

Health Care Reform: Tradeoffs and Implications

This *Issue Brief* describes the various proposals that have been offered to reform the health care delivery system; examines estimates on how each proposal would affect the coverage, costs, and quality of health care; and places each proposal in the context of the tradeoffs inherent in health care reform. The report attempts to describe proposals along the entire spectrum of health care reform plan types including those that have been advanced by members of Congress, research analysts, trade associations, and academics. The analysis explores expansion of continuation of health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, medical malpractice reform, small group insurance market reform, tax-based reform, public program expansion, employer mandates, play-or-pay employer mandates, managed competition, individual mandates, and national health insurance systems.

Quantitative analyses draw on a variety of studies and EBRI's own estimates. The studies provide order-of-magnitude effects rather than precise estimates of costs and benefits. The estimates are valuable, however, in illuminating the tradeoffs inherent in enacting any of the reform proposals. Although health care reform proposals attempt to expand access, improve quality, and/or reduce costs, no delivery system can accomplish all of these tasks simultaneously. This *Issue Brief* describes who could gain coverage and who is likely to switch from one source of coverage to another under alternative reform scenarios. As a result of improved coverage, costs are likely to increase or at least be redistributed. The change in total costs and the allocation of these costs among employers, employees, government, and taxpayers are discussed. Finally, the effects of changing the health care delivery system on the quality of care are explored throughout the report.

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◆ Executive Summary

The health care reform debate centers on the idea that health care expenditures are out of control, while at the same time a significant proportion of Americans lack access to the health care delivery system. This perception has led to a number of proposals for reform. This *Issue Brief* describes these proposals, analyzes the ways in which each proposal would affect the coverage, costs, and quality of health care, and attempts to place each proposal in the context of the tradeoffs inherent in health care reform.

Proposals for health care reform occupy almost every point along the spectrum from essentially fine-tuning the health care delivery system by changing tax or regulatory policy to abandoning the private market and adopting a national health care delivery system. Reform proposals have generally focused on costs and access to care. Those intended to reduce health care cost inflation have attempted either to correct flaws in the organization of health care financing and delivery or to place an overall cap on costs or prices.

Reform proposals or portions of reform proposals that attempt to increase access to care approach employment-based health benefits in different ways. Many attempt to build on the present system by expanding employment-based health benefits through either a mandate or tax incentives. Many of these proposals would also create a public program to cover the remaining uninsured. Conversely, other reform proposals would sever the link between health care and the work place, replacing employer-sponsored health benefits with a public plan at one extreme or individually purchased health benefits at the other.

The following section provides broad descriptions of the various health care reform proposals. In addition, it describes the impact of these proposals on coverage and costs. Proposals are arrayed in a spectrum according to the degree to which they would alter the structure of the current system. The report arbitrarily groups health

care reform proposals into three broad types to facilitate discussion: incremental reform, reorganization of health care delivery and financing, and national health care systems.

Incremental Reform Proposals

Incremental reform proposals generally maintain the current delivery structure but make specific changes to improve the health insurance coverage of the 36 million uninsured Americans and/or reduce health care cost inflation. Included in this category are malpractice insurance reform, expansion of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), small group insurance market reform, and changes in the tax treatment of health insurance.

Malpractice Insurance Reform—Although there are important differences among these reform proposals, they generally call for the development of alternative dispute resolution systems (i.e., arbitration or other processes outside the judicial system), limits on awards in malpractice suits, limits on attorneys' fees, research on health outcomes, and the development of clinical practice guidelines (table 1). Advocates of malpractice insurance reform suggest that limiting awards in malpractice suits and instituting alternative arbitration systems would help control health care cost inflation. By reducing the cost of malpractice insurance, these reforms would reduce providers' overhead costs, enabling them to charge lower fees. In addition, such reforms would reduce the utilization of health care services because they limit physicians' need to practice defensive medicine. However, the amount of health care services that is provided solely as a defense against malpractice suits has not been definitively determined, and it is unclear whether lower malpractice premiums would cause physicians to alter their practice patterns. However, such reforms could slow the rate of health care cost inflation to the extent that they reduce overutilization of health care services.

COBRA Changes—COBRA requires employers to allow employees and their dependents who would lose

health insurance coverage due to job loss or change in marital status to remain in their group health insurance plan for a specified number of months. **COBRA expansion proposals would extend the number of months that an employer must allow employees to remain in the group plan and/or expand the eligible groups** (table 1). A study of data from the National Medical Expenditure Survey found that 48 million Americans were uninsured at some point during 1987, but only 23 million were uninsured for the entire year. Temporarily uninsured individuals may incur medical costs that they are unable to pay or that represent a catastrophic loss. Providing these individuals with a means to purchase group health insurance coverage may prevent some of this individual loss and reduce the burden of uncompensated care that falls on providers and other payers.

Small Group Insurance Market Reform—Small group insurance market reform proposals would restrict practices that make it difficult for smaller firms to obtain insurance. Most of these proposals would guarantee small groups' access to insurance, limit restrictions on preexisting conditions, limit coverage restrictions on individuals changing jobs or groups changing insurers, restrict coverage cancelations because of high utilization, require insurers to offer coverage to all small groups (if they offer insurance to any), stabilize premium rates, and guarantee policy renewability (except for reasonable cause such as nonpayment of premiums) (table 1). Proponents of insurance market reform disagree on the means to achieve guaranteed access to insurance and on some of the features needed to make such a guarantee work, including limits on premium rates and rate increases.

Some policymakers support community rating, which would require insurers to offer coverage to all small groups at fixed rates. Others would allow insurers to adjust community rates for factors such as age, sex, geographic location, and industry type. Small group reform advocates argue that small employers would purchase health insurance if it were offered at the right price. However, it is likely that at least some small

employers would not be willing to purchase coverage in the absence of substantial federal or state subsidies. 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. However, only 17 percent of employers who previously did not offer insurance enrolled in even in the most successful RWJF project targeted at small employers.



Under the Bush administration health care reform proposal, eligible individuals would receive a health insurance voucher at a state agency.



Tax-Based Reform—Most tax-based approaches to health care reform focus on limiting the exclusion of employer contributions to health insurance from workers' taxable income and/or expanding individual tax credits. Advocates assume 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. They also assume that expanding individual tax credits would enable low-income individuals to more easily purchase health protection for themselves and their families (table 1). No specific analysis has been done to determine how changing the tax treatment of health benefits would affect coverage. Using the Tax Estimation and Analysis Model (TEAM), the Employee Benefit Research Institute (EBRI) estimated the impact of capping tax-exempt employer contributions to health plans at \$2,940 for family coverage and \$1,080 for individual coverage. EBRI found that the imposition of a tax cap would be regressive in the sense that lower income filers would

Table 1
**Summary of Coverage Effects, Cost Effects, and Quality Concerns
of Selected Health Care System Reform Proposals**

Proposal	Coverage	Costs	Quality
Malpractice Insurance Reform	<ul style="list-style-type: none"> • Not likely to significantly expand coverage. • If these reforms reduce cost, they could encourage small groups or individuals to purchase insurance. 	<ul style="list-style-type: none"> • Could reduce providers' overhead costs. • May reduce overutilization of health care due to defensive medicine. 	<ul style="list-style-type: none"> • Must continue to assure that patients receive adequate compensation for medical injury. • May induce more appropriate utilization.
COBRA Changes	<ul style="list-style-type: none"> • Would expand the number of terminated employees eligible to continue participating in an employer group health plan. • Unless reforms require employers to pay some of the cost of coverage, COBRA expansion may not significantly improve coverage. Only 10 percent to 21 percent of the currently eligible take advantage of COBRA provisions. 	<ul style="list-style-type: none"> • Terminated employees most likely to utilize COBRA continuation of coverage provisions are those with high medical costs or anticipated high medical costs. If employers can still only charge terminated employees 102 percent of the average premium, COBRA expansion would probably increase costs for employers. 	None.
Small Group Insurance Market Reform	<ul style="list-style-type: none"> • About one-half of all uninsured workers are either self-employed or in firms with fewer than 25 employees. Advocates of small group reform say that small employers would purchase insurance if it were available for a low price. • A Robert Wood Johnson Foundation demonstration project on health insurance access found that less than 20 percent of previously uninsured small firms purchased health insurance even when premiums were highly subsidized. 	<ul style="list-style-type: none"> • Small group reform without subsidies for small employers would not significantly increase government health spending. • If reform were successful, insurance expenditures would increase while out-of-pocket expenditures and the level of uncompensated care would decline. • Small group reform with subsidies for small firms would involve additional government spending (the level would depend on the number of small firms choosing to purchase insurance). 	<ul style="list-style-type: none"> • Coverage may increase for the previously uninsured. Without federal standards, benefits may vary widely. A federal standard benefit package may make coverage unaffordable for some employers.
Limit on Employer Contributions to Health Insurance That Can Be Excluded from Employee Taxable Income	<ul style="list-style-type: none"> • Could reduce coverage by increasing costs to employees and reducing incentives to employers. • If a tax cap were coupled with individual tax credits or deductions, it would equalize the tax treatment of health insurance for those with employment-based coverage and other private coverage. 	<ul style="list-style-type: none"> • Could increase the cost of health insurance to some workers (to the extent that the value of employer-provided health benefits is greater than the tax cap). • A tax cap would increase federal tax revenue if it were not offset by expanded health insurance deductions or credits. • Could decrease national health care cost inflation. 	<ul style="list-style-type: none"> • May lower coverage. • May reduce benefits purchased by those who elect coverage.
President Bush's Health Care Reform Proposal	<ul style="list-style-type: none"> • About 11 million low-income uninsured would be eligible to receive the full tax credit. • An additional 23 million uninsured would be eligible for a partial tax credit or a deduction for health insurance. • Many who were previously covered by private health insurance would also be eligible for tax credits or tax deductions. 	<ul style="list-style-type: none"> • Bush analysts estimate that the cost of the proposal would be \$35 billion annually after full implementation. They have not decided how to pay for the expansion. • States could bear a larger proportion of the costs through the funding of reinsurance pools. 	<ul style="list-style-type: none"> • Encourages states to drop Medicaid and provide private coverage with the tax credit voucher.

(continued)

Table 1 (continued)

Proposal	Coverage	Costs	Quality
Medicaid Expansion	<ul style="list-style-type: none"> • Illustrative expansions covering individuals with income below 200 percent of poverty indicate that Medicaid expansion could cover 12 million–21 million of the uninsured (35 percent to 60 percent). • An additional 2 million–13 million would be likely to drop nongroup coverage in favor of subsidized Medicaid. 	<ul style="list-style-type: none"> • National health expenditures could increase by \$10 billion–\$15 billion. • About \$30 billion in new costs would be paid by the government. These increases would be offset by reductions in direct patient spending and individual spending on private health insurance. • If benefit packages were standardized and/or reimbursement rates improved, costs could increase further by \$5 billion–\$30 billion. 	<ul style="list-style-type: none"> • State Medicaid programs have low reimbursement rates for physicians, so that some may not want to treat new Medicaid patients. • Because benefits provided by state Medicaid programs vary, a federal minimum benefit package may be necessary. • Because Medicaid has long been linked to welfare reciprocity, some of the working poor may choose not to participate. • Employers with a large percentage of low wage workers may drop health insurance coverage.
Employer Mandates	<ul style="list-style-type: none"> • Would improve coverage for 12 million–26 million of the uninsured (35 percent to 75 percent). • An additional 13 million–24 million previously insured individuals could switch from one source of coverage to another. • The number of individuals covered under the mandate changes with the characteristics of employers and employees who are exempt. 	<ul style="list-style-type: none"> • National health expenditures could increase by \$10 billion–\$15 billion. • Employers could spend an additional \$12 billion–\$86 billion, and employees could spend an additional \$9 billion (offset by a \$9 billion decline in direct patient spending). • Government spending could decline by about \$8 billion. • The distribution of costs would vary based upon the benefit package chosen and the characteristics of those exempted from the mandate. • If wages and other benefits did not adjust, between 200,000 and 1.2 million workers could lose their jobs. 	<ul style="list-style-type: none"> • Requiring employers to provide health insurance could adversely impact small employers. About one-half of workers who would gain coverage under a mandate are in firms with fewer than 25 employees.
Combination Medicaid Expansion and Employer Mandate	<ul style="list-style-type: none"> • About 80 percent of the uninsured could be covered: about 18 million under employment-based plans and about 11 million under Medicaid. Only about 5 million uninsured would remain. • An additional 16 million previously insured individuals may switch sources of coverage (13 million under employment-based plans and 3 million under Medicaid). 	<ul style="list-style-type: none"> • National health expenditures could increase by up to \$20 billion. • Federal and state government spending could increase by \$9 billion–\$32 billion, depending on who is covered by the mandate and Medicaid participation. • Employer and employee expenditures could increase by about \$26 billion and \$9 billion, respectively. • Direct patient spending and individually purchased private insurance could decline. 	<ul style="list-style-type: none"> • See quality items cited for employer mandates and Medicaid expansion.

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pay a larger percentage of their income than higher income filers toward the new tax.

Under the Bush administration health care reform proposal, eligible individuals would receive a health

Table 1 (continued)

Proposal	Coverage	Costs	Quality
Play-or-Pay Employer Mandate	<ul style="list-style-type: none"> • Would cover all of the previously uninsured. All of those not covered through an employer would be eligible for coverage under the public plan. • Between 50 percent and 77 percent of workers could be covered through an employer (depending on the payroll tax and employer behavior). • Between 33 percent and 50 percent of the previously uninsured could be enrolled in the public plan (depending on the payroll tax and employer behavior). 	<ul style="list-style-type: none"> • Employer costs could increase by \$30 billion–\$45 billion. • Government costs could increase by \$18 billion–\$37 billion. • Individual costs could increase by \$1 billion–\$8 billion. • Between 131,000 and 965,000 jobs could be lost under a play-or-pay employer mandate with a 9 percent payroll tax if other labor costs did not adjust. 	<ul style="list-style-type: none"> • Quality effects depend on features and funding of public plan. • Administration and structure of the public plan are important. If states have control, the plan could vary substantially from state to state.
Managed Competition with Public Sponsor	<ul style="list-style-type: none"> • More than 60 percent of the previously uninsured could gain coverage under an employer-sponsored plan. • The remaining uninsured would be eligible to purchase subsidized coverage through the public sponsor. 	<ul style="list-style-type: none"> • Employer costs could increase by about \$7 billion. Government costs could increase nearly 36 billion but could be offset by payroll taxes paid by employers and premium contributions employers paid by individuals. National health expenditures would increase by about \$5 billion. 	<ul style="list-style-type: none"> • Depends on the state run public sponsor. • Expansion of coverage improves quality of care for previously uninsured.
Individual Mandates	<ul style="list-style-type: none"> • Theoretically, all individuals would be covered by health insurance because they would be required to purchase coverage. 	<ul style="list-style-type: none"> • Costs for employers and the government would decline as individuals would assume responsibility for purchasing coverage. Reductions in government spending would be offset by increased individual tax credits. 	<ul style="list-style-type: none"> • Individuals may not have proper information to choose the most cost-effective health plan. • Expansion of coverage improves quality of care for previously uninsured.
National Health Insurance	<ul style="list-style-type: none"> • All Americans would be covered by health insurance. Under an all payer system, the previously uninsured would be covered by a public plan (possibly Medicare), while under a single payer system, all Americans would be covered by the same publicly sponsored system. 	<ul style="list-style-type: none"> • Cost estimates are diverse. Under a single payer system, estimates range from a decline in national health expenditures of \$26 billion annually to an increase in national health expenditures of \$30 billion annually. Wide variation among estimates is due to different assumptions regarding administrative costs and the level of health care utilization by the previously uninsured. 	<ul style="list-style-type: none"> • Fewer choices may be available to health care consumers. • Queues may form for selected procedures. • Quality will depend upon the financing and administration schemes chosen. • Expansion of coverage improves quality of care for previously uninsured.

Sources: See references.

insurance voucher at a state agency. In 1990, there were 11 million uninsured nonelderly Americans with income that would qualify for the full tax credit and an additional 6.5 million with income between the threshold and 150 percent of the threshold. These individuals, as well as the 5 million others in low-income groups who currently purchase nongroup insurance, could take advantage of the expanded credits. Participation in the

tax credit program would depend on the ease of application and the awareness of the eligible populations.

Reorganization of Health Care Financing and Delivery

Proposals to reorganize the health care financing and delivery system would fundamentally change these

functions by expanding the public sector's role, requiring employers to offer health insurance, or shifting responsibility to individuals. These types of proposals include public program changes, employer mandates, play-or-pay employer mandates, managed competition, and individual mandates. Many of these proposals would create a single payment schedule for health care services while retaining the present public-private mix in financing.

Public Program Changes—Reform of public health programs would extend coverage to additional population groups and/or enhance the benefits of individuals already covered. Generally, public program expansions would improve coverage under Medicare by reducing age limits or under Medicaid by eliminating or altering categorical eligibility requirements to allow families with higher income levels to participate (table 1). Current Medicaid expansion proposals are often used in conjunction with other reform measures such as employer mandates or play-or-pay proposals. Because 60 percent of the uninsured live in families with income below 200 percent of the federal poverty level, expanding public health programs for low-income families could reach many of the neediest uninsured. EBRI simulated the effects of an illustrative Medicaid expansion proposal that would cover all individuals in families with income below the poverty level and allow individuals in families with income between the poverty level and twice the poverty level to purchase Medicaid coverage on a sliding scale. To determine such a plan's maximum possible impact, it was assumed that all those eligible for coverage would enroll and that Medicaid coverage would still be secondary to all other sources of health insurance. The analysis estimated that the number of uninsured individuals would decrease by 21 million (table 2).

Employer Mandates—These proposals would require employers to provide health insurance to all employees (and pay a portion of the cost) or provide coverage only to employees working a minimum number of hours. Mandates attempt to provide coverage to the 85 percent of the uninsured who live in families with at

least one worker. Employer mandates vary according to the employers that are required to participate, classes of employees covered, and length of time allowed to comply with provisions (table 1). EBRI simulated the effects of an illustrative employer mandate, assuming that employers would be required to offer health benefits to all employees who worked more than 19 hours or 25 hours a week. Two simulations were performed, one in which employers with fewer than 25 employees were exempt and one that applied to all employers. Requiring all employers to provide health benefits (to employees working more than 19 hours per week) would decrease the number of uninsured individuals from 36 million to 10 million (table 2).



Pay-or-play proposals are designed to expand employer-provided health insurance without unduly burdening small employers.



