on the order of $1,250 per household, a combined total savings of $5,250.

Taking the national average monthly number of AFDC recipients in 1986 and converting this into recipient families, using the average size of AFDC families (2.93), these changes translate into a potential removal of more than 914,500 families from the AFDC rolls. This would result in a savings (based on average annual benefits) of nearly $4.8 billion in AFDC and food stamps, which would be partly offset by any increase—above the level of Medicaid coverage—in expenditures on private insurance coverage for these women and their families. These expenditures might result from differences in administrative costs, and from additional response of both the medical profession and these women and their families to the change in coverage. The big offset, however, would be the net additional cost of coverage (and use of medical resources) of individuals and families not on AFDC who would also be eligible for this program. Setting income cutoffs or requiring

income-conditioned payments would partly reduce such costs.

CONCLUSIONS

The behavior of poor families, especially those with health needs, is influenced by the opportunities to obtain health insurance coverage that are available to them. Medicaid enhances the value of welfare, and private insurance enhances the value of work. If private insurance were as comprehensive as Medicaid and readily available at all jobs, its impact in promoting work would be substantially greater than is the impact of Medicaid in promoting the use of welfare.

What are the implications of our evidence for current policy regarding health insurance for welfare recipients? What, for example, are the implications for the 12-month extension of Medicaid benefits under the 1988 Family Support Act? Clearly, our evidence that Medicaid attracts some female-headed families onto the AFDC rolls provides support for the motivation behind the legislation, which is the presumption that Medicaid is a factor deterring families from leaving the AFDC rolls.

On the other hand, our evidence on the importance of private health insurance—indeed, of its greater importance than Medicaid—suggests that the impact of the transitional benefits may be limited. In the absence of significant increases in health insurance coverage levels among working non-AFDC families, the same forces that encourage welfare dependency will continue to be present at the end of 12 months. The poor health conditions that are so important in making Medicaid attractive to some families are not likely to subside within this time period.

TECHNICAL NOTE

Indexes of Health Insurance Values

Creating indexes of the value of Medicaid and of private insurance is a multistep process. The first step is to estimate a multinomial logit equation on type of insurance among single females with children 18 years of age or under. The dependent variable can take on three values: A woman either has Medicaid coverage, has private coverage, or has no coverage. Those with both types of coverage, 33 women, are omitted from this equation. Included as independent variables are personal characteristics (age, race, education, health status indicators, prior marital status, etc.), child characteristics, several measures of income (mean, share contributed by single mother, coefficient of variation, home ownership, etc.), and State characteristics (average health expenditures, AFDC benefit for family of four, etc.) The results of this logit equation are used to create predicted probabilities for whether the woman has Medicaid coverage, private coverage, or no coverage.

In the second stage, two utilization equations are estimated—one for number of outpatient visits and one for number of inpatient nights. The included independent variables are a subset of the personal characteristics, State and income variables, the child characteristics; predicted values form the first stage for the probability the woman has Medicaid or private coverage. These equations are used to create estimates of outpatient and inpatient utilization under Medicaid coverage, private coverage, and no coverage.

- The Face of The 90's

THE BOSTON GLOBE • WEDNESDAY, MAY 11, 1994

The mood toughens on welfare

By Don Aucoin
GLOBE STAFF

SOMERVILLE – As he nursed a cup of coffee in Davis Square, the fatigue of 70-hour work weeks evident in his face, Jim Bryant couldn't help contrasting his lot with that of people on welfare.

Unlike welfare recipients, whose medical needs are covered by Medicaid, the 47-year-old salesman from Beverly has no health insurance for himself, his wife, or their two young sons.

Both boys had a big soccer game last Saturday, but their father couldn't be there to cheer them on because he had to hustle off to his second job.

Sometimes he and his wife get so discouraged, Bryant confessed suddenly, that "we've even discussed breaking up" so she and their sons would qualify for certain benefits denied to intact working families.

"I guess I'm a little bitter," Bryant admitted. "It is harder for working people to make ends meet, pay for their own medical, get jobs. That increases my anger about welfare."

Jim Bryant is no welfare-basher. He says he is glad that the safety net is there

WELFARE, Page 8

SHARE THE HEALTH

A socialized health-care system? Goodness, nobody wants that. But when you analyze the arguments, that's where everyone ends up—even the Republicans.

BY MICHAEL KINSLEY

IT'S very simple, House Minority Leader Bob Michel explains in a TV commercial sponsored by the Republican National Committee. "Yes, we can make health insurance portable now. Without the Clinton government-run health-care system. Congress simply needs to change the law so if you lose your job, you won't lose your coverage."

Characterizing the Clinton plan as an attempt to socialize one-seventh of the economy, many Republicans now argue that there is no health-care crisis that can't be taken care of through some minor adjustments in the insurance industry. Forbid discrimination based on "preëxisting conditions"—so that insurers can't turn you down, or charge you more, just because you are already sick or are more likely than average to get sick. Guarantee "portability"—so that insurers must continue to sell you coverage, at the same price, when you move or change your job. Create some new tax deductions. And—presto!—problem solved.

Insurance reform is the free lunch of health-care plans. As a political strategy, it is cynically designed to split off the great middle-class majority, which has health coverage but is frightened of losing it, from the minority, mostly the working poor, which has no coverage in the first place.

It might work politically, but it won't work in practice. Avoiding socialism in health care is harder than the Republicans—or Clinton, for that matter—would have you believe, and even harder, possibly, than they realize themselves. You can start by rejecting socialism, if you like, but you soon find yourself reinventing it.

THE first problem with insurance reform, as a purported alternative to big government, is that it's a tax increase. Republicans were quick to label the "employer mandate" in Clinton's original plan—the requirement that employers finance eighty per cent of their employees' health-care premiums—a "tax" on the reasonable ground that it would be a government-ordered payment, even though the proceeds wouldn't go to the Treasury. Insurance reform is similar. By requiring insurers to accept bad risks at nondiscriminatory rates—that is, take on customers who can now be rejected or charged more—reform will force insurers to raise prices for healthy customers.

