Health Reform: Examining the Alternatives

This Issue Brief examines the major issues of the health reform debate. The issues that must be resolved before reform can be enacted include: allocation of health care resources, universal coverage versus universal access, composition of risk pools, employer and individual mandates, and distribution of health care services' costs. This report also contains short descriptions and analyses of the following proposals: McDermott-Wellstone, Clinton administration, Cooper-Breaux, Chafee-Thomas, Michel-Lott, Nickles-Stearns, and Gramm.

Proposals without an individual mandate will not achieve universal coverage. An individual mandate raises significant enforcement issues. An employer mandate will not achieve universal coverage by itself. Depending on the number of hours an employee must work to be included in a mandate, an employer mandate could potentially extend health insurance coverage to as many as 85 percent of the currently uninsured.

Each individual has a risk of needing health care services. Restructuring the health insurance market is accomplished by changing the way individuals and their risks are pooled. The composition of these risk pools will determine the costs of health insurance and the distribution of these costs.

The theory behind medical saving accounts is that the market for health insurance currently leads to health care cost inflation because many events covered under most health insurance plans are not truly insurable. There are two issues involved in medical savings accounts—the impact on low-income individuals and individuals' ability to evaluate the quality of care they receive. The present market does not provide individuals with adequate information for assessing the quality or effectiveness of medical care.

Among the critical issues in health reform is how to reduce the rate of health care cost inflation. The effect of proposals that impose explicit budget caps or price controls on health care cost inflation can be more easily estimated than other means of controlling costs if it is assumed that the political will exists to hold these caps and price controls at the levels set in the proposal.

It seems unlikely that shortages or queues would develop in the near term if a single-payer health system were enacted. Currently, the U.S. health care system is characterized by overcapacity. In the longer term, however, with restrictions on hospitals' access to new technology and funds to invest in new equipment and beds, shortages and queues might develop.
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The release of President Clinton’s health reform proposal has provided a focal point but surprising little focus in the health reform debate. A wide range of proposals has been introduced into Congress since January 1993. These proposals would create very different health care delivery systems, ranging from a single-payer system in which the government would be the sole purchaser of health care services to proposals that alter the tax treatment of health care purchases to correct perceived failures in the health care services market.

The health reform debate is likely to revolve around several issues that must be resolved before reform can be enacted, including: allocation of health care resources, universal coverage versus universal access, composition of risk pools, employer and individual mandates, and distribution of health care services’ costs. These issues will determine the costs of health care and the distribution of these costs among taxpayers, employees, patients, providers, and employers. They will also determine the barriers to access to health care services, financial or otherwise, and the quality of health care services.

This Issue Brief begins by examining these major issues in health reform. Although references are made to specific proposals in this discussion, the proposals themselves are examined in the following section. That section begins with a brief description of the proposals, followed by an analysis of the proposals.

A fundamental question is whether health care resources should be allocated by markets or the government. In fact, the health reform proposals can be arrayed along a spectrum that moves from proposals advanced by those who believe an unfettered market is the best way to allocate resources and that tax code changes are needed to remove barriers to an efficient market to proposals advanced by those who believe the market can never allocate health care resources efficiently or fairly and the government should allocate health care resources. In between are proposals that alter the rules of the market in ways their proponents hope would move the health care services market toward a more efficient and equitable allocation of resources.

Another important issue in the health reform debate is universal coverage versus universal access. Universal coverage is usually defined as meaning that all Americans are entitled to a given set of health care services. In contrast, universal access usually means that all Americans could purchase a given set of benefits at roughly the same price. Universal coverage can only be achieved with an individual mandate that all Americans purchase health insurance coverage or by a single-payer system in which the government provides these benefits. Any other method will leave at least some individuals without coverage. Universal access will leave many Americans without health insurance coverage. Either approach may increase the costs of health insurance to those who choose to purchase it, or to taxpayers who, in many plans, subsidize the purchase of health insurance for low-income families. In a voluntary system, increasing costs may lead some individuals to opt not to purchase health insurance coverage.

The debate between universal coverage and universal access is one part of another important issue: the composition of risk pools. In the present health care delivery system the risk pools are generally tied to an individual’s employer. Every health reform proposal reconstitutes these risk pools; some would replace the private health insurance system with a system that makes the government the provider of...
health benefits, but most would alter the private health insurance system. The composition of the reconstituted risk pools will determine the costs of health care services to individuals, employers, and taxpayers.

One of the determinants of the risk pools’ composition is whether an employer or an individual mandate is imposed. Currently, 62.5 percent of non-elderly Americans receive health insurance coverage through an employment-based plan. Changing or expanding this coverage might impact labor markets, affecting the number and types of jobs available, but it most certainly would affect the distribution of health care costs. (See EBRI Issue Brief no. 145, “Sources of Health Insurance and Characteristics of the Uninsured,” for more information on insurance coverage.)

The distribution of the costs of health care services is another important issue. Health reform can be viewed as a redistribution of these costs. Who finally bears these costs will depend on a number of factors, including the tax treatment of health care services and health insurance purchases. Together the tax treatment of health insurance purchases and the composition of the risk pools will determine the future of the employer’s role in the provision of health insurance.

A feature of many health reform proposals is the creation of medical savings accounts as a means of financing the purchase of preventive care or care of routine or relatively minor ailments. These accounts are intended to improve the efficiency of the health care services market. The main issue raised by these accounts is the extent to which they might discourage individuals from purchasing preventive care. Moreover, for the market to operate efficiently, a mechanism for providing information to consumers must be created.

In the long run, the success or failure of health reform will depend on its effectiveness in reducing the rate of health care cost inflation without reducing the quality of care. This is of course the goal of health reform, but the different solutions offered in the proposals reflect their authors’ underlying faith, or lack of faith, in the ability of the health care services market to control costs. There is also a political element to this debate, in that proposals that rely on market forces to manage health care costs have little empirical evidence to support their assertions that a properly functioning market can accomplish this objective. Conversely, proponents of controlling costs through price controls, budgets caps, or other regulatory schemes can point to evidence from other countries of the efficacy of these approaches; however, they also face evidence that the quality of care may be lower in those countries than that currently received by privately insured individuals in the United States.

Single-Payer Versus Market-Based Reform

Arguments for a Nonmarket Approach—The McDermott/Wellstone proposal is the legislative representative of a number of proposals that call for the consolidation of financing mechanisms and purchasing power into a single national program. These proposals expand the role of government as the underwriter and/or administrator of a single insurance plan that provides coverage for all Americans. All participants would gain access through the same or similar mechanisms, regardless of job status, income, and age.

The authors of these proposals generally do not believe that markets are the most efficient, equitable, or appropriate methods for allocating health care resources. They offer several reasons for this belief. The first is that markets allocate resources by price. As a result, many Americans may choose not to purchase health insurance, or to put off medical care, in order to save their money for other purposes. While this decision might be rational for the individual, it may not be in society’s best interest if such individuals subsequently need health care, experience reduced productivity because of poor health, or their health status becomes a public health issue (i.e., they contract a contagious disease). In other words,
unless society is willing to let those who fail to purchase health insurance or timely preventive care suffer and die without care, society needs to find a way to distribute the cost of health care.

Second, allocating resources by price means that low-income individuals’ purchase of health care services will either need to be subsidized, or again, society will have to bear the public health and moral consequences. However, if the low-income population is given a separate program, this program will have to compete for funds with other government programs that may more directly benefit the average voter. As a result, low-income individuals may receive lower quality care. The Medicaid program is often cited as an example of how a separate program for low-income individuals may lead to lower quality care for its participants. Budget constraints on both the federal and state governments have led to restrictions on payments to providers under the Medicaid program, reducing the quality of care it makes available.

Third, and perhaps most importantly, is the notion that health care services are simply different from other types of goods and services, because of both the profoundly personal nature of these services and the unique features of health care delivery. The emotion attached to an individual’s health or the health of a loved one may preclude him or her from making rational decisions on the costs and benefits of health care services. Moreover, because individuals may lack the information necessary to evaluate the quality of care they receive, they may be unable to make rational decisions even if they are emotionally capable. This lack of information may also make it difficult for individuals to shop for treatments, physicians, hospitals, or even health insurance plans. Finally, because there are potentially large economies of scale in the production of health care services, particularly hospital services, competition may be undesirable. Analogies have been made to the operation of public utilities, such as electrical power companies, which permits a specific good to be delivered less expensively by one regulated company than it could be delivered by several competing companies.

Arguments for a Market Approach—Americans have generally found markets an attractive way to allocate resources in large part because decision making is decentralized. This is especially appealing in health care, because decisions often involve the most fundamental and personal tradeoffs between comfort and pain and between life and death. The decentralized nature of markets as a mechanism for allocating resources results in a greater variety of choices for consumers.

Under perfect conditions, the market system allocates scarce resources across competing demands for those resources so that the costs to society of producing this good is equal to the amount individuals are willing to pay for it. The matching of individual preferences with the costs of producing a good or service makes the market system an efficient way to allocate resources.

Moreover, markets create incentives for innovation. Nonmarket mechanisms for allocating resources require fixed rules, which are slower to change than markets. As a result, the rewards for innovations are reduced, and less innovation occurs than if the market were allowed to allocate resources.

The market for health care resources suffers from a number of defects that may prevent it from allocating resources efficiently. There is general, although not universal, agreement that the market for health care services has failed in the sense that the mix of health care services provided is not necessarily the one that fully informed consumers would wish to purchase. Information is costly for both providers and purchasers of health care services. Moreover, the health care delivery system is composed of interconnected local markets. Each of these markets has unique characteristics that
determine the relative market power of providers and purchasers. The diffusion of information is not uniform across these markets. (See EBRI Issue Brief no. 131, “Rationing: Resource Allocation in the Current Health Care Delivery System,” for further discussion of resource allocation.)

However, the evolution of the health care delivery system over the last 15 years gives some indication of the flexibility of even imperfect markets. The delivery system has become more consolidated; the practice patterns of physicians have changed; care has moved out of the hospital; managed care plan enrollment has grown explosively; and new information systems for consumers, purchasers, and providers have been developed, to name just a few of the changes.

These changes demonstrate not only the flexibility of markets in the face of innovation but the changing cost structure of the health care delivery system. The movement away from hospital care suggests that treating hospitals as public utilities may not be the most appropriate way to allocate health care delivery services. Moreover, competition in both the hospital and physician service markets appears to be moving toward price competition.

A number of analysts have suggested that the health care services market can allocate health care resources in an efficient manner if it is structured properly. One feature that has become an integral part of a number of health reform proposals is managed competition.

Managed Competition as a Form of Market Approach—Stanford Professor Alain Enthoven, building on earlier efforts by a number of analysts, developed the concept of managed competition in the late 1970s as an alternative to the present markets for health insurance and health services. A number of groups have integrated Enthoven’s concept into their health reform proposals, with adaptations. There are two basic forms of managed competition. One creates sponsors that act as collective purchasing agents for large groups of individuals. These sponsors negotiate with insurers or health plans and then offer their subscribers a menu of choices among different insurance plans with information on each plan’s quality of care and price. In the other form, these sponsors create a marketplace for the purchase of health insurance, much like a stock market creates a marketplace for equity. These two forms are quite different in their implications and administration but share the common goal of trying to shift the market for health insurance from competition based on risk to price competition. As a result, competition in the health care services markets will also theoretically move toward price competition. Both models also reduce administrative costs for small groups.

Aside from large employers, the organization of the sponsors differs from proposal to proposal. These sponsors, or health insurance purchasing cooperatives (HICPs), could be federal, state, or local government agencies; private, nonprofit organizations; or regulated for-profit entities such as public utilities. The organization of the sponsors is an important issue that needs to be addressed in implementing a managed competition model. These issues are discussed below.

Under both models of managed competition, the health insurance market would be altered by the injection of information. This would be done either by substituting the sponsor as a knowledgeable negotiator with health insurance plans for individual consumers or substituting an individual’s benefits managers or introducing mechanisms for sponsors to provide information to consumers. The sponsor would represent a group of consumers, whether they be the employees or dependents of employees of large employers or all individuals in a geographic area.

Insurers would be required to provide a standard benefits package to any individuals who purchase health coverage through the sponsor. In theory, the health insurance market would be fundamentally changed under managed competition in that insurers could no longer attempt to avoid poorer risks and would need to
find ways to control the costs of providing care.

Individuals under managed competition would be offered a menu of health plans and given price and quality of care information for each plan. Theoretically, they could then choose the plan whose price and quality combination most suits their preferences. Such a choice requires that insurance policies be standardized to facilitate consumer choice, consumers be given a financial stake in their choice, and quality measures be developed that consumers can use to make choices. (See EBRI Issue Brief no. 135, “Health Care Reform: Managed Competition and Beyond,” for further discussion of managed competition.)

Managed competition models must address several important issues before they can be implemented. The first is the construction of the risk pools. The organization of these pools determines the distribution of the costs of health care, the costs to the federal and state governments, and the effect of national reform on health care cost inflation.

Summary—The spectrum of health reform proposals can be viewed in the context of the above arguments. The proposals range from those based on the belief that the market unencumbered by present tax law will allocate resources efficiently to those based on the belief that the market for health care services is inherently inefficient and inequitable. In the middle are proposals that restructure the market for health care services in an attempt to make it function more efficiently and equitably.

Universal Coverage Versus Universal Access

One of the primary areas of controversy is whether health reform should provide for universal coverage or aim for the more modest goal of universal access by equalizing the cost of health care so that all Americans have an equal opportunity to purchase health insurance. Many individuals may rationally choose not to purchase health insurance coverage, in part due to low income and in part due to their own perception that their risks of needing health care services are low. Some of these individuals may be wrong in their self-assessment of their risks and may therefore require health care services that they may not be able to afford. Similarly, many employers choose not to provide health benefits to their employees because they face higher costs in providing these benefits than do their competitors and/or because their work force does not strongly demand them. Universal coverage cannot be achieved without requiring individuals to purchase health insurance.