Play-or-Pay Employer Mandates—Proposals that allow employers either to provide health insurance to their employees or contribute a percentage of their employees' wages to a public health insurance plan are called play-or-pay. These proposals are designed to expand employer-provided health insurance without unduly burdening small employers. Small employers (and others) would be able to enroll employees in the public plan rather than provide coverage directly, thereby limiting their health insurance costs to a specific percentage of payroll. Estimates of changes in health insurance coverage and costs of such a plan vary depending on the behavioral assumptions chosen. Recent analysis by the Urban Institute found that, with a 9 percent payroll tax, nearly 40 percent of nonelderly Americans would be enrolled in the public plan, and under a 7 percent payroll tax, 52 percent would be

Table 2
**Changes in Health Insurance Coverage and Health Care Spending
 Resulting from Alternative National Health Insurance Proposals**

	Employer Mandate ^a	Play-or-Pay Employer Mandate ^b	Medicaid Expansion ^c	Employer Mandate and Medicaid Expansion ^d	Individual Mandates ^e	Universal Public Plan ^f	Small Group Insurance Market Reform ^g
Number of Previously Uninsured Who Would Gain Coverage	12–26 million	33–36 million	12–21 million	about 28 million	36 million	36 million	0–14 million
Percentage of Previously Uninsured Who Would Gain Coverage	35%–75%	100%	35%–60%	about 80%	about 100%	100%	0%–39%
Increase in National Health Expenditures	↑ \$10–\$15 billion	↑ \$49–\$90 billion	↑ \$10–\$15 billion	↑ \$12–\$20 billion	unclear	↓ \$26–↑ \$30 billion	unclear
Cost to employers	↑ \$12–\$86 billion	↑ \$30–\$45 billion	↓ \$ 5 –\$0 billion	↑ \$ 8–\$26 billion	↓—unchanged ^h	↓ ⁱ	↑ ^j
Cost to government	↓ about \$8 billion	↑ \$18–\$37 billion	↑ \$26–\$33 billion	↑ \$ 9–\$32 billion	↓ \$4–↑ \$20 billion	↑ ^k	↑ ^l
Cost to individuals	↓ \$5–\$14 billion	↑ \$ 1–\$8 billion	↓ \$10–\$14 billion	↓ \$ 8–\$22 billion	↓ \$19–↑ \$5 billion	unclear ^m	unclear

(continued)

enrolled in the public plan. EBRI analysis found that between 33 percent and 51 percent of all Americans would be enrolled in the public plan if the payroll tax were set at 9 percent.

Managed Competition—Although this type of plan has features that make it similar to combinations of employer mandates and a Medicaid expansion, it is fundamentally different because of the role of the public sponsor in managing competition and the limit on the amount of employer contributions excludable from employees’ income. For example, such a plan could require employers to provide health insurance to all full-time employees and pay an 8 percent payroll tax for all employees not covered under the plan. Individuals not covered by an employment-based plan would have the option of purchasing affordable coverage on an individual basis. Each state would have powerful incentives to create a public sponsor for people otherwise not covered through an employment-based plan (table 1). A Congressional Budget Office (CBO) analysis found that under this plan 22 million of the

uninsured would gain coverage through an employer, while the remaining 13 million uninsured would be eligible to purchase subsidized coverage from a public sponsor. The CBO analysis also estimated that in the first full year of implementation, total health care expenditures would increase by approximately \$15 billion.

Individual Mandates—These proposals would shift responsibility for obtaining health insurance from the employer to the individual. Advocates of this approach argue that individuals are unaware of the high cost of health insurance and health care services. If they were required to choose their own health plan, they would be likely to choose a cost-efficient plan and curtail their use of health care services. In order to equalize the tax treatment of health insurance, these proposals would expand individual tax deductions or credits for health insurance. This approach would sever the relationship between employment and health benefits. It would reduce public sector involvement by offering a public plan only for the very poor (table 1).

Table 2 (continued)

Sources: EBRI tabulations using the March 1991 Current Population Survey, Stuart M. Butler and Edmund F. Haislmaier, *Critical Issues: A National Health System for America* (Washington, DC: The Heritage Foundation, 1989); Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage*, and *Universal Coverage Using Medicare's Payment Rates* (Washington, DC: U.S. Government Printing Office, 1991); Richard Darman, Testimony, U.S. Congress, House, Committee on Ways and Means (10 October 1991); Doug Koopman, "Problems with a Single Payer Health System: Reassessing GAO's Study of Canadian Health Care," paper prepared for Rep. Richard K. Arney (R-TX), 1992; Jack Needleman, Judith Arnold, John Sheils, and Lawrence S. Lewin, *The Health Care Financing System and the Uninsured*, prepared for U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research (Washington, DC: Lewin/ICF, 1990); Sheila Zedlewski, *Expanding the Employer-Provided Health Insurance System: Effects on Workers and Their Employers* (Washington, DC: The Urban Institute, 1990); Sheila Zedlewski, Gregory P. Acs, Laura Wheaton, and Colin W. Winterbottom, *Pay or Play Employer Mandates: Effects on Insurance Coverage and Costs* (Washington, DC: The Urban Institute, 1992); U.S. Bipartisan Commission on Comprehensive Health Care, *A Call to Action, Final Report* (Washington, DC: U.S. Government Printing Office, 1990).

- ^aProposals require employers to provide health insurance to their employees. Variation in coverage and cost estimates are a result of proposals excluding certain employers or employees, differences in the basic benefits packages, and methodology.
- ^bProposals require employers either to provide health benefits to their employees or contribute to a public plan. Variation in cost and coverage estimates is related to the size of the payroll tax, the presence or absence of subsidies for small employers, and methodology.
- ^cProposals expand Medicaid to cover substantial portions of the poor. Variation in coverage and cost estimates is related to differences in the target population, differences in the basic benefit package, whether or not adjustments are made to provider reimbursement rates, and methodology.
- ^dProposals require employers to provide health insurance to their employees and expand Medicaid to cover substantial portions of the poor. Variation in coverage and cost estimates is related to the employers and employees excluded, differences in the basic benefits package, differences in the target population, whether or not adjustments are made to provider reimbursement rates, and methodology.
- ^eProposals shift responsibility for obtaining health insurance from the employer to the individual. Variation in cost estimates is related to whether the government sponsors risk pools for the uninsurable, the size and availability of tax credits for individuals, whether or not employers are required to increase wages and salaries to offset reductions in health benefits, and methodology.
- ^fProposals call for the establishment of a single national health insurance system. Variation in cost estimates is related to differences in the basic benefits package, administrative costs, utilization changes, and methodology.
- ^gChanges in coverage and costs as a result of small group insurance market reform are difficult to measure because they require behavioral assumptions about small employers. The maximum number who would gain coverage is 14 million (the number of individuals in families whose family head works for a small employer).
- ^hEmployer expenditures under an individual mandate may be unchanged if the proposal requires employers to increase employees' wages and salaries by the amount previously paid for health benefits and may decline if there is no such provision.
- ⁱAggregate employer costs are likely to decrease because employers would no longer be directly providing coverage. However, a universal public plan is likely to require employers to contribute to the plan either through payroll taxes or maintenance of effort.
- ^jHealth insurance costs of small employers are likely to increase as the number of small employers providing coverage increases.
- ^kMost public plan proposals would shift financing responsibility to the government.
- ^lGovernment costs would increase if insurance subsidies were provided to small firms.
- ^mUniversal public plan proposals generally have limited cost sharing. Direct out-of-pocket costs and premium contributions are likely to decrease, while tax liability attributable to government-sponsored health coverage is likely to increase.

National Health Care Systems

A final set of proposals call for a uniform national health care system financed and administered by federal (or state) government. **These proposals vary according to their financing mechanisms, distribution of federal versus state administration, and the role of public-versus private-sector delivery of health care services but are similar in that they envision a national**

system. All participants would gain access through the same or similar mechanisms, regardless of job status, income, and age (table 1). Estimates of the cost of implementing a national health insurance system vary substantially, ranging from a decline in national health spending of \$26 billion to an increase of \$30 billion (table 2). Differences are primarily related to different assumptions regarding administrative cost savings and utilization increases by the uninsured population.

Health Care Reform: Tradeoffs and Implications

◆ Introduction

Health care costs have been increasing at twice the rate of general price inflation for more than a decade. Thirty-six million Americans lack health insurance, which limits their access to health care services. Studies indicating that between 10 percent and 30 percent of selected procedures are inappropriately or unnecessarily performed have caused concern about the quality of care Americans receive (Rustuccia et al., 1984). Aggregate measures of health, such as life expectancy and infant mortality, are no better in the United States than in other countries that spend much less per capita on health care.

The health care reform debate centers on the idea that health care expenditures are growing too fast, and at the same time a significant proportion of Americans lack access to the health care delivery system. This perception has led to a number of proposals for reform. This *Issue Brief* describes various proposals that have been offered to reform the health care delivery system, examines estimates on how each proposal would affect the coverage, costs, and quality of health care, and attempts to place each proposal in the context of the tradeoffs inherent in health care reform. It begins with a general discussion of these tradeoffs.

◆ Tradeoffs in Health Care Reform

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. In addition, the services provided are not produced at minimum cost. There is considerable disagreement over the remedy for this market failure. **Proposals for health care reform occupy almost every point along the spectrum from essentially fine-tuning the current health care delivery system by changing tax or regulatory policy to**

abandoning the private market and adopting a national health care delivery system. One of the fundamental issues in health care reform is whether the market for health care services can meet society's objectives for access, quality, and costs of health care.

Even when a market works perfectly, it usually excludes some segment of the population because of their low income. If access to health care is a right, as many have asserted, then those excluded from the market for health care services must be given the means to obtain some minimum level of care. It is often said that the United States is the only industrialized country that does not provide some degree of health care access to all citizens, but the United States does provide a minimal level of health care, which, for some, means emergency care for preventable illnesses. However, many believe that the minimum level is unacceptably low and that the costs of the care provided are not borne equitably.

The health care delivery system is actually composed of several distinct interconnected markets. The market for health insurance affects the market for health services in many ways, including altering the price of health services paid by consumers. **One of the causes of health care cost inflation has been the increased demand for health care services induced by the presence of health insurance.** The favorable tax treatment of health insurance has in turn increased the incidence of health insurance coverage.

Conversely, altering the incentives to purchase health insurance, for example, by including the value of employer-provided health benefits in taxable income, explicitly imposes tradeoffs on society. Individuals may rationally choose not to purchase health insurance, given its costs and their own estimation of risks. If one of these individuals subsequently experiences a catastrophic health care problem requiring services he or she cannot afford, should society provide that care? If so, how should that care be funded?

Ultimately, every system for financing and delivering health care services must involve tradeoffs. Dollars spent on health care are unavailable for national defense, education, or private and public investment. Money saved by forcing a 75-year-old person to live in discomfort waiting for care may be spent on prenatal care, defense, education, or infrastructure. Barriers limiting the access to care for workers and their families may increase the costs of production and slow economic growth. Limiting access to medical technology and slowing the diffusion of innovations may result in preventable suffering and death.

Choices for Employers and Employees

Health insurance costs in the private sector are not currently distributed equally among all payers. The cost of employer-sponsored health insurance depends on the characteristics of the employers' work force, risk factors attributed to the industry, and the local health care service market. There are significant differences in average costs among industries and between large and small employers. Health insurance for small firms may cost more because of higher administrative costs and insurers' reduced ability to pool risks.

Health expenditures represent an increasingly large component of employee compensation, public budgets, and individuals' disposable income. The employer share of national health expenditures has remained virtually constant since 1980, but national expenditures for health have grown faster than income. As a result, health benefits as a percentage of compensation (averaged over all workers whether they receive health benefits or not) have grown from 4.4 percent in 1980 to 6.4 percent in 1990 (Bureau of Economic Analysis, 1992). Although more employers today require employee contributions to group health plan premiums than they did 10 years ago and deductibles are higher and copayments more common, individual health spending as a share of adjusted personal income has increased by only 0.9 percentage points since 1965. Of course, the increase in health care as a component of total compensation means that employees bear at least

some of the costs attributed to employers in the form of lower wages or lower levels of other benefits.

These considerations have led many to argue that tying the financing of health care to the labor market results in an inequitable distribution of both benefits and costs. Presently, 64 percent of Americans under age 65 receive health insurance through an employer- or union-sponsored plan (Employee Benefit Research Institute, 1992). Separation from the labor market, either through job loss or divorce or death, may result in the loss of health insurance coverage. Individuals without health insurance are predominantly nonworkers, self-employed, workers in small establishments, or persons in families headed by a member of one of these groups. Moreover, if employees with health insurance coverage are reluctant to change jobs because of concern about health insurance, they may forgo opportunities that would increase their productivity. A number of health care proposals have suggested that both the costs and benefits of health care services could be more equitably distributed if the relationship between health insurance and employment were severed.

Actions by Public and Private Payers

Although the proportion of the total health care bill paid by governments has remained essentially constant since the implementation of Medicare and Medicaid, the share of public budgets consumed by health care continues to grow because public budgets have remained relatively fixed as a proportion of the Gross National Product while health care expenditures have increased. The increase in the proportion of public budgets consumed by health care expenses suggests that increases in public spending are occurring at the expense of other public expenditures such as infrastructure and education.

The absence of national health care reform does not imply a static health care delivery system. **Public and private purchasers are independently developing and implementing cost management strategies that could potentially have profound effects on the cost, access,**

and quality of health care services. Changes in the way that Medicare reimburses physicians, which began to be implemented in 1992, may alter the willingness of physicians of different specialties to accept Medicare patients and thus alter the type of treatment available. Both public and private payers are refining and implementing utilization management procedures that may alter incentives to providers and consumers. Private payers are beginning to selectively contract with providers in the hope of encouraging cost-effective practice styles. While these changes have the potential to reduce the rate of health care cost inflation, they may also segment the market, further differentiating the care received by those with private health insurance, beneficiaries of public programs, and the uninsured.

Choices for Reforming the Health Care System

Proposals to reform the health care system have focused on costs and access to care. Reform proposals intended to reduce health care cost inflation have attempted either to correct flaws in the organization of health care financing and delivery or place an overall cap on costs or prices. **Malpractice reform, small group insurance market reform, removal of regulatory barriers to managed care, and efforts to change the tax code are all intended to address specific problems. At the other extreme, a national health care system would create a single payer, which would essentially budget national health expenditures.** Between these extremes are a number of measures that would overlay some features of global budgeting on the present system or reform the system but retain a public-private mix in the financing and delivery of health care services.

Reform proposals or portions of reform proposals that attempt to increase access to care approach employment-based health benefits in different ways. Many attempt to build on the present system by expanding employment-based health benefits through either a mandate or tax incentives. Many of these proposals would also create a public program to cover the remaining uninsured. Conversely, other reform proposals would sever the link between health care and the work

place, replacing employer-sponsored health benefits with a public plan at one extreme or individually purchased health benefits at the other.



The costs of a transition to any proposed reform are potentially large.



The following section provides broad descriptions of the various health care reform proposals. Because specific proposals are extremely complex, space does not permit a detailed discussion of each one. In addition, the section describes the impacts of various health care reform proposals on coverage and costs. The analysis draws upon a variety of studies and EBRI's own estimates. Few of these studies have examined specific proposals, but rather they have modeled generic versions of proposal types. The studies provide order-of-magnitude effects rather than precise estimates of costs and benefits because the proposals themselves are so complex and the number of factors that would affect their impact is so large. However, the estimates are valuable in illuminating the tradeoffs inherent in enacting any of the reform proposals.

Most quantitative analyses examine the impact of the reform proposals as if all elements of a reform would be implemented immediately rather than focusing on the dynamic effects that would result from systemic change. **The costs of a transition to any proposed reform are potentially large. Actual costs would depend on a number of factors, including the length of the transition period and the degree of change from the current system.** Most of the reform proposals do not spell out the details crucial to estimating the transition costs. As a result, all of the estimated impacts described below assume that a particular reform is implemented immediately.

Even ignoring transition costs, the impact of any reform on costs, quality, and access may be difficult to estimate because estimates must incorporate assumptions about the behavior of participants in the health care system. For example, expanding Medicaid would initially increase coverage among members of low-income families who were previously uninsured. However, it is possible that employers with a high concentration of low-wage workers would cease providing health insurance coverage to these workers because the majority of them could be covered by the expanded Medicaid program. Behavioral changes would also affect coverage under an employer mandate. Because labor costs for employers who previously did not offer health insurance would increase, some would be required to reduce the number of workers they employ or reduce wages.



Even ignoring transition costs, the impact of any reform on costs, quality, and access may be difficult to estimate because estimates must incorporate assumptions about the behavior of participants in the health care system.



At least 60 separate health care reform proposals were introduced in the first session of the 102nd Congress, and additional proposals continue to be introduced in the second session. In addition, trade associations, research organizations, academics, and other special interest groups have introduced proposals calling for reform of the U.S. health care delivery system. President Bush has joined the health care debate by proposing tax-based health care reform.

For this discussion, we have arrayed proposals in a spectrum according to the degree to which they would alter the structure of the current system. The report arbitrarily groups health care reform proposals into three broad types: incremental reform, reorganization of

health care delivery and financing, and national health care systems.

◆ Incremental Reform Proposals

Incremental reform proposals generally maintain the current delivery structure but make specific changes to improve the health insurance coverage of the 36 million uninsured Americans or reduce health care cost inflation. Included in this category are malpractice insurance reform, changes to COBRA, small group insurance market reform, and changing the tax treatment of health insurance.

Malpractice Insurance Reform

Critics of the American health care system often point to the number of medical procedures inappropriately or unnecessarily performed as a primary cause of escalating health care costs. Some of these procedures may be the result of physicians practicing defensive medicine in order to avoid malpractice claims. The cost of physician malpractice insurance averaged \$9,000 annually for a general practitioner and \$35,000 for obstetricians/gynecologists in 1988 (U.S. Congress, 1990). The high cost of insurance is related to the large awards for medical malpractice suits. **There are significant differences among malpractice insurance reform proposals, but generally they call for the development of alternative dispute resolution systems (i.e., arbitration or other processes outside of the judicial system), limits on awards in malpractice suits, limits on attorneys' fees, research on health outcomes, and/or the development of clinical practice guidelines.** For example, H.R. 1004 introduced by Rep. Nancy Johnson (R-CT) would provide grants to states that establish alternative dispute resolution systems. Orrin Hatch (R-UT) introduced separate legislation (S. 1123) that would limit noneconomic damage awards in malpractice suits to \$250,000.