When people are all charged the same price for insurance, regardless of their likely health-care requirements, this is called "community rating." Government-mandated community rating will raise insurance costs for healthy people for two reasons. First, the insurer will have to cover the risk of your own long-term decline in health. Right now, the company can drop you or raise your rate if you develop an expensive condition. Second, the insurer will have to pool present good risks with present bad risks. This second element amounts to a government-imposed transfer of wealth from one group of people to another. Pure community rating, then, is the socialist principle applied to health care. Everyone puts the same amount of money into the pot and

is then entitled to withdraw it according to need.

Most insurance-reform proposals don't go all the way to pure community rating. They allow insurers to discriminate on the basis of a few discrete factors. Two of the most common are age and unhealthful behavior, such as smoking. But neither of these exceptions to the community-rating principle undermines the claim that insurance reform is socialism in health care, whether its proponents care to admit so or not; we all get older, we hope, and nobody needs to smoke. Even with these exceptions, insurance reform is designed to make it certain that the vagaries of fate will not be allowed to affect anyone's health-care costs.

And insurance reform is not just socialism in theory; in practice, it will require a big new government role. Ending discrimination between good and bad health risks is easier said than done. As the Princeton economist Uwe Reinhardt told the *Wall Street Journal* last month, community rating "forces a competing private insurer to look at a deathly ill patient, seeing a $100,000 bill, and cheerfully enroll that person for $2,000." Bill and Hillary Clinton were wrong to vilify insurance companies for their current practice of avoiding bad risks if they can. After all, the idea of commercial insurance is protection against the unknown, not the known or the predictable. If you sign up every hundred-thousand-dollar patient who comes along and charge him only two thousand dollars, you'll soon be out of business—unless your competitors are required to do the same, so that all of you spread the cost among other customers. But once the government does require nondiscrimination it must prevent cheating.

Writing in the journal *Health Affairs*, the Harvard health economist Joseph P. Newhouse has described various subtle ways that insurers (including health-maintenance organizations) can skew their customer base toward healthier people. What about advertising in some magazines (*Runner's World*) but not in others (*Cigar Aficionado*)? What about having a discount arrangement with a health club? Putting offices in affluent suburbs will attract a healthier clientele than putting them in working-class areas. Allowing access to fewer doctors in

certain specialties will discourage those with expensive diseases.

Even if insurers play it perfectly straight, customers, by their choices, will see to it that bad risks don't spread themselves evenly among insurers. Sicker people will naturally gravitate to the more elaborate plans (offering more choice of doctors, smaller deductibles, and so on), and, with a disproportionate share of the more expensive customers, these plans will have to charge more. Other plans, with a disproportionately healthy customer base, will be able to charge less. This disparity will undermine a primary objective of insurance reform, which is to allow bad risks to buy insurance at nondiscriminatory rates.

You will soon get what health economists call a "death spiral." As the gap between the prices of different plans grows, the process will feed on itself. Good risks will be less and less willing to pay an ever larger premium for the fancier plans. Ultimately, the fancier plans will become unsustainable. This will defeat the main purpose of those who favor insurance reform as an alternative to government-imposed, one-size-fits-all health care. Little variety will be left.

And, even if you could somehow prevent people from "gaming" the system this way, you couldn't prevent them from leaving the system. Some healthy people would decide to go without health insurance rather than share expenses with Uwe Reinhardt's hundred-thousand-dollar patient. Thus insurance reform could lead to *more* people being uninsured: hardly the idea. And when more healthy people go uninsured you get a second "death spiral." Rates for those who remain insured will go up; the higher rates will lead more people to drop their insurance; the lower number of customers will lead to yet higher rates; and so on.

That is why insurance reform probably won't work without mandated coverage of some sort. Yet it is precisely those conservatives who cherish the conceit that insurance reform can solve everything who object to mandates.

EVEN if everybody is in the system, and even if gaming by insurers and customers is held to a minimum, different insurers will end up with radically different collections of customers. To redress this unfairness (remember, these companies are under government orders to take all comers at nondiscriminatory rates), and to discourage the companies from discriminating on the sly, any serious insurance-reform plan must have a device for redistributing money among the insurance companies. Such distribution is called "risk adjustment."

Risk adjustment creates its own conundrums. Should it be done prospectively or retrospectively? That is, do you estimate insurance companies' costs according to the characteristics of their customers and redistribute money among the companies on that basis? Or do you wait and see how much money different insurers have actually had to spend, and then even things out? Newhouse, the Harvard economist, says that the science of prospective risk estimation is just too primitive to have much effect on the companies' incentive to discriminate in signing up customers. But if you redistribute retrospectively, according to what the companies actually spent, you are eliminating the whole point of private insurance. What incentive would companies have to control costs, if the government were going to step in and even out expenses between those who spent more and those who spent less? As the Cato Institute, a free-market think tank, put it in a recent broadside, retrospective risk adjustment "would ultimately eliminate the risk-bearing role of private insurers and create the functional equivalent of a single-payer health system." In other words, in our earnest effort to avoid "socialized medicine" we may have once again reinvented it.

Clinton's much derided "health-care alliances" were, among other things, an attempt to avoid some of the inherent complications of insurance reform by putting people into large pools, which would allow for the necessary cross-subsidies and risk adjustments—socialization, call it—automatically, without a lot of regulations. The argument was that the alliances would mean less bureaucracy, not more. But the Clintonites were demagogued to death by the very folks who say that "simple" insurance reform is the answer.

A NICE question is why we want to socialize health-care costs when we don't socialize anything else in our society. It's odd, when you think about it. One of the basic principles behind insurance reform holds not merely that the poor should be covered somehow but that everyone should pay the same for coverage, regardless of need. If Bill Gates gets cancer, a working-class family should be expected to share the financial burden equally with him. And vice versa, of course. But, mean-

"Have you heard the news? Ben & Jerry's is turning pro."

while, Bill Gates is not expected to share equally with that family the financial burdens imposed on it by the myriad other workings of fate. Why the difference?