A number of analysts have suggested that universal coverage is necessary for controlling health care cost inflation and for rationalizing the financing of health care services. While 38.5 million Americans have no health insurance, they still receive some health care. That care is often financed by cost shifting to private and public payers. In other words, fees paid by insured patients are raised to finance care for those who cannot pay. If there remain significant numbers of uninsured individuals, there will remain some implicit mechanism for financing their care. This hidden mechanism means that prices for health care services will not reflect the true costs of producing these services, the cost of health care services will vary by region and demographics, and these costs may be inequitably distributed. Having the costs of health care for the uninsured financed through cost shifting may make it difficult for the market to control costs. Without the ability to compete on true costs, many hospitals and other providers may successfully appeal for special treatment, which reduces both the amount of competition in the market and the market’s ability to control costs. In a similar manner, regulatory approaches to controlling costs may not be effective if significant numbers of people remain outside the system. (See EBRI Issue Brief no. 137, “Hospital
Table 1

Simulation of Single Adult Premiums under Various Assumptions Concerning Composition of Risk Pool. Assumes All Employees of Employers with Fewer Than 500 Employees Purchase Coverage Through Health Insurance Purchasing Cooperative (HIPC), All Other Employees Purchase Coverage Outside HIPC

<table>
<thead>
<tr>
<th>Composition of Risk Pool</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outside HIPC</td>
</tr>
<tr>
<td>Workers Only</td>
<td>$2,188</td>
</tr>
<tr>
<td>Workers and Nonworking Individuals</td>
<td>2,018</td>
</tr>
<tr>
<td>Workers, Nonworking Individuals, and Medicaid</td>
<td>1,683</td>
</tr>
</tbody>
</table>


Pricing: Cost Shifting and Competition,” for further discussion of hospital cost shifting.)

A single-payer system provides universal coverage through a government financed system. The private health insurance system is essentially eliminated. The requirement that all individuals purchase health insurance is made through the tax system, and the burdens of that requirement depend on the specific taxes used to finance health care delivery.

All of the health reform proposals that continue a role for private insurance need to address the classic insurance problem of adverse selection. Adverse selection occurs when those individuals in the greatest need for health care services are also the most likely to purchase health care insurance. A health insurance plan may suffer from adverse selection if it attracts more poorer risks than are present in the community at large.

Health reform proposals restructure the market for health insurance, moving from risk rating to some type of community rating for determining premiums. Community rating limits insurers’ ability to charge different premiums to groups on the basis of risk. Under community rating, the premium charged reflects the average cost of providing care to the community. As a result, moving toward community rating increases premiums for groups that represent good health risks, whose premiums now are based on their risks alone, while it reduces premiums for groups representing bad risks. Some of the healthier individuals would choose not to purchase health insurance as a result of the premium increase, while more of those who are in poorer health would purchase health insurance. The result would be an increase in the pool’s average risk, increasing premiums, and potentially the development of a vicious circle that would end with an unviable health insurance market.

Composition of the Insurance Risk Pools

Each individual has a risk of needing health care services. Restructuring the health insurance market is accomplished by changing the way individuals and their risks are pooled. In some proposals risks are pooled communitywide, while in others risks are pooled in purchasing cooperatives or alliances. The composition of these cooperatives or alliances will determine the costs of health insurance and the distribution of these costs. Generally, in the managed competition models that create purchasing cooperatives, low-income families, individuals not connected with an employment-based group insurance plan, and employees of small employers purchase coverage through the cooperative. Although employees of small firms may be on average healthier than most Americans, the other two groups are likely to be less healthy. Table 1 provides results of simulations of the premiums likely to be charged to single adult individuals in purchasing cooperatives under different assumptions about the cooperatives’ composition.

Table 1 estimates single adult premiums that would arise under different risk pools. The workers-only pool includes all employees of firms with fewer than 500 employees. The estimated premium is $1,976. When nonworking individuals are added to the pool, the annual premium rises by $118, and when individuals now receiving Medicaid are added, the premium rises by another $139 to a total of $2,236. Pooling working individuals with nonworkers and Medicaid eligible individuals increases their premiums by almost 13 percent, or $21 per month.

Managed competition models often require that employers under a certain size purchase coverage through a risk pool formed by regional
### Table 2
Simulated Single Adult Premiums Under Various Assumptions Concerning Size of Employer in Risk Pool and Exclusion of Medicaid Recipients

<table>
<thead>
<tr>
<th>Composition of Risk Pool</th>
<th>Employer Size Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Medicaid Recipients Excluded</td>
<td>$2,181</td>
</tr>
<tr>
<td>All Under Cap Included</td>
<td>2,336</td>
</tr>
</tbody>
</table>


**HIPCs or alliances.** As table 2 indicates, increasing the size of the employer required to purchase coverage through the HIPC or alliance decreases the premium charged for coverage within that pool by bringing in larger numbers of employed individuals. Including those currently covered by Medicaid in the pool increases the average premium by an average of about 7 percent. However, simulating the per capita costs of providing coverage to Medicaid recipients after reform indicates these costs to be $3,309, so including them in the risk pools lowers the costs to the federal and state governments by over 29 percent.

Tables 1 and 2 assume that all individuals purchase health insurance coverage. If some individuals choose not to do so and they are healthier on average than those who elect to purchase coverage, the premiums will be higher.

Proposals that do not have an individual mandate will not achieve universal coverage. These proposals attempt to achieve universal access by reducing the barriers to the purchase of health insurance coverage for individuals and employees of small employers. They may, for example, alter the tax code to give individuals the same tax advantages for the purchase of health insurance that are now enjoyed by employees. Because of adverse selection, the net effects of these changes on the premiums faced by individuals is difficult to determine and is likely to vary considerably from proposal to proposal.

**Lowering the costs of health insurance alone is unlikely to come close to achieving universal coverage,** as the following example in table 3 demonstrates. Table 3 assumes that all individuals below the federal poverty level are eligible for a tax credit equal to the full cost of health insurance and all of them take advantage of this credit. The remaining 27.9 million Americans are not eligible for the full credit but instead receive a partial credit or deduction. Assume that for individuals and families with income between 100 percent and 200 percent of the federal poverty level there is a partial credit that declines as income increases and that above 200 percent of poverty the cost of health insurance is fully deductible. The effect of lowering the effective price on the demand for health insurance depends on how sensitive individuals are to changes in price. Estimates in the economics literature vary widely (Pauly, 1986). Even assuming very strong price sensitivity, which is highly unlikely for low-income families, only about 43 percent of those presently uninsured in the income group between poverty and twice the poverty level are likely to become insured solely because of the partial credit and deduction. It should be emphasized that these simulations should be thought of as upper limits to the number of individuals who would choose to purchase health insurance solely as a result of changes in the tax code.

These simulations illustrate that it is extremely unlikely that simply lowering the costs of health insurance coverage will achieve universal coverage. In fact, given that all the health reform proposals that promote universal access restructure the health insurance market, reform may increase the cost of health insurance for many currently insured individuals.

If individuals are making a personally rational decision not to purchase health insurance, what is the rationale for requiring them to purchase it? Two general reasons have been advanced for seeking universal coverage rather than universal access. First, even individuals who have a low probability of needing health care before purchasing health insurance may unexpectedly need care. Without health insurance, many families may face the choice of financial ruin or simply not paying for care, passing on these costs to others. Moreover, several studies indicate that the care received by the uninsured is of lower...
quality than that received by privately insured individuals. Finally, the uninsured may underinvest in preventive care that could lower their private costs and society’s costs in the future.

The second reason is adverse selection, as discussed previously. The individuals most likely to opt out of the health insurance system are the good health risks. The premiums paid by individuals, employers, and the federal government are likely to be higher if coverage is optional than if all Americans are required to purchase health coverage. The higher the costs for the government the more revenue would be necessary to fund health reform, and the more difficult the political fight for passage of the health reform proposal.

### Table 3
Simulation of Effects of a Model Tax Subsidy on Numbers of Uninsured, Assuming No Other Reforms

<table>
<thead>
<tr>
<th>Percentage of Federal Poverty Rate</th>
<th>Number Currently Uninsured</th>
<th>Uninsured After Tax Subsidy 1 to 1 Sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–99%</td>
<td>10,935,810</td>
<td>0</td>
</tr>
<tr>
<td>100%–199%</td>
<td>12,542,296</td>
<td>7,105,846</td>
</tr>
<tr>
<td>200% or More</td>
<td>15,400,080</td>
<td>14,106,292</td>
</tr>
<tr>
<td>Total</td>
<td>38,878,185</td>
<td>21,212,137</td>
</tr>
</tbody>
</table>


*Model tax subsidy gives 100 percent credit for cost of coverage to those below poverty, 75 percent credit to those between 100 percent and 125 percent of poverty, 50 percent credit to those between 125 percent and 150 percent of poverty, 30 percent credit to those between 150 percent and 200 percent of poverty, and full deductibility to those with incomes above 200 percent of poverty.

*Assumes a 10 percent fall in cost of insurance results in 10 percent more individuals purchasing insurance.

### Employer Mandate Versus Individual Mandate

There have been two proposals for requiring individuals to purchase health insurance coverage: an individual mandate and an employer mandate. An employer mandate builds on the present employment-based financing system and reaches a large number of the uninsured. Depending on how many hours an employee must work to be included in the mandate, an employer mandate could potentially extend health insurance coverage to as many as 85 percent of the currently uninsured (table 4). (See EBRI Issue Brief no. 145, “Sources of Health Insurance and Characteristics of the Uninsured,” for a complete analysis of the uninsured.) This assumes that all indi-

### Table 4
Effects of an Employer Mandate on Number of Americans without Health Insurance Under Different Definitions of Workers Covered by Mandate, Assuming No Other Reforms and All Individuals Covered by Mandate Purchase Coverage

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Number of Americans without Health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Present System</td>
</tr>
<tr>
<td></td>
<td>Mandate</td>
</tr>
<tr>
<td>Under $5,000</td>
<td>4,788,161</td>
</tr>
<tr>
<td>$5,000–$9,999</td>
<td>4,789,953</td>
</tr>
<tr>
<td>$10,000–$19,999</td>
<td>10,840,000</td>
</tr>
<tr>
<td>$20,000–$29,999</td>
<td>7,150,677</td>
</tr>
<tr>
<td>$30,000–$39,999</td>
<td>4,078,066</td>
</tr>
<tr>
<td>$40,000–$49,999</td>
<td>2,532,646</td>
</tr>
<tr>
<td>$50,000–$59,999</td>
<td>1,789,493</td>
</tr>
<tr>
<td>$60,000–$69,999</td>
<td>902,839</td>
</tr>
<tr>
<td>$70,000 or more</td>
<td>2,004,534</td>
</tr>
<tr>
<td>Total</td>
<td>38,876,369</td>
</tr>
</tbody>
</table>


<sup>a</sup>Assumes that all employees who work more than 30 hours per week and their dependents are included in the mandate.

<sup>b</sup>Assumes that all employees who work more than 20 hours per week and their dependents are included in the mandate.

<sup>c</sup>Assumes that all employees who work more than 10 hours per week and their dependents are included in the mandate.
An employer mandate would not achieve universal coverage by itself. It has been argued that universal coverage cannot be achieved without a mandate that all individuals purchase health insurance coverage, regardless of their connection with the work force. The Clinton proposal has an individual mandate and an employer mandate.

**Economic Impacts**—An employer mandate potentially affects the economy by changing the costs of labor, the composition of total compensation, or both. Concern has been expressed about the effect of an employer mandate on employment and small employers. Economic theory suggests that in the long run an employer mandate and an individual mandate have very similar impacts. A mandate does not affect the intrinsic value of a worker to an employer or change the number of workers available. It does affect the composition of total compensation. In the long run, the cost of hiring a worker would not change, but the markets would adjust so that the way a worker is paid would change: wages or other benefits would decrease to compensate for the increase in the cost of the mandated benefit. This has been shown to be the case in other instances of mandated benefits such as worker’s compensation insurance (Gruber and Kruger, 1990).

In the short and medium run, however, markets may not adjust completely. In these cases, the cost of the mandate would be divided among workers in the form of lower wages and/or fewer jobs, employers in the form of lower profits, and consumers in the form of higher prices. The actual share of the burden or benefit is likely to vary by geographic region, occupation, industry, and size of employer. (The impact of an employer mandate on jobs is explored more thoroughly in this report’s section on the Clinton administration’s proposal.)

An employer mandate results in a redistribution of income. In the current system, higher income workers are more likely to have coverage than lower-income workers. Under a mandate, many of these higher-income workers would, at worst, see no changes in their total compensation, and they might find that their wages or other benefits increase. Conversely, workers who do not now receive health insurance through their employer—who tend to be lower income workers—would face lower real wages, less job security, or both, as a result of a mandate. Many of these workers would find they have a health insurance benefit that they did not have before; however, 30 million of the workers who do not now have employment-based coverage have coverage from a spouse’s plan or purchase coverage as individuals. Even if the benefit package provided after reform is more generous than the plans these individuals have now, it is unclear whether they would feel better off as a result of this reform.

**Basis for Employment-Based Health Benefits**—The employment-based health care financing system has developed in the United States for three basic reasons. The tax preferences given to employment-based health plans, lower administrative costs, and the ability to avoid or reduce adverse selection give employer health plans a considerable cost advantage over individually purchased plans. Financing health care benefits through the work place avoids, or mitigates, the problem of adverse selection in that the risk pools created by employees and their dependents tend to have risks at least as good as the community and often represent better risks. As health benefits became widespread after
World War II, Congress codified what had been the standard accounting practice of excluding the employer’s contribution for health benefits from the employee’s income for tax purposes.

Almost all of the health reform proposals, not only single-payer proposals, have the effect of removing the unique rationale for employment-based health benefits. All of the proposals change the way risks are pooled so that individuals and employees of small employers gain access to group coverage. Most of the proposals change the tax treatment of health care as an employee benefit and the tax treatment of health insurance by individuals.

The result of these changes would be to weaken the incentive for employers to offer health insurance as an employee benefit. However, it is unlikely that employers would immediately discontinue the provision of health benefits if any of the non-single payer reforms were enacted. The work place is still a convenient way to pool risks and lower administrative costs. Removing the advantages of employment-based coverage without an employer mandate would no doubt decrease the number of employers who offer health insurance benefits.

In the long-run, the economic impacts of an employer mandate and an individual mandate are nearly identical. An employer mandate would result in currently uninsured workers receiving lower wages in exchange for health insurance, although these effects might be mitigated by subsidies (through the tax code, for example). An individual mandate would result in individuals giving up part of their income, from whatever source, for health insurance. An individual mandate is the only mechanism for achieving universal coverage. Because an employer mandate is tied to employment, it does not reach all of the uninsured. Moreover, that tie to employment means that the impact of an employer mandate is similar to that of a payroll tax. An individual mandate can be divorced from the work place, and the impact of that mandate is similar to a head tax. The effects of either mandate can be affected by the tax code. The payment of subsidies or changing the deductibility of premium costs can alter the distribution of health care costs. (See EBRI Special Report SR-19, “An Employer Mandate: What’s Known and What Isn’t,” for further discussion.)