Coverage and Costs—Advocates of malpractice insurance reform suggest that limiting awards in mal-

practice suits and instituting alternative arbitration systems would help control health care cost inflation (U.S. Congress, 1990). By reducing the cost of malpractice insurance, they argue that these reforms would reduce providers' overhead costs so that they could charge lower fees. In addition, advocates say such reforms would reduce the utilization of health care services as physicians' need to practice defensive medicine is reduced. **However, the number of health care services that are provided solely as a defense against malpractice suits has not been definitively determined, and it is unclear whether lower malpractice premiums would cause physicians to alter their practices.** Theoretically, lower health care costs would translate into lower insurance costs, which would facilitate health insurance coverage for individuals and small businesses. No studies have examined the changes in health insurance access that would occur as a result of medical malpractice insurance system reform. These types of reform proposals are not likely to substantially reduce national health care expenditures or change the distribution of costs among payers. However, such reforms could slow the rate of health care cost inflation to the extent that they reduce overutilization of health care services (U.S. Congress, 1990).

COBRA Changes

COBRA requires employers to allow employees and their dependents who would lose health insurance coverage due to job loss or change in marital status to remain in their group health insurance plan for a specified number of months.¹

COBRA expansion proposals would extend the number of months that an employer must allow employees to remain in the group plan and/or expand the eligible groups. Rep. Patricia Schroeder (D-CO)

¹Employers may charge former employees up to 102 percent of the premium. The number of months that a qualified beneficiary is eligible depends on the nature of the separation from employment-based coverage.

and Sen. Barbara Mikulski (D-MD) introduced legislation (H.R. 1116 and S. 514, respectively) that would extend COBRA eligibility to older individuals and lengthen the period of coverage for disabled beneficiaries. Some more comprehensive reform proposals, such as H.R. 2535 introduced by Rep. Henry Waxman (D-CA), call for the elimination of COBRA continuation-of-coverage requirements because of the costs they add to employer-provided health insurance. This legislation would reduce the need for COBRA, however, since it expands coverage and enhances benefit portability.

Coverage and Costs—A study of data from the National Medical Expenditure Survey found that 48 million Americans were uninsured at some point during 1987, but only 23 million were uninsured for the entire year. Individuals who are only temporarily uninsured may incur medical costs that they are unable to pay or that represent a catastrophic loss. Providing these individuals with a means to purchase group health insurance coverage may prevent some of this individual loss and reduce the burden of uncompensated care that falls on providers and other payers in the health care system (U.S. Department of Health and Human Services, 1992).

Using COBRA continuation coverage as a mechanism to extend coverage to the uninsured would have important cost consequences. The rationale for continuation-of-coverage mandates is to provide temporary coverage for individuals who lose coverage because of separation from employment-based insurance. Although nearly all employment-based health insurance plans pay part of the premium, few employers contribute an explicit amount toward the premium for separating workers. Many of those eligible for continuation coverage face significant increases in their out-of-pocket expenditures for health insurance if they elect COBRA coverage. Most of those eligible for COBRA coverage decline it, probably because of the cost. Those who request COBRA coverage have a higher risk of needing health care.

Estimates have shown that between 10 percent and 21 percent of those eligible for COBRA coverage actually participate. The average cost of providing coverage to individuals who elect COBRA is approximately 50 percent higher than the average cost of providing coverage to active employees (Spencer's Research Reports, 1991). However, employers may only charge 2 percent more than their average premium cost for employees choosing COBRA. As a result, the costs of providing COBRA coverage are borne by the employer and active employees in the plan.

Small Group Insurance Market Reform

The goal of small group insurance market reform is to restrict insurance practices that make it difficult for smaller firms to obtain insurance. Small groups often face higher costs per participant because of their higher per capita administrative cost and insurance companies' limited ability to pool risks. By removing barriers that prevent insurers from pooling small groups, employment-based coverage may expand to include many of the employed uninsured in small firms and their dependents (who constitute 39 percent of the nonelderly uninsured).



Most small group insurance market reform proposals include some means for guaranteeing that all small groups have access to insurance and are not denied coverage based on individual characteristics.



Although there are significant differences among small group reform proposals, there is agreement on some basic principles: small groups should be guaranteed access to insurance, restrictions on preexisting conditions should be limited, new restrictions should not be imposed when individuals change jobs or when

groups change insurers, coverage should not be canceled because of high utilization of services, insurers should be required to offer coverage to all small groups (if they offer insurance to any), premium rates should be stabilized, and policies should be renewable (except for reasonable cause such as nonpayment of premiums). Proponents of insurance market reform disagree on the means to achieve guaranteed access to insurance and on some of the measures needed to make such a guarantee work, including limits on premium rates and rate increases (George Washington University Health Policy Forum, 1991).

Most proposals include some means for guaranteeing that all small groups have access to insurance and are not denied coverage based on individual characteristics. However, proponents of insurance market reform recognize that guaranteed availability alone accomplishes little unless premium rates for small groups are stabilized. Without some limits, insurers could use rating practices to raise the cost of coverage for riskier groups until the price becomes so high that these groups choose not to purchase insurance. Some proponents suggest moving toward community rating so that insurance would be offered to all small groups at fixed rates. Others would allow insurers to adjust community rates for factors such as age, sex, geographic location, and industry type (class rating). Generally, proposals would limit medical underwriting and restrictions on preexisting conditions.

Premium limits are similar in proposals offered by the National Association of Insurance Commissioners (NAIC), the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA). The Bush administration proposal would also impose similar premium limits, but only on an interim basis. These proposals would allow insurers to use medical underwriting and factors such as claims experience, health status, age, and sex to set rates but only within permitted rate bands. Congressional proposals allowing limited medical underwriting include those introduced by Sen. Lloyd Bentsen (D-TX) (S. 1872), Sen. John Chafee (R-RI) (S. 1936),

Sen. Dave Durenburger (R-MN) (S. 700), and Rep. Nancy Johnson (H.R. 1565). Others, such as proposals by Sen. George Mitchell (D-MA) (S. 1227), Rep. Dan Rostenkowski (D-IL) (H.R. 3626), and Rep. Pete Stark (D-CA) (H.R. 2121), would instead impose community rating with limited adjustment allowed for age and sex differences.² **Some analysts argue that mandating community rating or eliminating demographic adjustments would raise rates for many groups and create adverse selection.**

Adverse selection occurs when individuals with greater health risks are disproportionately enrolled in a particular plan. **Community rating limits insurers' ability to charge different premiums to groups on the basis of risk because the premium charged under a community rating scheme would reflect the group's average risk.** As a result, premiums for groups that represent good health risks would rise with the implementation of community rating, while premiums for groups representing bad risks would fall. Some of the good risks would choose not to purchase health insurance as a result of the premium increase, while more of the bad risks would purchase health insurance. The result would be an increase in the pool's average risk, increasing premiums and potentially creating a vicious circle that would end with an unviable health insurance market. The likelihood of this scenario actually occurring depends on the sensitivity of the demand for health insurance to changes in premiums among good and bad risks and on the ability of individuals to determine their own risk status.

One mechanism for preventing adverse selection is to reinsure the poor risk by direct subsidization through a state risk pool. A number of proposals include measures that would encourage the creation of either public or private reinsurance pools to reduce the effects of

²The Mitchell bill calls for community rating within blocks of business with adjustment allowed for age and sex differences. Rates in the most expensive block of business may not exceed 120 percent of rates charged for a similar plan in the least expensive block of business.

adverse selection. These pools would allow individual insurance plans to cap the costs of the poorer risks, allowing them to offer premiums closer to those offered to good risks. Proposals introduced by the Bush administration, HIAA, Sens. Bentsen and Mitchell, and Reps. Johnson, Stark, and Rostenkowski either require or encourage the use of reinsurance pools. The Bush administration proposal would require states to implement two health risk pools: one for small group coverage and another for coverage provided to individuals and families receiving health insurance tax credits. Health plans covering a population that is less healthy than average would receive a net payment from the pool, while other health plans would be net payers into the pool.



Some analysts argue that mandating community rating or eliminating demographic adjustments would raise rates for many groups and create adverse selection.



Another issue addressed by most proposals is the guarantee that group policies cannot be canceled by the insurer due to changes in the health status of individuals in the group. Many carriers currently refuse to renew high-risk groups or only offer to renew policies at significantly higher rates. Some insurers charge low rates initially and then raise premiums substantially when small groups renew (durational rating). Small groups often change insurers frequently to avoid these increases. This process subjects small businesses to repeated medical underwriting and works against companies with less healthy employees by raising premiums even higher and constantly imposing new waiting periods for individuals with preexisting conditions. Other insurers use tiered rating to establish renewal rates for groups too small to be experience rated. Tiered rating sets renewal rates based on an

analysis of each enrollee who incurred high medical expenses and the likelihood of continued high expenses. Rating practices such as these have reduced the premium rates for some small groups but overall have increased segmentation in the small group market (George Washington University Health Policy Forum, 1991).

Most proposals would limit annual premium increases to eliminate durational rating. Industry advocates recommend that carriers limit premium increases to the rates established for new businesses plus an adjustment factor of up to 15 percent. However, congressional bills generally do not allow for such an experience adjustment and limit renewal rates to those established for new policies.

Coverage and Costs—Because nearly one-half of all uninsured workers are self-employed or working in firms with fewer than 25 employees, proposals of all types have included as part of their package a set of small group insurance market reform proposals. Small group reform advocates argue that small employers would purchase health insurance if it were offered at the right price. However, it is likely that at least some small employers would not be willing to purchase coverage in the absence of substantial federal or state subsidies.

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 current national proposals would, their goals are similar: to stabilize the cost of insurance to small businesses and distribute these costs more equitably. Previously uninsured small employers began to offer insurance to their employees during the enrollment phase of the demonstration projects. **However, only 17 percent of employers who previously did not offer 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.

State mandates (including benefit mandates, provider mandates, and coverage mandates) increase the cost of health insurance. One study found that without state mandates 16 percent of the small firms currently not offering health insurance would begin to offer a plan (Gable and Jensen, 1989). Some state legislatures have passed basic benefits laws that exempt small firms from state mandates in order to make health insurance more affordable for small firms. However, most of the laws were enacted in 1991, and their effectiveness in expanding access to small firms is not yet known. Oregon's basic benefits law, which has been in effect since 1989, facilitated the enrollment of 12,000 employees of small firms and their dependents by October 1991.

The effect of small group insurance market reform on national health expenditures will depend on the success of the program in increasing health insurance coverage. The removal of preexisting condition exclusions would make health benefits more portable and lower costs for some employers. However, restricting premiums by imposing community rating or limiting premiums within bands would likely increase some employers' costs. Many economists have found that subsidizing groups by altering prices is less efficient than subsidizing those same groups through a direct transfer of income (Feldman, 1987). However, the administrative costs of identifying those individuals needing an income transfer may outweigh the costs of an inefficient insurance market.

The development of reinsurance markets, or state risk pools to subsidize the insurance costs for poor risks may alleviate some concerns about restrictions on premiums. However, public and private reinsurance schemes distribute the cost burden differently. If a private reinsurance market develops, the costs of providing expanded access to poorer risks will be borne

by the purchasers of insurance. The premium paid by individuals and employers for health coverage will include the premium paid by insurers for the reinsurance of poorer risks. On the other hand, the burden of the costs of a public risk pool will depend on the financing mechanism for that pool. Most state risk pools are now financed by state insurance premium taxes. Employers who self-insure are exempt from these taxes under the Employee Retirement Income Security Act of 1974 (ERISA). As a result, the cost of risk pools is borne by individuals and employers who purchase commercial insurance. A major reform proposal would presumably spread the costs of the risk pool in a different manner, perhaps by financing through general revenues. Most proposals do not specify any financing mechanism for reinsurance pools.



Most tax-based approaches (to reform) focus on limiting the exclusion of employer contributions to health insurance from workers' taxable income and expanding individual tax credits.



The Bush administration's health care reform proposal would also create health insurance networks (HINs) that would allow small employers to band together to purchase health insurance. Although HINs would be similar to multiple employer welfare associations (MEWAs), ERISA pre-emption would be extended to HINs, whereas it is not to MEWAs. The result of such pre-emption would be exemption from state mandated benefit laws, state health insurance premium taxes, and state laws that restrict the use of managed care. Adverse selection is a potential problem with HINs. The extent to which small groups with good risks could obtain lower premiums outside of HINs depends on a number of factors, including state regulation and taxes, the structure of the premium bands enacted as part of a

small group insurance market reform package, and the administrative costs associated with small groups.

It is not clear whether HINs with ERISA pre-emption would also participate in state administered reinsurance pools. If the HIN participants are included, then these risk pools would need to find other revenue sources than premium taxes in order to cover the reinsurance pool's total cost. Without more detailed information it is not clear how the incentives to participate in a HIN would be affected if participants are not eligible for the reinsurance pools.

Tax-Based Reform

The Bush administration and many members of Congress support fundamental changes in the tax code as the basis for comprehensive reform. 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 employers do not 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.

Rep. Bill Dannemeyer (R-CA) introduced a proposal (H.R. 3084) that would provide eligible individuals with a tax credit of up to \$2,000 (based on age) for health premiums. In addition, employer contributions to group health plans in excess of \$1,478 for individuals or \$3,695 for families would no longer be excluded from employees' gross income. Separate legislation (S. 1936) introduced by Sen. Chafee has similar tax credits coupled with specific coverage extension provisions but does not cap the employer contribution to group health

insurance. The bill would create a tax credit for health costs, including both premiums and direct expenditures, of \$600 for individuals and \$1,200 for families. Additional tax credits would be available for businesses offering health insurance and individuals using preventive services.

Coverage and Costs—No specific analysis has been done to determine how changes in the tax treatment of health benefits would affect coverage. A number of attempts have been made to estimate the effect of limiting the amount of employer contributions to health insurance that is excluded from employees' taxable income. An HIAA analysis of such a proposal issued by the U.S. Department of the Treasury found that the effect of such a cap on individual taxable income would vary by region, firm size, and income (Health Insurance Association of America, 1985). For example, a worker earning \$15,000 in a small firm in Los Angeles with fully

employer paid insurance would have to pay an additional \$718 in federal income and Social Security taxes under the proposal—a 36 percent increase in tax liability under 1985 tax law, compared with a 17 percent tax increase for higher earners (table 3).

EBRI used its Tax Estimation Analysis Model (TEAM) to estimate the impact of capping tax-exempt employer contributions to health plans at \$2,940 for family coverage and \$1,080 for individual coverage. The analysis found that the imposition of a tax cap would be regressive in the sense that lower income filers would pay a larger percentage of their income than higher income filers toward the new tax (table 4).

Along with shifting the distribution of the tax burden, capping the tax exemption of employer contributions to qualified health plans would also generate additional

Table 3
Estimated Tax Increase If All Employer Contributions to Health Insurance Were Included in Employees' Taxable Income, 1985

City	Size of Group and Employer Contribution	Annual Cash Wage			
		\$15,000		\$35,000	
		Increase in Taxes ^a	Percentage Increase	Increase in Taxes ^a	Percentage Increase
Los Angeles	2–9 employees, employer pays all	\$718	36%	\$1,042	17%
	2–9 employees, employer pays 75%	409	21	612	10
	500 employees, employer pays all	267	14	407	7
Chicago	2–9 employees, employer pays all	430	22	642	10
	2–9 employees, employer pays 75%	204	10	312	5
	500 employees, employer pays all	180	9	276	4
New York ^b	2–9 employees, employer pays all	365	19	552	9
	2–9 employees, employer pays 75%	161	8	246	4
	500 employees, employer pays all	170	9	260	4

Source: Health Insurance Association of America, *The Case Against the Taxation of Employee Health Benefits* (Washington, DC: Health Insurance Association of America, 1985).

^aBased on federal income and Social Security taxes for a family of four with no other income. In 1985, the total of such taxes are \$1,971 for the \$15,000 wage earner and \$6,256 for the \$35,000 earner, excluding any tax on health benefits. Itemized deductions were assumed to be the greater of \$3,540 or 23 percent of adjusted gross income. Increases in state income taxes were not included.

^bIncludes only the Manhattan area.

Table 4
Distribution of the Tax Burden If Employer Contributions to Health Coverage above \$1,080 for Individual Plans and \$2,940 for Family Plans Were Included in Employees' Gross Income, by Income Level, 1991

Income	Average Adjusted Gross Income per Return ^a	Average Change in Taxes per Return ^b	New Taxes as a Percentage of Income per Return ^c
Total	\$ 28,515	\$ 272	0.95%
Less than \$5,000	403	9	2.16
\$5,000–\$19,999	12,820	249	1.94
\$20,000–\$29,999	26,218	329	1.25
\$30,000–\$49,999	41,317	478	1.16
\$50,000–\$99,999	70,204	766	1.09
\$100,000–\$199,999	144,651	858	0.59
\$200,000 or More	455,213	957	0.21

Source: Employee Benefit Research Institute Tax Estimation Analysis Model, 1992.

^aIncome before taxes in 1991.

^bAverage increase in taxes per return as a result of imposing a cap on tax-excluded employer contributions to health insurance at \$1,080 for individual plans and \$2,940 for family coverage.

^cAverage increase in taxes divided by average income class of the income group.

federal revenue. The greatest increase would occur among taxpayers with annual incomes of \$50,000–\$100,000—\$29.3 billion in additional taxable income. This compares with \$228 million in additional taxable income among taxpayers with annual incomes of less than \$5,000 (table 5). EBRI also used TEAM to estimate increases in federal tax liability resulting from an annual cap of \$6,000 for family coverage and \$2,400 for individual coverage. The largest increase in taxable income would again occur among taxpayers with annual incomes between \$50,000 and \$100,000 (\$20.4 billion), followed by taxpayers with annual income between \$30,000 and \$50,000 (\$18.0 billion) (table 5).

President Bush's Health Care Reform Proposal—In addition to reforming the small group health insurance market, President Bush's health care proposal

calls for changes in the taxation of health benefits.

The administration proposal would create a refundable tax credit of up to \$3,750 for families and \$1,250 for individuals for the purchase of health insurance. In practice, the credits would function as payment vouchers to be used by recipients to purchase private health insurance (subject to certain conditions) so that, in effect, the credit would be taken by the state, not the individual. Individuals with income below a threshold defined in the proposal would be eligible for the full credit, while those with income between the threshold and 150 percent of the threshold would receive a partial credit.³

Under the Bush administration proposal, eligible individuals would receive a health insurance voucher at a state agency. In 1990, there were 11 million uninsured nonelderly Americans with income that would qualify for the full tax credit and an additional 6.5 million with income between the threshold and 150 percent of the threshold.⁴ These individuals, as well as the 5 million individuals in low-income groups who currently purchase nongroup insurance, could take advantage of the expanded credits (table 6).