This question does not trouble the Heritage Foundation, a conservative think tank that favors modified community rating. A recent Heritage tract made the case as eloquently as one could wish:

> A lawmaker voting for risk-based insurance would have to tell a constituent with cancer contracted through no fault of his own, or a mother who contracted AIDS because of a blood transfusion after childbirth, or even an individual with a family history of cancer that if they wanted to buy insurance they would face significantly higher premiums than individuals not posing such a risk. Similarly, lawmakers would have to tell a young constituent with a chronic heart condition that paying a lot more for health insurance than her peers is just part of life; and they would have to warn all their constituents that as health insurance companies refine their techniques for calculating risk, such as gene analysis, even seemingly healthy people in the future could face high premiums—or be classified as uninsurable—under a pure risk-based system.

It seems obvious, doesn't it? Yet the Cato Institute is clearly correct in maintaining that the thinking reflected in this passage violates the basic precepts of free-market capitalism. Why *shouldn't* a young woman with a heart condition not pay "a lot more for health insurance than her peers"? If most other sorts of misfortune befell her, with equivalent financial cost, the Heritage Foundation would not leap to suggest a government program of redistribution to negate her bad luck. But when it comes to health care the Heritage Foundation stares at its own principles—and blinks. Or at least it posits, correctly, that any conservative politician would blink. Regarding health care, we are all socialists now.

INSURANCE reform, if it proved successful, would solve the problem of those who are without coverage because of bad health or a lost job. But it wouldn't help those who are without coverage because they simply can't afford it. In fact, by raising rates for healthy people, reform would make insurance unaffordable for many who can afford it now. Medicaid already covers the very poor. But health insurance can easily cost five thousand dollars a year for a family of four—a sum that is beyond the reach of many who don't qualify for Medicaid. Clinton's proposed solution was to require all employers to supply health coverage, as most do now. The small-business lobby may well have beaten that one down.

Yet few participants in the health-care debate—and certainly no politicians—have the guts to admit that they're willing to leave the working poor out of the community of health-care socialism. Even those conservatives who ostentatiously oppose a "new entitlement" of "universal health care" generally claim to have some other method of achieving the same result; they don't dare say outright that people who can't afford decent medical care should go without it. Since employer mandates seem to be verboten, that leaves some sort of government subsidy as the only viable alternative.

But government subsidies create their own puzzles, even aside from the obvious one of how to pay for them. The subsidy proposal in Representative Jim Cooper's health-care plan is a typical one. Cooper, a Tennessee Democrat, has been peddling a plan he calls Clinton Lite, which he says has all the nice parts of Clinton's plan while avoiding all the nasty bits. Cooper would have the government pay a hundred per cent of the health costs of families at the poverty line—currently about $14,800 for a family of four—and gradually reduce the subsidy to zero at double the poverty line.

Henry Aaron, a liberal economist at the Brookings Institution, and Martin Feldstein, a conservative economist at Harvard, have both pointed out the devastating flaw in this idea. The gradual phase-out of the subsidy amounts to a stiff marginal tax on earnings within the phase-out range. That is, for every extra dollar of earnings up to almost thirty thousand dollars a year, a family of four would not just pay ordinary taxes but would also lose part of its health-care subsidy. Feldstein calculates that the combined tax rate would be as high as seventy-two per cent. Such a rate would lead many families to conclude that the effort to make additional income (a second job, say, or a stay-at-home spouse's going to work) wouldn't be worth it. The negative impact on total employment and national output would surely

greater than that of Clinton's employer mandates.

Feldstein, writing in the *Wall Street Journal*, points out a second flaw. Many of those who, if they were uninsured, would qualify for the Cooper subsidies do have health insurance now, through their employers. The employers would surely be tempted to drop this benefit once the government stood willing to pay for it instead. That means much of the government subsidy would be wasted on people who already have insurance. Feldstein calculates (perhaps a bit tendentiously) that the Cooper subsidy could cost the government six thousand dollars for each currently uninsured individual above the poverty line who is brought into the system, or twenty-four thousand dollars for a family of four.

The Feldstein-Aaron analysis applies not just to the Cooper plan but to any government subsidy of private health care that is phased out as income rises, whether directly or, as some conservatives prefer, through tax credits. The subsidy has to start out large enough, at low incomes, to make health insurance affordable. From that point on, the faster you phase out the subsidy, the higher the effective tax rate becomes. But the slower you phase it out, the greater the cost becomes.

An unheralded advantage of employer mandates is that they would avoid both of the problems created by income-linked government subsidies—nightmarish marginal tax rates and employer shirking. Although it is fair enough to label employer mandates a "tax," at least they are a tax that homes in on the cost of insuring those who aren't insured now.

Of course, neither insurance reform nor subsidies for the poor will do anything to bring health-care costs under control. On cost control, everyone purports to reject the big-government (socialist) solution in favor of a "market-oriented" approach. Clinton contends that his health alliances would promote greater competition in health-care markets, though his plan contains so-called global budgets (limits on total health-care spending), implemented through limits on insurance-rate increases, as backup devices. Jim Cooper's plan is widely praised for using free-

"So, how's your snit coming?"

• •

market competition rather than government controls to restrain prices, but in reality the Cooper plan has hardly any market reform that isn't in the Clinton plan, too. Various conservative and Republican plans either ignore the cost issue or address it through tax changes.

The free market works well enough to hold down costs in other industries—why not in health care? First, because insurance keeps market forces at bay. To the extent that they're insured, people don't mind how much health care they avail themselves of or how much it costs. An experiment conducted by RAND, the research organization, compared, among others, a group of people with insurance coverage of a hundred per cent with a similar group whose insurance had a large annual deductible. The fully insured group spent forty per cent more on health care—no surprise—with no discernible improvement in the health of the average participant. To the extent that the insurance itself is paid for by employers or by a government program like Medicare, individuals are doubly isolated from the cost of their health-care decisions.