An employer mandate may be easier to enforce. The employment-based system for financing health insurance developed in part because of the lower administrative costs. Enforcing an individual mandate would require enforcement mechanisms at the point of health care service delivery and perhaps some mechanism through the tax code.

Changing the Tax Code

Most tax-based approaches focus on limiting the exclusion of employer contributions to health insurance from workers’ taxable income and expanding individual tax credits. Because no employer contributions to health insurance are currently included in employees’ taxable income, proponents of this type of reform argue that neither employers nor employees have any incentive to choose the most cost-effective plan. They suggest that if contributions are limited to a maximum dollar amount or to the average cost of a basic health plan in a geographic area, employers and employees would be more likely to choose cost-effective providers. By expanding individual tax credits, advocates hope that low-income individuals would be more easily able to purchase health protection for themselves and their families.

The tax preference currently given to employer contributions to health insurance is intended to expand access to health care by encouraging health insurance coverage. Many analysts have concluded that the tax preference leads to the purchase of too much health insurance, insulating insured individuals from the financial consequences of their health care service purchases and at least contributing to health care cost inflation.

Additionally, the tax preference is often said to
be regressive because the value of the exclusion is greater for higher-income individuals. This occurs for two reasons. First, although the value of the benefit is generally the same for the lowest- and highest-income individuals within the same employer, higher-income workers face a higher marginal tax rate. The same dollar exclusion is thus worth more to them. This advantage was substantially reduced when the tax rate structure was condensed by the Tax Reform Act of 1986 (TRA '86). The second reason that the tax preference is regressive is that the probability that an individual has employment-based health insurance decreases as his or her income decreases. Low-income individuals are less likely to have coverage and are therefore less likely to benefit from the exclusion.

However, for those individuals who receive coverage through an employer and whose employer contributes to that coverage, the exclusion of that contribution from taxable income may be progressive. The costs of providing health coverage do not generally vary by income, so if tax rates were proportional (with everyone paying the same percentage of income in taxes), the exclusion would be a larger percentage of a low-wage worker's income than of a higher-wage worker's income. As tax rates become more progressive (higher-income individuals pay a larger proportion of their income in taxes), the value of the exclusion increases for higher-income individuals, and the tax preference becomes less progressive. The flattening of the tax rates under TRA '86 made the exclusion more progressive.1

As an example, take the four families in table 5, each of which has health care benefits through an employer. The employer's contribution for each family is $3,000, so the employer's contribution to the health plan is 25 percent of the first family's income, 15 percent of the second family's income, 6 percent of the third family's income, and 3 percent of the fourth family's income. Currently, the first family faces a 0 percent marginal tax rate, while the marginal tax rates for the second, third, and fourth families are 15 percent, 28 percent, and 31 percent, respectively. The value of the exclusion is greater for the families with higher incomes, but as a percentage of each family's income it rises at the lowest income levels and then is less for the higher-income families. For families that currently receive health benefits, counting the employers' contribution to the benefits in the families' taxable income would likely be regressive.

In aggregate, it is estimated that the total revenue expenditures for employer contributions to health benefits was approximately $60 billion in 1992—about $33 billion in lost income tax revenues and the remainder in FICA tax revenues. These estimates assume that no behavioral change would occur if the tax law were altered. They should not therefore be viewed as projections of the revenue gain that could be achieved if the exclusion were removed but rather as the absolute maximum revenue gain possible. It is more likely that the revenue gain would be much smaller.

Although the Clinton proposal does not change the tax treatment of employer contributions for health benefits until the year 2004, and then only for coverage beyond the basic benefit package, most managed competition proposals, including the Cooper-Breaux and Chafee bills, change the tax treatment of employer contributions for health benefits. The Chafee bill caps the exclusion at the minimum premium offered in a region. The Cooper-Breaux bill does not change the exclusion for individuals, but it imposes an excise tax on employers for any amount they contribute above the premiums of the lowest cost plan in an area.

The cap on the exclusion of employer contributions is usually tied to the lowest cost plan in a

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1 The Omnibus Budget Reconciliation Act of 1993 had a very small impact on how progressive or regressive the tax exclusion is to individuals.
Table 6
Estimated Change in Tax Liability If Exclusion of Employer Contributions Above a Given Amount Are Included in Employee’s Taxable Income and Assuming Wages Do Not Adjust to Account for Changes in Employer Contributions, Using 1992 Tax Law\textsuperscript{a}

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Average Tax Change</th>
<th>Total Change in Tax Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $5,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>$5,000–$9,999</td>
<td>47</td>
<td>20,335,830</td>
</tr>
<tr>
<td>$10,000–$19,999</td>
<td>49</td>
<td>267,469,218</td>
</tr>
<tr>
<td>$20,000–$29,999</td>
<td>81</td>
<td>664,696,627</td>
</tr>
<tr>
<td>$30,000–$49,999</td>
<td>130</td>
<td>2,002,673,779</td>
</tr>
<tr>
<td>$50,000–$99,999</td>
<td>244</td>
<td>3,844,153,945</td>
</tr>
<tr>
<td>More than $100,000</td>
<td>296</td>
<td>967,283,640</td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>7,766,579,221</td>
</tr>
</tbody>
</table>


\textsuperscript{a}Premiums are assumed to be $2,202 per single adult, $4,008 for a single adult with children, $4,404 for a couple with no children, and $6,210 for two adults with children. Estimates use Clinton administration mandate methodology for determining employer contributions that can be excluded from employee income and estimates of actual employer contributions from NMES. Employer contribution is prorated for part-time workers. Assumes that wages do not adjust.

geographic area. Table 6 presents the results of a simulation of the incidence of capping the exclusion. The cap in this simulation was modeled by using Employee Benefit Research Institute (EBRI) estimates of the premiums that would arise if the Clinton mandate were put into effect and all employers with fewer than 500 employees were required to purchase coverage through a regional alliance. Table 6 also assumes that no behavioral changes occur as a result of the change in the exclusion.

Medical Savings Accounts

The theory behind medical saving accounts is that the market for health insurance currently leads to health care cost inflation because many of the events covered under most health insurance plans are not truly insurable. An insurable event is one whose occurrence is outside the control of the insured individual, for example, a car accident (auto insurance) or a serious illness or injury (health insurance). Health insurance with low deductibles and cost-sharing arrangements provides benefits for events well within the control of the insured individual. For example, individuals may choose to see a physician for a bad cold if part or all of that visit is paid for by an insurance plan, while they would not do so if they were purchasing health care with their own money. Moreover, the insurance concept of moral hazard may be important in health insurance. Moral hazard occurs when insured individuals engage in riskier activities, precisely because they are insured, than they would in the absence of insurance. Insured drivers may tailgate, insured homeowners may store oily rags in the basement, and insured individuals may visit the doctor more frequently.

Medical savings accounts would allow individuals to place money into a savings account on a tax-preferred basis. Money could only be withdrawn from that account to cover medical expenditures. In conjunction with the medical savings account, individuals could also purchase a catastrophic health plan: a health insurance plan with a large deductible, for example. Thus, individuals would spend their own money for routine care and treatment of minor ailments and remain covered for the treatment of serious illnesses. Insurance would be less expensive not only because the coverage would be less extensive but also because the problem of moral hazard would be mitigated. Individuals desiring care would have an incentive to search out the most cost-effective care because they would be spending their own money. The health care delivery system would have to find ways to provide cost-effective treatment to meet the demands of patients.

There are two issues involved in medical savings accounts. One is the impact of this proposal on individuals with low income. Clearly, low-income individuals would have difficulty saving sufficient amounts to fund the health care that they need. Moreover, these individuals might not purchase preventive care. For example, the Rand Health Insurance experiment found that low-income individuals with lower coinsurance rates experienced specific health gains for three prevalent chronic problems—high blood pressure, myopia, and dental care—relative to individuals enrolled in high cost-sharing plans. All three conditions are relatively inexpensive to diagnose and treat.

The second issue is individuals’ ability to evaluate the quality of care they receive. The present market does not provide individuals with ad-
equate information for assessing the quality or effectiveness of medical care. In the absence of such information, individuals are likely to use other criteria in choosing among competing providers or treatments. Proponents of medical savings accounts argue that once individuals have the need for such information, a market for these services will be created. To the degree that such information is a public good (a good that has value for all of society, not only the users) both economic theory and empirical evidence indicate that a competitive market would not produce a socially optimal amount. If a portion of the failure of the current markets for health care services can be attributed to the monopoly power of providers that results from inadequate information, medical savings accounts might exacerbate the inefficiencies in the market.

Cost Containment

Among the critical issues in health reform is how to reduce the rate of health care cost inflation. This is both a policy and political issue. The policy issue is simply how best to structure the health care delivery system to manage health care cost inflation. The political issue is that the savings from any of the health reform proposals are difficult to estimate. Except for the proposals that have explicit budget caps or price controls, health reform proposals generally rely on the market for health care services to reduce health care cost inflation. The fact that many private plans have not adopted state-of-the-art health plan design makes it difficult to assess the impact of these private efforts to manage health care costs. As a result, projecting their impact to the entire system is speculative at best.

The effect of proposals that impose explicit budget caps or price controls on health care cost inflation can be more easily estimated if it is assumed that the political will exists to hold these caps and price controls at the levels set in the proposal. However, price controls require that care be rationed. Patients’ concern over the quality of care, coupled with providers’ concern over the redistribution of income, may produce pressure on policymakers to alter the budgets. It is difficult to assess the degree to which budget caps and price controls would be adhered to under such intense political pressure.

Private health plans and public programs have evolved rapidly in the last decade in response to health care cost inflation. Employers’ reaction to increases in health care costs has varied depending on the labor market they face, the amount of competition in their product market, and the level of their market power in their specific health care services markets. In general, employers have adopted four types of cost management strategies: cost sharing; utilization review; managed care plans, including health maintenance organizations (HMOs); and selectively contracting with providers. (See EBRI Issue Brief no. 118, “Issues in Health Care Cost Management,” for further discussion of these strategies.)

There is some question as to whether HMO cost reductions stem from selection bias. Some employers offering an HMO option in addition to a comprehensive plan have claimed that employees who represent lower risk opt for the HMO, while higher cost patients remain in the comprehensive plan, resulting in higher overall health care costs. One study found that families selecting HMOs were younger, had lower income, and had lower claimed health care expenses prior to enrollment than families selecting a fee-for-service plan (Buchanan and Cretin, 1986).

The Rand Health Insurance experiment randomly assigned individuals to an HMO. The individuals assigned to the HMO had lower utilization rates than those in the indemnity plans, although not as low as those who chose the HMO. The study found no differences in health outcomes between individuals enrolled in HMOs and those in indemnity plans with no cost sharing, except for low-income individuals who entered the experiment in poor health. The Rand researchers concluded the cost differences resulted mainly from cost-effective practice styles rather than from differences in enrollees.
Purchasing Decisions—The evolution of the private health care insurance market has altered the way decisions on the purchase of health care services are being made. The constraint individuals have on their choice of health plans, and the constraints that choice places on their choices of providers and procedures, means that the relevant decision makers are at least to some extent moving further away from the patient. These changes, coupled with changes in the way publicly financed health care programs reimburse providers, have also changed the incentives to providers and altered their decision making.

At issue is whether the evolution of the health care delivery system is enough to control health care cost inflation. There has been some research suggesting that the savings from managed care plans in general, and HMOs in particular, are one-time reductions: after reducing inefficient treatments and care, the drivers of health care cost inflation still remain.

The increasing demand for health care services has led to a concurrent increase in the demand for new medical technology. Medical researchers, with financial assistance from the government and other sources, have responded impressively. The number of diagnostic tools a physician can apply to a given set of symptoms and the number of potential therapeutic procedures for a given diagnosis have increased dramatically in the last 25 years.

The supply of physicians has also grown rapidly. The number of physicians per capita grew by 40 percent between 1970 and 1985 and is projected to grow by another 20 percent by 2000 (Kletke, Marder, and Silberger, 1987). The demand for physician services is related to technology and the supply of new procedures. New technology increases the number of procedures that can be performed for a given condition and the number of conditions that can be treated, raising the demand for treatment. Concurrently, as the supply of physicians increases, they tend to specialize, performing fewer types of procedures (Baumgardner, 1988). Researchers project that, at current rates of increase in the intensity of care provided, the supply of physicians will roughly equal the demand from the present to 2000 (Schwartz, Sloan, and Mendelson, 1988).

These factors suggest that slowing the rate of health care cost inflation may be difficult in the short run. It has been argued that it can never be brought under control without rationing health care (Aaron and Schwartz, 1984 and 1990). If technology is the driving force behind health care cost inflation, some entity is going to have to deny patients access to new technology or technology that is of low marginal benefit. This is, again, one of the fundamental differences among the health reform proposals: can the decentralized market be made to operate efficiently enough to control health care cost inflation or will it be necessary to use government controls to ration care? (See EBRI Issue Brief no. 136, “Making Choices: Rationing in the U.S. Health System,” for further discussion.)

There are essentially three types of health reform proposals: single payer, managed competition, and individual markets. Single-payer proposals create a system in which the government is the sole purchaser of health care services. All Americans would be guaranteed access to a defined set of health care services. These services generally would be subject to a budget and fee schedules and would be financed through taxes.

The basic feature of managed competition is the creation of sponsors that would act as collective purchasing agents for large groups of individuals. These sponsors would negotiate with insurers or health plans and then offer their
subscribers a menu of choices among different insurance plans, with information on each plan’s quality of care and price. Managed competition is intended to shift the market for health insurance from competition based on risk to price competition. As a result, competition in the health care services markets would also theoretically move toward price competition. Managed competition models differ in the composition of the risk pools, the role of employers, the inclusion of budget controls, the issue of mandates on employers or individuals, and the tax treatment of health insurance purchases.

Proposals intended to advance individual markets change the insurance markets to community rating, so that individuals are not at a disadvantage relative to groups in purchasing health insurance. They also change the tax code to provide incentives for individuals to purchase health insurance, removing the incentives for purchasing health insurance through an employment-based plan. Most importantly, many of these proposals create savings plans allowing individuals to accumulate money tax free to pay for health care services. These proposals are intended to alter the two problems their authors feel are the root of health care cost inflation: the incentives in the tax code to purchase more insurance than is necessary and the overconsumption of health care services by insured individuals.