States may also encourage low-income families that would have previously gained coverage through Medicaid to take advantage of the voucher program. Participation in the tax credit program would depend on the ease of application and the awareness of the eligible populations. Separate analysis by the CBO found that 98 percent of previously uninsured tax units would be eligible for either the tax credit or the tax deduction (Reischauer, 1992). Among all tax units, 47 percent would be ineligible for either the credit or the deduction for health care services, either because their income exceeded the threshold or because they were

³The proposal defines the poverty level as the income level at which a family begins to pay income tax.

⁴These estimates are calculated using family income, family size, the standard deduction, and exemptions. Other individuals may also qualify for the full credit depending upon their individual situations.

Table 5
Estimated Impact of Capping Tax Exempt Employer Contributions to Health Insurance on Federal Tax Liability, by Income

Income	Taxable Returns			Adjusted Gross Income			Taxable Income			Total Change in Tax Liability (\$ millions)
	Number of Returns (thousands)	Current law	After tax cap	Current law	After tax cap	Change	Current law	After tax cap	Change	
\$1,080 for Individual Coverage and \$2,940 for Family Coverage										
Total	134,077	88,007	88,752	\$3,703,517	\$3,823,203	\$119,686	\$2,533,209	\$2,623,154	\$89,945	\$36,494
<\$5,000	35,763	1,116	1,193	12,578	14,415	1,837	8,815	9,043	228	311
\$5,000-<\$10,000	14,503	8,445	8,554	113,513	115,877	2,364	22,928	24,054	1,126	549
\$10,000-<\$15,000	13,028	9,634	9,731	166,741	171,005	4,264	61,026	64,142	3,117	1,272
\$15,000-<\$20,000	11,459	9,974	10,272	204,788	212,956	8,168	103,249	109,412	6,163	2,566
\$20,000-<\$30,000	17,801	17,395	17,556	446,806	466,708	19,902	268,589	283,785	15,196	5,856
\$30,000-<\$50,000	21,879	21,812	21,814	868,417	903,985	35,568	593,806	619,729	25,923	10,458
\$50,000-<\$100,000	15,950	15,942	15,943	1,081,556	1,119,751	38,196	800,455	829,725	29,271	12,220
\$100,000-<\$200,000	2,779	2,775	2,775	394,981	401,986	7,005	311,814	318,311	6,498	2,385
\$200,000 +	915	914	914	414,138	416,520	2,382	362,529	364,952	2,423	876
\$2,400 for Individual Coverage and \$6,000 for Family Coverage										
Total	134,077	88,007	88,536	3,703,517	3,783,654	80,137	2,533,209	2,594,888	61,679	24,830
<\$5,000	35,763	1,116	1,151	12,578	13,873	1,295	8,815	8,968	154	201
\$5,000-<\$10,000	14,503	8,445	8,520	113,513	115,167	1,654	22,928	23,662	734	376
\$10,000-<\$15,000	13,028	9,634	9,693	166,741	169,504	2,763	61,026	63,026	2,001	828
\$15,000-<\$20,000	11,459	9,974	10,173	204,788	210,272	5,484	103,249	107,368	4,119	1,744
\$20,000-<\$30,000	17,801	17,395	17,553	446,806	460,479	13,674	268,589	279,040	10,452	4,088
\$30,000-<\$50,000	21,879	21,812	21,814	868,417	892,309	23,892	593,806	611,765	17,959	7,052
\$50,000-<\$100,000	15,950	15,942	15,943	1,081,556	1,106,873	25,317	800,455	820,825	20,370	8,391
\$100,000-<\$200,000	2,779	2,775	2,775	394,981	399,620	4,639	311,814	316,165	4,352	1,598
\$200,000 +	915	914	914	414,138	415,648	1,510	362,529	364,068	1,539	552

Source: Employee Benefit Research Institute Tax Estimation Analysis Model, 1992.

Table 6
Eligibility of the Nonelderly Population for Various Levels of Assistance under the Bush Administration Health Care Reform Proposal,^a 1990

	Sources of Coverage under Current Law				
	Total	Uninsured	Total (non Medicaid) insured	Individually purchased private	Medicaid recipients who may switch to credits
			(thousands)		
Total Nonelderly Eligible for Expanded Health Insurance Deductions or Credits ^b	215,909	35,745	158,596	19,736	21,568
No Deduction or Subsidy	169,126	34,420	134,705	17,249	21,403
Deduction or Subsidy	46,774	1,280	45,495	2,451	na
Eligible for Full Credit (below tax threshold)	17,866	11,083	6,783	3,031	15,352
Single	3,208	2,070	1,139	690	1,039
Married couple ^c	3,346	1,961	1,385	703	2,713
Family ^d	11,312	7,052	4,260	1,637	11,600
Eligible for Partial Credit (100%– 149% of the tax threshold)	16,261	6,453	9,808	2,081	2,957
Single	1,865	981	884	377	319
Married couple ^c	2,758	1,144	1,614	475	492
Family ^d	11,639	4,327	7,312	1,230	2,145
Eligible for the Minimum Credit or Full Deduction	123,104	16,273	106,831	11,199	2,976
Single	16,428	3,389	13,039	1,780	269
Married couple ^c	24,401	3,227	21,174	2,667	460
Family ^d	82,276	9,657	72,618	6,752	2,246
Eligible for the Minimum Credit or Partial Deduction	11,894	611	11,283	937	119
Single	1,366	77	1,289	87	3
Married couple ^c	3,046	117	2,928	232	5
Family ^d	7,483	417	7,066	618	111

Source: Employee Benefit Research Institute tabulations of the March 1991 Current Population Survey.

^aThe proposal would provide all individuals in families with income below the tax threshold line with a credit equal to \$1,250 for single persons; \$2,500 for married couples (and other two-person families); and \$3,750 for families with three or more members. The credit would be reduced for those individuals with income between the tax threshold and 150 percent of the tax threshold. Individuals in families above this level would be eligible for the minimum credit or a deduction also equal to \$1,250 for single persons; \$2,500 for married couples (and other two-person families); and \$3,750 for families with three or more members. The full deduction would only be available if family income were below \$40,000 for singles (partial deduction for income of \$40,000–\$49,999); \$55,000 for families with two members (partial deduction for income of \$55,000–\$64,999); and \$70,000 for families of three or more (partial deduction for income of \$70,000–\$79,999).

^bActual coverage would depend on the number of individuals taking advantage of the expanded credits or deductions. Low-income uninsured persons would be likely to utilize the credit. In addition, individuals in families below the tax threshold currently purchasing nongroup insurance coverage would be likely to utilize the credit. Finally, some states may enroll their entire Medicaid population in private insurance and utilize the credit rather than continue Medicaid. The extent to which individuals in families with higher levels of income would take advantage of the new deductions or credits depends on the cost of insurance in their area and their previous source of coverage. The numbers shown here represent the maximum number of nonelderly Americans who would be eligible for assistance under the Bush plan but does not estimate the extent to which these individuals would utilize the benefits.

^cIncludes all families with two members.

^dIncludes all families with three or more members.

already covered by a public health program such as Medicare or Medicaid.

This proposal raises several issues. The first is its impact on access to health care. Assuming that all individuals

eligible for the full credit take advantage of it, the question is how many of the remaining 23 million Americans not eligible for the full credit and presently uninsured would purchase insurance as a result of the incentives provided by a partial credit or deduction. The demand for health insurance among families with incomes between 100 percent and 150 percent of the poverty level will depend on the sliding scale that determines the amount of the credit they will be eligible for. For those above 150 percent of poverty, the value of the deduction is determined by their marginal tax rate. The effect on their demand for health insurance depends on how sensitive individuals are to changes in price. Estimates in the economic literature vary widely. For most uninsured families with incomes between 150 percent and 200 percent of the poverty level, the marginal tax rate is 15 percent, which means that the deduction would lower their health insurance costs by 15 percent. Even assuming very strong price sensitivity, which is unlikely for low-income families, fewer than 30 percent of those presently uninsured in this income group are likely to become insured solely because of the partial credit and deduction (Pauly, 1986). Therefore, of the 5.1 million uninsured who live in families with income between 150 percent and 200 percent of poverty, more than 3.5 million would remain uninsured. **It is unlikely that more than 7 million of the 23 million uninsured eligible for the partial credit or deduction would choose to purchase health insurance as a result of those incentives alone.**

A second issue is the burden of costs. Although the federal government would bear the responsibility for funding the tax credit, states would be required to create risk pools. These risk pools are an important component of both small group insurance market reform and coverage for those receiving the full credit. **Although in most areas of the country \$3,750 would purchase adequate health insurance coverage for most workers, the population eligible for the full credit (the poor) may have higher health risks than workers. If that is true, the state risk pools will bear the burden of these higher costs.** This change, coupled with changes in the calculation of the federal contribu-

tion to Medicaid, may result in a large shift of health care costs from the federal government to state governments.

A third issue is the effect of the proposal on health care cost inflation. **While the partial credit and deduction may be insufficient to induce the uninsured to purchase health insurance, it may represent a significant price decrease for those who already purchase health insurance.** These individuals may choose to purchase more insurance as a result. Twenty years ago, Martin Feldstien argued that one of the causes of health care cost inflation is the tax incentive to purchase too much insurance (Feldstein, 1973). To the extent that this is true, the administration proposal appears to exacerbate health care cost inflation.

◆ Reorganization of Health Care Financing and Delivery

The proposals to reorganize health care delivery and financing would require fundamental changes such as expanding the role of the public sector, requiring employers to offer health insurance, and/or shifting responsibility to individuals. These types of proposals include expanded public programs, employer mandates, play-or-pay proposals, and managed competition. Many of these proposals would create a single payment schedule for health care services while retaining the present public-private mix in financing. For example, H.R. 8, introduced by Rep. Mary Rose Oaker (D-OH) would allow states to set payment rates for health services provided by physicians and hospitals that would also apply to Medicare benefits. Some play-or-pay employer mandates, such as S. 1227, introduced by Sen. Mitchell, have included this aspect of national health care systems in their proposals. S. 1227 would arrange for negotiations between a national health care board and representatives of physicians and hospitals to set national reimbursement rates.

Even proposals for health care system reform that do not involve such a fundamental change of the health care delivery system require that some groups be made

worse off so that others may benefit. For example, mandated coverage changes the ability of employers and employees to find their optimal wage-benefit mix, thereby disrupting the labor market.

Public Program Changes

Reform of public health programs would extend coverage to additional population groups and/or enhance the benefits of individuals already covered. Each year between 1985 and 1990, Congress enacted legislation requiring states to extend Medicaid benefits to additional groups. Although the number and percentage of nonelderly individuals receiving Medicaid increased from 18.5 million (8.7 percent) in 1989 to 21.6 million (10.0 percent) in 1990, Medicaid still covers only about one-half of the nonelderly poor.

Generally, public program expansions would improve coverage under Medicare by reducing age limits or under Medicaid by eliminating or altering categorical eligibility requirements to allow families with higher income levels to participate.⁵ Legislation introduced by Rep. Rostenkowski (H.R. 3205) would expand Medicare eligibility to individuals aged 60–64. More comprehensive Medicare expansion proposed by Rep. Stark (H.R. 650) and Rep. Sam Gibbons (D-FL) (H.R. 1777) is examined under the national health care system section because it would cover the entire population under a national system. There are no proposals currently before Congress that would expand Medicaid further without making substantive changes to the health care system, because states are still struggling to finance the Medicaid expansion legislation passed in

the late 1980s. Current Medicaid expansion proposals have been introduced in conjunction with other reform measures such as employer mandates or play-or-pay proposals. However, many of the play-or-pay proposals choose to create a new public program rather than simply expand Medicaid because of the welfare stigma attached to Medicaid and the wide variation among state Medicaid programs. Also included in public program expansion would be increased funding for community-based health centers, rural health clinics, or school-based care.

Coverage and Costs—Because 60 percent of the uninsured live in families with income below 200 percent of the federal poverty level, expanding public health programs for low-income families could reach many of the neediest uninsured. Currently, Medicaid eligibility is linked to receipt of cash public assistance, and benefits are set (within federal guidelines) by each state. Federal law requires states to provide coverage to certain groups, including pregnant women and children in families with income below 133 percent of poverty and older children (up to age 9 in 1992) in families with income below poverty. Medicaid expansion proposals would eliminate categorical requirements for Medicaid eligibility, require medically needy programs, standardize income eligibility levels, and/or change the required benefits.

EBRI simulated the effects of an illustrative Medicaid expansion proposal that would cover all individuals in families with income below the poverty level and allow individuals in families with income between the poverty level and twice the poverty level to purchase Medicaid coverage on a sliding scale. To determine the maximum possible impact of such a plan it was assumed that all those eligible for coverage enroll, and that Medicaid coverage is still secondary to all other sources of health insurance, the number of uninsured would fall by 21 million individuals (table 7). An additional seven million individuals in low-income families who were previously covered by individually purchased plans may drop that coverage in favor of subsidized Medicaid. If employers with large numbers of low-wage workers

⁵Not all individuals in families below the poverty level are covered by Medicaid—only those who meet certain conditions. In general, Medicaid coverage is currently granted to all persons receiving cash public assistance such as Aid to Families with Dependent Children and Supplemental Security Income. In addition, pregnant women and children aged 6 or under whose family income is below 133 percent of the poverty level are eligible for Medicaid. Coverage is being phased in for children up to age 18 in families with income below the poverty level.

began limiting or eliminating their health benefits plans because of their employees' new eligibility for Medicaid, employment-based coverage could decline (and Medicaid coverage could increase) by as many as 21 million individuals.

These estimates represent the maximum number of people who would be affected. A number of factors might reduce the number of individuals who move into the Medicaid program. One factor is the perceived quality of care received by Medicaid enrollees. To the extent that Medicaid is perceived to provide a relatively low quality of care, people may be reluctant to enroll. Moreover, it is unclear how sensitive the demand for health insurance is to price decreases. **Clearly, not all individuals who lack health insurance would choose to purchase coverage if they received a 10 percent, 20 percent, or even an 80 percent subsidy.** Research literature has produced a wide range of estimates on the sensitivity of the demand for health insurance price changes, but even assuming a high level

of sensitivity, it would take a large subsidy to get large numbers of individuals to purchase coverage through the Medicaid program.

Another study analyzed the effects of extending Medicaid to all individuals in families with income below the federal poverty level (eliminating categorical eligibility); allowing individuals in families with income between the poverty level and 150 percent of the poverty level to buy into Medicaid; increasing the deduction for the self-employed to 100 percent; and enacting specific small group insurance market reforms (Advisory Council on Social Security, 1992). **The analysis found that 24 million additional residents would be covered under the expanded Medicaid program. An additional 3 million persons would gain coverage as a result of other provisions in the proposal.** About 13 million of those who would be covered by Medicaid were persons previously insured by another source of coverage during at least part of the year (table 8).

Table 7
Maximum Coverage under an Illustrative Medicaid Expansion^a for Families with Income above and below 200 Percent of the Federal Poverty Level, 1990

Source of Coverage	Before Enactment		After Enactment	
	Above 200% of poverty	Below 200% of poverty	Above 200% of poverty	Below 200% of poverty
	(millions)			
Total	148,258	67,649	148,258	67,649
Group Health Insurance	118,054	20,601	118,054	20,601
Individually Purchased				
Private Insurance	12,481	6,723	12,481	0
Medicaid	1,203	15,993	1,203	44,184
Medicare	797	1,835	797	1,835
CHAMPUS ^b	1,448	1,029	1,448	1,029
Uninsured	14,276	21,469	14,276	0

Source: Employee Benefit Research Institute tabulations of the March 1991 Current Population Survey.

^aThe illustrative option would cover all individuals in families with income below the poverty line and allow individuals in families with income between poverty and twice poverty to purchase Medicaid coverage on a sliding scale. The analysis assumes that all those eligible for coverage enroll and that Medicaid coverage remains secondary to all other sources of health insurance coverage.

^bThe Civilian Health and Medical Program of the Uniformed Services.

A third illustrative Medicaid expansion would cover all individuals in families with income below the federal poverty level, allow individuals with income between the poverty level and 200 percent of poverty to buy into the Medicaid program (with sliding premium

contributions), and maintain minimal copayments for beneficiaries (Congressional Budget Office, 1991).⁶ This analysis assumes that all eligible individuals choose to participate. Medicaid would continue as a secondary payer to employment-based plans and to Medicare as under current law. In practice, Medicaid would replace individually purchased private health insurance for those eligible because families would probably drop that coverage in favor of subsidized Medicaid coverage. The illustrative option would greatly expand the Medicaid program, becoming the primary payer for 40 million Americans, up from the current 15 million (table 9).

Table 8
Effects of an Illustrative Medicaid Expansion and Insurance Market Reform Proposal^a on Health Insurance Coverage, 1991

	Number Who Obtain Insurance		
	Total	Previously insured	Previously uninsured
	(thousands)		
Extend Medicaid to All below Poverty	12,158	6,324	5,834
Medicaid Buy-In through 150 Percent of Poverty	11,877	6,940	4,937
Insurance Market Reform	921	406	515
Eliminate State Mandated Benefits	2,314	1,100	1,214
Increase Self-Employed Deduction	181	90	91
Combined Impact	27,451	14,860	12,591

Source: Social Security Advisory Council, *1991 Advisory Council on Social Security, Commitment to Change: Foundations for Reform* (Washington, DC: U.S. Government Printing Office, 1991).

^aThe illustrative plan would encourage employment-based health insurance by increasing the deduction for the self-employed to 100 percent and providing small firms (with fewer than 25 employees) with a refundable tax credit for health benefits costs in excess of 5 percent of gross revenue. Categorical Medicaid requirements would be eliminated, and all individuals in families with income below poverty would receive Medicaid. Provider reimbursement for Medicaid patients would be increased to Medicare levels. A uniform Medicaid package (comparable to the median package now available) would be offered nationwide. Individuals with family income between poverty and 150 percent of poverty could buy into the Medicaid program (premiums phased in). There would be some cost sharing for those buying into Medicaid, including \$250 individual and \$500 family deductibles, 80 percent coinsurance (50 percent for mental health) but no cost sharing for prenatal or well child care. Insurance market changes include guaranteed issue and renewability, limits on pre-existing conditions, elimination of state minimum benefit laws, limits on premium variation, limitation of annual premium increases to 15 percent of the general cost trend, and reinsurance pools for high-risk individuals and small group policies.

Expanding the role of the public sector would affect national health expenditures and the distribution of costs among individuals, employers, and the government. The CBO estimated that national health expenditures would rise by \$13 billion if its illustrative Medicaid expansion were implemented (table 10). The largest increase in expenditures would be made by federal and state and local governments, which would spend an additional \$16 billion and \$9 billion, respectively. This would be offset by a \$10 billion decline in direct patient spending and a \$3 billion decline in private health insurance spending (Congressional Budget Office, 1991).