But even if every individual paid every single health-care expense out of his or her own pocket, the free market would not work very well to hold down prices. Most health-care-purchasing decisions are made not by the consumer but by a doctor. The doctor decides that you should take this drug, or see this specialist, or have this operation—and the doctor isn't paying for any of these. When the consumer does decide, it is hard for him or her to decide intelligently. How can I know whether such-and-such a test is really needed, or whether a hundred-dollar allergist isn't just as good as one charging a hundred and fifty dollars? But even an intelligent, informed, and tightfisted consumer will hesitate to vindicate Adam Smith when the subject is health. Who is going to shop around for the best price on chemotherapy, or bargain with a brain surgeon?

Despite these limitations, the free market in health care could be made to work better than it works now. Ironically, the key would be to discourage the very thing—insurance—most people think health-care reform ought to promote. Right now the tax subsidy for health care is perverse. If your employer pays for your insurance, you needn't declare it as income, and your employer can deduct it from taxable earnings. But, if you buy your insurance yourself, your premiums and all out-of-pocket medi-

cal expenses are (unless they exceed a significant percentage of your income) paid for in post-tax dollars.

A free-market purist would say that there should be no tax preference for medical costs at all: by favoring medical spending over other forms of consumption, the tax break naturally leads to overspending on health care. No one is that pure. A milder option is to make the tax system neutral between insured and uninsured expenses, and between employer-paid and self-paid insurance premiums, by making them all equally deductible. And, if you're really serious, you ought to consider going further and tilting the incentives against insurance.

From this menu of possibilities, most current reform proposals take the sweets and leave the spinach. Ostensibly free-market Republicans, in particular, are all for making individual insurance premiums and direct health expenses deductible—with the usual fanciful explanations of how the government will finance these gifts. Even more, the Republicans by and large reject any limitations on the deductibility of employer-paid insurance. That, after all, would amount to a tax increase! Representative Cooper's plan has a cap on insurance deductibility. President Clinton's plan has a cap on it, too—but only after ten years. These sort of caps might control costs by discouraging lavish insurance plans; but not by much.

So genuine free-market cost control isn't going to be given a chance, and probably wouldn't work if it were to be. If it did work, it would feature many of the same disadvantages as government-imposed cost controls. More and more Americans would find themselves in health maintenance organizations and other managed-care arrangements. Drug and medical research would decline as the invisible hand of competition ruthlessly sought out and squeezed the generous profit margins that had previously sustained them. There might not be rationing per se, but individuals would regularly forgo necessary treatment to save money. I suspect that after a few years of the rigors of genuine free-market medical care the citizenry would be screaming for genuine socialism.

Meanwhile, back in the real-world health-care-reform debate, we move inexorably toward socialism anyhow, while denying it every step of the way. ♦

THE NEW YORK TIMES, TUESDAY, JUNE 28, 1994

THE DETAILS

Study Sees Problems in Subsidies to Help the Poor Buy Insurance

By ROBERT PEAR
Special to The New York Times

WASHINGTON, June 27 — A new study finds serious, unsuspected problems with many proposals for the Federal Government to help low-income people buy private health insurance by subsidizing their premiums.

Such subsidies are a feature of most of the health insurance bills being considered in Congress. Subsidies have been suggested as a way to make sure that all Americans obtain health insurance, with or without a requirement that employers contribute to the cost of workers' coverage.

But the study, issued today by the Center on Budget and Policy Priorities, a nonpartisan research institute, says that if subsidies are not carefully designed they will discourage people from working and may encourage companies to drop health insurance they now provide to employees.

Moreover, the study, which looked at all proposals, says there are serious problems in plans to limit the amount the Government could spend on subsidies in any year: "they make no adjustment for recessions."

To stay within the spending limits, the study says, subsidies would be reduced at the very moment when the need was greatest, in recessions, as the numbers of poor and unemployed people rose.

Government subsidies to help people buy insurance have been in health plans proposed by President Clinton; Representative Jim Cooper, Democrat of Tennessee; Senator John H. Chafee, Republican of Rhode Island, and Senator Edward M. Kennedy, Democrat of Massachusetts. Spending on such subsidies would be subject to limits set by Congress. None of the proposals would increase the spending limits in time of recession.

On Providing Subsidies

Robert Greenstein, director of the Center on Budget and Policy Priorities, said the cost of subsidies would be much higher if there was no requirement for employers to pay any of the premiums for their workers. But, he observed, in the absence of an employer mandate, companies would have "powerful incentives" to drop coverage for their employees and to shift costs to the Government, which would subsidize the premiums.

Describing what would happen without an employer mandate, Mr. Greenstein said the study found: "Employers could terminate coverage without jeopardizing poor workers. The workers would continue receiving similar coverage, with their premiums fully paid by the public subsidy system."

Moreover, it says, "Firms that employ large numbers of low-income workers would be able to make themselves and their employees better off by terminating health coverage and converting some or all of the savings into higher wages or other employee benefits."

Mr. Cooper defended his proposal, saying, "It is essential that health care reform include subsidies to make coverage affordable for low-income people."

The study says that the proposed subsidies will become extremely expensive if they are available to large numbers of people in middle-income families. On the other hand, it says, if the subsidies decline sharply as earnings rise, they may discourage people from trying to earn more, especially people with incomes between the poverty level and twice that amount ($15,000 to $30,000 a year for a family of four). In other words they would lose their benefits and be subjected to more taxes as well.

Gradual Phasing Down Urged

People just above the poverty level already pay a high "tax" on additional earnings because they may lose food stamps, tax credits and other benefits as their incomes rise.

Thus, the study concludes: "Low-income subsidies should be phased down very gradually. Otherwise, incentives to work will be weakened too much."

A family of four is classified as poor by the Government if it had cash income less than $14,764 in 1993. For each additional dollar earned, the report says, a family of four that has income 25 percent above the poverty level and receives food stamps would lose a total of 76 cents under the Clinton proposal, 78 cents under the Kennedy proposal, 90 cents under the Chafee proposal and 95 cents under the Cooper proposal.