Within these broad groupings there is considerable variation among the health reform proposals. The Clinton administration’s proposal, for example, has many elements of both the single-payer and managed competition models. Following is a short description and analysis of each of the key proposals submitted to Congress as of February 1994. (Also see the side by side comparison of the proposals on p. 40.) For simplicity, each proposal is listed under the names of the sponsors most often associated with it.

**Single Payer**

**McDermott-Wellstone**—Rep. Jim McDermott (D-WA) and Sen. Paul Wellstone (D-MN) are the chief sponsors of the single-payer legislation, the American Health Security Act of 1993 (H.R. 1200, S. 491). Under this bill, every citizen and legal resident would be covered on enactment through a single program administered by the states. The market for health care services would be constrained by state budgets and fee schedules.

Because everyone would be covered through a single-payer system, an employer mandate would not be imposed per se, although the plan would be financed through a variety of tax increases, including corporate and payroll taxes.

Health plans would cover full payment of doctor and hospital bills for covered services, nursing home care, prescription drugs, and mental health and chemical dependency treatment. There would be no coinsurance, deductibles, or copayments for acute and preventive benefits covered under the plan.

The bill would be financed through an increase in the corporate and individual income tax rate as well as a payroll tax on all employers. Funds currently spent on Medicare, Medicaid, and Department of Defense Health Services would be redirected, and personal and business tax deductions would be changed. States would be responsible for covering 15 percent of the program’s costs.

**Under the proposal, costs would be contained through the establishment of a national health care budget.** States would develop their own budgets (to be approved by a national health board) and would pay providers in accordance with the set budgets. Growth in expenditures would be held to the rate of the annual increase in the Gross Domestic Product (GDP), and administrative costs would be limited to 3 percent of current annual expenditures.
Analysis—A national single-payer health care system rejects the market as an allocator of health care services. Individuals would not be the primary decision makers in determining the allocation of health care resources. Under the McDermott/Wellstone bill, federal boards would set budgets that would determine the amount of resources available to the entire system, develop practice parameters that would determine the types of treatments available to individuals with a given diagnosis, evaluate new technology to decide if it should be adopted, and determine providers’ qualifications. States would determine the amount of money available to hospitals and other facilities and control their access to funds for construction or the purchase of new equipment. Such a system implies that care would be rationed.

Under the bill, all individuals would receive coverage regardless of their work status, employer size, or income. As a result, workers would have greater mobility across jobs or even occupations. This separation of health insurance from employment might affect the labor market and the composition of total compensation.

The McDermott/Wellstone proposal would partially finance care through a 8.4 percent payroll tax. The effect of this tax is likely to be similar to the effect of the employer mandate in the Clinton administration proposal (see p. 22). That is, for employers who now provide health benefits, replacing the costs of providing these benefits with a payroll tax is likely to be effectively similar to capping the percentage of payroll an employer contributes to employees’ health insurance under the Clinton mandate.

National health expenditures reached $942.5 billion in 1993, representing over 14 percent of the country’s GDP. Personal health spending, that is, expenditures on services received directly by the patient, were $914 billion. A single-payer system would reallocate the funds now spent in the health care delivery system. Money now spent for health care services by private individuals or organizations would be spent by the government. The variation in costs faced by individuals and employers would be replaced by a variation in tax burdens.

The extension of benefits to Americans without health insurance and the expansion of benefits to individuals whose coverage is not as comprehensive as the benefit package in a single-payer health system would increase the demand for health care services. Estimates of the costs of extending coverage to the uninsured under the present system range from $34 billion to $75 billion. If the costs of expanding the benefits available to Americans who already have health insurance are included, the estimated costs range from $45 billion to $90 billion.

Restructuring the System—Health reform as envisioned by a single-payer health system would not simply expand coverage, however; it would also fundamentally restructure the health care delivery and financing system. Several features of the new health system might at least partially offset the increased costs caused by increased demand for health care services.

First, administrative costs would be reduced. How much this system would actually reduce costs is unclear. A U.S. General Accounting Office (GAO) analysis of a Canadian-style single-payer national health care system concluded that such a system would have saved Americans $67 billion in insurance, hospital, and physician administrative overhead in 1991 (U.S. General Accounting Office, 1991). The study also estimated that increased utilization by previously uninsured and/or underinsured individuals would increase spending by $64 billion under a national health system with no deductibles or coinsurance.

A later study prepared by the Joint Economic Committee (JEC) reviewed and disputed GAO’s esti-

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mates (Koopman, 1992). The JEC report asserts that the research relied upon by GAO and the methodology employed consistently understated the financial costs of adopting a Canadian-style system. The major area of disagreement between the two reports was their analysis of the administrative cost savings that would result from moving to a single-payer system. The GAO report estimated that 95 percent of current administrative costs could be eliminated by moving to a single payer. The JEC report estimated that the administrative cost reduction would be about 60 percent. A 1993 Congressional Budget Office (CBO) report estimated that a single-payer health system similar to the one described in the McDermott/Wellstone proposal would reduce administrative costs by $52 billion.

A second feature of a single-payer health care system that might reduce total health care is the increased access to preventive care. In the present system many individuals may not receive or may delay preventive care, which may result in more severe conditions arising that require more resources to treat. The actual costs savings that might be realized from increased access to preventive care are difficult to quantify.

The Financing Mechanism—The most important cost management feature of a single-payer health system would be its financing mechanism. As the sole purchaser of health care services, the government could control national health expenditures. The American Health Security Standards Board created by the bill would determine the national budget for health care, and each state’s health care budget would be determined within that national budget. States would then develop global budgets for hospitals and other health facilities. These global budgets would determine the amount of money each facility has to provide services within a fiscal year. Purchases of capital equipment would require approval by the appropriate district and state boards, and they would fall within the state’s budget. Global budgets might also be applied to comprehensive health service organizations, or they might be reimbursed on a capitated basis. Independent physicians would be paid on a fee-for-service basis according to a fee schedule determined by the American Health Security Standards Board after negotiating with physicians.

The creation of a national budget with fee schedules would give the government the ability to determine national health expenditures prospectively. Theoretically, this implies that actual national health expenditures could be any amount. More likely, costs would be targeted to amounts approximating the costs of the present system. CBO estimated that if hospitals were given global budgets and Medicare’s reimbursement mechanism were used to determine physician fee schedules, the net effect of a change to a single-payer health care system (including lower administrative costs and higher health care service demand) would be an increase of $37 billion in national health expenditures.

Quality of Care—At issue is whether there is the political will to limit the growth of global budgets. Whatever funding sources are found for health care benefits, it is likely that fewer resources would be devoted to health care services after enactment of a single-payer health system than are currently allocated. If one of the advantages of a single-payer system is its ability to control costs, the impact of cost controls on the quality of care is a matter of some dispute. The McDermott/Wellstone proposal has a number of provisions intended to monitor the quality of care, but political battles over the budget could take precedence, because the effects of tight budgets on quality may be more difficult to quantify than the impact of higher expenditures on the budget.

A federal board, the American Health Security Council, would be established to promote outcomes research and develop practice parameters. Each state would be required to establish organizations to review the quality of care within its system and assure that it
meets the practice guidelines established by the federal board. New mechanisms would be developed to review utilization patterns and to monitor care. A national electronic data base of all patient records would be developed that would facilitate systematic quality review and outcomes research.

It seems unlikely that shortages or queues would develop in the near term if a single-payer health system were enacted. Currently, the U.S. health care system is characterized by overcapacity. There are over 6,649 hospitals in the United States with 1,213,000 beds. On average, just over 30 percent of these beds are unoccupied. Hospitals have generally competed with one another for physicians (and the patients they admit) on the basis of quality signals such as the range of services or technologies available at the hospital. Thus, hospitals have had an incentive to invest in new technologies as they are introduced, to create overcapacity to provide instant access to care, and to create amenities that are attractive to patients and physicians. As a result, for example, 36 percent of hospitals with more than 200 beds have magnetic resonance imaging, and 86 percent have CT scanners—expensive technology that in many cases is underutilized.

In the longer term, however, with restrictions on hospitals’ access to new technology and funds to invest in new equipment and beds, shortages and queues might develop. One of the criticisms of single-payer health care systems worldwide is that they necessarily ration care—that patients are denied beneficial treatment or that they must wait for care that privately insured citizens of the United States currently receive on demand. The cost controls that McDermott-Wellstone proposal would put into place would alter the incentives providers face in the current health care delivery system.

Managed Competition

The Clinton Administration Proposal—The Clinton administration proposal, the Health Security Act of 1993 (S. 1757, H.R. 3600), would set up a system of managed competition through regional and corporate alliances, require employers to pay a portion of employee health premiums, establish a standard benefits package, and set a national budget target to control health care costs.

Although the plan incorporates many of the features of managed competition, it constrains the markets for health insurance and health care services by imposing premium caps and fee schedules. Increases in premiums would be limited to increases in the consumer price index (CPI) (plus an adjustment factor that declines to zero over four years). Provider fees in indemnity plans would be determined by a fee schedule negotiated with the states.

The plan seeks to achieve universal coverage by mandating that every American citizen and legal resident enroll in a health plan and pay a portion of the premium. The standard benefit package would be available to every citizen and legal resident regardless of health history or preexisting condition. Subsidies would be available for small, low-wage businesses and for low-income individuals.

The Clinton plan includes three separate risk pools. Medicare would remain a separate program. Unemployed individuals and employees of employers with fewer than 5,000 employees and their dependents would purchase coverage through a regional alliance. Large employers would have the option of forming a corporate alliance or joining a regional alliance.

The plan’s employer mandate requires that employers pay 80 percent of the weighted average premium for employees. The premium would be capped as a percentage of payroll, not to exceed 7.9 percent. Firms with 5,000 or more employees would have the option of establishing corporate alliances, but their contribution to employee premiums would not be capped as a percentage of payroll, and they would have to pay an additional 1 percent payroll tax. Employers would be responsible for paying a pro-rated premium for part timers working 40–120 hours per month.

Employers would retain deductibility for all
health care premiums. Employer contributions to the cost sharing for health care benefits would not count as employee income, although excess benefits would be taxable to employees. The self-employed would be able to deduct 100 percent of the amount paid for the standard benefit package.

Each state would be responsible for setting up one or more regional alliances and assuring that they comply with the law. Alliances would have to offer at least one fee-for-service plan and two other types of plans offering the standard benefit package. Regional alliances would receive subsidy payments from the federal government to assist certain small, low-wage businesses and low-income individuals. Corporate alliances would have to fund subsidies for low-wage workers themselves.

The plan would be funded through premiums paid by employers and employees, revenue gains when firms spend less on health and increase wages, a tobacco tax, an assessment on corporate alliances that opt out of the regional plans, and cuts in the growth of Medicaid and Medicare.

To control costs, a national health board would publish an allowable inflation rate for each regional health alliance based on the CPI. Alliances would then cap the growth of health plan premiums with which they contract to provide the standard benefit package.

Analysis—The administration’s plan combines many of the features of managed competition and a single-payer system. It creates sponsors in the form of regional and corporate alliances that negotiate with health plans and present a menu of health plans to consumers. The plan also caps premiums if they exceed the rate of inflation as measured by the CPI and creates state budgets and state negotiated fee schedules for providers.

The plan itself is composed of many interlocking parts. The proposal would create a relatively generous basic benefit plan. The generosity of this plan would reduce the number of individuals whose benefits would decrease on adoption of the plan, which in turn would reduce the resistance to moving from purchasing coverage through an employer to purchasing coverage through an alliance. The employer mandate would ease the administrative burden in the collection of premiums, while the individual mandate would assure the risk pools a sufficient number of good risks to balance out the poorer risks.

The Clinton plan attempts to achieve universal coverage through a combination of mandates on employers and individuals. As demonstrated below, the employer mandate itself redistributes income in a variety of ways. The cap on the percentage of payroll an employer whose employees are covered through a regional alliance must contribute to health benefits redistributes income from lower wage workers to higher wage workers. Because employers must contribute a given amount per worker, depending on his or her premium category, the average weighted premium in the alliance, and the alliance’s adjustment factor, families with more than one worker subsidize the health insurance coverage of families with only one worker. Because the number of single parent families are included in calculating the adjustment factor for families with children, and the premiums are blended, two parent families subsidize the purchase of health insurance coverage for single parent families.

Premium Costs—Perhaps the most important factor in determining the impact of the President’s proposal on national health expenditures and the distribution of the burden of these expenditures is the cost of the premiums that would be required by the regional health alliances. A number of estimates have been made of the premiums that would be charged if the proposal were fully implemented. Table 7
Table 7

<table>
<thead>
<tr>
<th>Premium Category</th>
<th>Clinton</th>
<th>CBO</th>
<th>EBRI</th>
<th>Wyatt</th>
<th>Hewitt</th>
<th>HIAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Adult</td>
<td>$1,932</td>
<td>$2,100</td>
<td>$2,202</td>
<td>$2,285</td>
<td>$2,440</td>
<td>$2,509</td>
</tr>
<tr>
<td>Couple without Children</td>
<td>3,865</td>
<td>4,200</td>
<td>4,404</td>
<td>4,570</td>
<td>4,880</td>
<td>5,419</td>
</tr>
<tr>
<td>Single Parent</td>
<td>3,893</td>
<td>4,095</td>
<td>4,008</td>
<td>4,603</td>
<td>4,619</td>
<td>4,270</td>
</tr>
<tr>
<td>Two Parent</td>
<td>4,360</td>
<td>5,565</td>
<td>6,210</td>
<td>5,155</td>
<td>6,946</td>
<td>7,278</td>
</tr>
</tbody>
</table>


Table 7 is not intended to be comprehensive but rather to demonstrate the range of estimates that have been produced. There are many other estimates that were not included in table 7 for lack of space or because they were for different years.

The administration’s premiums were estimated by the Health Care Financing Administration (HCFA) using actuarial methods. Presumably they used a variety of government data sets.

EBRI’s estimates were produced using econometric methods and the National Medical Expenditure Survey of 1987 (NMES), adjusted for inflation and imputed to the March 1993 supplement to the Current Population Survey (CPS). Thus, EBRI used the utilization patterns of the entire population to assess risk rather than data drawn from a more limited population. It was assumed that no employment-based plans would opt to form corporate alliances (see below for justification of this assumption), so these premium estimates represent true community rating. Within the econometric model the utilization of the currently uninsured was increased so that it would mimic that of similar insured individuals.