One factor contributing to perceived and actual problems with the quality of care provided to Medicaid enrollees is the relatively low reimbursement rates for providers. If a Medicaid expansion were to increase physician and hospital reimbursement rates, costs to the federal and state governments would be much higher. Currently, physicians treating Medicaid patients are reimbursed only 69 percent of the Medicare reimbursement for the same services, on average (Physician Payment Review Commission, 1991).

⁶The analysis provides estimates as of March 1990; these estimates do not reflect legislative changes that became effective after that date (including those in the Omnibus Budget Reconciliation Act of 1990).

Table 9
**Effects of an Illustrative Medicaid Expansion^a on
 the Sources of Health Insurance Coverage
 of the Total Population, 1989**

Source of Insurance	Before Enactment	After Enactment ^b	Change
		(millions)	
Total	246.3	246.3	0.0
Employment-Based Coverage	152.3	152.3	0.0
Individually Purchased			
Private Insurance	14.7	10.0	-4.7
Medicare	30.5	30.5	0.0
Medicaid	14.6	39.9	25.3
CHAMPUS ^c	0.8	0.5	-0.3
Uninsured	33.4	13.1	-20.2

Source: Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage* (Washington, DC: U.S. Government Printing Office, 1991).

^aThe expansion would cover all individuals with income below the federal poverty line and allow individuals with income up to 200 percent of poverty to buy into the Medicaid program. The analysis assumes that all eligible individuals participate and that Medicaid continues as secondary payer to employment-based plans and Medicare.

^bThese figures do not include the 6.8 million individuals who would get Medicaid coverage as a second payer to employment-based plans (4.3 million) or Medicare (2.5 million).

^cThe Civilian Health and Medical Program of the Uniformed Services.

Employer Mandates

Proposals for employer mandates would require employers to provide health insurance to all employees (and pay a portion of the cost) or provide coverage only to employees working a minimum number of hours. Mandates attempt to provide coverage to the 85 percent of the uninsured who live in families with at least one worker. Employer mandates vary according to the employers that are required to participate, classes of employees covered, and the length of time provided to comply with provisions. Because requiring employers to provide health insurance could burden small firms, employer mandates often exempt these employers, do not require them to contribute to the cost of coverage, or give them a longer time to comply with the legisla-

tion. Most proposals require employers to cover full-time employees, although the definition of full-time ranges from 17.5 hours per week to 30 hours per week.

Health care reform legislation often includes special provisions for small employers. For example, many proposals include elements of small group insurance market reform (which may reduce the cost of providing coverage). Legislation (H.R. 2535) introduced by Rep. Waxman and Sen. Jay Rockefeller (D-WV), (based on recommendations of the U.S. Bipartisan Commission on Comprehensive Health Care), would give small employers (with 5–24 employees) five years to comply with the legislation. If, within that time, at least 80 percent of small employers began providing coverage, the mandate would not affect the remaining firms.

Table 10
**National Health Expenditures before and after
 Enactment of an Illustrative Medicaid
 Expansion,^a 1989**

Source of Payment	Before Enactment	After Enactment	Change
		(\$ billions)	
Total	\$740	\$753	\$13
Private Insurance	238	236	-3
Government	321	347	26
Federal	220	236	16
Medicare	123	123	b
Medicaid	52	69	16
other	44	44	b
State and local	102	111	9
Medicaid	40	52	12
other	62	59	-3
Other	180	170	-10
Direct patient	149	139	-10
Other	31	31	b

Source: Congressional Budget Office. *Selected Options for Expanding Health Insurance Coverage* (Washington, DC: U.S. Government Printing Office, 1991).

^aThe expansion would cover all individuals with income below the federal poverty line and allow individuals with income up to 200 percent of poverty to buy into the Medicaid program. The analysis assumes that all eligible individuals participate.

^bLess than \$500 million.

In addition, the Mitchell bill (S. 1227) would not require new small businesses to provide coverage during their first two years of operation.

Coverage and Costs—Employer mandates, coupled with public program expansions, would change the current system more than other coverage extension proposals but would also improve health insurance coverage substantially. Mandating employment-based health insurance could improve access to health services for the 20 million working uninsured and their dependents. A number of researchers have analyzed the effects of an employer mandate on health insurance coverage.

EBRI simulated the effects of an illustrative employer mandate assuming that employers would be required to offer health benefits to all employees who worked more than 25 hours per week (for small employers) or 19 hours a week (for all employers). Two simulations were performed, one in which employers with fewer than 25 employees were exempt and one that applied to all employers. Requiring all employers to provide health benefits would decrease the number of uninsured from 36 million to 10 million (table 11). **Because many of the uninsured work for small firms, exempting employers with fewer than 25 employees would only reduce the number of uninsured to about 25 million.** The analysis assumes that there are no changes in employment as a result of a mandate, even though health benefits represent a significant component of total compensation (11 percent of payroll among employers who offer health benefits) (A. Foster Higgins & Co., 1992). Clearly, if a mandate were implemented without a transition period, so that other elements of total compensation (such as wages) could not adjust, the cost of labor would increase substantially, possibly causing some job loss.

EBRI simulated changes in employment that would occur as a result of mandating that all employers offer health benefits (wages and other elements of total compensation were held constant). The sensitivity of employer demand for workers to changes in the price of

Table 11
Coverage Effects of an Illustrative
Employer Mandate, 1990

	Number Covered under		
	Present system	Mandate large ^a	Mandate all ^b
	(millions)		
Total	248.9	248.9	248.9
Private			
Direct employer	71.2	86.6	117.7
Indirect employer	68.7	75.3	71.4
Other private	19.5	13.9	5.4
Public			
Medicare	31.4	30.6	29.2
Medicaid	17.2	15.5	13.3
CHAMPUS ^c	4.8	1.8	1.0
Uninsured	36.0	24.6	10.3

Source: Employee Benefit Research Institute simulation using March 1991 Current Population Survey.

^aThe mandate requires all employers with 25 or more employees to provide health insurance to employees working 25 or more hours per week.

^bThe mandate requires all employers to provide health insurance to employees working more than 19 hours per week.

^cThe Civilian Health and Medical Program of the Uniformed Services.

labor is crucial in this simulation. The EBRI analysis used a range of estimates of this sensitivity based on economic literature (Hamermesh, 1986).⁷ It should be noted that other values supported by the economic literature could be cited that would increase or decrease the estimated employment effects by large amounts. The other crucial assumption used in this simulation was the costs of the mandated health benefits. Without specifying the actual component services that would be covered, separate EBRI simulations were conducted using different estimates of the average annual cost of health benefits per individual employee: \$970, \$1,450, and \$2,430. The cost of each additional dependent was assumed to be 60 percent of the individual cost. Again, these estimates assume that wages and other benefits do not change as health benefits are added. Clearly, if

⁷The analysis used a price elasticity range of 0.30 to 0.05 for labor demand.

wages adjust, fewer individuals would become unemployed as a result of a mandate. This result indicates that workers would bear a large part of the costs of increased health care coverage achieved through an employer mandate.

EBRI's simulations estimated that between 200,000 and 1.2 million workers could become unemployed as a direct result of a mandate that employers provide health benefits to their employees. The higher estimates were the result of higher average costs of the mandated health plan and greater price sensitivity of the demand for labor.

Another simulation of the effects of employer mandates on health insurance coverage assumed that the mandate would require all employers to provide a broad package of benefits to employees (and their dependents) working 17.5 or more hours per week (Lewin/ICF, 1990). Small employers (with fewer than 10 employees) were modeled

as offering a low-cost catastrophic plan rather than a more costly basic benefits package, and employers with five or fewer employees would have five years to comply with the legislation. Employers would be required to pay at least 80 percent of the premium for employees (and their dependents) who earn more than 125 percent of the minimum wage and the full premium for employees earning less than that amount. Participation in the plan would be mandatory for employees who work 25 hours or more per week, while employees working fewer hours could decline coverage. The analysis assumes that workers will decline coverage only if the premium costs exceed 5 percent of their income. In this simulation, the mandate increases the number of workers with employment-based coverage by 30 million and the number of dependents with employment-based coverage by 18 million (table 12). The mandate would cover 26 million individuals who were previously uninsured and cause 24 million to switch sources of coverage (table 13).

Table 12
Effects of an Illustrative Employer Mandate^a on the Health Insurance Coverage of the Total Population, 1988

Characteristics of Individuals with Employment-Based Coverage under a Mandate	Total	Workers	Dependents
		(millions)	
Total	193.8	99.5	94.3
Individuals Already Covered by Employment-Based Plan	144.1	69.9	74.2
Individuals Who Become Covered under the Mandate	49.7	29.6	17.7
Dependents covered under existing plans ^c	2.4	b	2.4
Part-time workers covered under existing plans ^d	6.4	4.8	1.6
Workers in firms newly providing coverage	40.9	24.8	16.1

Source: Jack Needleman, Judith Arnold, John Sheils, and Lawrence S. Lewin, *The Health Care Financing System and the Uninsured*, prepared for U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research (Washington, DC: Lewin/ICF, 1990).

^aAll employers would be required to offer health benefits to employees working 17.5 hours or more per week. Small employers (with fewer than 10 employees) would only have to offer a low-cost catastrophic plan rather than the basic benefits plan. Participation is mandatory for those working 25 or more hours per week and voluntary for those working 17.5 to 25 hours per week.

^bNot applicable.

^cBecause the mandate would require employers to contribute 80 percent of the premium, the analysis assumes that all employees will elect the family coverage option if they have uninsured dependents.

^dThe analysis estimates that 65 percent of all part-time workers who do not have coverage on their own job work for a firm that offers its full-time employees coverage.

Table 13
**Persons Covered under an Illustrative Employer
Mandate^a by Source of Current Coverage, 1988**

Characteristics of Individuals	Covered by Mandate ^b
	(millions)
Total Affected by the Mandate	75.6
Total Covered under Newly Established Plans	49.7
Previous source of coverage	
insured	23.8
dependent children covered on own job	0.1
individually purchased private insurance	17.2
Medicare	3.1
CHAMPUS ^c /other government	1.1
Medicaid	5.3
uninsured	25.9
Workers and Dependents in Firms Required to Improve Benefit Package ^d	25.9

Source: Jack Needleman, Judith Arnold, John Sheils, and Lawrence S. Lewin, *The Health Care Financing System and the Uninsured*, prepared for U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research (Washington, DC: Lewin/ICF, 1990).

^aAll employers would be required to offer health benefits to employees working 17.5 or more hours per week. Small employers (with fewer than 10 employees) would only have to offer a low cost catastrophic plan rather than the basic benefits plan. Participation is mandatory for those working more than 25 hours per week and voluntary for those working 17.5 to 25 hours per week. The analysis assumes that all employees will elect the family coverage option if they have uninsured dependents. The analysis estimates that 65 percent of all part-time workers who do not have coverage on their own job work for a firm that offers its full-time employees coverage.

^bIndividual items do not sum to total because individuals may have had coverage from more than one source previously.

^cThe Civilian Health and Medical Program of the Uniformed Services.

^dIncludes firms where the plan must be modified to include the plan's minimum level of benefits and premium provisions.

The CBO analyzed the effects of a plan requiring all employers with 10 or more employees to extend coverage to employees (and their dependents) who work 25 hours or more per week (Congressional Budget Office, 1991). Employers would be required to pay at least 75 percent of the premium, and employees would be required to accept coverage and pay the remaining 25 percent of the premium. In addition, firms with fewer than 25 employees would be required to purchase

insurance through an insurance pool with community rated premiums. Although the plan would cover more than one-half of the currently uninsured, nine million individuals in working families would remain uninsured after the mandate presumably because the workers do not meet the requirements of the illustrative option (i.e., worked too few hours per week or worked for small employers) (table 14). Thirteen million individuals whose previous source of coverage was publicly sponsored insurance or an individually purchased private policy would also be affected by the mandate (table 15).

Under the CBO version of employer-mandated health insurance, total national health care spending would increase by the same amount as under their illustrative Medicaid expansion proposal (\$13 billion), but the distribution of these costs would be quite different (table 16). The change in total health care expenditures is relatively small because more than 40 percent of those newly covered by employment-based policies were already covered by another source (so that for them, the mandate would represent a switch from one type of coverage to another). In addition, since the currently uninsured use some health care services, the increase in their health spending would be less than the total cost of new coverage. Although the overall increase is small, expenditures are redistributed so that employment-based premiums increase by \$35 billion, and nongroup private premiums, government spending, and individual spending combined decline by \$22 billion. Most employers would not be affected by the mandate because they already offer insurance plans that meet its requirements. Many employers may be required to pay premiums for workers who would not have purchased coverage for themselves or their dependents in the absence of a mandate. Employers who did not offer insurance to their workers before the mandate would experience large increases in their total compensation costs, averaging about \$1,900 per employee. A large proportion of small employers would be affected by the mandate because 32 percent of workers in firms with 10–24 employees would gain coverage (Congressional Budget Office, 1991).

Table 14
**Characteristics of the Uninsured before and after an
 Illustrative Employer Mandate,^a 1989**

Characteristic	Before	After	Percentage Covered as a Result of Mandate
	Enactment	Enactment	
	(millions)		(percentage)
Uninsured	33.4	15.8	52.6%
Age and Sex			
Under age 18	8.5	3.5	59.1
Aged 18–24	6.4	3.0	52.3
Aged 65 and over	0.3	0.3	17.0
Women			
aged 25–34	3.3	1.5	55.2
aged 35–44	2.1	0.9	56.1
aged 45–54	1.7	0.9	47.6
aged 55–64	1.5	1.1	25.3
Men			
aged 25–34	4.6	2.1	53.3
aged 35–44	2.5	1.2	52.7
aged 45–54	1.5	0.7	53.6
aged 55–64	1.0	0.6	37.5
Family Income as a Percentage of Poverty			
0%–99%	9.6	6.0	37.8
100%–199%	10.6	4.8	54.8
200%–299%	5.9	2.3	61.4
300% or more	7.2	2.8	61.9
Race			
White	25.9	11.9	54.1
Black	5.8	3.2	45.6
Other	1.7	0.8	54.4
Family Structure			
Unrelated individual	6.0	3.4	43.4
Single parent family	9.1	5.1	43.3
Two-parent family	15.7	6.2	60.2
Childless couple	2.6	1.1	56.4
Family Work Status ^b			
Employed	26.8	9.2	65.6
Unemployed	2.0	2.0	0.0
Not in labor force	4.6	4.6	0.0

(continued)

Table 14 (continued)

Source: Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage* (Washington, DC: U.S. Government Printing Office, 1991).

^aThe mandate would require all employers with 10 or more employees to provide coverage to employees (and their dependents) who work 25 or more hours per week. Employers would be required to pay at least 75 percent of the premium, and employees would be required to accept coverage and pay the remaining 25 percent of the premium. Firms with fewer than 25 employees would be required to purchase coverage through an insurance pool with community rated premiums.

^bA family's work status is defined as follows: employed if either the head of household or the spouse is employed; unemployed if neither the head of household nor the spouse is employed and one or both are unemployed; and not in the labor force if neither the head of household nor the spouse is in the labor force.

trative employer mandate would increase spending by employers on employer-sponsored health benefits by \$33 billion to \$86 billion. The wide range between the estimates is related to assumptions about health plan costs. If employers with fewer than 25 employees were exempt from the mandate, spending would increase by \$12 billion to \$33 billion. Costs for employer-sponsored health benefits would also be redistributed. Workers who had previously been covered under another employer's plan would now be covered directly under their own employer's plan. For example, under a mandate with an average health plan cost of \$1,450 per individual employee and no employer size exemptions, about \$20 billion in costs would be redistributed from one employer to another. About 45 percent of these transferred costs (\$9 billion) would be redistributed to small employers. If small employers were exempt from the mandate, the total costs redistributed among all employers would be only about \$5 billion.

The question of whether uninsured workers and their families would be better off if health insurance were extended to them under a mandate centers on the issue of whether they are uninsured by choice. Do workers select jobs that do not offer health benefits in order to receive higher levels of cash compensation or

EBRI analysis also found that the cost of an employer mandate would be borne primarily by small employers and their employees. Using the same model described in the coverage section, EBRI estimated that an illus-

Table 15
**Workers and Dependents Affected by an
 Illustrative Employer Mandate,^a 1989**

Source of Coverage	Total	Workers	Dependents
		(millions)	
Total Number Affected ^b	30.6	15.0	15.6
Previously Uninsured	17.6	8.8	8.7
Previously Insured by			
Nonemployer source	13.1	6.1	6.9
Medicare	1.7	0.8	0.9
Medicaid	2.8	0.8	2.0
CHAMPUS ^c or other government	0.4	0.3	0.1
Individually purchased private insurance	8.2	4.3	3.9

Source: Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage* (Washington, DC: U.S. Government Printing Office, 1991).

^aThe mandate would require all employers with 10 or more employees to provide coverage to employees (and their dependents) who work 25 or more hours per week. Employers would be required to pay at least 75 percent of the premium, and employees would be required to accept coverage and pay the remaining 25 percent of the premium. Firms with fewer than 25 employees would be required to purchase coverage through an insurance pool with community rated premiums.

^bAn additional 3.1 million workers who already have group coverage would have to insure one or more dependents who are not covered under employment-based plans. These workers are not shown in this table as being affected by the illustrative mandate, but their newly insured dependents are counted.

^cThe Civilian Health and Medical Program of the Uniformed Services.

other benefits? If employees are choosing a total compensation package that does not include health benefits, any measure that forces them to accept a package with health benefits will make them worse off. However, society may benefit by forcing individuals to purchase health insurance. Individuals who choose to not purchase health benefits are gambling that they will not need health care services. They may make that bet knowing that care will be available to them in the case of a catastrophic event. Thus, society may bear at least a part of the risk that the individual chose not to insure against.

An employer mandate is essentially a payroll tax, although the burden of that tax is not distributed equally across all employees, employers, or consumers. Some of the costs of mandated health benefits would be passed on to employees in the form of lower wages, lower levels of other noncash benefits, or unemployment. Low-income workers would have less opportunity to trade wages for health benefits and would be more likely to experience the effects of an employer mandate in the form of unemployment. Some of the costs might be passed on to consumers in the form of higher prices. The remainder of the costs of a

Table 16
**National Health Expenditures before and after an
 Illustrative Employer Mandate,^a 1989**

Source of Payment	Before Enactment	After Enactment	Change
	(\$ billions)		
Total	\$740	\$753	\$13
Private Insurance	238	269	31
Employment based	222	257	35
Employer share	184	210	26
Employee share	38	46	9
Other	17	12	-5
Government	321	313	-8
Federal	220	215	-5
Medicare	123	120	-4
Medicaid	52	51	-1
Other	44	44	b
State and local	102	98	-4
Medicaid	40	39	-1
Other	62	59	-3
Other	180	171	-9
Direct patient	149	140	-9
Other	31	31	b

Source: Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage* (Washington, DC: U.S. Government Printing Office, 1991).