Put another way, such a family would keep 24 cents of each additional dollar earned under the Clinton proposal, but only 5 cents of each additional dollar under the Cooper proposal.

The Use of Overtime

Such high marginal tax rates could easily discourage extra work effort because people would keep relatively little of their additional earnings, the report says.

Mr. Greenstein said that an employer mandate could also have some unintended effects. For example, he said, it would create incentives for companies to make greater use of overtime by full-time workers, rather than hiring additional employees. "Use of overtime does not increase health care premium costs, while hiring new employees would do so," he said.

The study by the Center on Budget and Policy Priorities examines the effects of subsidies on people at different income levels. The work of the center was assisted by a grant of $20,000 from the Henry J. Kaiser Family Foundation.

Taking issue with a crucial part of plans to overhaul health insurance.

Officials See Health Plan as Shot in the Arm for Welfare Reform

White House says universal coverage will allow many to seek work. But critics say the proposal may backfire.

By ELIZABETH SHOGREN
TIMES STAFF WRITER

WASHINGTON—President Clinton's health care reform plan will reap more than health benefits because the universal coverage in the proposal will encourage hundreds of thousands of people to get off welfare and get jobs. Administration officials say.

"I will not even apply for a job without a health care plan that includes my children," said Rosemary Arrington, who has supported her four children with welfare off and on for 13 years.

Arrington stopped receiving Aid for Families with Dependent Children about a year ago when she got a temporary job, but she was able to extend her Medicaid coverage for a year. Now that extension is running out, and she is out of a job again.

She said she may have no choice but to apply for the AFDC benefits again so she can continue her family's medical coverage, but she would rather support her family on her own.

Anecdotal evidence suggests that one of the major reasons people remain on welfare is to get medical coverage for their children and themselves, coverage they are now unable to obtain because of existing medical conditions or because prospective employers do not offer health benefits at all.

The Administration's plan would require all employers to provide health coverage for their employees and would ensure that everyone qualifies for coverage no matter what their health status.

"We want people to be able to become independent and go to work," First Lady Hillary Rodham Clinton said earlier this fall, answering a question from a woman receiving public assistance. "And one of the things that this [health care reform] will do is to begin to break that welfare lock so that you and others can go out and become employed, but not have to worry about losing your health care."

But the belief that health care reform could help solve the welfare problem is not universal.

Some economists and Republican welfare-reform advocates in Congress argue that by requiring employers to pay medical benefits, the President's plan will decrease the supply of low-skill jobs, forcing more people to seek public assistance.

Even some of the 5.6 million people receiving AFDC benefits are skeptical about the plan.

"I now have free health care for my children. I don't pay a deductible and I don't pay co-payments," said Sherry Smith, 24, a single mother in San Pedro, Calif., who supports her three preschool-age children solely with public assistance. "Under the Clinton plan, if I got a job, I'd have to pay my deductible and co-payments. That's not an incentive to go to work, that's a disincentive."

The Clinton plan would eventually abolish Medicaid, which covers medical expenses for people on welfare. People on public assistance would pay a discounted co-payment to go to the doctor and would not have to pay a share of the premium.

If they went to work, however, they probably would have to pay a larger co-payment and a share of the premium. Some say that would raise costs enough to discourage them from seeking jobs.

There is little statistical data on the subject. Alice Rivlin, deputy budget di-

rector, told a congressional hearing that "the anecdotal data is very persuasive, and the number of welfare mothers who stay on welfare because they have a sick child [is] a persistent anecdote."

Barbara Wolfe, a professor of economics and preventive medicine at the University of Wisconsin in Madison, has studied the impact of medical coverage on welfare participation. She said the Administration's estimates of the probable impact of health care reform are consistent with her research.

Her analysis of Census Bureau material showed that 18% of the people receiving AFDC funds gave up the welfare benefit when they were assured that their job provided medical insurance, even if the coverage was inferior to Medicaid.

Since that data was collected, welfare rules have changed and publicly funded medical insurance is available for children in low-income families that are not eligible for AFDC. Taking that into consideration, welfare participation should drop by about 15%, or by 840,000 people, with the introduction of the President's health care reform proposal, she said.

Most likely to leave the welfare system would be people who have higher than average medical expenses, she added, such as families with lots of children or those with a parent or child who has a chronic medical condition.

Such a person is Marie Kostos-Weber, one of Clinton's most poignant examples in his speeches promoting his health care reform plan.

Kostos-Weber, a divorced mother, quit her $50,000-a-year job and depleted her savings to get Medicaid—the only way to pay for her terminally ill child's $100,000-a-month medical expenses.

"Who would insure a burning building? That's what the insurance companies said about her," said Kostos-Weber, whose daughter died in July at age 10.

The repercussions of that forced decision five years ago have lingered.

"I'm going to have to take something for a lot less because I've been out of the work force for so long," said Kostos-Weber, who previously worked as a headhunter for managerial positions. "Not only have I lost my daughter, but I've lost everything that made me feel good about myself."

The Clinton plan would allow people like Kostos-Weber to keep working and be confident that their children's medical needs will be met, said David Ellwood, a co-chairman of the Administration's welfare reform task force.

Predicting the size of the exodus from welfare if the health care plan is enacted is difficult because most people who rely on welfare do so for a mix of reasons.

Xzavia White, who has three children, has received public assistance checks, food stamps and Medicaid for the last three years since he lost his job restoring fire-damaged homes.

Even with the guarantee of medical coverage, he said, many people like himself still will not be able to give up public support.

"Health care probably isn't enough," White, 24, said as he was waiting for a friend outside a public assistance office in Washington, D.C. "We have a lot of people who don't want to be on welfare but don't have a choice."

The Administration plans to address this problem by radically overhauling the welfare system. The plan, which is expected to be released early next year, will stress job training and enforcement of child-support payments as well as put a two-year limit on receiving public assistance checks for most people.