The CBO and the Wyatt Company essentially took national personal health expenditures, adjusted for changes in utilization by the currently uninsured, and an estimate of how much more comprehensive the benefits in the administration’s plan were compared with an average private health insurance plan. That total was then divided by the estimated number of families in each premium category to arrive at an estimate of the premiums.

Hewitt Associates and the Health Insurance Association of America (HIAA) used actuarial models and data drawn from their own surveys and data bases. They made assumptions on how utilization by the currently uninsured and the Medicaid population would change after implementation of the President’s proposal.

Estimation of the premiums is the fundamental step in assessing the impact of the administration’s proposal. The extent to which this proposal reduces or exacerbates the federal budget deficit depends on the size of premiums because the amount of government subsidies to employers, individuals, and families will be determined by that premium. All of the estimates of premiums, including those reported above, are extremely sensitive to the underlying assumptions used to generate them. Estimates of the financial impact of the proposal should properly be expressed as a range rather than a point estimate. The CBO’s analysis of the administration’s proposal found that, using the administration’s estimated premium, the Clinton proposal would begin to reduce the budget deficit in 1999, while using CBO’s estimated premium delays deficit reduction until 2004. If premiums 10 percent higher than CBO’s are used (roughly half way between EBRI’s estimated premiums and Hewitt’s estimated premiums), the proposal “would add substantially to the deficit each year . . .”. (Congressional Budget Office, 1994).

The Employer Mandate—One of the most controversial issues in health reform concerns the employment effects of an employer mandate.
Analysts must make three basic assumptions in order to arrive at an estimate of the impact of an employer mandate on jobs. They must determine the cost of the benefit being mandated. They must use an estimate of the sensitivity of the demand for labor to a change in the cost of labor. Finally, and most importantly, they need to make an assumption about the operation of the labor market and the speed with which it adjusts.

A report by the Employment Policies Institute (EPI) (O'Neill and O'Neill, 1993) estimates that 3.1 million jobs would be lost as a result of an employer mandate. The study was done before the Clinton administration released its health plan, so it did not incorporate the actual mandate contained in the administration’s proposal. EPI assumed that the mandated benefit would cost $2,400 for an individual and $5,900 for a family. They further assumed that employers would pay 90 percent of the premiums. Finally, they assumed that wages would not change as a result of an employer mandate, so that employers would bear the full costs. They used the March supplement to the 1991 CPS to derive their estimate. Using similar, but not identical, methodology and EPI assumptions on the premiums, EBRI arrived at an estimate of 2.9 million jobs lost due to a mandate, based on the March supplement to the 1993 CPS.

In contrast to the assumptions used in the EPI and most other studies of the effects of an employer mandate, the Clinton administration’s proposal creates four premium categories: single adults, single adult families, couples with no children, and couples with children. Health insurance plans within an alliance area would submit premiums for each of the categories to the alliance. The alliance would then determine the weighted average premium for each category by multiplying each plan’s premium by the number of individuals who enroll in that plan, summing the results over all plans, and dividing that sum by the total number of participants in the alliance. The resulting weighted average premium is the basis for determining the employer’s contribution.

Employer’s Contribution to Premiums—The employer’s contribution for each worker in each category is 80 percent of the weighted average premium divided by an adjustment factor. The adjustment factor is the number of workers in each category divided by the number of families in each category in the alliance (see table 8). Many families have more than one worker, so if employers were to contribute a full 80 percent of the average weighted premium for each worker, the alliance would collect more than the total premiums.

The adjustment factor ensures that the employer contribution for each employee within a premium category is identical. Because in two worker families both employers would contribute, the total premiums collected would amount to more than those charged by the plan (see table 8). In single worker families the total amount collected would be less than that charged by the plan. In aggregate, the sum of all premiums collected from all sources would equal the total premiums charges. What this means is that two worker families would subsidize one worker families.

For single adults the adjustment factor is 1; for couples and families with children it depends on population in their alliance (see table 9). EBRI simulated these adjustment factors assuming that each alliance was composed of an entire state. As table 9 indicates, there is considerable variation in these adjustment factors by state. The estimates are likely to understate the variation in these adjustment factors across alliances because in many states the alliances would cover a smaller geographic area than the state.

In order to prevent the employer contribution for single parent families from differing from that of two parent families, these two premium categories undergo a further adjustment. The weighted average premiums for the two parent families and the single parent families are themselves averaged, and the common adjustment factor for families with children present is applied to that average premium. Thus the employer contributions for single parent families and two parent families are identical, even though the premiums charged by the
Table 8
Examples of Health Insurance Premium Costs for Employers and Families, by Family Type, under Proposed Clinton Administration Health Security Act

In the following examples, for single individuals, and for couples without children, the employer contribution is calculated as 80 percent of the average weighted premium$ divided by the adjustment factor. For the employer contribution for single parent and two parent families with children, see footnote c. The family contribution for all family types is calculated as follows. If the family chooses a plan whose total annual premium is equal to the average weighted premium, its yearly contribution is equal to 20 percent of the average weighted premium. If the family chooses a plan whose premium is more expensive than the average weighted premium, the contribution equals 20 percent of the average weighted premium plus the difference in cost between the total annual premium of the chosen plan and the average weighted premium. If the family chooses a plan whose premium is less expensive than the average weighted premium, the yearly contribution equals 20 percent of the average weighted premium minus the difference between the premium of the chosen plan and the average weighted premium.

<table>
<thead>
<tr>
<th>Family Type</th>
<th>Single Individuals/ Single Parent Families</th>
<th>Couple/Two Parent Families</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Annual Premium$</td>
<td>Average Weighted Premium$</td>
</tr>
<tr>
<td>Single Individual (Worker, no children)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>plan A</td>
<td>$1,902</td>
<td>$2,202</td>
</tr>
<tr>
<td>plan B</td>
<td>2,102</td>
<td>2,202</td>
</tr>
<tr>
<td>plan C</td>
<td>2,202</td>
<td>2,202</td>
</tr>
<tr>
<td>plan D</td>
<td>2,602</td>
<td>2,202</td>
</tr>
<tr>
<td>Single Parent Family (Worker with children)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>plan A</td>
<td>3,708</td>
<td>4,008</td>
</tr>
<tr>
<td>plan B</td>
<td>3,908</td>
<td>4,008</td>
</tr>
<tr>
<td>plan C</td>
<td>4,008</td>
<td>4,008</td>
</tr>
<tr>
<td>plan D</td>
<td>4,408</td>
<td>4,008</td>
</tr>
<tr>
<td>Two Parent Family (Two workers with children)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>plan A</td>
<td>5,810</td>
<td>6,210</td>
</tr>
<tr>
<td>plan B</td>
<td>6,010</td>
<td>6,210</td>
</tr>
<tr>
<td>plan C</td>
<td>6,210</td>
<td>6,210</td>
</tr>
<tr>
<td>plan D</td>
<td>6,810</td>
<td>6,210</td>
</tr>
<tr>
<td>Two Parent Family (One worker with children)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>plan A</td>
<td>5,810</td>
<td>6,210</td>
</tr>
<tr>
<td>plan B</td>
<td>6,010</td>
<td>6,210</td>
</tr>
<tr>
<td>plan C</td>
<td>6,210</td>
<td>6,210</td>
</tr>
<tr>
<td>plan D</td>
<td>6,810</td>
<td>6,210</td>
</tr>
<tr>
<td>Couple (Two workers, no children)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>plan A</td>
<td>4,004</td>
<td>4,404</td>
</tr>
<tr>
<td>plan B</td>
<td>4,204</td>
<td>4,404</td>
</tr>
<tr>
<td>plan C</td>
<td>4,404</td>
<td>4,404</td>
</tr>
<tr>
<td>plan D</td>
<td>5,004</td>
<td>4,404</td>
</tr>
<tr>
<td>Couple (One worker, no children)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>plan A</td>
<td>4,004</td>
<td>4,404</td>
</tr>
<tr>
<td>plan B</td>
<td>4,204</td>
<td>4,404</td>
</tr>
<tr>
<td>plan C</td>
<td>4,404</td>
<td>4,404</td>
</tr>
<tr>
<td>plan D</td>
<td>5,004</td>
<td>4,404</td>
</tr>
</tbody>
</table>

Source: Employee Benefit Research Institute simulations.

$The average weighted premium is based on Employee Benefit Research Institute simulations of 1994 premiums.

$The adjustment factor is calculated as the number of workers in a particular type of family (single individuals, couples, or singles or couples with children) in a health alliance, divided by the number of families of that type in the alliance.

$The employer contribution for families with children equals 80 percent of the sum of the average weighted premium for two parent families multiplied by the number of two parent family units, plus the average weighted premium for single parent families multiplied by the number of single parent family units, all divided by the total number of workers in all families with children. Note: there are 24.22 million two parent families with children, and 10.14 million single parent families with children.

$In this table, the total annual premiums are calculated under the assumption that each plan (A, B, C, or D) serves exactly 25 percent of the eligible population. The total annual premiums designated in this table are to be used only as examples.

$The Employer 2 contribution applies only if there are two adult workers in the household.
health plans for the two categories could be much different.

Thus the actual costs to the employer for family coverage would be lower than the costs paid by employers who currently provide this coverage. In fact, as demonstrated in the example presented in table 8, this methodology results in a subsidy of one worker couples paid by two worker couples. That is, the sum of the contributions (employer plus family) of two worker couples will exceed the premiums for their premium category, while the sum of the contributions of one worker families will be lower than the premiums for their premium category.

An alternative solution to this problem could be to allow each family to designate which spouse's employer had to contribute to the alliance. This would not only be administratively expensive but would create incentives for employers to avoid hiring employees who would designate them as the contributing employer.

The Clinton administration's proposal would also cap the costs employers must pay as a percentage of payroll. At most, employers would be required to pay 7.9 percent of payroll, although the amount might be as low as 3.5 percent for firms with fewer than 25 workers and an average payroll of less than $12,000 (table 10).

In 1992, employers contributed a total of $221.4 billion for health benefits, according to estimates of the Bureau of Labor Statistics (U.S. Department of Labor, 1993). That total was just under 7.5 percent of total wages and salaries. These figures include employers who did not offer health benefits as well as those who did. For employers who did offer health benefits, the percentage of payroll is higher. Respondents to Foster-Higgins' survey of employers reported that employer contributions for health care averaged just under 11 percent in 1992 (A. Foster Higgins & Co., Inc., 1992). EBRI simulations using the CPS and NMES found that, for employees who receive health benefits, the employer contribution averages 14 percent of wages.

The cap on employer contributions as a percent-

### Table 9

**Number of Workers per Unit Adjustment Factor: Determination of Employer per Worker Contribution, by State, 1992**

<table>
<thead>
<tr>
<th>State</th>
<th>Couples with No Children</th>
<th>Couples/Single Parents with Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Total</td>
<td>1.46</td>
<td>1.39</td>
</tr>
<tr>
<td>Alabama</td>
<td>1.36</td>
<td>1.36</td>
</tr>
<tr>
<td>Alaska</td>
<td>1.51</td>
<td>1.36</td>
</tr>
<tr>
<td>Arizona</td>
<td>1.30</td>
<td>1.38</td>
</tr>
<tr>
<td>Arkansas</td>
<td>1.30</td>
<td>1.44</td>
</tr>
<tr>
<td>California</td>
<td>1.40</td>
<td>1.35</td>
</tr>
<tr>
<td>Colorado</td>
<td>1.54</td>
<td>1.34</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1.64</td>
<td>1.42</td>
</tr>
<tr>
<td>Delaware</td>
<td>1.50</td>
<td>1.44</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>1.58</td>
<td>1.25</td>
</tr>
<tr>
<td>Florida</td>
<td>1.38</td>
<td>1.33</td>
</tr>
<tr>
<td>Georgia</td>
<td>1.46</td>
<td>1.27</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1.67</td>
<td>1.48</td>
</tr>
<tr>
<td>Idaho</td>
<td>1.25</td>
<td>1.38</td>
</tr>
<tr>
<td>Illinois</td>
<td>1.47</td>
<td>1.41</td>
</tr>
<tr>
<td>Indiana</td>
<td>1.42</td>
<td>1.40</td>
</tr>
<tr>
<td>Iowa</td>
<td>1.50</td>
<td>1.52</td>
</tr>
<tr>
<td>Kansas</td>
<td>1.54</td>
<td>1.49</td>
</tr>
<tr>
<td>Kentucky</td>
<td>1.42</td>
<td>1.38</td>
</tr>
<tr>
<td>Louisiana</td>
<td>1.39</td>
<td>1.30</td>
</tr>
<tr>
<td>Maine</td>
<td>1.49</td>
<td>1.35</td>
</tr>
<tr>
<td>Maryland</td>
<td>1.59</td>
<td>1.41</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1.63</td>
<td>1.40</td>
</tr>
<tr>
<td>Michigan</td>
<td>1.45</td>
<td>1.37</td>
</tr>
<tr>
<td>Minnesota</td>
<td>1.51</td>
<td>1.53</td>
</tr>
<tr>
<td>Mississippi</td>
<td>1.36</td>
<td>1.35</td>
</tr>
<tr>
<td>Missouri</td>
<td>1.32</td>
<td>1.47</td>
</tr>
<tr>
<td>Montana</td>
<td>1.42</td>
<td>1.39</td>
</tr>
<tr>
<td>Nebraska</td>
<td>1.51</td>
<td>1.63</td>
</tr>
<tr>
<td>Nevada</td>
<td>1.30</td>
<td>1.32</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1.56</td>
<td>1.38</td>
</tr>
<tr>
<td>New Jersey</td>
<td>1.63</td>
<td>1.39</td>
</tr>
<tr>
<td>New Mexico</td>
<td>1.25</td>
<td>1.32</td>
</tr>
<tr>
<td>New York</td>
<td>1.47</td>
<td>1.33</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1.46</td>
<td>1.43</td>
</tr>
<tr>
<td>North Dakota</td>
<td>1.39</td>
<td>1.60</td>
</tr>
<tr>
<td>Ohio</td>
<td>1.48</td>
<td>1.35</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1.44</td>
<td>1.31</td>
</tr>
<tr>
<td>Oregon</td>
<td>1.50</td>
<td>1.38</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1.48</td>
<td>1.42</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>1.60</td>
<td>1.33</td>
</tr>
<tr>
<td>South Carolina</td>
<td>1.47</td>
<td>1.39</td>
</tr>
<tr>
<td>South Dakota</td>
<td>1.42</td>
<td>1.64</td>
</tr>
<tr>
<td>Tennessee</td>
<td>1.41</td>
<td>1.39</td>
</tr>
<tr>
<td>Texas</td>
<td>1.40</td>
<td>1.42</td>
</tr>
<tr>
<td>Utah</td>
<td>1.45</td>
<td>1.49</td>
</tr>
<tr>
<td>Vermont</td>
<td>1.50</td>
<td>1.48</td>
</tr>
<tr>
<td>Virginia</td>
<td>1.67</td>
<td>1.50</td>
</tr>
<tr>
<td>Washington</td>
<td>1.34</td>
<td>1.37</td>
</tr>
<tr>
<td>West Virginia</td>
<td>1.26</td>
<td>1.19</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>1.60</td>
<td>1.53</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1.40</td>
<td>1.50</td>
</tr>
</tbody>
</table>