^aThe mandate would require all employers with 10 or more employees to provide coverage to employees (and their dependents) who work 25 or more hours per week. Employers would be required to pay at least 75 percent of the premium, and employees would be required to accept coverage and pay the remaining 25 percent of the premium. Firms with fewer than 25 employees would be required to purchase coverage through an insurance pool with community rated premiums.

^bUnchanged.

mandate would be borne by the investors and owners of the firms subject to the mandate. The distribution of this burden would vary by industry, region, firm size, and ownership type. These considerations are some of the reasons that proposals that combine public program expansion and employer mandates have been introduced.

Several of the proposals for health care reform that combine an employer mandate with a Medicaid (or other public program) expansion would cover a larger proportion of the uninsured. The CBO combined its illustrative Medicaid expansion and employer mandate options (both discussed above) and found that up to 85 percent of the currently uninsured (28 million) would gain health insurance coverage (table 17). In addition, 16 million individuals who were previously insured would switch their source of health insurance.

The illustrative employer mandate and Medicaid expansion analyzed by the CBO could increase total national health care expenditures by \$20 billion (table 18). This increase would include a \$53 billion increase in Medicaid spending and employment-based insurance premiums offset by a \$33 billion reduction in other spending by governments and individuals.

Play-or-Pay Employer Mandates

Proposals that would allow employers either to provide health insurance to their employees or contribute a percentage of their employees' wages to a public health insurance plan are called play or pay. **Nearly all proposals introduced during the 102nd Congress are play-or-pay proposals rather than straight employer mandates. These proposals are designed to expand employer-provided health insurance without unduly**

Table 17
Insurance Status of People before and after Enactment of an Illustrative Employer Mandate and an Illustrative Medicaid Expansion,^a 1989

	Coverage Before Enactment	Continue Existing Coverage	Changes in Coverage		Coverage After Enactment
			Employment based	Medicaid	
			(millions)		
Total	246.2	201.7	30.6	13.8	246.2
Insured	212.8	196.7	13.1	3.0	241.2
Employment based	152.3	152.3	b	b	182.9
Individually purchased					
private insurance	14.7	3.7	8.2	2.8	3.7
Medicare	30.5	28.8	1.7	b	28.8
Medicaid	14.6	11.8	2.8	b	25.6
CHAMPUS ^c	0.8	0.2	0.4	0.2	0.2
Uninsured	33.4	5.0	17.6	10.8	5.0

Source: Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage* (Washington, DC: U.S. Government Printing Office, 1991).

^aThe mandate would require all employers with 10 or more employees to provide coverage to employees (and their dependents) who work 25 or more hours per week. Employers would be required to pay at least 75 percent of the premium, and employees would be required to accept coverage and pay the remaining 25 percent of the premium. Firms with fewer than 25 employees would be required to purchase coverage through an insurance pool with community rated premiums. The Medicaid expansion would cover all individuals with income below poverty and allow individuals with income up to 200 percent of poverty to buy into the Medicaid program. The analysis assumes that all eligible individuals participate.

^bLess than 50,000.

^cThe Civilian Health and Medical Program of the Uniformed Services.

Table 18
**National Health Expenditures before and after
 Enactment of an Illustrative Employer Mandate and
 an Illustrative Medicaid Expansion,^a 1989**

Source of Payment	Before Enactment	After Enactment	Change
	(\$ billions)		
Total	\$740	\$760	\$20
Private Health Insurance	238	267	29
Employment based	222	257	35
employer share	184	210	26
employee share	38	46	9
Other	17	10	-6
Government	321	331	9
Federal	220	226	6
Medicare	123	120	-4
Medicaid	52	62	10
other	44	44	b
State and local	102	104	3
Medicaid	40	47	8
other	62	57	-5
Other	180	162	-18
Direct patient	149	131	-18
Other	31	31	b

Source: Congressional Budget Office *Selected Options for Expanding Health Insurance Coverage* (Washington DC: U.S. Government Printing Office, 1991).

^aThe mandate would require all employers with 10 or more employees to provide coverage to employees (and their dependents) who work 25 or more hours per week. Employers would be required to pay at least 75 percent of the premium, and employees would be required to accept coverage and pay the remaining 25 percent of the premium. Firms with fewer than 25 employees would be required to purchase coverage through an insurance pool with community rated premiums. The Medicaid expansion would cover all individuals with income below poverty and allow individuals with income up to 200 percent of poverty to buy into the Medicaid program. The analysis assumes that all eligible individuals participate.

^bLess than \$500 million.

burdening small employers. Small employers (and others) would be able to enroll employees in the public plan rather than provide coverage directly, thereby limiting their health insurance costs to a specific percentage of payroll. Senate Majority Leader George Mitchell introduced play-or-pay legislation (S. 1227) that would require employers to provide health insurance to all employees working at least

17.5 hours per week. Similar legislation (H.R. 3205) was introduced by Rep. Rostenkowski. Individuals not covered through an employer would be automatically enrolled in the public plan for which they may be required to pay premiums.

Although some play-or-pay proposals retain and expand Medicaid to cover all those not included in an employment-based plan, most replace Medicaid with a new public program. Play-or-pay proposals would expand the role of the public sector because the new public plan would include both individuals covered on an employment basis (whose employer chose to pay) and individuals in families with income below certain thresholds.

Play-or-pay proposals limit the costs that employers would face under an employer mandate by allowing employers to pay a payroll tax rather than provide health benefits. The revenue generated by the payroll tax would be used to fund a comprehensive public program.

Coverage and Costs—Estimates of changes in health insurance coverage and costs of such a plan vary substantially, depending on the behavioral assumptions chosen. Simulations of these proposals must determine which employers will continue (or begin) to provide health insurance and which will instead pay the public plan to cover its employees. A recent study by the Urban Institute assumed that employers would base their choice of whether or not to participate in the plan on cost alone (Zedlewski, 1992). If their average per capita premium would be lower under the pay option, employers would enroll their workers in the public plan. The study analyzed both a 7 percent and a 9 percent payroll tax. **It found that under the 9 percent tax scenario nearly 40 percent of nonelderly Americans would be enrolled in the public plan, and under the 7 percent scenario 52 percent would be enrolled in the public plan** (table 19).

EBRI simulation of a play-or-pay mandate also made the assumption that employers whose actual or prospec-

Table 19
Shifts in Health Insurance Coverage of the Nonelderly Population after Enactment of a Play-or-Pay Employer Mandate^a with 9 Percent and 7 Percent Payroll Taxes, 1991

Coverage under Current System	Total	Employment Based		Public Plan		
		Workers	Dependents	Workers	Dependents	Others
Coverage under a Play-or-Pay Mandate with a 9 Percent Payroll Tax						
Total	216.6	77.5	54.3	39.6	17.5	27.7
Employment-Based Plan						
Own employer	71.3	56.5	0.0	14.9	0.0	0.0
Other employer	70.9	8.8	44.7	9.2	8.2	0.0
Individually Purchased						
Private Insurance	18.2	3.7	2.0	4.5	1.8	6.2
Public Plan	22.9	1.4	2.8	1.9	3.3	13.3
Uninsured	33.4	7.1	4.8	9.1	4.2	8.2
Coverage under a Play-or-Pay Mandate with a 7 Percent Payroll Tax						
Total	216.6	60.3	44.4	56.8	27.4	27.7
Employment-Based Plan						
Own employer	71.3	46.1	0.0	25.2	0.0	0.0
Other employer	70.9	6.3	38.1	11.7	14.8	0.0
Individually Purchased						
Private Insurance	18.2	2.6	1.4	5.6	2.4	6.2
Public Plan	22.9	1.0	1.9	2.3	4.2	13.4
Uninsured	33.4	4.3	3.0	11.9	6.0	8.2

Source: Sheila Zedlewski, *Pay-or-Play Employer Mandates: Effects on Insurance Coverage and Costs* (Washington, DC: The Urban Institute, 1991).

^aEmployers must either pay 80 percent of the cost of a uniform benefit package or pay the payroll tax for all employees working 18 hours or more per week. Employers must pay a payroll tax for employees working fewer than 18 hours per week. Workers must accept coverage through their own employer. Dependents are covered through the primary worker's plan. Workers must pay 20 percent of the cost of the premium, or, if working less than full time, 20 percent of the cost of the public plan less subsidies for low-income workers. Persons not covered through an employer would enroll in the public plan. Families not enrolled in an employment-based plan pay the full public plan premium less any subsidies for low-income persons.

tive health benefit costs were greater than the payroll tax would choose to enroll employees in the public plan rather than provide health benefits directly. Again, three different estimates of the average annual cost of health benefits per individual employee were used in the simulation: \$970, \$1,450, and \$2,430. The cost of each additional dependent was assumed to be 60 percent of the individual cost. The analysis found that between 33 percent and 51 percent of all Americans would be enrolled in the public plan if the payroll tax were set at 9 percent. The percentage of nonelderly enrolled in the public plan would range between 24 percent and 45 percent. Of the new enrollees in the

public plan, between 10 million and 45 million would have previously received benefits through an employer-sponsored health plan. The relative size of the public plan has important implications for the distribution of the costs of play-or-pay proposals.

The proportion of employers that would actually drop their health benefits if a play-or-pay proposal were enacted depends on a number of factors. If the public plan were considered inferior to private plans, employers might continue to offer private health benefits in order to gain a competitive advantage in the labor market. An employer's willingness to continue health

benefits may depend on the characteristics of its local health care market. Employers that lack confidence in their ability to manage their health care costs may be more likely to drop health benefits. Conversely, if the public plan attracted a large proportion of poor health risks, the cost of private insurance may fall, prompting many employers to continue to offer health benefits.

The characteristics of the public plan are, therefore, the most important determinant of the willingness of employers to drop their health benefits. If, for example, the public plan is identical to the Medicare program, some employers may opt to offer plans similar to Medigap policies currently available to Medicare recipients. Given the limits on balanced billing for physicians and the limits on reimbursement to hospitals currently incorporated in the Medicare program, large employers may find they can offer a private benefit package that offers significantly higher quality care than the public plan, even when the public plan is supplemented with a Medigap-like plan. To the extent that these employers are able to attract and retain a higher quality work force as a result of the private benefit, they may be willing to incur costs above the payroll tax.

When analyzing the costs of a play-or-pay reform proposal, the proportion of Americans who enroll in the public plan has important cost implications for employers, government, and individuals. In general, the lower the tax rate for participation in the public plan, the higher the cost to the government as more employers choose to drop health benefits. Again, employers' desire to do so will depend on the public plan's characteristics and labor market competition.

If all employers whose health care costs were greater than 9 percent of payroll dropped their health benefits and paid the payroll tax (assuming a play-or-pay mandate with an average cost of \$1,450 per employee), such a proposal could increase employer spending by approximately \$45 billion overall. Employers with fewer than 25 employees would face increased costs of \$18 billion. Interestingly, if average costs per employee were \$2,430, total new costs to

employers would be only \$41 billion overall, \$19 billion of which would be paid by small employers. Fewer additional costs would be expended by employers overall because some employers who currently offer insurance would choose to drop their plan in favor of paying the payroll tax, which costs less on a per employee basis than providing insurance. The number of employers currently offering health benefits who could save money by dropping health benefits and paying the payroll tax would begin to offset the increased spending among employers newly providing coverage or increasing coverage to meet requirements under a benefit package with higher average costs.

The sheer size of the public program under a play-or-pay proposal would affect the delivery of health care services. Depending on how many employers retain their health benefits after a reform proposal of this type is enacted, between 33 percent and 51 percent of all Americans could be enrolled in the public plan. The public plan would probably insure the poorest health risks in the population: the disabled, those too sick to work, the poor, and the elderly. As a result, health expenditures accounted for by the public plan would likely be larger than the 33 percent to 51 percent of total per capita spending. A current example of this is the Medicare program that covers about 12 percent of the total population but accounts for 27 percent of hospital expenditures and 24 percent of expenditures for physician services (U.S. Department of Health and Human Services, 1991).

The public plan's reimbursement policies would determine the number of employers who provide health benefits, provider income, the magnitude of health care cost inflation, and the quality of care. If wages and other components of total compensation could not adjust, some unemployment would result. EBRI analysis estimated that between 131,100 and 965,000 jobs could be lost under a play-or-pay proposal with a 9 percent payroll tax if other labor costs did not adjust.⁸ Again, as

⁸Again, the analysis used a price elasticity range of 0.3 to 0.05 for labor demand.

under an employer mandate, these estimates assume no transition period nor any adjustment in other components of total compensation. In practice, the impact on employment is likely to be lower than these estimates indicate, although the costs of a play-or-pay proposal would be distributed among employers, employees, and consumers.

Although illustrative options generally do not examine cost management features in connection with their cost analyses, the characteristics of private and public plans under these options have important implications for beneficiaries, providers, and payers. **Employer mandates and play-or-pay proposals generally call for expanded use of managed care, elimination of state mandates, and elimination of state legislation restricting the use of managed care.** In addition, some proposals would establish an all-payer rate setting system, institute capital budgets, encourage community rating for small firms, and establish peer review organizations.



Employer mandates and play-or-pay proposals generally call for expanded use of managed care, elimination of state mandates, and elimination of state legislation restricting the use of managed care.



It seems unlikely that real provider income would continue to grow under a play-or-pay type proposal. The public plan's ability to set fees and monitor utilization and the pressures of politically determined budgets would likely decrease most providers' income. The reduced number of private plans, coupled with employers' willingness to drop health benefits as costs increase, would limit cost-shifting to the private sector. Moreover, some advocates of an expansion of the public sector have proposed requiring private plans to use the same reimbursement methodology as public plans.

Conversely, limits on provider revenues may reduce the number of providers, their ability to invest in technological innovation, and their ability to finance health care services research. It is unclear how this would affect the quality of care in the short run. Many argue that the United States has overinvested in health care technology and overtrained physicians. A reduction in expenditures for these purposes may free resources needed to finance care for those who have faced barriers to access in the past. However, in the long-run there may be less innovation in health care and fewer of the "best and the brightest" entering the medical profession.

Managed Competition

Stanford professor Alain Enthoven has proposed the development of a **Consumer Choice Health Plan for the 1990s (CCHP)**, which would maintain employment-based coverage and expand the role of the public sector. Although this plan has features similar to those of other plans based on combinations of an employer mandate and a Medicaid expansion, it is fundamentally different because of the role of the public sponsor in managing competition and the limit on the amount of employer contributions excludable from employees' income.

The CCHP would require employers to provide health insurance to all full-time employees (working 25 hours or more per week) and pay an 8 percent payroll tax (up to \$22,500) for all employees not covered under the plan (including part-time, seasonal, and temporary workers). Individuals not covered by an employment-based plan would have the option of purchasing affordable coverage on an individual basis. In addition, the amount of an employer's contribution to health benefits that could be excluded from employees' taxable income would be limited to 80 percent of the average cost of a qualified plan in the employer's geographic area (Enthoven and Kronick, 1989).

Each state would have powerful incentives to create a public sponsor that would enroll people otherwise not

covered through an employment-based plan. The public sponsor would select the health plans to be offered, contract with providers and consumers, manage the enrollment process, collect premium contributions, and distribute the premiums to health plans. Public sponsors would cover all individuals not included in an employment-based plan as long as they enrolled during the annual open enrollment period and remained covered throughout the year. Small employers (with fewer than 25 employees) would also be able to purchase coverage for their employees through the public sponsor.

Both the public sponsor and the employer would be required to pay 80 percent of the average cost of a qualified health plan. Employees and individuals enrolled through the public sponsor would be required to contribute the remaining 20 percent of the cost. Small employers purchasing coverage through a public sponsor would not be required to pay more than 8 percent of payroll for a plan with basic benefits (the public sponsor would subsidize any additional cost).

A group of analysts called the Jackson Hole Group, led by Dr. Paul Ellwood and Alain Enthoven have expanded on this proposal. Their proposal would create an independent federal agency, the National Health Board (NHB), which would develop a set of uniform health benefits, licensing standards for accountable health partnerships (AHPs) that would function as both insurer and provider of health care services, and health insurance purchasing corporations (HIPC)s to act as purchasing agents for small employers and individuals. The tax treatment of health benefits would change in two ways. First, that portion of any premium attributable to benefits that exceed the NHB's minimum benefit package would be taxable. Second, where employers offer a choice of health plans, only premiums for the least costly plan would be exempt from taxation. Finally, low-income individuals' purchase of health insurance would be subsidized through a payroll tax and the revenue from the new limit on the deductibility of health benefits.

Coverage and Costs—The CCHP is similar in many ways to an employer mandate. However, the features of the plan that expand the role of the public sector would produce significant differences in the sources of health insurance coverage that would be available after implementation. In addition, the CCHP emphasis on mandatory cost sharing and managed competition would be likely to motivate participants differently than other employment-based reforms. CBO analysis of the plan found that 22 million of the uninsured would gain coverage through an employer, while the remaining 13 million uninsured would be eligible to purchase subsidized coverage from a public sponsor (table 20) (Enthoven and Kronick, 1989). An additional 6 million people currently purchasing nongroup insurance would also be eligible to purchase subsidized coverage from a public sponsor. Although there is no precise basis for determining rates of participation by the currently uninsured population, the plan's authors predict that participation would be high because of the highly subsidized premiums and state incentives to enroll residents.

CBO analysis of the CCHP found that in the first full year of implementation, total health care expenditures would increase by approximately \$15 billion. More recent analysis of the consumer choice model by Lewin/ICF estimated that total health spending would increase by only \$5 billion annually (Social Security Advisory Council, 1992).

Individual Mandates

These proposals would shift the responsibility for obtaining health insurance from the employer to the individual. Advocates of this approach argue that individuals are unaware of the high cost of health insurance and health care services. If they were required to choose their own health plan, they would be likely to choose a cost-efficient plan and curtail their use of health care services. In order to equalize the tax treatment of health insurance, these proposals would expand individual tax deductions or credits for health insurance.