Bruce Reed, the other co-chairman of Clinton's welfare reform task force, said he believes that the combination of those reforms, guaranteed medical coverage and earned income tax credits for low-wage workers will turn the welfare system from one that often fosters a lifetime of dependency into a temporary safety net that pushes people into the work force.

"If they refuse to work, we will require them to work," Reed said.

Rep. Rick Santorum (R-Pa.), who leads the GOP welfare reform initiative in the House, said the Administration is moving too slowly on its plans to redesign welfare and is using its health care reform plan as an excuse for the delay.

Furthermore, he said he expects the President's health care reform plan to increase welfare rolls because it requires employers to provide coverage, which will force staff cuts.

"I think you're going to see massive unemployment from what the President proposed," he said.

William Custer, an economist for the Employment Benefits Research Institute, agreed. "The supply of workers may increase, but the demand for workers may decrease."

Some Republicans in Congress, however, concede that making affordable health care available to all Americans is an important element of welfare reform.

"It would have some effect, but I'm not sure it would be a huge, measurable change," said Rep. Fred Grandy, (R-Iowa), a co-author of an alternative health care reform plan that would offer government subsidies for low-income families. "But I think we're going to need more than that to get people off welfare."

SENATE FINANCE COMMITTEE'S BILL

BENEFITS

- Standard benefit package equal to the actuarial value of the Blue Cross/Blue Shield Standard Option under the Federal Employee's Health Benefits (FEHB) program (this is 8 percent less than the HSA premium).

- Expanded public coverage of home and community services for the severely disabled.

- No Medicare drug coverage.

INSURANCE MARKET

- Community rating, adjusted for age and type of plan (individual, family) is available to firms with fewer than 100 employees, the self-employed, and individuals.

- Voluntary cooperatives through which individuals and firms under 100 can purchase coverage. States are required to establish a cooperative, if necessary.

- Individuals and small groups allowed to join FEHB plans, but would pay a community rate. (Federal employees remain in a separate premium-rating pool.)

- Firms with more than 100 employees are allowed to self-insure, along with large Taft-Hartley plans.

- Guaranteed issue, annual open enrollment, restrictions on pre-existing condition clauses (one-time open-enrollment with no limitations, then maximum 6-month exclusion only for the previously uninsured)

- Mandatory risk-adjustment of premiums (developed by HHS and implemented by the States) for all plans in the community-rated market.

MANDATE

- SOFT TRIGGER: If 95% of Americans are not insured by 2002, a national commission makes recommendations to Congress in the form of draft legislation about ways to increase coverage to 95 percent.

- Non-discrimination: Employers that voluntarily contribute towards the coverage of employees must make the same contribution for all full-time and part-time workers (pro-rated), or pay an excise tax equivalent to denying the employer's tax deduction for health benefit expenses.

SUBSIDIES

- Premium subsidies available to individuals and families up to 200 percent of poverty. Full subsidy up to 100 percent of poverty, pegged to the average premium for community-rated plans in the area. The subsidized share of the premium decreases by each percentage point over the poverty line. Subsidies reduced dollar-for-dollar by the amount of any employer contributions.

- Premium subsidies also available to uninsured pregnant women and children under age 18 below 250% of poverty. Full subsidy up to 185% of poverty, phased out according to a sliding scale. Mandatory maintenance of effort for employers currently offering coverage of children.

- Cost-sharing for the poor is reduced to "nominal" levels. Plans are required to absorb reduction. Two billion dollars per year is available to the States, who must match Federal payments, to structure and provide cost-sharing subsidies to persons between 100% and 200% of poverty.

- Individuals (including the self-employed) without employer contributions are allowed to deduct 100% of premiums for the standard benefit package from their taxable income.

MEDICAID

- AFDC and non-cash Medicaid recipients are integrated into the subsidized community-rated pool.

- Medicaid recipients receiving SSI are not included in the community rate. States negotiate with health plans for rates to enroll the disabled.

- Current Medicaid rules governing covered services and recipient eligibility would be retained.

COST CONTAINMENT

- Savings from competition

- Plans whose premiums exceed the 60th percentile in the area, and are not among the lowest 25 percent of geographically-adjusted premiums nationally, are assessed 25% of the difference between the plan premium (including both standard package and supplementals) and the average standard premium in the area. The assessment and evaluation of plans that are not community-rated is done on "an actuarial basis."

- FAIL-SAFE FEDERAL DEFICIT CONTROL: OMB determines annually, through 2003, whether enactment of health care reform had caused an

unprojected increase in the deficit. Any deficit increase would trigger proportional reductions in premium subsidies (through a delay of eligibility), revenue losses from the tax deduction for individually purchased insurance, and increases in out-of-pocket limits in the benefit package. The National Commission may propose and Congress may enact an alternative proposal for offsetting the deficit effect. Congress may vote to suspend these procedures in the event of two consecutive quarters of real economic growth of less than one percent.

FINANCING

- Increases tobacco tax to $1.24 per pack
- Tax of 1.75% on insurance premiums to fund academic health centers and research.
- Extends Medicare HI tax to all State and local employees
- Recaptures Medicare part B subsidies for individuals with incomes over $90,000 and couples with incomes over $115,000

STATE FLEXIBILITY

- If a State demonstrates that a single-payer program would substantially increase coverage or lower health care spending, it can be exempted from the ERISA preemption.

SENATOR DOLE'S HEALTH REFORM PROPOSAL

BENEFITS

- Every health plan selling in the individual and small group market (firms 50 and under) must offer the "FedMed" benefit package, which would be defined by the Secretary of HHS and would have an actuarial value of the package of the highest enrollment plan under the FEHB program in 1994 (Blue Cross Standard Option).

- Health plans could offer supplemental packages to the FedMed package, but could not require an individual or a group to purchase supplemental coverage or link the pricing of a supplemental benefit package to that of the standard package.

- Large self-insured employers would not have to offer the FedMed package.

- Medical savings accounts (MSAs) would be linked with the purchase of catastrophic coverage.

- No changes in Medicare benefits (i.e., no prescription drug coverage).