Table 10

Maximum Percentage of Payroll Employers Must Contribute Under Clinton Health Reform Proposal, by Employer Size

<table>
<thead>
<tr>
<th>Number of Employees</th>
<th>Average Payroll</th>
<th>Less than $12,000</th>
<th>$12,000–$14,999</th>
<th>$15,000–$17,999</th>
<th>$18,000–$20,999</th>
<th>$21,000–$23,999</th>
<th>$24,000 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 25</td>
<td></td>
<td>3.5%</td>
<td>4.4%</td>
<td>5.3%</td>
<td>6.2%</td>
<td>7.1%</td>
<td>7.9%</td>
</tr>
<tr>
<td>25–50</td>
<td></td>
<td>4.4%</td>
<td>5.3%</td>
<td>6.2%</td>
<td>7.1%</td>
<td>7.9%</td>
<td>7.9%</td>
</tr>
<tr>
<td>51–74</td>
<td></td>
<td>5.3%</td>
<td>6.2%</td>
<td>7.1%</td>
<td>7.9%</td>
<td>7.9%</td>
<td>7.9%</td>
</tr>
<tr>
<td>More than 75</td>
<td></td>
<td>7.9%</td>
<td>7.9%</td>
<td>7.9%</td>
<td>7.9%</td>
<td>7.9%</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

Source: Health Security Act (S. 1757).

age of payroll redistributes the cost of health care. Employers who do not currently offer health insurance benefits would find their contributions increase, while many of those who do would find their contributions would fall.

Labor Market Adjustments—In the short run, markets may not adjust completely, and employers may bear some of the costs of the mandate. In the long run, the markets would adjust and the effect of a mandate would simply be to rearrange total compensation. While markets would adjust at different speeds in different industries, occupations, and geographic areas, we can place bounds around the likely impacts of a Clinton mandate on employment. Using the assumption that wages or other benefits do not adjust, so that any cost increases or savings due to the mandate are borne by the employer, we find that the Clinton administration’s proposal would create between 512,701 and 625,620 net new jobs, depending on the premiums (tables 11, 12 and 13). Approximately 600,000 jobs would be lost from employers who would experience new costs, and approximately 1.2 million new jobs would be created by employers who would experience lower costs as a result of the mandate.

The assumption that wages or other benefits

Notes on Tables 11, 12, and 13

Tables 11, 12, and 13 compare the job loss or gain estimates resulting from an employer mandate using a variety of assumptions. The tables demonstrate the sensitivity of these estimates to the assumptions used. Each column represents the results of simulations using a particular set of assumptions:

Column (1): These estimates assume a family premium of $5,900 and an individual premium of $2,400. All families composed of more than one person pay the family premium. It is assumed that employers contribute 90 percent of these premiums. It is assumed that wages and other compensation do not change with the implementation of the employer mandate.

Column (2): These estimates assume a family premium of $5,900 and an individual premium of $2,400. All families composed of more than one person pay the family premium. Employers contribute an amount equal to 80 percent of the premium divided by an adjustment factor. This adjustment factor is equal to the number of workers in families divided by the number of families. There is a separate adjustment factor for couples and families with children (see table 8). Employer contributions are capped at 3.5 percent of payroll for individuals employed by employers with fewer than 25 employees and paying wages of less than $24,000, increasing to 7.9 percent for employers with more than 75 employees. It is assumed that wages and other compensation do not change with the implementation of the employer mandate.

Column (3): These estimates assume premiums to be $1,800 per single adult, $3,600 for a single adult with children, $3,600 for a couple with no children, and $4,200 for two adults with children. All families composed of more than one person pay the family premium. This adjustment factor is equal to the number of workers in families divided by the number of families. There is a separate adjustment factor for couples and families with children (see table 8). Employer contributions are capped at 3.5 percent of payroll for individuals employed by employers with fewer than 25 employees and paying wages of less than $24,000, increasing to 7.9 percent for employers with more than 75 employees. It is assumed that wages and other compensation do not change with the implementation of the employer mandate.

Column (4): All assumptions are identical to column (3) except that wages are assumed to adjust to completely eliminate the change in total compensation except for workers close to the minimum wage. For these workers, it is assumed that wages will fall to the minimum wage and employers will bear any additional costs due to the mandate.

5 Note differences between this assumption and Clinton proposal, which uses average payroll of employer, rather than the individual’s wages, and has a sliding scale for the premium cap that is 3.5 percent for employers with an average payroll of less than $12,000 up to 7.9 percent for small employers with salaries of over $24,000.
Table 11
Estimates of Job Losses (–) or Gains Due to an Employer Mandate, Using Various Assumptions on Costs to Employers, Caps on Employer Contributions, and Changes in Wages, by Employer Size

<table>
<thead>
<tr>
<th>Number of Employees</th>
<th>(1) High Premiums Current Methodology</th>
<th>(2) High Premiums Clinton Methodology</th>
<th>(3) Clinton Premiums Clinton Methodology</th>
<th>(4) Clinton Premiums Wages Adjust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 10</td>
<td>–647,731</td>
<td>–8,317</td>
<td>5,437</td>
<td>–53,193</td>
</tr>
<tr>
<td>10–24</td>
<td>–418,663</td>
<td>36,763</td>
<td>51,224</td>
<td>–35,099</td>
</tr>
<tr>
<td>100–499</td>
<td>–397,526</td>
<td>86,876</td>
<td>82,700</td>
<td>–35,095</td>
</tr>
<tr>
<td>500–999</td>
<td>–133,636</td>
<td>55,340</td>
<td>53,479</td>
<td>–9,992</td>
</tr>
<tr>
<td>1,000+</td>
<td>–765,999</td>
<td>272,169</td>
<td>261,400</td>
<td>–66,681</td>
</tr>
<tr>
<td>Total</td>
<td>–2,858,248</td>
<td>512,701</td>
<td>625,620</td>
<td>–247,303</td>
</tr>
</tbody>
</table>

Source: Employee Benefit Research Institute simulations using the March 1993 supplement to the Current Population Survey (CPS). Employer contributions are derived from the National Medical Expenditure Survey, adjusted for inflation, and imputed to the CPS.

Table 12
Estimates of Job Losses (–) or Gains due to an Employer Mandate, Using Various Assumptions on Costs to Employers, Caps on Employer Contributions, and Changes in Wages, by Average Hours Worked Per Week

<table>
<thead>
<tr>
<th>Average Hours Worked per Week</th>
<th>(1) High Premiums Current Methodology</th>
<th>(2) High Premiums Clinton Methodology</th>
<th>(3) Clinton Premiums Clinton Methodology</th>
<th>(4) Clinton Premiums Wages Adjust</th>
</tr>
</thead>
<tbody>
<tr>
<td>10–19 Hours per Week</td>
<td>–55,674</td>
<td>–8,498</td>
<td>5,362</td>
<td>–71,331</td>
</tr>
<tr>
<td>20–29 Hours per Week</td>
<td>–803,518</td>
<td>40,070</td>
<td>57,056</td>
<td>–69,856</td>
</tr>
<tr>
<td>30–35 Hours per Week</td>
<td>–404,249</td>
<td>22,262</td>
<td>32,887</td>
<td>–32,086</td>
</tr>
<tr>
<td>Full Time</td>
<td>–1,594,808</td>
<td>458,868</td>
<td>530,315</td>
<td>–74,030</td>
</tr>
<tr>
<td>Total</td>
<td>–2,858,248</td>
<td>512,701</td>
<td>625,620</td>
<td>–247,303</td>
</tr>
</tbody>
</table>

Source: Employee Benefit Research Institute simulations using the March 1993 supplement to the Current Population Survey (CPS). Employer contributions are derived from the National Medical Expenditure Survey, adjusted for inflation and imputed to the CPS.

Table 13
Estimates of Job Losses (–) or Gains Due to an Employer Mandate, Using Various Assumptions on Costs to Employers, Caps on Employer Contributions, and Changes in Wages, by Family Income

<table>
<thead>
<tr>
<th>Total Family Income</th>
<th>(1) High Premiums Current Methodology</th>
<th>(2) High Premiums Clinton Methodology</th>
<th>(3) Clinton Premiums Clinton Methodology</th>
<th>(4) Clinton Premiums Wages Adjust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $5,000</td>
<td>–51,960</td>
<td>–1,266</td>
<td>–703</td>
<td>–4,937</td>
</tr>
<tr>
<td>$5,000–$9,999</td>
<td>–268,381</td>
<td>10,832</td>
<td>18,539</td>
<td>–35,099</td>
</tr>
<tr>
<td>$10,000–$14,999</td>
<td>–312,622</td>
<td>57,726</td>
<td>67,102</td>
<td>–33,743</td>
</tr>
<tr>
<td>$15,000–$19,999</td>
<td>–261,217</td>
<td>77,186</td>
<td>94,465</td>
<td>–24,557</td>
</tr>
<tr>
<td>$20,000–$29,999</td>
<td>–472,428</td>
<td>140,602</td>
<td>168,142</td>
<td>–43,358</td>
</tr>
<tr>
<td>$30,000–$49,999</td>
<td>–732,929</td>
<td>214,276</td>
<td>245,939</td>
<td>–54,501</td>
</tr>
<tr>
<td>$50,000–$99,999</td>
<td>–664,415</td>
<td>38,846</td>
<td>57,166</td>
<td>–44,249</td>
</tr>
<tr>
<td>$100,000 or More</td>
<td>–94,297</td>
<td>–25,500</td>
<td>–25,210</td>
<td>–6,776</td>
</tr>
<tr>
<td>Total</td>
<td>–2,858,248</td>
<td>512,701</td>
<td>625,620</td>
<td>–247,303</td>
</tr>
</tbody>
</table>

Source: Employee Benefit Research Institute simulations using the March 1993 supplement to the Current Population Survey (CPS). Employer contributions are derived from the National Medical Expenditure Survey, adjusted for inflation and imputed to the CPS.
would not change after a mandate is enacted or announced is highly unrealistic. It represents an upper bound on change in employment that would result from an employer mandate. At the other extreme is the assumption that wages adjust, upward or downward, to completely absorb the costs of an employer mandate. In this case, the employers' costs would be unchanged, and their demand for labor would be unchanged except for workers at or near the minimum wage. Because these workers' wages could fall to the minimum wage but no further, employers of minimum wage workers would face higher costs as a result of the mandate. Using the assumption that wages adjust completely except for workers near the minimum wage, we estimate that an employer mandate would cause the loss of about 158,000 jobs. This estimate would be larger if higher premiums were used in the simulation.

Using the national average premiums estimated by the Clinton administration, a reasonable range for the impact of the employer mandate on jobs is between 625,620 net jobs created and 247,303 jobs lost. Higher premiums would reduce the number of jobs created at one extreme and increase the number of jobs lost at the other extreme, but it is unlikely that range would exceed one-half of 1 percent of the work force in either direction.

Regional and Corporate Alliances—The risk pools created by the Clinton proposal include almost all Americans other than Medicare beneficiaries. Table 14 presents estimates of the numbers and percentages of Americans purchasing coverage through a regional alliance under different assumptions of who must purchase coverage within the alliance. These simulations indicate that if all employment-based groups that were eligible to form corporate alliances did so, 70 percent of Americans would purchase health insurance coverage through a regional alliance.

Excluding the Medicare population, 17 percent of Americans would receive coverage from a corporate alliance. An employer or employment-based health plan evaluating whether to form a corporate alliance would discover several incentives to join a regional alliance. First, only employers in the regional alliance have their contributions capped at 7.9 percent of payroll. That alone provides a powerful incentive for employers to join the alliance, even if their percentage of payroll is currently less than 7.9 percent, because health care costs have been rising faster than wages. Second, all employers who opt to form a corporate alliance would face a 1 percent payroll tax. Third, the states could assess premium and other taxes on corporate alliances. Fourth, the corporate alliances would be responsible for paying subsidies to employees earning less than $15,000 annually. Finally, corporate alliances would be required to undertake certain administrative responsibilities in terms of offering at least three plans, one of which has to be an indemnity plan; gathering and disseminating information; and complying with potentially very different state health plan regulations.

It seems unlikely that many employers would elect to form corporate alliances under the Clinton plan as currently written. It is even more unlikely that reducing the minimum employer size for eligibility to form corporate alliances without any other changes would induce more employers to form them. The CBO's analysis of the President's proposal estimates that employers would have to save at least $800 per employee for it to be advantageous to form a corporate alliance.

Early Retiree Health Benefits—The risk pools under the Clinton plan would also include early retirees not yet eligible for Medicare (those aged 55–64). Under the Clinton plan, the federal government would pay 80 percent of the cost of early retiree health coverage, with the retiree paying the remaining 20 percent. The employer would be responsible for paying the 20 percent retiree share if it was providing fully employer-paid retiree health benefits as of October 1, 1993. Employers would be required to pay a one-time gain charge during the transition if they experience a reduction in retiree costs. Retirees with
Table 14
Simulation of Americans Purchasing Coverage Through Regional Alliance under Various Assumptions Concerning Composition of Alliance\(^a\) Program

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Minimum Employer Size for Corporate Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number in regional alliance</td>
</tr>
<tr>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Includes No Public Employees/</td>
<td>82,294,591</td>
</tr>
<tr>
<td>Medicaid Recipients(^b)</td>
<td></td>
</tr>
<tr>
<td>Includes No Medicaid Recipients(^c)</td>
<td>111,224,150</td>
</tr>
<tr>
<td>All Included</td>
<td>128,034,878</td>
</tr>
<tr>
<td>Percentage in regional alliance</td>
<td>32.7%</td>
</tr>
<tr>
<td>Includes No Public Employees/</td>
<td></td>
</tr>
<tr>
<td>Medicaid Recipients(^b)</td>
<td>32.7%</td>
</tr>
<tr>
<td>Includes No Medicaid Recipients(^c)</td>
<td>44.2</td>
</tr>
<tr>
<td>All Included</td>
<td>50.9</td>
</tr>
</tbody>
</table>


Note: Total population = 251,680,848; Medicare population = 32,795,464 (13.0 percent).
\(^a\) Assumes all employees of employers with fewer employees than employer size cap purchase coverage through regional alliance, all other employers create corporate alliance, and Medicare remains a separate program.
\(^b\) Assumes Medicaid a separate program and public employees are outside the health insurance purchasing cooperative unless their employing unit falls under the minimum employer size.
\(^c\) Assumes Medicaid remains a separate program.

incomes of $90,000 ($115,000 for couples) would be responsible for paying back all or a portion of the subsidy when filing for yearly income taxes.