Table 20
**Current Source of Health Insurance Coverage by Coverage under
the Consumer Choice Health Plan (CCHP),^a 1988**

	Total	Coverage under the Consumer Choice Health Plan		
		Employment based	Medicare, Medicaid, or CHAMPUS ^b	Public sponsor
		(millions)		
Total	241.2	178.3	44.0	18.9
Current Source of Coverage				
Employment based	135.1	135.1	0.0	0.0
Individually purchased private insurance	19.7	13.6	0.0	6.1
Medicare, Medicaid, or CHAMPUS ^b	51.1	7.1	44.0	0.0
Uninsured	35.3	22.5	0.0	12.8

Source: Alain Enthoven and Richard Kronick, "A Consumer Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy. Part I," *New England Journal of Medicine* (January 5, 1989): 29–37.

^aEmployers would be required to cover all full-time employees (and their dependents not otherwise covered) and pay an 8 percent payroll tax on the first \$22,500 of wages of all employees not covered. Employers would be required to offer all full-time employees (those working at least 25 hours per week) a choice of qualified plans and to contribute at least 80 percent of the average cost of the basic coverage. Those not enrolled through an employer (as well as the self-employed) could purchase coverage through a public sponsor that would negotiate premiums on behalf of its members.

^bThe Civilian Health and Medical Program of the Uniformed Services.

One proposal would require all individuals to obtain basic health insurance coverage. The maximum out-of-pocket expenditure would be linked to family income, and more complete coverage would be required for low-income families (Pauly, et al., 1991). The federal government would collect bids from local health plans to provide the required minimum coverage. One or more such plans would be designated in each area as fallback coverage for individuals who do not obtain coverage in the private market. Employer contributions to health insurance would no longer be excluded from taxable income. Instead, refundable tax credits would be available to individuals purchasing insurance. The amount of the credit would be related to the individual's premium and inversely related to family income. The proposal would allow individuals to purchase coverage through an employment-based group.

A separate proposal by the Heritage Foundation also shifts responsibility to the individual. Their plan would develop a tax system that promotes individual insur-

ance and out-of-pocket expenditures. The plan would encourage individuals to purchase health insurance policies to cover a federally prescribed basic package, which would include catastrophic stop-loss insurance, hospital and physician services, and routine preventive care for themselves and their dependents. The out-of-pocket deductible and co-payment could not exceed 10 percent of adjusted gross income. Refundable tax credits would be available for both health insurance purchases and out-of-pocket purchases of health services (Butler, 1991).

Coverage and Costs—Often included as a part of tax-based reform, individual mandates would, theoretically, cover all Americans because they would require all individuals to purchase health coverage. This approach would sever the relationship between employment and health benefits. It would reduce the public sector, offering a public plan only for the very poor (Butler, 1991). It is unclear how the health insurance market would be affected by this plan. There would be clear incentives for insurers to attempt to identify and select

good risks. Conversely, the administrative costs of a nongroup health insurance market would be considerably higher than those of the present market, which is dominated by group plans. Moreover, some plans would experience adverse selection and consequently would have a disproportionate share of poor health risks. It is not clear whether such a market would be stable.

◆ National Health Care Systems

A final set of proposals calls for a uniform national health care system financed and administered by federal (or state) government. These proposals vary according to their financing mechanisms, distribution of federal versus state administration, and role for public- versus private-sector delivery of health care

services, but they are similar in their concept of a national system. A number of proposals 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.

Proponents of a universal health care system have argued that the market for health services is by its nature exclusionary, and the poor will never be able to reach an acceptable level of health care even if they are subsidized because the political process works against them. Their argument is that the majority can afford adequate health care, but because there are competing

Table 21
Per Capita Health Spending in U.S. Dollars and
Percentage Growth in Per Capita Health Spending, Selected Countries 1970–1989

	1970	1975	1980	1985	1986	1987	1988	1989
Per capita health spending								
United States	\$346	\$592	\$1,059	\$1,700	\$1,813	\$1,955	\$2,140	\$2,354
Canada	274	478	806	1,315	1,427	1,507	1,581	1,683
France	192	365	656	991	1,036	1,088	1,173	1,274
Germany	199	422	749	1,046	1,082	1,139	1,250	1,232
Japan	126	252	515	785	828	907	978	1,035
Netherlands	207	418	707	931	954	1,033	1,076	1,135
Sweden	274	475	864	1,187	1,192	1,266	1,328	1,361
United Kingdom	146	272	454	658	697	747	793	836
Average annual growth rate in per capita health care spending								
	1970–1975	1975–1980	1980–1985	1985	1986	1987	1988	1970–1988
United States	11.3%	12.3%	9.9%	6.6%	7.8%	9.5%	10.0%	11.2%
Canada	11.8	11.0	10.3	8.5	5.6	4.9	6.5	10.6
France	13.7	12.4	8.6	4.5	5.0	7.8	8.6	11.1
Germany	16.2	12.2	6.9	3.4	5.3	9.7	-1.4	10.7
Japan	14.9	15.4	8.8	5.5	9.5	7.8	5.8	12.4
Netherlands	15.1	11.1	5.7	2.5	8.3	4.2	5.5	9.9
Sweden	11.6	12.7	6.6	0.4	6.2	4.9	2.5	7.4
United Kingdom	13.3	10.8	7.7	5.9	7.2	6.2	5.4	10.2

Source: Organization for Economic Cooperation and Development. "United States Continues to Lead Industrialized World in Health Expenditures" *News from OECD* (20 May 1991).

uses for tax dollars, they will be reluctant to vote for expanded health care services for the minority. Therefore, to assure adequate health care for the entire population, everyone must be affected equally by the majority's decisions.

If the market is an inappropriate allocation method for health care when it works, its appropriateness is clearly problematic when it fails. It has been suggested that the money required to purchase administrative services, marketing, duplicative investment in expensive technology, and wasteful medical practice in a failed market system could be used to provide more health care or other social goods in a publicly sponsored health care system. Market incentives that contribute to health care cost inflation, such as competition to adopt new procedures and incentives to providers to offer more intensive care, are not present in a nationalized system. Generally, countries with national health systems have had lower rates of health care cost inflation than the United States during the last 20 years (table 21).

However, national health care systems must develop some process for rationing care. A system must determine not only who receives care but which of the competing procedures is appropriate for a given set of symptoms. Most national health care systems are characterized by queues for elective procedures. Moreover, the mix of health care services provided in Canada, England, and in the countries of northern Europe is different from that provided in the United States. Although there is considerable variation in the technology available to practitioners across countries with centralized systems, the United States is at or near the top in investment per capita in technology. The effects of differences in practice style on the quality of health care are unknown; the information problems that have affected the performance of the health care services market in the United States do not disappear under a national health care system.

There are several different ways to organize the financing and delivery of care under a national health care

system. One way is to retain a private delivery system but impose an all-payer system in which providers are reimbursed by all payers according to a common fee schedule. One advantage of this approach is that it eliminates price discrimination. Currently there are wide differences in the prices paid by public, small private payers, and large private payers for health care services. It is often asserted that these price differences reflect cost shifts from public payers to private payers. To the extent this is true, the cost of care provided to those in public programs and those who are uninsured is subsidized by higher costs in the private sector. These price differences may also reflect relative market power, which increases costs to some payers.

While an all-payer system would eliminate price discrimination, it would also impose a system of administered prices (i.e., prices that are determined arbitrarily rather than by market forces) on the health care services market. In general, administered prices are inferior to market determined prices because they do not reflect the underlying costs of producing a service or the demand for that service. In practice, administered prices are often used in industries characterized by monopoly power, such as public utilities. As the number of interrelated services increases, it becomes increasingly difficult to administratively set prices that accurately reflect underlying costs and demands. Setting efficient prices in the health care services market, which is currently characterized by large differences in costs determined by provider type, region, and patient type, may prove to be much more difficult. Conversely, if health care service prices do not now accurately reflect costs and demands as a result of provider monopoly power, then administered prices may in fact be an improvement. **Whether an all-payer system of administered prices would be an improvement over prices as currently determined depends on the mechanism used to generate prices in an all-payer regime.**

Generally, national health care proposals have limited cost sharing with beneficiaries. For example, legislation introduced by Rep. Marty Russo (D-IL) (H.R. 1300)

would not require any individual cost sharing. Instead, cost savings would be realized through standardized payment rates to physicians and hospitals, reduction in administrative waste, and strict capital budgets. Other proposals, such as S. 1446 introduced by Sen. Bob Kerrey (D-NE), require individual deductibles and copayments. Because a national insurance plan would be the sole purchaser of services, it would be able to arrange prices below those that would otherwise prevail in the market.



A wholly federal system would require uniformity of benefits and financing across states and would likely create a large administrative role for the federal government.



National health insurance proposals often differ on the appropriate distribution of responsibility between federal and state governments. Reps. Gibbons and Stark advocate expanding Medicare to cover the entire population—creating a federally administered and financed program. Alternatively, other national health insurance proposals, including H.R. 1300, have been modeled after the Canadian system, with joint federal/state administration and financing. Some proposals promote a larger state role in national health insurance. For example, H.R. 2530, introduced by Rep. Bernard Sanders (I-VT), would contribute federal funds to those state plans that meet certain criteria (uniform, comprehensive, accessible, and portable coverage).

A wholly federal system would require uniformity of benefits and financing across states and would likely create a large administrative role for the federal government. Designing a single national system may be difficult because of disagreement over the appropriate

services to include in a minimum benefits package. However, individuals could be allowed (as they are in Canada) to purchase private coverage for benefits and services that are not covered by the public plan. **Although a joint federal/state program would allow for differences across states, the success of such a program would depend on state administrative capacity and would require difficult decisions about which elements must be consistent among all states.** Under a national health insurance system, by definition, all Americans would be covered by some form of health insurance. The benefits of a single-payer system include the ability to cap costs and universal coverage.

Other proposals for a national health care system would retain a role for the federal government in the financing of health care but allow the states some latitude in organizing the delivery of health care services. For example, Sen. Kerrey's proposal would allow each state to determine its own minimum benefit package and licensing requirements for private health insuring organizations. This plan has the advantage of recognizing the differences in health care delivery that now exist among states and even within them. To the extent that these differences reflect local preferences, preserving them may benefit consumers. To the extent that they reflect underlying market failure, inefficiencies may also be preserved.

The estimates of cost savings and/or cost increases are quite different when it comes to national health care systems. For example, the Office of Management and Budget (OMB), which is charged with providing official estimates of the costs of legislation, reported that legislation introduced by Rep. Russo (H.R. 1300) would be underfunded by between \$109 billion to \$197 billion (Darman, 1991). Their estimate of the cost of separate national health insurance legislation introduced by Sen. Kerrey (S. 1446) was between \$57 billion and \$107 billion. The latter legislation is estimated to be less underfunded because of its greater emphasis on state level financing. In addition, both of these proposals include measures to provide long-term care.

Coverage and Costs—CBO compared the cost of moving from the current system to either a national health care system with a single payer or a system with an all-payer approach expanding Medicare to cover the uninsured. The analysis also assumed that balance billing would be prohibited under both the all-payer and the single-payer systems.⁹ Under the all-payer approach, only those currently without coverage could take advantage of the option to enroll in Medicare; those with Medicaid or private insurance could not switch to Medicare. Under the single-payer approach, private insurance would not cover the copayments required by the universal health plan, but a residual Medicaid program would continue to supplement benefits for those eligible. The analysis may overstate savings that would result from the elimination of balance billing and the reduction in hospital payment rates for privately insured patients. It may also understate the effects of a national health care system on nonhospital and nonphysician services (such as prescription drugs and nursing home care), which are assumed not to change. In addition, under a single-payer system, overhead costs for insurers offering coverage for services not included in the universal plan were not estimated.

One alternative modeled by CBO would set Medicare physician service rates at 70 percent of actual charges, 84 percent of private insurance rates, and 140 percent of Medicaid rates. The alternative assumes that the uninsured would increase their utilization of physician services by 42 percent and of hospital services by 48 percent. In addition, Medicaid patients would increase their use of these services by 16 percent and 13 percent, respectively. Finally, overhead costs in an all-payer system would be 13.3 percent of personal health expenditures (PHE) for providers and 6.6 percent of PHE for insurers. The overhead costs would be lower in a single-payer system: 11.6 percent of PHE for providers and 2.4 percent of PHE for insurers. Under these assumptions, CBO estimated that spending

for provider services would increase by \$12.5 billion—\$3.3 billion for physician services and \$9.2 billion for hospital services. Because of differences in administrative costs, the impact on total national health expenditures would be different for an all-payer and a single-payer system (table 22).

A U.S. General Accounting Office (GAO) analysis of a Canadian-style single-payer national health care system concluded that such a system would save 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 estimates (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 and indicated that this cost saving would not reduce the federal budget but would be dispersed to consumers in the form of lower premiums or enhanced coverage.**

Administrative Costs—Administrative costs have become a major concern in the national health care system debate. At least some of this debate involves the definition of administrative costs and the assumptions used to estimate these costs. Administrative costs have been defined both narrowly as the costs of filling out, filing, and paying claims and broadly as all costs not directly linked to patient care, such as traveling and waiting times for care, the tax burden for public health

⁹Medicare physician charges to a beneficiary that are above the level of payment allowed under the Medicare program.

Table 22
**Illustrative Changes in National Health Expenditures after
 Adoption of a Single Payer or an All Payer National Health Care System, 1989**

	Actual Spending	Estimated Spending at Medicare Rates	
		Single Payer ^a	All Payer ^b
		(\$ billions)	
Total (Alternative 1) ^c	\$604.1	\$611.5	\$634.1
Payments to Affected Providers	287.9	317.3	317.3
Service component	208.4	234.0	234.0
Overhead component	79.5	83.3	83.3
Insurers Overhead	35.3	13.2	35.9
All Other Spending	281.0	281.0	281.0
Total (Alternative 2) ^d	604.1	577.9	609.8
Payments to Affected Providers	287.9	283.8	293.0
Service component	208.4	220.9	220.9
Overhead component	79.5	63.0	72.1
Insurers Overhead	35.3	13.1	35.8
All Other Spending	281.0	281.0	281.0
Total (Alternative 3) ^e	604.1	546.0	586.8
Payments to Affected Providers	287.9	252.2	70.1
Service component	208.4	208.6	208.6
Overhead component	79.5	43.6	1.5
Insurers Overhead	35.3	12.9	35.7
All Other Spending	281.0	281.0	281.0

Source: Congressional Budget Office, *Universal Health Insurance Coverage Using Medicare's Payment Rates* (Washington, DC: U.S. Government Printing Office, 1991).

^aSingle public insurer for basic medical services. Private insurers could offer coverage for excluded services but Medigap-type coverage would be prohibited. A residual Medicaid program would continue. The plan and the residual Medicaid program would be financed through new taxes. Any private insurance would be financed by premiums paid by the insured or their employers. Medicare rates would be used for physician and hospital services, and balance billing would be prohibited.

^bRetains current mix of private and public insurers. Medicare coverage would be extended to the uninsured, and Medigap coverage would continue. Shifting from Medicaid or private insurance to Medicare would be discouraged. Medicare coverage for the previously uninsured would be financed through new taxes. Medicare rates would be used for physician and hospital services, and balance billing would be prohibited.

^cMedicare rates are 73.5 percent of actual charges, 88.2 percent of private insurance rates, and 147 percent of Medicaid rates for physician services. Medicare rates are 74.7 percent of actual charges, 92.4 percent of private insurance rates, and 134.4 percent of Medicaid rates for hospital services. The uninsured use 56 percent more physician services and 64 percent more hospital services than they do currently. Medicaid patients use 23.5 percent more physician services and 19.8 percent more hospital services than they do currently. Overhead costs in an all payer system are 15 percent of personal health expenditures (PHE) for providers and 6.5 percent of PHE for insurers. Overhead costs in a single payer system are 15 percent of PHE for providers and 2.4 percent of PHE for insurers.

^dMedicare rates are 70 percent of actual charges, 84 percent of private insurance rates, and 140 percent of Medicaid rates for physician services. Medicare rates are 71.2 percent of actual charges, 88 percent of private insurance rates, and 128 percent of Medicaid rates for hospital services. The uninsured use 42 percent more physician services and 48 percent more hospital services than they do currently. Medicaid patients use 15.7 percent more physician services and 12.7 percent more hospital services than they do currently. Overhead costs in an all payer system are 13.3 percent of PHE for providers and 6.6 percent for insurers. Overhead costs in a single payer system are 11.6 percent of PHE for providers and 2.4 percent for insurers.

^eMedicare rates are 66.5 percent of actual charges, 79.8 percent of private insurance rates, and 133 percent of Medicaid rates for physician services. Medicare rates are 67.6 percent of actual charges, 83.6 percent of private insurance rates, and 121.6 percent of Medicaid rates for hospital services. The uninsured use 28 percent more physician services and 32 percent more hospital services than they do currently. Medicaid patients use 15.7 percent more physician services and 9.1 percent more hospital services than they do currently. Overhead costs in an all payer system are 11.6 percent of PHE for providers and 6.7 percent for insurers. Overhead costs in a single payer system are 8.2 percent of PHE for providers and 2.4 percent for insurers.

benefits, and the costs of overconsumption of health care due to overinsurance.

Even if researchers agreed on the appropriate definition of administrative costs, the savings in the administrative costs of insurance that would be gained by moving to a single-payer system are less obvious than is often asserted. Some of the analysis of the administrative costs of insurance have compared the ratio of administrative costs to claims paid for the Medicare program and private insurers. However, administrative costs do not generally increase as the size of the claim increases. Using this measure, a plan covering a less healthy population with higher health care costs will have a lower administrative cost per claim paid than an identical plan covering a healthier population. Table 23 provides a comparison of administrative costs for Medicare and Blue Cross/Blue Shield plans. Using administrative costs per benefit paid to estimate the savings associated with moving to a single-payer system will generate much higher estimates than using administrative costs per enrollee.

One category of administrative costs not often included in estimates is the costs borne by patients in receiving and paying for care. These costs might include the costs of traveling and waiting time; limits on choice of providers, treatments, and sites of care; and the costs of filing out forms for eligibility and claims payment. These costs are more difficult to

quantify and would depend on the payment system's characteristics. Clearly, any system that reduces excess capacity to the point where queues form imposes some costs on patients. Limits on choice of providers, treatment styles, and treatment sites also impose costs that, while difficult to quantify, are real. It is clear that all health care delivery systems impose costs on patients that need to be considered even if they are difficult to quantify.

A final source of administrative costs often excluded from estimates is the tax burden imposed on the economy as a result of the public funding of health care delivery. All taxes reduce the amount of private goods and services produced in the economy. The extent of the burden depends on the design of the tax. While there are clearly benefits from the public provision of many services, the costs need to be considered in choosing among alternatives. In comparing the administrative costs of different systems, the tax burden may need to be considered.