INSURANCE MARKET

- Community rating, adjusted for age and type of plan (individual, family) for firms with fewer than 50 employees, the self-employed, and individuals. The ratio between the highest and the lowest age factor may not exceed 4:1 for the first 3 years after implementation and 3:1 thereafter.

- Administrative costs could vary based on size of group.

- Possible voluntary cooperatives could be put in place for individuals and firms under 50.

- Self-employed individuals and small employers with 50 or fewer employees would have the option to purchase health benefit plans though the FEHB program. Insurers would have to offer these enrollees the same benefit plan(s) that are available to Federal employees at the same premium price plus an administrative fee.

- All health plans (large firms included) would have to have guaranteed issue and annual open enrollment. They could keep some restrictions on pre-existing condition clauses, such as a 6 month exclusion for those who did not previously have insurance. Each state will set an initial 90 day open enrollment period during which individuals who have not previously had health

benefit coverage can enroll without being subject to pre-existing condition limitations.

- States are to risk adjust (for the individual and small group market only) across insured health plans and self-insured plans of employers with 50 or fewer employees. All employers with 50 or fewer employees are required to carry "stop loss" insurance.

MANDATE

- No mandate.

SUBSIDIES

- Partial premium subsidies would be available to individuals and families up to 90 percent of poverty. This subsidy would be pegged to the amount the Federal government uses to calculate its maximum contribution (75 percent) for Federal employees under the FEHB program. Individuals would not be eligible for any subsidies if their employers contribute anything to their health costs.

- If additional funding becomes available, subsidies would be extended up to 100 percent of poverty, phasing out up to 150 percent of poverty.

- Self-employed individuals and individuals who do not get insurance through their employers would get a tax deduction equal to 100 percent of the cost of insurance (phased-in by the year 2000).

MEDICAID

- AFDC and non-cash Medicaid recipients can be gradually integrated into the small group pools at State option.

- Federal Medicaid spending for acute care services, including expenditures for payments to qualified health plans, will be subject to an annual per capita payment cap for each state.

- Current Medicaid rules governing covered services and recipient eligibility would be retained.

COST CONTAINMENT

- Savings from competition

- FAIL-SAFE FEDERAL DEFICIT CONTROL: OMB determines annually whether enactment of health care reform had caused an unprojected increase in

the deficit. Any deficit increase would trigger a freeze in the phase-in of tax deductions, a freeze in contributions to MSAs, and the low income subsidy phase-in would be slowed or rolled back.

FINANCING

- Savings from public programs, primarily Medicare reductions and cap on Federal Medicaid payments.

HOUSE WAYS AND MEANS BILL

BENEFITS

- Guaranteed national benefit package equivalent to Medicare Part A and B (newly named Medicare Part C) with several improvements including additional coverage for women and children, the mentally ill, the chemically dependent, as well as prescription drug and preventative service coverage.

- Deductible of $500, no out-of-pocket limit until 2003; separate $500 deductible and $1000 out-of-pocket limit for drugs.

- New public long-term care program for home and community services.

INSURANCE MARKET

- Community rating, adjusted for geographic region and type of plan (individual, single parent, or family) required for all markets except large group (employers with more than 100 employees).

- Firms with more than 100 employees would be able to self insure.

- Regional health alliances could be established by a State or local government with a population of at least 1 million. Alliances could be mandatory with State approval.

- Community-rated, supplemental benefit policies available in 10 standardized packages.

- Guaranteed renewable coverage, no denial or limiting of coverage based on pre-existing conditions, and no discrimination against an individual.

MANDATE

- Individuals would be covered under a private health plan or Medicare Part C (for low-income employees in firms of 100 or fewer employees; temporary, part-time or seasonal workers; the unemployed; and AFDC and SSI recipients) by January 1, 1998. Individuals would be required to pay for their premium minus the employer contribution.

- Employers would be required to contribute 80 percent of the premium of the standard benefit package. Employers with more than 100 workers would need to meet this obligation by January 1, 1996; employers with less than 100 employees and those self-insuring through Medicare Part C would be required to do so by January 1, 1998.

- Employers would be required to offer both a managed care plan and a plan that offers unlimited choice of providers.

- Employers would be required to provide coverage for family members, but would receive credits for these premiums from the employers who do not have to supply coverage because their employees are covered by another employer.

- These employer responsibilities apply to employees working over 25 hours per week and for longer than 4 months, and for retirees.

SUBSIDIES

- Individuals below the poverty line would pay no premium. Individuals between the poverty line and 240% of poverty would pay less, based on a sliding scale. These subsidies would be phased in from 1998 to 2003.

- Employers with 50 or fewer employers with average salaries below $26,000 would be eligible for tax credits to reduce premium costs. The maximum credit would be 50 percent for firms with 25 or fewer employers and average salaries below $12,000.

- Self-employed individuals would be allowed to deduct up to 25 percent of premium costs through December 31, 1997, and 80 percent thereafter.

- A wrap-around benefit package provided under Part C to all persons below 100 percent of poverty. All early and periodic screening, diagnostic, and treatment services included in the wrap-around for children up to age 18, as well as vision and hearing.

MEDICAID

- Individuals currently covered by Medicaid would be covered by Medicare Part C, equivalent to the standard benefit package, beginning January 1, 1998. Premiums to be subsidized as detailed above.

COST CONTAINMENT

- Savings from competition.

- Stand-by controls on private expenditures and immediate controls on Medicare (A/B and C) expenditures. National and State expenditure targets established by statute in 1996, by type of service. Target gradually reduced from current path to 5-year average of per-capita GDP. Beginning in 2001, if a State exceeds a target for private expenditures, maximum payment rates based on Medicare methodologies will go into effect provided that the National Health Cost Commission does not propose, and Congress does not approve, an

alternative cost containment system.