**EBRI has estimated that the federal government’s total annual cost of providing subsidized benefits to the nonworking population aged 55–64 would range from $9.1 billion to $19.6 billion in 1994.** Approximately 6.9 percent of the near elderly population retire each year. Additional workers would be induced to retire because the federal government would pay most of the costs of their health benefits. Nonworkers who have met the Social Security covered quarters requirement would also be covered under the President’s reform plan. All of these costs are uncertain because the level of induced retirement, the number of qualifying nonworkers, and the actual premium costs cannot be precisely estimated. The lowest total annual cost the federal government would face is $9.1 billion, assuming the administration’s estimated premium for a single adult is $1,932, that additional workers do not retire early, and only 50 percent of nonworkers qualify for the subsidized benefits. At the other end of the range, assuming that the premium for a single adult is $2,509, 20 percent of workers retired early, and 90 percent of the nonworking population aged 55–64 would qualify for subsidized benefits, the highest total annual cost the federal government would face becomes $19.6 billion.

While we know that the costs to the federal government of providing these benefits are large, and that workers will retire early if they are guaranteed subsidized health care benefits, we should also assume that these benefits would change the process of retirement. Currently, if an individual retires early, he or she can always return to work. Some workers use early retirement as a way to ease themselves out of the labor force. Many of these workers only retire partially, finding part-time work until they are closer to age 65. Under the Health Security Act, retired individuals would lose their subsidized benefits if they returned to work. The proposed employer mandate would inhibit early retirees from returning to work because as employees they would not get subsidized health benefits and their employers would have to provide these benefits. The human capital costs must also be accounted for when estimating the costs of providing subsidized benefits to workers aged 55–64. (See **EBRI Issue Brief** no. 121, “The Work and Retirement Patterns of Older Americans,” for more information on the retirement process.)

**Tax Implications—**Although employer contributions for benefits not included in the package would, after a phase-in period, no longer be excluded from the employee’s income for tax purposes, the generosity of the benefit package means that for most health benefits the tax code would remain unchanged with regard to employer contributions. One of the basic tenets of managed competition is that people who spend their own money will make choices among health plans that will drive the system toward cost containment. Continuing the tax
exclusion of employer contributions reduces this incentive. The weakening of the market incentives for reducing cost inflation increases the need for budgets, premium caps, and fee schedules.

*The Cooper-Breaux Proposal*—Rep. Jim Cooper (D-TN) and Sen. John Breaux (D-LA) introduced the Managed Competition Act of 1993 (H.R. 3222/ S. 1579). This bill reorganizes the market by creating health plan purchasing cooperatives (HPPCs) for unemployed individuals and employees, and their dependents, of employers with fewer than 100 employees. States would be required to establish at least one nonprofit HPPC. All employers with fewer than 100 employees would be required to join a HPPC (states could raise this threshold). HPPCs could cross state lines in some instances, but only one HPPC would be allowed for each geographic area. No more than 50 percent of a state’s population could enroll in HPPCs. Within that framework the proposal relies on the market to allocate health care resources.

The bill would provide universal access rather than universal coverage by requiring small employers to join HPPCs and large employers to offer health plans, and it would establish a standard benefit plan through a national commission. Individuals could not be turned down due to preexisting conditions or be charged higher rates due to a history of higher medical expenses. Individuals would have the opportunity every year to choose from a menu of qualified health plans in the area.

There is no employer or individual mandate in this plan. Employers would not be required to contribute to the cost of employee premiums. Enrollment in a qualified health plan would be free to individuals at or below 100 percent of the poverty line. Subsidies would be provided for individuals up to 200 percent of the poverty line.

There would be many different risk pools under this plan. Medicaid would be folded into the purchasing cooperatives for employees of small employers and unemployed individuals. Premiums would be community rated within the purchasing cooperative. Medicare would remain separate. Thus, medium and large employers would continue to form their own risk pools.

Only premiums paid to federally qualified accountable health plans (AHPs) would be tax deductible. The employer deduction for premiums would be capped at the lowest priced AHP in the local HPPC. Premium payments by individuals to AHPs would be 100 percent deductible, as would coverage for the self-employed.

In addition to capping employer deductions for health expenses, the bill would phase out the Medicare Part B premium subsidy for upper income beneficiaries, prefund federal retiree health benefits, and reduce increases in Medicare provider reimbursements.

*Analysis*—The Cooper-Breaux plan is a pure managed competition model in the sense that it relies on market forces to constrain health care cost inflation. It does not contain a mandate and therefore would not achieve universal health insurance coverage. In fact, it is unlikely to significantly decrease the numbers of Americans without health insurance coverage.

This plan would create a risk pool composed of nonworking or self-employed individuals, employees of small employers and their dependents, and Medicaid beneficiaries. This pool would be community rated, which would increase the premium costs of the best risks, decreasing the probability that they would purchase health insurance. The Medicaid program would be eliminated. Individuals in families with incomes below 200 percent of the federal poverty line would have their coverage subsidized in two ways. First, the maximum premium that could be charged to these individuals by the AHP would be reduced from the standard premium for the basic benefit package. This reduction would be determined initially by the percentage of the state’s Medicaid expenditures that are received from the federal
Health Reform and ERISA

Many of the health reform proposals that attempt to build on the employment-based system for financing health insurance coverage directly or indirectly affect the Employee Retirement Income Security Act of 1974 (ERISA). ERISA established uniform standards that employee benefit plans must follow to obtain and maintain their tax-favored status. ERISA sec. 514(a) provides that ERISA generally supersedes or preempts all state law otherwise applicable to pension and welfare plans, with the exception of state law regulating insurance, banking, and securities. The exception for insurance in effect allows certain indirect state regulation of insured health plans. Recent court decisions have affirmed that ERISA exempts employers who self-insure their health insurance benefits from many such state laws. Many employers choose to self-insure because this exempts them from state mandated benefit laws, which specify certain types and levels of coverage that group policies must include. Moreover, self-insured plans have been able to invoke ERISA preemption protection to avoid paying taxes on insurance premiums or taxes that fund state pools to insure poor risks. As a result, ERISA preemption has limited states’ ability to finance health care proposals.

Federal versus state regulation of employee benefit plans is the essential question surrounding ERISA and health plans. States have traditionally regulated insurance. With the enactment of ERISA, the federal government took the role of regulating employee benefit plans. Many multistate employers strongly support ERISA preemption because it allows employee benefit plans to be regulated by a uniform standard instead of potentially 50 different state laws. ERISA provides significant financial and fiduciary regulation of health plans, but very little in terms of what a plan must provide in the way of benefits. Many of the health reform proposals create risk pools, standardized benefit packages, and health insurance purchasing groups that would require amendments to ERISA to implement. Moreover, proposals that charge states with the responsibility of regulating risk pools, or of bearing some of the costs of financing care for low-income individuals, must change ERISA preemption to give the states either the ability to regulate or perhaps to tax self-insured benefit plans.

Several of the proposals make specific changes to ERISA. The Clinton proposal adds a new chapter to ERISA that defines corporate alliances and their regulations. Chafee amends ERISA to redefine who is eligible for preemption under ERISA. Michel extends key elements of ERISA preemption to all group health plans. Cooper repeals the Consolidated Budget Reconciliation Act (COBRA) continuation coverage. Cooper also requires small groups to purchase coverage through a purchasing cooperative. That provision and those in other proposals leave unclear the role of ERISA in regulating employment-based health plans and the formation of risk pools. For example, could small employers with good risks opt to self-insure (with heavy stop-loss) and avoid the purchasing cooperative?

ERISA preemption presents policymakers with an explicit tradeoff: increased state flexibility in health reform requires that ERISA be modified, but significantly altering ERISA preemption forces multistate employers to comply with potentially large differences in regulation and tax burdens by state in providing health benefits. Presently, employees of a multistate self-insured employer can receive the identical health plan everywhere in the nation; without ERISA preemption they may face 50 different plans in very different health care delivery systems.

government and by the individuals’ income level. A redistribution of premiums would be made by the federal board and the HPPC to give AHPs with a disproportionate share of low-income individuals a subsidy from their competitor AHPs. In that way, AHPs would not have an incentive to avoid covering low-income individuals.

The second subsidy would be provided by the federal government on a sliding scale, depending on income. For individuals in families below the federal poverty level, the federal government would pay all of the reduced premium. For those who live in families with incomes between 100 percent and 200 percent of the poverty level, the subsidy would be reduced as income increases.

This subsidy would be financed by funds currently allocated to the Medicaid program and by an excise tax on public and private employers. An excise tax would be levied on employers for the amount they contribute to their employees’ health benefits above the cost of the basic benefit package. The exclusion from the
employees’ taxable income of the employers’ contribution to health benefits would be maintained, while self-employed individuals and those without employment-based health benefits would be given a 100 percent deduction for health insurance premiums paid to an AHP.

Most of the proposal’s revenue comes from the Medicaid program, which currently covers about one-half of the population below poverty. The plan proposes to spread Medicaid’s funds over the larger population of individuals below 200 percent of poverty by requiring AHPs to reduce their premiums to low-income individuals. As a result, the standard nonadjusted premiums would have to increase to pay for that subsidy. This has the effect of reducing the number of the uninsured above the poverty level who will choose to purchase health insurance, exacerbating the adverse selection problem, ultimately increasing federal expenditures.

It is seems likely that the risk pools formed by the Cooper-Breaux proposal would be unsustainable. The pool would include workers for small employers, individuals not connected to the work place, and the very poor. The costs of providing care would be largely borne by the employees of these small employers, who tend to be younger and healthier. Community rating within the risk pool is likely to raise their premiums above what they now pay. Adding the implicit subsidy to fund the discount that health plans are required to give the low-income group would increase their premiums even more. As a result, many of these individuals might choose not to purchase health insurance, further reducing the average risk in the pool and increasing premiums to those who remain. Over time, enough healthy individuals might choose to drop out of that pool, either by simply remaining uninsured or by finding employment with employers who have more than 100 employees and can therefore avoid the pool.

The Chafee-Thomas Proposal—Legislation sponsored by Sen. John Chafee (R-RI) and Rep. Bill Thomas (R-CA), Health Equity and Access Reform Today (S. 1770/H.R. 3704), reforms the health insurance market by instituting insurance reforms, creating a mechanism for states to establish voluntary purchasing cooperatives, and encourages the establishment of medical savings accounts.

The bill promotes universal coverage by guaranteeing eligibility, barring insurance providers from denying coverage based on an applicant’s health or preexisting condition, and requiring that individuals obtain health care coverage. All individuals would be required to obtain health insurance coverage by the year 2005. Under this bill, individuals would be required to purchase a comprehensive benefit package from a health plan. Individuals who seek health care services without having insurance would be assessed a penalty equal to the average yearly premium of the local area plus 20 percent. Subsidies to purchase health insurance would begin in 1997 for people at or below 90 percent of the poverty line, extending to 240 percent of the poverty line by 2005. Subsidies would be phased in only if savings occur as scheduled.

The bill stipulates that employers would be required to offer a health plan to their employees, but they would not be required to contribute to the cost of coverage. Employers with 100 employees or fewer would be required to offer a standard benefit package or alternative catastrophic insurance obtained from a qualified health plan. These small employers would be able to join state-created purchasing cooperatives. Large employers would be required to offer both a standard and catastrophic benefit package to all employees. The plans would be required to comply with all consumer protection and insurance reforms. Large employers could form purchasing groups as well.

The Chafee-Thomas proposal would create a number of risk pools. Small employers could choose to form purchasing cooperatives but would not be required to purchase insurance through a cooperative. Premiums could vary by age but otherwise would be community rated within a purchasing cooperative. There could be
any number of cooperatives in a given geographic area. A risk adjustment would be built into each plan’s premiums. States could opt to enroll Medicaid beneficiaries in private health plans. The bill calls for the development of a proposal for enrolling Medicare beneficiaries in private health plans.

Medical savings accounts would be permitted to be a part of any qualified catastrophic benefit plan. Contributions to these accounts would be fully deductible up to the applicable dollar limit. If the employer makes the contribution, the amount would be excluded from the employee’s income. Medical savings accounts would be available to pay the cost-sharing requirements of the catastrophic health plan and could also be used to purchase long-term care.

The bill would cap the employer tax deduction for health coverage at the average cost of the lowest-priced one-half of plans in a geographic area. The employer premium contribution in excess of the cap would be treated as taxable income to employees. The health insurance deduction for the self-employed would be 100 percent deductible up to the applicable dollar limit.

To finance subsidies for the poor, the bill would reduce the annual growth rate in Medicare and Medicaid. The bill calls for means testing the Medicare Part B premiums, phasing out payments to hospitals for uncompensated care, and instituting a managed care program for Medicaid.

Analysis—The Chafee-Thomas proposal reaches universal coverage through a mandate on individuals. The proposal differs from the other two managed competition proposals in that a number of different purchasing cooperatives could operate in the same geographic area. This would create the potential for segmentation of risk pools. The proposal requires that each state create a mechanism for adjusting for risk that redistributes premium income across insurers on the basis of risks. This mechanism is intended to remove risk selection as a barrier to cost competition among insurers. Insurers of health plans that have a healthier than average enrollee population would be required to transfer some funds to plans with a less healthy population. This requirement would limit the rewards for attempting to attract a healthier population.

An important issue is the factors that are used to determine the risk adjustment among insurers’ populations. These factors may introduce unintended incentives if they do not completely capture the observable differences in characteristics associated with health care services utilization across enrollee populations. If insurers can identify risk factors not captured by the risk adjustments, they may be able to exploit these factors and create adverse selection.