A University of Pennsylvania study estimated that, under a Canadian-style health insurance system, administrative costs would be more than 45 percent of paid claims, compared with less than 8 percent under the current system (Danzon, 1991). The analysis includes in the definition of administrative costs the burden imposed on the economy by increased taxes, the value of the time patients spend waiting for care, and

Table 23
Administrative Cost Comparison between Medicare Plans and Blue Cross/Blue Shield Plans, 1990

Administrative Measure	Cost of Administration		Medicare as a Percentage of Blue Cross/Blue Shield
	Medicare	Blue Cross/Blue Shield	
Administrative Costs per Dollar of Benefits	\$ 0.02	\$ 0.10	20%
Administrative Costs per Claim	4.91	6.42	76
Administrative Costs per Enrollee	66.57	82.29	81

Source: Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, *1991 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (Washington, DC U.S. Department of Health and Human Services, 1991); Health Care Financing Administration, unpublished data; and Blue Cross and Blue Shield Association (Chicago, IL) unpublished data.

the value of the care patients are unable to receive because of budget constraints in a purely public health care system.

Finally, administrative costs, whatever definition is used, are simply costs of inputs to the financing and delivery of health care services. The composition of health care costs is less important than the comparison of total costs to total benefits. If high administrative costs mean increased access to health care services, higher quality health care, and/or lower total health care costs, the level of administrative costs should not be a policy concern. Conversely, if any inputs, including physician, hospital, or administrative costs, are employed inefficiently or wastefully, reducing these inputs would decrease the costs of health care services. The optimal level of administrative costs cannot be determined without examining the benefits of employing these inputs.

◆ Conclusion

This *Issue Brief* has attempted to describe the full range of health care reform proposals that have been advanced and draw out at least some of the tradeoffs implicit in health care reform. All of the reform proposals make some individuals better off while making others worse off. Moreover, what makes health care

reform a difficult political problem is that almost everyone gains something and loses something under all of the alternatives. There are few groups that can correctly view health care reform as a win-win or a lose-lose proposition. Many of the tradeoffs are not readily apparent. Table 1 in the executive summary describes some of these tradeoffs.

The *Issue Brief* also illustrates some of the limits in determining the effects of these proposals. Important details of many of the proposals have not been developed. Moreover, the literature on important questions such as the effects of tax changes, increased labor costs, or provider response to changes in reimbursement is often incomplete or contradictory. The greater the amount of change proposed by a reform proposal the greater the uncertainty of estimates regarding costs and coverage. Analysts generally have the tools to examine the impact of relatively small changes rather than global changes. Health care reform—even those proposals that we have arbitrarily labeled incremental reform—is likely to have wide-ranging effects.

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Appendix

Public Opinion: Health Care Reform

◆ The Current System—Are We Satisfied?

Individual Situation

Overall, 73 percent of respondents to an EBRI/Gallup survey who had health insurance were satisfied with their individual health benefits, rating them either good (48 percent) or excellent (25 percent). Despite this, 24 percent of respondents to a similar EBRI/Gallup survey stated that their health insurance coverage has gotten worse overall in the last few years. In addition, 35 percent of respondents to an unrelated survey stated that the current health care system is not completely meeting their needs.

How do you rate your current health insurance benefits?

Excellent	25%
Good	48
Fair	19
Poor	6

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Benefits, Part 2*, EBRI Report no. G-31 (Washington, DC: Employee Benefit Research Institute, March 1992).

Note: Based on interviews of 1,000 U.S. adults conducted December 1991.

In the last few years, has your health insurance coverage:

Gotten better overall	16%
Remained more or less the same	58
Gotten worse overall	24

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Benefits, Part 1*, EBRI Report no. G-30 (Washington, DC: Employee Benefit Research Institute, February 1992).

Note: Based on interviews of 1,000 U.S. adults conducted November 1991.

Is the current health care system meeting the needs of you and your family?

Strongly believe the current health care system is meeting these needs	37%
Believe the system is meeting these needs, but not strongly	24
Believe the system is not meeting these needs, but not strongly	9
Strongly believe the system is not meeting these needs	26

Source: Survey by Mellman and Lazarus and Public Opinion Strategies for the Health Insurance Association of America.

Note: Based on interviews of 800 adults, conducted January 4–5, 1992.

◆ The U.S. Situation

Despite a majority of respondents stating that they are satisfied with their individual health benefits, 85 percent of respondents to an EBRI/Gallup survey rated the U.S. system as either fair (41 percent) or poor (44 percent). In addition, 91 percent of respondents to a separate survey felt that at least some changes to the current health care system are needed.

How would you rate the U.S. health care system overall?

Excellent	6%
Good	27
Fair	41
Poor	44

Source: Employee Benefit Research Institute/The Gallup Organization, Inc. *Public Attitudes on Health Insurance, 1991*, EBRI Report no. G-26 (Washington, DC: Employee Benefit Research Institute, October 1991).

Note: Based on interviews of 1,000 U.S. adults conducted July 1991.

The current health care system :

Is basically sound	7%
Is basically working but some changes are needed	24
Could work, but significant changes are needed	41
Is beyond repair and needs to be rebuilt	26

Source: Survey by Mellman and Lazarus and Public Opinion Strategies, for the Health Insurance Association of America.

Note: Based on interviews of 800 adults conducted January 4–5, 1992.

◆ What Are Our Most Pressing Problems?

Health care is seen as one of the most important issues faced by the U.S. today. Eighty-three percent of respondents to an ABC News/Washington Post survey stated that health care is either the most important single issue (11 percent) or one of several important issues (72 percent) which will determine their vote in the next presidential election. An EBRI/Gallup survey found that within the health care system, cost was ranked as the most pressing problem on both an individual basis (49 percent) and for society (79 percent). In addition, 26 percent of respondents to a CBS News poll consider cost the aspect of our health care system most in need of change.

In the next presidential election, how important will a candidate's position on health care be in determining your vote?

Most important single issue	11%
One of several important issues	72
Won't have much influence	16

Source: Survey by ABC News/Washington Post, December 11-15, 1991.

For your own health care and that of your family, which of the following is your biggest concern?

Cost	49%
Quality	36
Access and Availability	12

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Benefits, Part 2*, EBRI Report no. G-31 (Washington, DC: Employee Benefit Research Institute, March 1992).
Note: Based on interviews of 1,000 U.S. adults conducted December 1991.

For society as a whole, what do you think is the biggest problem in health care?

Cost	79%
Access and Availability	13
Quality	6

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Benefits, Part 2*, EBRI Report no. G-31 (Washington, DC: Employee Benefit Research Institute, March 1992).
Note: Based on interviews of 1,000 U.S. adults conducted December 1991.

What is the single most important change you'd like to see in the U.S. health care system?

Lowered cost/cheaper fees/lowered hospital costs	26%
Universal cost/care—national health insurance	22
Medicare coverage/elderly	14
Cheaper insurance costs	4
Government regulation	3

Source: Survey by CBS News/*New York Times*, August 18-22, 1991.

◆ **Costs and Access**

Although the majority of respondents rated health benefits as their most important benefit (61 percent in May 1990, 65 percent in April 1991, and 64 percent in September 1991), and although most respondents feel health care costs are too high, most are unsure just how much money these benefits are worth. The response to three separate EBRI/Gallup polls, conducted in May 1990, April 1991, and September 1991, was predominantly “*don't know*” when respondents were asked how much more money an employer would need to give to make the individual willing to give up currently provided employer health care benefits. Respondents were more definite when asked what percent of their income they were willing to pay under a system that would provide health insurance for all; one percent and five percent were the predominate responses, with 39 percent and 34 percent designating these amounts respectively.

Respondents were also more definite when asked if everyone should have access to care whether or not they had the ability to pay. Eighty-eight percent of respondents to an EBRI/Gallup poll either strongly agreed (41 percent) or agreed (47 percent) that everyone should be entitled to the same amount of health care, whether or not they can pay for that care. In addition, in response to this same poll, 36 percent stated that the patient's ability to pay should have no influence in decisions about when patients should get expensive, highly-technical medical services, versus 33 percent who felt it should have a minor influence, and 27 percent who felt it should have a major influence.

Which of the following employee benefits is the most important to you?

	May 1990	April 1991	September 1991
Health Benefits	61%	65%	64%
Pensions	17	15	14
Disability Insurance	5	2	5
Long Term Care Insurance	4	1	na
Life Insurance	4	3	4
Child Care	3	3	na
Savings Plan	2	3	na
Annual Leave	2	4	na
Parental Leave	1	less than 1%	na
Don't Know	2	na	1

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on the Value of Benefits*, EBRI Report no. G-12 (Washington, DC: Employee Benefit Research Institute, September 1990); *Public Attitudes on the Value of Benefits, 1991*, EBRI Report no. G-23 (Washington, DC: Employee Benefit Research Institute, July 1991); *Public Attitudes on Benefit Trade Offs, 1991*, EBRI Report no. G-28 (Washington, DC: Employee Benefit Research Institute, December 1991).

Note: Based on interviews of 1,000 U.S. adults conducted May 1990, April 1991, and September 1991.

How much more money would you or your family member's employer have to give you each year to make you willing to give up your current employer-provided health benefits?

May 1990		April 1991		September 1991	
\$0-\$1,000	9%	0-\$1,000	13%	0-\$1,000	11%
\$1,000-\$3,000	21	\$1,001-\$3,000	22	\$1,001-\$3,000	19
\$3,001-\$8,000	22	\$3,001-\$8,000	25	\$3,001-\$5,000	15
\$8,001 or more	15	\$8,000 or more	12	\$5,000 or more	22
Don't know	35	Don't know	27	Don't know	29

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on the Value of Benefits*, EBRI Report no. G-12 (Washington, DC: Employee Benefit Research Institute, September 1990); *Public Attitudes on the Value of Benefits, 1991*, EBRI Report no. G-23 (Washington, DC: Employee Benefit Research Institute, July 1991); *Public Attitudes on Benefit Trade Offs, 1991*, EBRI Report no. G-28 (Washington, DC: Employee Benefit Research Institute, December 1991).

Note: Based on interviews of 1,000 U.S. adults conducted May 1990, April 1991, and September 1991.

What percentage of your income would you be willing to pay under a system that would provide health insurance for the entire population? This would be a total for taxes, health premiums, deductibles, co-pays, etc.

Nothing	9%
1 percent; that is \$100 for every \$10,000 you earn	39
2 percent	1
3 percent	1
5 percent; that is \$500 for every \$10,000 you earn	34
10 percent	6
More than 10 percent	1

Source: Employee Benefit Research Institute/The Gallup Organization, Inc. *Public Attitudes on Health Care System Changes*, EBRI Report no. G-33 (Washington, DC: Employee Benefit Research Institute, May 1992).

Note: Based on interviews of 1,000 U.S. adults conducted February 1992.

Do you strongly agree, agree, disagree, or strongly disagree with the following statements?

	Strongly Agree	Agree	Disagree	Strongly Disagree
Everyone should be entitled to the same amount of health care, whether or not they can pay for that care	47%	41%	9%	2%
Everyone should be expected to pay something toward the cost of their health care	51	3	9	3
Individuals with higher incomes should pay more towards their health insurance premiums than individuals with low incomes for the same health insurance coverage	36	20	33	9
Those who can afford it, should be permitted to buy very expensive treatment, such as a heart or liver transplant, that might not be available to everyone	36	11	31	19

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Care System Changes*, EBRI Report no. G-33 (Washington, DC: Employee Benefit Research Institute, April 1992).
 Note: Based on interviews of 1,000 U.S. adults conducted February 1992.

In your judgement, how much of an influence should the following factors be in decisions about when patients should get expensive, highly-technical medical services?

	Major Influence	Minor Influence	No Influence
How likely it is to improve patient's quality of life	70%	15%	11%
Number of years it is likely to add to the patient's life	57	20	18
Whether the patient is more than 75 years old	35	31	32
Cost of treatment	33	35	28
Whether the patient is able to pay	27	33	36

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Care System Changes*, EBRI Report no. G-33 (Washington, DC: Employee Benefit Research Institute, April 1992).
 Note: Based on interviews of 1,000 U.S. adults conducted February 1992.

◆ What Should Be Done?

When asked about the best way to deal with our nation's health care problem, confusion seems to be the norm. The majority of respondents to a Gallup survey conducted in January 1992 preferred reform of the current system (64 percent), as opposed to adopting a government-sponsored national health insurance program (30 percent). In addition, in support of this finding, 48 percent of respondents to an EBRI/Gallup survey felt that employers should be most responsible for providing health benefits to full-time employees and their dependents as opposed to the government (31 percent) or the individual (14 percent).

However, also in response to the EBRI/Gallup survey, the majority of respondents either strongly favored (25 percent) or favored (54 percent) some type of national health insurance. In addition, respondents to a Louis Harris and Associates survey stated a preference for the Canadian system (68 percent) versus the U.S. system (29 percent).

Despite the finding in an EBRI/Gallup survey that 79 percent of respondents either favored or strongly favored a national health insurance system, the majority (47 percent) of respondents to the survey felt that a national health insurance system would afford citizens less choice in picking doctors, versus 10 percent who felt that more choice would be available and 43 percent who felt that the same choice would be available. In addition, 46 percent felt that longer waiting time would be required for tests and procedures versus only 14 percent who felt that less time would be required and 43 percent who felt that the same amount of time would be required. Costs, considered to be the most pressing problem in our health care system, were seen as likely to increase for the individual by 50 percent of respondents and to increase for the nation as a whole by 41 percent of respondents. Finally, only 24 percent of respondents felt that quality of care would improve and a full 41 percent felt that, even under a national health insurance system, some citizens would not have health care coverage.

Employer Focus

Which of the following do you think is the better way to deal with our nation's health care problems?

Reform of Our Current Private Health Care System	64%
Government-Sponsored National Health Insurance	30

Source: Survey by the Gallup Organization for CNN and *USA Today*, January 28, 1992.

Note: Asked of 462 adults who had viewed the State of the Union address.

Who do you think should be most responsible for providing health benefits for full-time employees and their dependents in the U.S.?

Employers	48%
Federal government	31
Individuals	14
All the same	3

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Benefits, Part 2*, EBRI Report no. G-31 (Washington, DC: Employee Benefit Research Institute, March 1992).

Note: Based on interviews of 1,000 U.S. adults conducted December 1991.

Do you think employers should be required to provide health benefits at no charge to their employees?

Yes	57%
No	41

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Insurance, 1991*, EBRI Report no. G-26 (Washington, DC: Employee Benefit Research Institute, October 1991).

Note: Based on interviews of 1,000 U.S. adults conducted July 1991.

Do you think employers should be required to provide health insurance to their employees if the employees pay a portion of the costs?

Yes	83%
No	16

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Health Insurance, 1991*, EBRI Report no. G-26 (Washington, DC: Employee Benefit Research Institute, October 1991).

Note: Based on interviews of 1,000 U.S. adults conducted July 1991.

Government/National Focus

In general, do you strongly favor, favor, oppose, or strongly oppose the implementation by the U.S. government, of some type of national health insurance system?

Strongly favor	25%
Favor	54
Oppose	14
Strongly oppose	4

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on National Health Insurance*, EBRI Report no. G-32 (Washington, DC: Employee Benefit Research Institute, April, 1992).

Note: Based on interviews of 1,000 U.S. adults conducted January 1992.

In Canada, they have a system of national health insurance, under which the government pays most of the cost of health care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals. Under the Canadian system, people can choose their own doctors and hospitals. On balance, would you prefer the Canadian system or the system we have here?

Canadian system	68%
U.S. system	29
Not sure	3

Source: Survey by Louis Harris and Associates, November 13-18, 1991.

Under a national health insurance system, how much choice do you think consumers would have in picking doctors?

More choice	10%
Same amount of choice	43
Less choice	47

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on National Health Insurance*, EBRI Report no. G-32 (Washington, DC: Employee Benefit Research Institute, April, 1992).

Note: Based on interviews of 1,000 U.S. adults conducted January 1992.

Which statement do you think best applies to a national health insurance system? People would have to _____ for tests and procedures.

Wait more time	46%
Wait the same amount of time	40
Wait less time	14

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on National Health Insurance*, EBRI Report no. G-32 (Washington, DC: Employee Benefit Research Institute, April, 1992).

Note: Based on interviews of 1,000 U.S. adults conducted January 1992.

Which of these two statements do you agree with most? A national health insurance system would _____.

Save money for the country, because there would be less paperwork and less profit for doctors, hospitals, drug companies, malpractice lawyers, and insurance companies	57%
Cost the country more, because a national health insurance system would be less efficient than private insurance is now	41

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on National Health Insurance*, EBRI Report no. G-32 (Washington, DC: Employee Benefit Research Institute, April 1992).

Note: Based on interviews of 1,000 U.S. adults conducted January 1992.

If the U.S. were to adopt a national health insurance system, do you think the total amount you would pay for health care, in taxes, insurance premiums, and out-of-pocket health care expenses would _____?

Increase	50%
Stay the same	25
Decrease	24

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on National Health Insurance*, EBRI Report no. G-32 (Washington, DC: Employee Benefit Research Institute, April 1992).

Note: Based on interviews of 1,000 U.S. adults conducted January 1992.

If the U.S. were to adopt a national health insurance system, do you think the quality of health care you receive would _____?

Get better	24%
Stay the same	51
Get worse	24

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on National Health Insurance*, EBRI Report no. G-32 (Washington, DC: Employee Benefit Research Institute, April 1992).


Note: Based on interviews of 1,000 U.S. adults conducted January 1992.

Which statement do you agree with most?

Under a national health insurance system, every citizen would have health care coverage	58%
Even if we have a national health insurance system, some citizens would not have health care coverage	41

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on National Health Insurance*, EBRI Report no. G-32 (Washington, DC: Employee Benefit Research Institute, April 1992).

Note: Based on interviews of 1,000 U.S. adults conducted January 1992.



◆ What's in Store?

Four out of ten respondents to an EBRI/Gallup survey felt that the most likely scenario for the future is some change to the current system, but no drastic change, such as the adoption of a national health care system, while 36 percent said they think the United States would adopt some form of national health insurance.

Over the next ten years, which of the following do you think is most likely to occur?

The U.S. will adopt some form of a national health insurance system	36%
No major changes will be made to the current U.S. health care system	22
The U.S. will alter its present health care system somehow, but will not adopt a national health insurance system	41

Source: Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on National Health Insurance*, EBRI Report no. G-32 (Washington, DC: Employee Benefit Research Institute, April 1992).

Note: Based on interviews of 1,000 U.S. adults conducted January 1992.