FINANCING

- Increases tobacco tax to 69 cents by 1999.
- Eliminates exclusion from income of employer-provided accident or health coverage provided through a cafeteria plan or flexible spending arrangement.
- Imposes a 2 percent excise tax on health insurance premiums and self-insured plans.
- Extends Medicare HI tax to all State and local employees.
- Employers not enrolling their employees and dependents because they are covered by another employer would pay 80 percent of an individual Part C premium which would fund a premium credit for employers paying for more than their employees.

STATE FLEXIBILITY

- States would be given broad flexibility to establish their own health care reform plans as long as the cost of the program is less than without the program and the plan covers all residents. Self-insuring employers with more than 5,000 employees in at least two states would be able to exempt out of state benefit management programs.

SENATE LABOR COMMITTEE

(Kennedy)

BENEFITS

- HSA standard benefit package.
- Enhanced benefits, including additional coverage for women, children, the disabled, and the mentally ill (financed by raising the out-of-pocket limit).

INSURANCE MARKET

- Every American will have the option to participate in the Federal Employees Health Benefits Plan.
- In addition to the FEHBP option, the each state must create at least one "voluntary consumer purchasing cooperative".
- Large businesses of over 1,000 employees will have to purchase insurance outside of the community-rated purchasing cooperative system (but they will be able to join together with other large businesses to form their own purchasing cooperatives).
- Firms with 500 to 1,000 employees that choose to self-insure must pay an assessment of one percent of payroll and forego any government subsidies.

MANDATE

- All employers with more than 10 employees will be required to contribute 80 percent of the premium for their workers.
- CARVEOUT: Small businesses with 10 or fewer employees and average wages of less than $24,000 per worker will not be required to provide health insurance for their employees. Firms with 2-5 employees would pay a 1 percent payroll assessment and firms with 6-10 employees would be required to contribute 2 percent of payroll toward the cost of the program if they chose not to offer coverage.

SUBSIDIES

- Employers with more than 75 workers will have their contribution capped at 12 percent of each worker's wages.
- For employers with fewer than 75 workers, the employer's share of the cost will be capped on a sliding scale from 4.2 percent to 12 percent of each employee's wage, based on the size of the firm and the average payroll.

- Individual contributions for the 20 percent share are capped at 3.9 percent of income for all families. Workers' contributions in exempt firms will be capped on a sliding scale of 4 to 6 percent of income.

MEDICAID

- Not in jurisdiction; assumed Administration proposal.

COST CONTAINMENT

- National Health Board sets fallback premium caps to limit growth in premiums.

- The Board may recommend reductions in benefits to reduce costs in order to avoid increasing the federal deficit. Such recommendations would be considered by Congress under fast-track procedures.

FINANCING

- Increases the cigarette tax to $1.74 per pack.

- Assessment of 1 percent of payroll on large employers that self-insure (employers with more than 1,000 employees must self-insure; those with over 500 can if they so choose).

HOUSE EDUCATION AND LABOR BILL

BENEFITS

- HSA standard benefit package.
- Enhanced benefits, including expanded mental illness, dental, and women's and children's coverage.

INSURANCE MARKET

- Consumer purchasing cooperatives established by the States or private clearinghouses for each community rated area required.
- Firms with more than 1,000 or more employees would be able to self-insure.

MANDATE

- All firms with less than 1,000 employees are required to purchase 80% of community-rated insurance for employees.
- Firms with more than 1,000 employees are required to provide 80% of experience-rated insurance or self -insure.

SUBSIDIES

- Firms with average annual wages below $24,000 and with 25 to 75 workers receive subsidies to keep insurance costs below 3.5 to 7.9 percent of payroll depending on firm size. Small businesses with less than 25 employees will not have to pay more than 2 percent of payroll (more generous than HSA which had limit of 3.5 percent of payroll).
- Extends premium subsidies in the HSA for the "20-percent share" to 200% of poverty, and increases the income disregard from $1000 to $2000.
- Wrap-around benefit package provided for children up to 200 percent of poverty; for pregnant women up to 185 percent of poverty.

MEDICAID

- AFDC and non-cash Medicaid recipients are integrated into the subsidized community-rated pool.

COST CONTAINMENT

- Savings from competition.
- Premium caps if insurance and market reforms do not reach cost containment targets.

FINANCING

- Increases tobacco tax to 99 cents per pack.
- Imposes a 1 percent payroll assessment on firms of 1,000 or more employees.

ORIGINAL COOPER/BREAUX PLAN -- 91 PERCENT OPTION

BENEFITS

- Not defined.

INSURANCE MARKET

- Modified community rating, adjusted for age and type of plan (individual, family) for those in accountable health plans (AHPs).
- Standard benefit package.
- One voluntary health plan purchasing cooperative (HPPC) in each geographic area.
- Tax cap at lowest cost plan, or "reference premium" (lowest cost plan that has a specified minimum enrollment).

MANDATE

- Employers must **offer**, but are not required to provide insurance.
- Individuals and firms of up to 100 employees would purchase coverage through a HPPC, all others would have to buy coverage outside of the HPPC.
- Small firms would have to buy through the HPPC in order to get the tax deduction.

SUBSIDIES

- Individuals with incomes of up to 100 percent of poverty would be fully subsidized to the reference premium (with some wrap-around benefits).
- Subsidies phased out between 100 and 200 percent of poverty.
- Health plans would have to absorb subsidy shortfalls if Federal revenues were not sufficient.
- No subsidies for employer contributions.
- Cost-sharing subsidies for out-of-pocket expenditures for individuals with incomes below 200 percent of poverty would be constant up to 200 percent of poverty.

MEDICAID

- Abolished and fully integrated into private plans (with subsidies above).

COST CONTAINMENT

- Savings from competition.
- Tax cap on plans above the reference premium.

FINANCING

- Deductibility cap on employer health insurance expenditures.
- Reduced Medicare provider payments.
- Phase-out of Medicare's disproportionate share payments to hospitals.
- Increase Medicare premiums for upper-income beneficiaries.

Clymer: Concerned your old bill - went in -

Bentsen: climate not right for
[illegible] utility bills

Hinsley : Age Rating

Zgwitz : 55%