Moreover, there is a question of whether these factors should be applied prospectively, that is, without any adjustment for actual utilization, or retrospectively, after it is clear that one insured group has incurred more costs than another. In the first case, a set of demographic characteristics would be identified as risk adjusters, and an insurer who attracted a healthier group based solely on these characteristics would be required to transfer some of its premium income to another insurer whose risk profile based on these characteristics was poorer. Retrospective adjustment would transfer income based on actual utilization by plan enrollees. If prospective risk adjusters accurately predict the risks faced by the insurer, they preserve the incentive for the health plan to manage care efficiently. Retrospective adjustments may be a more accurate measure of the differences in risks faced by competing health plans because they are based on actual utilization, but they may also reduce the incentive to practice cost-effective medicine. The selection of the risk adjustment mechanism would be an important determinant of the distribution of the burden of health care costs under the Chafee-Thomas plan.

Individual Markets

The Michel-Lott Proposal—Legislation sponsored by Rep. Robert Michel (R-IL) and Sen. Trent Lott (R-MS), Affordable Health Care Now Act of 1993
(H.R. 3080/S. 1533), reforms the health insurance market by instituting insurance reforms, creating a mechanism for states to establish voluntary purchasing cooperatives, and encouraging the establishment of medical savings accounts.

The bill promotes universal access by limiting preexisting condition restrictions and ending job lock by assuring continuous availability of coverage through an employer. Employer health plans could not be canceled or denied renewability. Health plans would be required to cover essential and medically necessary medical, surgical, hospital, and preventive services. Plans could not be mandated to provide specific services or benefits. A national commission would determine a minimum coverage level for health plans. The bill would provide subsidies for individuals up to 200 percent of the poverty level to obtain health coverage.

There is no mandate for individuals to obtain coverage under this proposal. The bill would require all employers to offer a basic insurance plan to their employees. While employers would not be required to contribute to the cost of their employees’ coverage, they would be required to allow employees to pay their premiums through payroll deductions.

This plan creates a number of separate risk pools. Employers could form purchasing cooperatives to negotiate for lower rates. Current legal restrictions on the formation of multiemployer plans would be relaxed. The Medicaid and Medicare programs would remain separate. The bill would give states more flexibility in administering their Medicaid programs, including the option to use private insurance for Medicaid beneficiaries and to permit uninsured people to buy into the Medicaid program. Insurers would have limited ability to vary premiums among groups, purchasing cooperatives, or individuals by rating bands. Thus there would be a limited form of community rating.

The bill encourages the creation of personal medical savings accounts (Medisave). Employees choosing a Medisave plan would be required to purchase a health insurance plan with a deductible of at least $1,800 ($3,600 for families). Both the cost of the health insurance plan and contributions to the Medisave account would be tax deductible. Contributions to the Medisave account would be limited to the deductible or $2,500 ($5,000 for families) per year.

Under the Michel-Lott plan, self-employed individuals could deduct 100 percent of their coverage costs. In addition, employers would use tax-exempt trusts to fund health care benefits.

Cost containment would be achieved through the operation of a more efficient market. Additional savings would be achieved through medical malpractice and antitrust reform, administrative savings, and limitation of the annual increases in premium rates. Financing of the bill’s provisions would be achieved by increasing the federal retirement age from 55 to 62 and increasing Medicare Part B premiums for certain individuals.

Analysis—This proposal is unlikely to achieve universal coverage. Researchers evaluating the Robert Wood Johnson Foundation (RWJF) projects for the medically uninsured found that small employers’ primary reason for not offering health insurance was the high cost of coverage—85 percent of employers not offering insurance cited high premiums as an important reason (McLaughlin, 1991). Although the RWJF demonstration projects did not reform local small group insurance markets the way that this proposal would, their goals are similar: to stabilize the cost of insurance to small businesses and distribute these costs more equitably. However, only 17 percent of employers who had not previously offered insurance enrolled even in the most successful RWJF project targeted at small employers (McLaughlin, 1991). If the experience of these projects is representative of national experience, small group insurance market reform may result in a minority of small employers choosing to purchase health insurance. (See EBRI Issue Brief no. 125, “Health Care Reform: Tradeoffs and Implications,” for more informa-
tion on small market insurance reform.)

Changes in the insurance market might stabilize premiums somewhat, but the ability of individual groups to select the risks they associate with would likely result in continued segmentation of the risk pool. Small employers would probably continue to face higher premiums than larger employers, and individuals would continue to face higher costs than those who purchase health insurance in a group.

The Nickles-Stearns Proposal—The bill sponsored by Sen. Don Nickles (R-OK) and Rep. Cliff Stearns (R-FL), the Consumer Choice Health Security Act (S. 1743/H.R. 3698), reforms the health insurance market, places a mandate on individuals to purchase health coverage, ends employment-based coverage, eliminates the tax exclusion for employment-based health plans and replaces it with individual tax credits to purchase federally qualified insurance, and encourages the establishment of medical savings accounts.

The bill attempts to achieve universal coverage by mandating that individuals purchase health insurance or lose their personal exemptions for income tax purposes. The bill would end employment-based health benefits, with the requirement that employers who currently provide these benefits pay employees higher wages in lieu of the previously provided premiums. Employers would be responsible for withholding each employee's health insurance premium for remittance to the employee's chosen plan.

The bill would create community rating by allowing premiums to vary only by age, sex, and geographic characteristics. Geographic characteristics are not defined in the bill. Defining these characteristics would be an important determinant of the degree to which the market is segmented by risk. The narrower these geographic boundaries are drawn the greater the segmentation of the market.

Allowing premiums to vary by age removes the implicit subsidy of older individuals by younger enrollees contained in true community rating proposals (such as Clinton's). It may also leave a particularly vulnerable group potentially uncovered: women aged 55–64. This is

The employee tax exclusion for health benefits received from the employer would be eliminated and replaced with a tax credit for individuals and families to purchase federally qualified health insurance coverage. Individuals could establish tax-preferred medical savings accounts to pay for premiums and deductibles. Contributions to these accounts would be tax free and limited to $3,000 a year or $500 per dependent.

This proposal would be financed through the elimination of the current employee exclusion for health benefits and through savings from Medicare and Medicaid, which purportedly would make the bill revenue neutral. Costs would be controlled by making the individual responsible for his or her own coverage. The assumption is that individuals would become more conscientious buyers of health insurance coverage, thus creating competition for affordable coverage among insurance providers.

Analysis—The individual mandate in the Nickles proposal may leave an important low-risk group out of the risk pool. The penalty for not purchasing health insurance would be that individuals may not claim personal exemptions in calculating their federal income tax. Thus the penalty for nonpurchase of health insurance would be dependent on an individual's filing status and income. For example, the penalty for low-income single individuals for not purchasing health insurance would be at most 15 percent of the value of the exemption ($2,350) in tax year 1993, or $352. Given that the premium for a young individual is likely to average between $1,400 and $1,800, these individuals might rationally opt not to purchase health insurance.

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the only age group in which women are more likely to be uninsured than men. Generally, uninsured women in this age group have separated from the employment-based system through divorce or the death of their spouse. They tend to be low income. The premiums they would face under this proposal are likely to be similar to the ones they face now. The penalty for not purchasing health insurance might well be much less than the cost of the plan.

The Gramm Proposal—The bill introduced by Sen. Phil Gramm (D-TX), the Comprehensive Family Health Access and Savings Act (S. 1807), reforms the health insurance market by instituting insurance reforms, creating a mechanism for small businesses and other organizations to voluntarily group together to pool health insurance purchases, and encourages the establishment of medical savings accounts.

There are no mandates in this proposal. It attempts to achieve universal access through insurance reform and by providing the option of paying an adjusted premium on the basis of a $1,000 or $3,000 deductible in order to reduce the monthly premium payment for COBRA continuation coverage. In order to pay for health insurance coverage during the period between jobs, individuals could make penalty-free withdrawals from individual retirement accounts. The proposal requires that individual policies be renewable, and premiums could not be increased because of illness. The bill would require group policies to give each participant the right to convert to an individual policy when leaving the group. The individual policy could be rated on actuarial data but could not be canceled due to the health status of those covered by the policy. No policies, group or individual, could be canceled due to illness of anyone covered by the policy. To assist individuals who are uninsured due to preexisting conditions, the federal government would pay that amount of the premium in excess of 150 percent of the average for those of the same sex, age, and geographic area and 7.5 percent of the individual’s or family’s income. The subsidy would not cover premiums that are higher because of current behavior deemed risky or unhealthy.

Medicare recipients would have the option of staying in the current system, receiving comparable government assistance to enroll in a private health care arrangement, or establishing a medical savings account. The decision to opt out of Medicare would be final.

To assist low-income workers, a credit would be available for individuals and families below 200 percent of the poverty level who are not eligible for Medicaid. For families below the poverty level, the credit would fully fund the cost of a catastrophic insurance policy with an annual deductible equal to 20 percent of income, not to exceed $3,000. The credit would be phased in over five years.

To reform Medicaid, states would receive an annual payment—which would vary by risk categories—equal to the average federal cost per Medicaid enrollee on a state-by-state basis. States could then continue the existing structure, enroll recipients in HMOs or other arrangements, or establish medical savings accounts to cover the recipients’ medical expenses. In these accounts no amount other than for qualified medical expenses could be withdrawn that would take the account below the annual catastrophic deductible limit.

The risk pools under this proposal would be similar to those in the present system, except that insurance would be available to some individuals currently denied coverage.

For employer contributions to remain excludable from employee income and deductible by the employer, employers electing to offer coverage would be required to offer at least three options: continued coverage under the current arrangement; an HMO or any other health care arrangement in which the employer pays an amount equivalent to the current employer-paid share of health insurance costs to the alternate plan chosen by the employee; and establishment of a medical savings account program in which the employer would contribute
the amount currently being spent on the existing health insurance arrangement. Contributions to such an account of up to $3,000 would be tax exempt. Tax-free withdrawals could be made to pay for qualifying out-of-pocket expenses that apply to the insurance policy’s $3,000 deductible.

Self-employed workers would be able to exclude from gross income a percentage of their medical insurance coverage equal to the national average that employers contribute. Individuals without employment-based coverage would be given similar tax treatment. The exclusion would apply to the purchase of conventional insurance, HMO coverage, medical savings accounts contributions, or any other prepaid medical plan.

The plan calls for paperwork reduction, medical liability reform, and the removal of antitrust barriers. It also maintains that none of the benefits would take effect until savings accrued by the reforms occur.

Total costs of the plan are estimated at $144.2 billion over five years, with savings over that period of $189.7 billion. Based on these figures, the plan estimates a deficit reduction contribution of $45.5 billion.

Analysis—The major features of this proposal are the insurance reform, the creation of medical savings accounts, and changes in the tax code to induce increased coverage. As discussed above, these changes will not achieve universal coverage. Together they would have important impacts on the health care delivery system, but these features would be more likely to accelerate the evolution of the current health care delivery system than to change its direction.

Many choices must be made before a health reform proposal can be enacted and implemented. The role of the market in the allocation of health care resources is one of the most important choices. It will determine not only how equitable the health care delivery system is but also who makes the decisions concerning an individual’s health care.

If the reformed delivery system assigns a role to the private health insurance market, the way risks are pooled will be an important determinant of the costs of health care to individuals, employers, and taxpayers. In turn, these costs will determine the viability of the risk pools themselves. If these pools experience adverse selection, with healthier individuals dropping out, leaving less healthy individuals in the pool to drive up premiums, the system may not be viable.

The problem of adverse selection would be alleviated if individuals were mandated to purchase health insurance coverage. Mandates can be imposed on employers or individuals. An employer mandate could potentially disrupt the labor market, at least in the short run, but would be easier to enforce than a mandate on individuals. The latter would have less of an impact on labor markets and could be structured through the tax code to more directly subsidize low-income individuals. A mandate on individuals is the only mechanism that would achieve universal coverage in a private system.

Health reform will impact every American. Reform is intended to improve access to care and to slow the rate of health care cost inflation, but it will also affect important sectors of the economy and the labor market. Health reform will redistribute income. Determining the winners and losers under the various health reform proposals is difficult given their complexity and the uncertainty surrounding the behavioral response of patients, providers, employers, employees, insurers, taxpayers, and others.

Conclusion—Health reform will impact every American. Reform is intended to improve access to care and to slow the rate of health care cost inflation, but it will also affect important sectors of the economy and the labor market. Health reform will redistribute income. Determining the winners and losers under the various health reform proposals is difficult given their complexity and the uncertainty surrounding the behavioral response of patients, providers, employers, employees, insurers, taxpayers, and others. Many choices must be made before a health reform proposal can be enacted and implemented. The role of the market in the allocation of health care resources is one of the most important choices. It will determine not only how equitable the health care delivery system is but also who makes the decisions concerning an individual’s health care.

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It is difficult for individuals to determine whether they themselves are winners or losers under any given health insurance plan because many individuals are unsure of the costs or benefits of the care they are now receiving. As a result, the political ramifications of
health reform may depend on the extent to which consumers become educated about the present system.

The plan that will ultimately win approval from Congress has not yet been written. No proposal has achieved enough support in Congress to pass on its own merits. However, an evaluation of each proposal is critical to understanding the package that will likely result from compromises on the issues discussed in this report.


______. Single-Payer and All-Payer Health Insurance Systems Using Medicare’s Payment Rates. CBO Staff Memorandum, April 1993.


### Health Reform Bills, 103rd Congress

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<tr>
<th>Bill Sponsor</th>
<th>Role of Market</th>
<th>Coverage</th>
<th>Composition of Risk Pools</th>
<th>Mandates</th>
<th>Tax Code Changes</th>
<th>Financing</th>
<th>Cost Containment</th>
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<tr>
<td>McDermott/Wellstone</td>
<td>No health insurance market.</td>
<td>Universal by 1995.</td>
<td>All citizens.</td>
<td>Government provides benefits.</td>
<td>8.4% payroll tax.</td>
<td>2.1% income tax, payroll tax, taxes on tobacco and ammunition.</td>
<td>Budget caps, Fee schedules.</td>
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<tr>
<td>Cooper/Breaux</td>
<td>Managed competition.</td>
<td>Full credit for those below poverty. Subsidies for those under 200% of poverty.</td>
<td>Medicaid eliminated. All employees of small employers grouped with nonworking families and individuals; all others through employer.</td>
<td>None</td>
<td>Employer pays tax on any contribution over cap. Individual premium payments fully deductible up to cap.</td>
<td>Uses Medicaid funds. Forces implicit subsidy paid by employees of small employers. Individual premiums.</td>
<td>Market forces.</td>
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